

	Policy No.: 313	Signature: 	
	Created: 10/2003	Reviewed: 5/2018	Revised: 5/2018

USE OF SCRIBES AND MEDICAL STUDENTS

SCOPE:

All Envision Physician Services and its subsidiaries' (the "Company") colleagues providing medical services. For purposes of this policy, all references to "colleague" or "colleagues" include temporary, part-time and full-time employees, independent contractors, clinicians, officers and directors.

PURPOSE:

The purpose of this policy is to set forth documentation guidelines for scribes and medical student documentation.

POLICY:

This policy outlines the use of scribes and medical students who in their assigned roles may be responsible for recording information in the patient record.

1. Scribes:

A scribe is also known as a Physician Record Assistant (PRA). Their line of responsibility is limited to being a documentation technician. Their duties are limited to accompanying a physician during patient care services in order to transcribe a history during the physician's interview with the patient. The PRA records the physical examination or procedures as they are rendered by the physician and orders any diagnostic tests as the physician explains them to the patient. The PRA may also record test results, diagnostic impression, prescriptions and family discussions or follow-up instructions in accordance with recommendations and practice design of the physician to whom he/she serves. The PRA is not licensed to perform patient care activities and does not act independently.

Documentation of scribed services must clearly indicate:

- Who performed the service;
- Who recorded the service;
- A notation from the physician that he/she reviewed the documentation for accuracy (Upon review of the documentation, the physician should correct or add any supplemental information, as necessary); and
- Signature/authentication and dated by the performing physician/NPP.

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- Sample Practitioner attestations:

1. "The documentation recorded by the scribe accurately reflects the service I personally performed and the decisions made by me." Signature_____

Date_____Time_

2. "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 _____

2. Medical Student Documentation:

Most hospital organizations have policies and procedures outlining the activities of medical students and what documentation from students can be entered in the patient record. With regard to the recording of the history and physical by the medical student, the history and physical entered into the patient record must be performed, documented and authenticated by a licensed independent provider with approved clinical privileges, or delegated to a non-licensed provider (see exception below) when allowed by the organizational bylaws. Since the medical student is not licensed, they do not meet the aforementioned criteria. In their role as ancillary health care personnel, the medical student is able to solicit from the patient and record those answers in the medical record regarding the system review (ROS) and past family and social history (PFSH).

Additionally, upon approval by individual organizational medical staff and governing bodies and in accordance with their bylaws and regulations, students may provide direct patient care activities under the direct supervision of a Teaching Provider (TP). If the medical student documents E/M services, the TP must verify and redocument the history of present illness (HPI), as well as perform and redocument the physical exam (PE) and medical decision making (MDM) components of the encounter. The licensed physician ultimately is legally accountable for the student's activities and documentation. (See Policy 309 for documentation and supervision requirements.)

A medical student (not a resident) may serve in the role of a PRA (scribe) so long as the delineation of responsibilities is in accordance with those activities outlined above.

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All departments and individuals shall comply with the Company's billing and coding policies, and interpretations different from or actions inconsistent with this policy are prohibited.

POLICY REVIEW

The Ethics & Compliance Department will review and update this Policy and all HIPAA policies when necessary in the normal course of its review of the Corporate Ethics & Compliance Program.