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On the topic:

Medical Scribes - Documentation & Optimization

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Medical Scribes Documentation & Optimization

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Overview

• Definition and History of Scribe
• Roles and Responsibilities
• Scribe Legal Considerations
• Implement Scribe Documentation Guidelines
• Common Documentation Duties for Medical Scribes
• Benefits of Having a Scribe
• Evaluate the Cost of a Scribe
• Tips for Managing and Monitoring Scribes
• Monitor Education and Qualification
• Maintain Provider Engagement

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Why Utilize Scribes?

- Transitioning to electronic health records (EHRs) and the need for more detailed documentation
- Increased time spent capturing this information
- Less face-to-face time with providers viewed as “hindrance to quality of care”

Definition of Scribe

- The Joint Commission defines a scribe as
  “An unlicensed individual hired to enter information into the electronic health record (EHR) or chart at the direction of a physician or licensed independent practitioner…”

Source: www.jointcommission.org
**History of Scribe**

- The job of being a scribe is an ancient one, and has its roots in ancient Egypt, where a scribe was considered one of the most important professions.

- At that time, scribes were used primarily for copying texts and making records using hieroglyphics. Scribes were part of the royal court and did not have to pay taxes.

- With the invention of printing over the next few millennia, the profession became obsolete… until now!

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**CMS Guidelines for the Use of Scribes in Medical Record Documentation**

- "Scribe" situations are those in which the physician utilizes the services of his, or her, staff to document work performed by that physician, in either an office or a facility setting.

- In Evaluation and Management (E/M) services, surgical, and other such encounters, the "scribe" does not act independently, but *simply documents the physician's dictation and/or activities during the visit*.

- The physician who receives the payment for the services is expected to be the person delivering the services and creating the record, which is simply "scribed" by another person.
CMS Guidelines for the Use of Scribes in Medical Record Documentation

- 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*, unless "incident to" guidelines have been met (see IOM 100-02, Chapter 15, Section 60.2).

- Only when the "incident to" guidelines have been met, should the physician's name and NPI be used to bill Medicare for that service.
Physicians using the services of a "scribe" must adhere to the following:

- E/M guidelines for the place of service of that visit. According to the Centers for Medicare & Medicaid Services (CMS) Internet-only Manual (IOM), Publication 100-04, Chapter 12, Section 30.6.1 [Link to external site].
- Documentation supports both the medical necessity of the level of service billed and the level of the Key Components required of the service in the 1995 E/M Guidelines or the 1997 E/M Guidelines [Link to external site] (whichever is applicable).
- Record entry notes the name of the person "acting as a scribe for Dr. X."
- Physician co-signs the note indicating the note is an accurate record of both his/her words and actions during that visit.


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Roles and Responsibilities of Medical Scribes

- To capture accurate and detailed documentation (handwritten, electronic, or otherwise) of the encounter in a timely manner
- Not permitted to make independent decisions or translations while capturing or entering information into the health record or EHR beyond what is directed by the provider
- Assisting the provider in navigating the EHR
Roles and Responsibilities of Medical Scribes

- Responding to various messages as directed by the provider
- Locating information for review (i.e., previous notes, test results, and laboratory results)
- Entering information into the EHR as directed by the provider
- Researching information requested by the provider

• Dependent upon the provider, practice, and setting.

• Role must be clearly defined and communicated, with documented job descriptions and policies and procedures to optimize their use and minimize challenges.

• Important to obtain a signed agreement between the provider and the scribe delineating expectations and accountability.
Considerations for Utilizing Clinical Assistants as Scribes

- A provider may select a clinical assistant (non-licensed clinical staff) who has performed clinical duties and worked with the provider to perform scribe services.

- It is NOT recommended to allow an individual to fill the role of scribe and clinical assistant simultaneously during the same encounter
  - Raises legal and other issues regarding job role and responsibilities
  - EHR security rights (role-based access) for a scribe and clinical assistant are different

Considerations for Utilizing Clinical Assistants as Scribes

- Scribes have nearly the same security rights as a provider.

- Security rights are more limited for clinical assistants than those of the provider.

- A clinical assistant enters information independently and only within the individual's scope of practice.

- When a scribe is acting as a clinical assistant during the same encounter, the scribe must log in with one set of security rights as a clinical assistant, log out, and then log back in with another set of rights to perform the scribe duties.

- To avoid this situation, limit the scribe to filling one role during the single encounter
Sample Job Description

• Medical Scribes are individuals trained in medical documentation who assist a physician throughout their shift. The primary goal of a Medical Scribe is to increase the efficiency and the productivity of the physician they are working for. The Medical Scribe allows the doctor to focus on what is most important, the patient.

• A summary of a Medical Scribes duties include performing all clerical and information technology functions for a physician in a clinic setting. This includes primary responsibility of the operation of the electronic health records and electronic dictation system. You also must be able anticipate physician needs to facilitate the flow of clinic.

QUALITIES REQUIRED

• Medical Scribes must be discreet, tactful, and modest in performance of duties so as not to distract medical staff from patient care.

• Good judgment, organizational ability, initiative, attention to detail, and the ability to be self-motivated are especially important when working as a Medical Scribe.

• You must be adaptable and versatile since you will be responsible for many tasks. Good attendance is also an important element of this job since you will be hard to replace.
Policies and Protocols are Important – Sample Job Duties

• Detailed job duties and responsibilities of a Medical Scribe:

1. Accurately and thoroughly document medical visits and procedures as they are being performed by the physician, including but not limited to:
   • Patient medical history and physical exam,
   • Procedures and treatments performed by healthcare professionals, including nurses and physician assistants.
   • Patient education and explanations of risks and benefits.
   • Physician-dictated diagnoses, prescriptions and instructions for patient or family members for self-care and follow-up
   • Prepare referral letters as directed by the physician

Sample Job Duties

2. Dictation/faxing/phone calls and clerical tasks.
   • Medical Scribes are asked to prepare referral letters as directed by the physician, via dictation or summary of the medical record.
   • Scribes also ensure that letters are mailed or faxed on a daily basis to all physicians involved in a patient’s care, and with all copies of pertinent reports or tests attached.
   • Scribes may be asked to research contact information for referring physicians, coordinate referrals, prepare operative reports, make phone calls, and other clerical tasks as assigned.
Sample Job Duties

3. Medical Scribes also spot mistakes or inconsistencies in medical documentation and check to correct the information in order to reduce errors. All addenda must be signed off by a physician.

- Medical Scribes ensure that all clinical data, lab or other test results, the interpretation of the results by the physician are recorded accurately in the medical record. Alert physician when chart is incomplete.

- Medical Scribes must comply with specific standards that apply to the style of medical records and to the legal and ethical requirements for preparing medical documents and for keeping patient information confidential.

Sample Job Duties

4. Medical Scribes collect, organize and catalog data for physician quality reporting system and other quality improvement efforts and format for submission. You will assist in developing and maintaining systems to track patient follow up and compliance.

5. Attend trainings on diverse subjects such as information technology, legal, HIPAA and regulatory compliance, billing and coding. Quickly assimilate new knowledge into processes and procedures. Medical Scribes proofread and edit all the physician’s medical documents for accuracy, spelling, punctuation, and grammar.
Sample Qualifications

• To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

1. **Language Skills** – The ability to write routine reports and correspondence. Medical Scribes must be proficient in typing and good at spelling, punctuation, grammar, and oral communication. Must be able to listen to complex medical information and summarize in a clear, complete, and concise fashion. Excellent English composition skills required to generate professional, polished writing at a high rate of production. Handwriting must be clear and legible.

2. Understanding of medical terminology, anatomy and physiology, diagnostic procedures, pharmacology, and treatment assessments to the extent required to understand and accurately transcribe dictated reports. Translate medical abbreviations into their expanded forms.

3. **Mathematical Skills** – Ability to add, subtract, multiply, and divide in all units of measure, using whole numbers, common fractions, and decimals. Prepare and interpret charts and graphs. Have the ability to compute ratio and percent.

4. **Reasoning Ability** – Ability to apply common sense understanding to carry out instructions furnished in written, oral, or diagram form. Ability to apply logic and draw conclusions based on knowledge. Have the ability to refer to reference materials to solve problems.
Sample Qualifications

5. **Computer Skills** – To perform this job successfully, an individual should be able to learn and use all functions of electronic medical record software and transcription software. Must accurately enter data into a database, search for information, send and receive email and attachments. Must be proficient in Microsoft Word in order to prepare correspondence, medical reports, and other documents. Must use Microsoft Excel to prepare flowcharts and organize data. Must use the internet to access schedules, research information, etc.

6. **Other Skills and Abilities** – Must be able to type words and numbers quickly and accurately; **must comply with HIPAA confidentiality standards when accessing or communicating patient information.**

Sample Qualifications

7. **Physical Demands** – While performing the duties of this Job, a Medical Scribe is regularly required to stand; sit; walk; use hands to type, write with a pen, finger, handle, or feel; reach with hands and arms and talk or hear. The Medical Scribe is occasionally required to climb or balance and stoop, kneel, crouch, or crawl. The Medical Scribe must regularly lift and/or move up to 10 pounds. Specific vision abilities required by this job include close vision, distance vision, color vision, depth perception and ability to adjust focus.

- As you can see, Medical Scribes are an invaluable asset to physicians in busy emergency departments, hospitals, or clinics. With more time to focus on interacting with their patients, doctors see more patients while the Medical Scribe is documenting the patients visit and care plan – alleviating that burden from the doctor. As you can see, Medical Scribes are becoming more and more important to a doctor and a profession that is in high demand.

Legal Considerations

• State laws must be reviewed to ensure compliance and proper use of scribes by mid-level providers.

  For example:
  In some states, physician assistants are not considered licensed independent practitioners and therefore, may not be eligible to use scribes.

• Scribe responsibilities are controlled by the regulatory requirements and policies established by a healthcare setting, and the level of risk an employer is willing to accept.

Legal Considerations

• 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.

• In the opinion of Texas Medical Association Trustee Douglas Curran, M.D., “It gives you an opportunity to touch patients, to lay hands on them.” (“Hiring Scribes”, www.texmed.org by Kara Nuzback, Reporter, August, 2014)
Implement Scribe Documentation Guidelines

The Joint Commission released guidelines in 2011 recognizing that scribes may be used across various settings:

- Verbal orders may neither be given to or by scribes.
- Signing (including name and title/credentials) and dating of all entries into the medical record is necessary.
- Must be clearly identifiable and distinguished from that of the physician or licensed independent practitioner and other staff.

For example:

“Scribed for Dr. (name of physician) by (name of scribe), (date and time of entry).”

- Orientation and training must be specific to the organization and role.
- Competency assessment and performance evaluations should be performed.
- If the scribe is employed by the physician, all non-employee HR standards also apply.
- Scribes must meet all information management, HIPAA, HITECH, confidentiality, and patient rights standards, just as other medical personnel.
Common Documentation Duties for Medical Scribes

- History of the patient's present illness
- Review-of-systems (ROS) and physical examination.
- Vital signs and lab values
- Results of imaging studies
- Progress notes
- Continued care plan and medication lists

Scribe’s Notes

- Documentation of scribed services should indicate who performed the service and who recorded the service:
  - The name of the provider providing the service
  - The date and time the service was provided
  - The name of the patient for whom the service was provided
  - Authentication, including date and time
**Scribe Documentation Example**

- The name, title, and signature of the scribe.
- The name of the practitioner providing the service.
- Sample Scribe attestations:
  - Entered by_____________________, acting as scribe for Dr./PA/NP_____________________."
  - Signature_________________ Date________________
    Time__________________
  - I personally scribed for Dr. ______ on 12/10/XX at 0736. Electronically signed by scribe_____ on date _______ at time ________.

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**The Provider’s Notes**

- Documentation of services should must include:
  - Affirmation of provider’s presence during the time the encounter was recorded
  - Verification that the provider reviewed the information
  - Verification of the accuracy of the information
  - Any additional information needed
  - Authentication, including name and time
Provider’s Documentation Example

- Sample Practitioner attestations:
  - "The documentation recorded by the scribe accurately reflects the service I personally performed and the decisions made by me." Signature_________________________ Date__________________________ Time________________________

- Portions of this note were transcribed by scribe ________. I, Dr. ________, personally performed the history, physical exam and medical decision making; and confirmed the accuracy of the information in the transcribed note. Authenticated by Dr. ________________ on __________ at _________.

Source: https://www.acep.org/Physician-Resources/Practice-Resources/Administration/Financial-Issues-/Reimbursement/Scribe-FAQ/

Benefits for Practice

- Scribes focus on capturing medical information at the point of care.
- Physicians focus on bedside manner and provide hands-on, attentive, face-to-face care that increases both patient and provider satisfaction.
- Patients may perceive their visit negatively if the provider spends the majority of their time looking at the computer monitor instead of the patient.
Benefits for Practice

• Improves the overall quality of documentation
  • granularity,
  • level of specificity,
  • improved documentation to support “meaningful use” EHR Incentive Program
  • improve compliance with quality monitors, billing and reimbursement
• Increases provider efficiency and productivity; more time for physicians to engage in patient care

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Benefits for Practice

• Quicker availability of scribes’ documentation
• More detailed and comprehensive documentation
• The patient’s plan and details of the encounter captured in “real time”
• Increased physician job satisfaction, retention and lower burnout rates as they spend the day doing what they were trained to do

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Study on Benefits of Scribes

• A 2013 study published last year by the National Center for Biotechnology Information found physician productivity in a cardiology clinic was 10 percent higher when scribes were used.

• The study compared the productivity during routine clinic visits of 10 cardiologists using scribes versus 15 cardiologists without scribes.

• According to the study, physicians with scribes saw 9.6 percent more patients per hour than physicians without scribes.

Study on Benefits of Scribes

• Physician productivity in a cardiology clinic, overall, was 10 percent higher for physicians with scribes.

• This study showed physicians with scribes generated an additional revenue of $24,257 by producing clinical notes that were coded at a higher level.

• Total additional revenue generated was $1.4 million at a cost of roughly $99,000 for the employed scribes.

Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3745291
Improving Patient Engagement

• While a medical practice may hire scribes to improve efficiency and capture revenue, remember too that scribes can also play an important role in enhancing the patient experience.

• Having a scribe in the room allows the physician to focus on key drivers of patient experience such as eye contact, body language, position (sitting vs. standing), therapeutic touch, and active listening.

• During the physical exam, physicians are able to describe and articulate the findings to the patient and the scribe at the same time, making the patient feel informed and involved in their care.

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Improving Patient Engagement

• Research shows that scribes can indeed have a positive effect on patient experience. One study published in the American Journal of Emergency Nursing found that the introduction of scribes into the emergency department resulted in decreased patient length of stay, and emergency physician satisfaction and increased patient satisfaction.

• Another study published in Dove Medical Press Ltd showed that the use of scribes resulted not only in improved physician productivity, but also in an increase in patient satisfaction.

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Improving Patient Engagement

• The presence of a scribe can enhance the physician's ability to function as an active listener.
  – For instance, when summarizing a conversation for the benefit of the scribe, the physician may state "What I hear you saying is that you've been having abdominal pain the last three weeks, but that it has gotten much worse in the last 24 hours."
  – This validates the physician is attentive to the patient's concerns while it allows the scribe to summarize the important notes.

Example of what a patient interaction might sound like using the 'A' and 'I' in Studer Group's AIDET® communication framework:

<table>
<thead>
<tr>
<th>A</th>
<th>Acknowledge</th>
<th>Provider makes eye contact, smiles and acknowledges patient and family members upon entering the room.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Introduce</td>
<td>“Hello, Ms. Phillips. My name is Dr. Kosowsky and I’ll be the physician taking care of you today. I’d like to introduce my colleague, Lisa. Lisa is a scribe at in our emergency department, and I’ve had the pleasure of working with her for the last 3 years. Her role is to document our encounter and to make sure your medical record is complete, accurate and reflects everything we discussed. This allows me to spend more time face-to-face with you, focusing on your concerns and how we can try to address them.”</td>
</tr>
</tbody>
</table>

Source: https://www.studergroup.com/aidet

Managing the Cost

- Cost allocation options:
  - Provider
    - provider employs the scribe
    - pays hourly wage
  - Provider Practice
    - regulate what scribe services will be and use current transcription compensation model (paying per line, per minute, or both)
  - Shared
    - providers and practice/organization share the cost
    - providers who use scribes are responsible for a certain percentage of the cost
Managing the Cost

- Time and motion studies
- Tools used to scribe
  - Dictation
  - Handwritten
  - Data entry
    - Turnover time
    - Specialties assigned
    - Patient volume
      - Number of lines scribed
      - Number of records scribed
      - Account turnaround

So, let’s look at the numbers..

**What is the average revenue per patient visit?**

- Number of patients seen in last three months: 1056
- Receipts for physician’s services in last three months: $85,000
- Average revenue per patient visit: $80.49

**How many more patients will you be able to see in a day with a scribe?** The most conservative approach is to assume the scribe will get you to pre-EHR levels of productivity, although it is likely that an effectively utilized scribe will make you more productive.

- Number of patients seen in three months just before EHR implementation: 1320
- Number of weekdays in three months (3x22): 66
- Number of patients per day, pre-EHR: 20

Source: http://www.physicianspractice.com/blog/costs-vs-benefits-is-hiring-a-medical-scribe-worth-it
How many patients do you currently see each day?

- Number of patients seen in two months: 660
- Number of weekdays in two months: \((2 \times 22) = 44\)
- Number of patients per day, post-EHR: 15

What is the currently unmet demand for your services? The most conservative approach is to assume the demand for your services is what it was pre-EHR, although there may have been unmet demand then.

- Patient demand per day: 20 visits

Estimated monthly increase in revenue with addition of medical scribe

- Average revenue per patient visit: $75
- Average days per month: 22
- \(5 \times 75 \times 22 = 8,250\)

Source: http://www.physicianspractice.com/blog/costs-vs-benefits-is-hiring-a-medical-scribe-worth-it

Estimated monthly increase in costs with addition of medical scribe

- Monthly salary: \($43,000/12 = 3,583\)
- Monthly taxes and benefits: \(3,583 \times 3 = 1,075\)
- \(3,583 + 1,075 = 4,658\)

Marginal monthly income

- Increase in monthly revenue - increase in monthly costs = increase in monthly income
- \(8,250 - 4,658 = 3,592 \times 12 = 40,084\)

Source: http://www.physicianspractice.com/blog/costs-vs-benefits-is-hiring-a-medical-scribe-worth-it
Challenges

• A non-physician provider (i.e., nurse practitioner, physician assistant) in the role of a scribe in a physician setting would be counterproductive in most cases.

• Scribes in the exam room may cause patients to be less honest and forthcoming with pertinent information for accurate diagnosis and treatment that would impact quality of care.

• Using scribes will change workflows. These workflows need to be redefined and streamlined.

• Provider verification and authentication of scribed documentation for accuracy may slow down workflow.

• If scribe is inexperienced and does not have medical terminology and clinical workflow knowledge, this may cause documentation errors leading to greater issues.

Challenges

• Some providers may not take the time to review scribed entries for accuracy before authentication. These errors can effect patients’ plan of treatment, coordination of care, coding, billing and other documentation requirements due to lack of detail and accurate documentation in the heath record.

• Scribes in the exam room may not result in the providers’ ability to generate additional revenue to offset the expense of the scribe.

• When a scribe is not available, providers may not be able to navigate the system independently or efficiently.
Tips for Managing and Monitoring Scribes

• Manage and maintain with the same quality assurance and compliance expectations of other patient care documentation.

• Must be included in overall compliance program.

• Monitored for accuracy, adherence to guidelines

• Develop policies and procedures, training, and overall management.

Scribe Education and Qualification

• The demand for medical scribes is rising

• Many organizations are concerned about the appropriate skill set, competency, and training of scribes.

• The only certification program currently offered for scribes is issued by the American College of Clinical Information Managers (ACCIM).

• To be eligible for certification as a clinical information manager (CIM), individuals must have worked at least 100 hours as an unassisted scribe and have received training in an approved CIM training program.
Clinical Information Manager Certification and Aptitude Test (CIMCAT)

- Medical terminology and technical spelling
- Basic anatomy
- Basic coding
- HIPAA compliance
- Medico-legal risk mitigation
- Computer aptitude, including functions of the EHR
- Essential elements of documenting a provider-patient encounter
- Centers for Medicare and Medicaid Services Physician Quality Reporting System (PQRS)
- The Joint Commission’s Accountability Measures
- General knowledge of the roles and responsibilities of medical personnel

Provider Engagement

- Physician providers need to remain connected to all patient information.
- Provider’s review and authentication of the scribed documentation ensures medical procedures have been performed, ordered, and documented, electronic record alerts have been addressed, and patient care has been accurately recorded.
Tips, Tools, and Techniques

- View current processes to evaluate need for scribe(s) to increase efficiencies, improve patient/provider satisfaction
- Conduct cost vs. benefits analysis
- Define roles and responsibilities
- Be aware of your individual state’s regulatory requirements
- Monitor your scribe program, adhere to compliance standards, and seek continuing training opportunities
- Maintain provider engagement

References


QUESTIONS?

• Thank you!

• Get your questions answered on PMI’s Discussion Forum:
  http://www.pmimd.com/pmiForums/rules.asp