

# The Use of Scribes



On June 6, [Medicare Transmittal 713](#) will take effect, addressing CMS' stance on scribes (an individual hired to enter information into the medical record at the direction of a physician or licensed independent practitioner) signature requirements. Confusion has existed in the past as to what the requirements were for documenting the use of a scribe in the medical record and whose requirements to follow, be it CMS, The Joint Commission, Medicare carriers or professional bodies such as the American Health Information Management Association or the American College of Emergency Physicians.

CMS' new guidance states that *"...When a scribe is used by a provider in documenting medical record entries (e.g. progress notes), CMS does not require the scribe to sign/date the documentation....Reviewers shall not deny claims for items or services because a scribe has not signed/dated a note."*<sup>1</sup>

This stance is in sharp contrast to guidance from agencies such as The Joint Commission, which accredits many of Diamond's owned and managed facilities. While The Joint Commission has neither endorsed nor prohibited scribes, they have provided insight into their expectations surrounding scribe documentation in the medical record. Most notably, that *"the role and signature of a scribe must be clearly identifiable and distinguishable from that of the physician or licensed independent practitioner or other staff"* and evidencing Joint Commission standards, RC.01.01.01, *"The organization maintains complete an accurate clinical/case records"* and RC.01.02.01, *"Entries in the clinical/case record are authenticated."*

**So what is a provider or organization to do?** Though CMS' new guidance does not require the signature of a scribe in the medical record, Diamond recommends providers and organizations understand and comply with the Joint Commission's guidance.

From an operational and compliance perspective, scribe policies should be built to meet best practice standards for quality and accreditation that take into account conditions of participation and surveyor standards. Being able to clearly identify all staff documenting in a paper or electronic record, as well as what portions were documented by whom, is a critical component in record maintenance and information management. To aid our providers and client hospitals, a sample policy that can be tailored to each facility's needs and is located on Diamond's Corporate Integrity SharePoint site<sup>2</sup>.

<sup>1</sup><https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R713PI.pdf>

<sup>2</sup><https://www.diamondhealth.com> → Employees → SharePoint → Corporate Integrity → Policies and Procedures → Sample Policies and Forms → Sample Policy\_Scribe Services