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Insights

Clarification on Use of Documentation Assistants or Scribes

August 22, 2018

By: Stephanie T. Eckerle and Meghan M. Linvill McNab

The Joint Commission ("JC") recently released a new Standards FAQ ("FAQ") setting forth guidelines that should be followed when physicians or other licensed independent practitioners ("LIPs") use documentation assistants (referred to herein as "scribes") to assist with documentation. In the FAQ, the JC recognizes that while the electronic medical record ("EMR") holds great potential, the immediate effect of the EMR is to increase the time required for physicians and LIPs to document patient encounters and enter orders, and that physicians/practitioners are addressing this by using scribes to assist with the documentation process.

Prior to this FAQ the JC had prohibited scribes from entering orders. However, in the FAQ the JC revises its previous definition and states that it does not support or prohibit the use of scribes. The JC adopts a new definition of documentation assistant or scribe as "an unlicensed, certified, (MA, ophthalmic tech) or licensed person (RN, LPN, PA) who provides documentation assistance to a physician or other (LIP) (such as a nursing practitioner) consistent with the roles and responsibilities defined in the job description, and within the scope of his or her certification or licensure." The JC then sets forth minimum education/training requirements for scribes, and suggests that organizations consider the following components for purposes of defining scribes' roles/responsibilities:

- Organizations should develop a policy or procedure regarding:
  - The process for scribes to perform documentation assistance;
  - The scope of documentation that scribes may enter;
  - Review by physician/practitioner; and
  - Order entry and submission process
- Organizations should develop a job description with minimum qualifications, authorized scope of activities, and ongoing education/training for scribes.

The JC also clarifies that all scribes may, at the direction of a physician or LIP, enter orders into an EMR. However, the use of repeat-backs to verify the orders is recommended. In addition, scribes who are not authorized to submit

orders should leave the order as pending for a certified or licensed personnel to activate or submit the orders after verification. The JC also explains that transcribing an order into the EMR while providing documentation assistance is not considered a verbal order.

Note, CMS does not provide official guidance on the use of scribes, although CMS has released the following that briefly address scribes:

- FAQ on Meaningful Use Objectives and Measures that briefly addresses the use of scribes and CMS' position that, in general, scribes are not included as medical staff that may enter orders for purposes of the computerized provider order entry (CPOE) meaningful use objective, but then hedges that the ability to enter an order relates to the individuals training, knowledge and experience. *See* CMS FAQ on Meaningful Use Objectives and Measures, FAQ 2851.
- Transmittal stating that a scribe is not a provider of items or services and therefore is not required to sign/date notes the scribe enters. Rather, the treating physician/LIP should sign the note affirming that the note adequately documents the care provided. *See* CMS Program Integrity Manual (Pub 100-08), Transmittal 751 (Oct. 20, 2017).

Please contact Stephanie T. Eckerle, Meghan M. Linvill McNab or your regular Krieg DeVault attorney with any questions about using documentation assistants or scribes.