Medical Scribes

BY CINDY PARMAN, CPC, CPC-H, RCC

According to a January 12, 2014, article in *The New York Times*, physicians once pinned their hopes on computers to help them manage the overwhelming demands of office visits.[1] Instead, this article postulates that electronic health records (EHRs) have become a disease in need of a cure, as physicians do their best to diagnose and treat patients while continuously feeding the data-hungry computer.

Medical Scribe Do's & Don'ts

According to the American Medical Association (AMA), the medical scribe industry is poised for significant growth in the next few years.[2] The Joint Commission (TJC) defines a scribe as an unlicensed individual hired to enter information into the EHR or chart at the direction of the physician or licensed independent practitioner. Of importance, the individual acting as a scribe *does not*:

- Evaluate the patient in any clinical capacity
- Assist directly with patient care
- Make independent decisions
- Interject their personal observations or impressions in the documentation.

The primary function of a scribe is collaborating with the physician in the creation and maintenance of the patient's medical record in a timely manner, which is performed under the supervision of the attending physician.[3] Additional functions of a scribe may include performing other clerical and information technology functions for the physician.[4] For example, the medical scribe may:

- Accompany the physician into the examination room
- Transcribe physician orders for diagnostic tests or medications
- Document procedures performed by the physician
- Research pertinent past medical records
- Enter documentation on patient progress into the medical record
- Document discharge and/or follow-up instructions, as dictated by the physician
- Prepare referral letters as directed by the physician
- Fax or transmit medical information as instructed by the physician
- Collect, organize, format, and catalog data for quality reporting initiatives
- Support workflow and documentation for medical record coding
- Be available for physician concerns and questions and ready to assist at all times.

Medical students often act as scribes in the Emergency Department (ED) or other hospital outpatient settings. This role is not to be confused with the medical student's participation in a specific service as part of their training. According to the Centers for Medicare & Medicaid Services (CMS) in the Medicare Claims Processing Manual:[5]

E/M Service Documentation Provided By Students. *Any contribution and participation of a student to the performance of a billable service (other than the review of systems and/or past family/social history which are not separately billable, but are taken as part of an E/M service) must be performed in the physical presence of a teaching physician or physical presence of a resident in a service meeting the requirements set forth in this section for teaching physician billing.*

Students may document services in the medical record. However, the documentation of an E/M service by a student that may be referred to by the teaching physician is limited to documentation related to the review of systems and/or past family/social history. The teaching physician may not refer to a student's documentation of physical exam findings or medical decision making in his or her personal notes. If the medical student documents E/M services, the teaching physician must verify and re-document the history of present illness as well as perform and re-document the physical exam and medical decision making activities of the service.

While this policy does not prohibit using medical students as scribes, it is important to distinguish between scribed services and patient care performed and documented by the medical student to support a service rendered by the attending physician.

Salary & Certification

The Joint Commission states if an organization chooses to allow the use of scribes, surveyors will expect to see:

- A formal job description that clearly defines the qualifications and extent of responsibilities
- Documentation of orientation and training, competency assessment, and performance evaluations
- Documentation that all information management, confidentiality, and patient rights standards are met by the medical scribe.

Make certain that the range of duties to be performed by the scribe has been carefully considered before hiring an individual for this position. For example, will the scribe only make notes in the medical record, or will he or she also provide patient education materials, distribute the physician's prescriptions, and answer relevant questions? Establishing job functions in advance will help determine if a non-clinical staff person, medical assistant, nurse, or nonphysician practitioner is best suited for the practice setting.

According to *Medical Scribe*, a scribe can attain certification through vocational schools and through community colleges or state universities.[6] These degree programs average nine months to two years and typically result in either a certificate of completion or an associate degree. Bachelor degrees are available for human resource or hospital administration programs, which may be a career path for medical scribes.

Although salaries for scribes may vary regionally and based on the practice setting, beginning scribes generally receive $12 to $18 an hour while certified medical scribes can make up to $28 an hour with benefits. In contrast, the Medical Group Management Association (MGMA) *Physician Compensation and Production Survey 2013* lists the average annual nurse practitioner salary at $93,977 and the average annual physician assistant salary at $92,635.[7] According to the American College of Emergency Physicians (ACEP):[8]

A scribe records the findings of a physician. If the NPP independently obtains the history and performs a physical exam, many third party payers might not consider this as a scribe function but rather an independent service component by a healthcare provider, hence subject to the payer's relevant payment policies.

Most payers do not anticipate that midlevel providers will be hired to scribe for a physician practice or in the outpatient hospital setting.

Documentation

Make certain to review local payer information with respect to documentation for scribed services. For example, the Texas Medical Association states:[9]

For Medicare to cover a service for which you use a scribe, the documentation must clearly indicate:

- *Who performed the service*
- *Who recorded the service*
- *The qualifications (e.g., professional degree, medical title) of each.*

Example: "Leslie Smith, RN, recording E&M service performed by Jay B. Jones, MD."

Further, both the physician and scribe must sign the documentation.

According to WPS Medicare, the J5 MAC Part B Contractor:[10]

Hospital or nursing facility E/M services documented by a Non Physician Practitioner (NPP) for work that is independently performed by that NPP, with the physician later making rounds and reviewing and/or co-signing the notes, is not an example of a "scribe" situation. Such a service cannot be billed under the physician's National Provider Identifier (NPI), since it would not qualify as a split/shared visit. Neither would it qualify as "incident to," which is not applicable in a facility setting. In this case, the service should be billed under the NPP's name and NPI.

In the office setting, the physician's staff member may independently record the Past, Family, and Social History (PFSH) and the Review of Systems (ROS), and may act as the physician's "scribe," simply documenting the physician's words and activities during the visit. The physician may count that work toward the final level of service billed. However, in the same setting, an NPP accomplishing not only the PFSH and ROS, *but the entire visit*, should report those services under his or her own PTAN (Provider Transaction Access Number), unless "incident to" guidelines have been met. Only when the "incident to" guidelines have been met, should the physician's name and NPI be used to bill Medicare for that service.

Under the above circumstances, "scribe" situations are appropriate and can be a part of the physician's billing of services to Medicare. It is important, however, to be certain that the "scribe's" services are used and documented appropriately, and that the documentation is present in the medical record to support that the *physician* actually performed the E/M service at the level billed.

As stated above, scribed documentation must clearly support the name of the individual acting as a scribe, which means that the scribe must use their own security rights when logging into the EHR. Key to scribed documentation is the ability of an EHR to capture *both* the signature of the scribe and the separate signature of the physician. The performing physician remains responsible for all documentation in the patient medical record and must verify that

the scribed notes accurately reflect the service provided.

In addition, a scribe may be able to enter documentation of physician services, but depending on local regulations or provider policy, may not be able to scribe physician orders (e.g., orders for imaging studies, laboratory tests, nutrition services, etc.). Last, TJC guidelines state that verbal orders may not be given by scribes or to scribes.

Return on Investment

Each healthcare organization needs to perform its own return on investment (ROI) summary, but here is a general formula to use when deciding if employing medical scribes will be cost effective.

First, establish the scribe salary and benefits package (if a full-time employee). For the purposes of this example, a salary of $18 per hour ($144 per day) will be used. If benefits are 20 percent of salary (about $28 per day), then the total per diem cost for the scribe will be approximately $172.

Next, determine the increased physician productivity that will result from employing a medical scribe. For example, if the physician spends two hours of the workday performing medical record documentation, and these duties are assumed by the medical scribe, then the physician can potentially see an additional four to six patients during that time period. Physician revenue is therefore increased by approximately $292 to $438 per day.

In this example, the ROI is $120 to $266 per day (the amount of increased physician income minus the salary of the medical scribe). Assuming 220 workdays a year, this represents and annual revenue increase of $26,400 to $58,520 (not to mention more satisfied physicians who can focus on patient care).

The potential downside of a scribe arrangement was recently detailed in an article at www.newsobserver.com:[11]

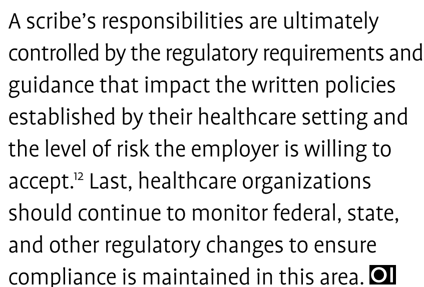
Dr. Donald Gehrig, a St. Paul physician in private practice, said doctors working with scribes likely feel pressure to see more patients in order to cover the cost of a scribe. Patients might be reluctant to talk about issues ranging from sexual health issues and marital problems to abuse in the home when there's a scribe in the room, Gehrig said.

Therefore, even if the numbers make sense, it is essential that the cancer program survey patients and provide physicians with an opportunity to voice concerns related to the employment of medical scribes.

Closing Thoughts

Scribes are responsible for capturing medical information at point-of-care, which allows the physician to deliver hands-on patient treatment. Organizations that employ medical scribes or anticipate hiring for this position should:

- Set goals for the scribe program
- Define the scribe role and responsibilities
- Ensure appropriate examination room setup to maximize scribe use
- Communicate with patients and maintain physician engagement.



A scribe's responsibilities are ultimately controlled by the regulatory requirements and guidance that impact the written policies established by their healthcare setting and the level of risk the employer is willing to accept.[12] Last, healthcare organizations should continue to monitor federal, state, and other regulatory changes to ensure compliance is maintained in this area. OI

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