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## What You Need to Know About Unlicensed Scribes In Your Hospital

Perhaps you have noticed that when some of your medical staff visit their patients in the hospital there is another individual with them in tow. Chances are that the individual accompanying the physician is a “scribe” and that they are there to assist the physician with his or her documentation, along with navigating the medical record for relevant clinical information. While the role of the scribe today, in substance, is not very different from the role of a scribe in ancient times, the use of scribes in a regulated environment such as a hospital presents some unique risks and legal challenges that should not be ignored. Moreover, given increasing demands for more comprehensive documentation from third-party payers and the omnipresent electronic health record spurred by the CMS Meaningful Use Program, the use of scribes is likely to continue to grow. In order to avoid running afoul of legal and regulatory requirements, hospitals should be prepared to provide clear direction, by way of policies, education and auditing, to inform, guide and monitor all those involved in using or relying upon scribes in the hospital setting.

### **1. Training and Health Clearance.**

Currently, there are no specific federal regulatory guidelines that set forth the job qualifications or training required for an individual to perform the role of a scribe. While some scribes may in fact be licensed individuals such as nurses, physician assistants or nurse practitioners, many are unlicensed individuals without any prior experience in the health care field. Despite the lack of specified job qualifications or training, the very nature of the role of a scribe requires that the scribe accompany the physician to the patient’s bedside. Given the inevitable exposure to the patient (albeit no physical contact), hospitals should, at a minimum, require that the scribes undergo the same basic orientation and training that all hospital workforce members are required to receive.

Most hospitals already have robust processes in place for orientation, education and health screening of their workforce. Although some physician employers may want to assume responsibility for providing evidence relating to the scribe satisfying certain health clearance requirements, the hospital may want to consider making its own occupational health services available to the scribe. To the extent that the hospital does provide such health clearance services, it is advisable that the physician himself or herself incur

the costs associated with the screening because it is important: (1) that the scribes are viewed as agents of the physician and not the hospital; and (2) to avoid having the hospital run afoul of Stark and/or the Anti-kickback laws by providing illegal remuneration (i.e. benefit) to the physician. Notwithstanding, with respect to HIPAA and other education provided to all workforce members, including volunteers, those services may be provided by the hospital, at no cost to the physician, simply because the hospital has a strong interest in making sure that the required regulatory substantive content is being covered in the training.

## **2. Privacy Concerns.**

The use of scribes in the hospital could potentially raise privacy concerns among your patients. Most patients are not bold enough to question the presence of others accompanying their physician to their bedside, and if your hospital is a teaching hospital, it is not unusual for patients to see a large entourage of anonymous white coats accompanying their physician each time the physician rounds. However, there are some patients who will have strong privacy concerns and question the presence and necessity of each of the individuals presenting at their bedside, including the scribe. By way of example, one orthopedic surgeon started using a scribe to accompany him into all settings in the hospital. The physician did not explain to the patient what the role of the scribe was and how he was assisting the physician. After leaving the hospital, the patient contacted the hospital's licensing authority and made a complaint against the hospital alleging that, because he never consented to the scribe having access to his health information, his privacy had been violated. Upon investigating the matter, (the hospital confirmed that the scribe documented in the patient's medical record on behalf of the physician and accompanied the physician into the operating room to observe the case), the hospital quickly discovered that neither the hospital nor the physician had provided the scribe with any HIPAA privacy or security training. The state licensing authority cited the hospital for privacy violations and required the hospital to implement an extensive corrective action plan related to scribes in the hospital. This example demonstrates the importance of having clear policies delineating the role of the scribe, including training and accountability issues.

## **3. Medical Record Entries and Meaningful Use.**

Hospital policies must also guide the medical staff as to any limits as it relates to a scribe making entries into the medical record on behalf of the physician. If the state law applicable to your hospital does not have any specific guidance with respect to whether an unlicensed individual such as a scribe can make entries in the legal medical record, the hospital must, at the very least, comply with both the Medicare Conditions of Participation and the Joint Commission Standards. The Medicare Conditions of Participation set forth in 42 CFR § 482.24(c)(1) require that "all entries in the medical record must be dated,

timed, and authenticated, in written or electronic form, by the person responsible for providing or evaluating the service provided.”<sup>1</sup> Specifically, the hospital must have a policy requiring that each practitioner take specific action to verify that the entry being authenticated is his/her entry or that he/she is responsible for the entry, and that the entry is accurate. The process of authentication requires that the practitioner responsible for the entry sign and date the entry even if the date and time of the entry is different from the actual time when the practitioner authenticates the entry. While Medicare does not require that the person making the entry on behalf of the practitioner actually sign the entry, it is advisable that hospital policy require that the scribe sign his/her note in addition to it being authenticated by the practitioner responsible for the accuracy of the entry in the event that subsequent legal and regulatory issues arise. If the hospital is going to grant the scribe access to its electronic health record, the scribe will need to undergo training as it relates to the obligations associated with such access privilege, including but not limited to the process for authenticating access. Most importantly, the scribe must understand that access to the system is a privilege that can be terminated by the hospital at any time.

With respect to the CMS Meaningful Use Program Phase 2 Computerized Provider Order Entry (“CPOE”) requirements, only “licensed healthcare professionals and credentialed medical assistants can enter orders into the medical record for purposes of including the order in the numerator for the objective of CPOE if they can originate the order per state, local and professional guidelines. Credentialing for a medical assistant must come from an organization other than the organization employing the medical assistant.”<sup>2</sup> Thus, when a physician is working with an unlicensed scribe, the practitioner responsible for the patient’s care must enter his/her own medication, laboratory and radiology orders if the hospital desires to satisfy CMS Meaningful Use Program requirements, unless the scribe is either a licensed person or the medical assistant has undergone training from an independent medical organization other than the hospital. According to CMS, by having the ordering practitioner enter the orders, he/she is alerted by the CPOE system of drug interactions, errors and duplications that would otherwise be missed if a non-ordering surrogate was entering the orders. Please note, if the scribe is also a nurse practitioner or physician assistant in your hospital and is both credentialed and permitted by your state law to enter such orders, the issues applicable to a non-licensed person writing orders for laboratory, medication or radiology services is not an issue under the CMS Meaningful Use Program. Regardless of the CPOE requirements under the CMS Meaningful Use Program, the hospital may want to impose a requirement in its policies that states that

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1 See State Operations Manual, Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals (Rev. 105, 03-21-14) at [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_a\\_hospitals.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf).

2 See [http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/Stage2\\_EPCore\\_1\\_CPOE\\_MedicationOrders.pdf](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/Stage2_EPCore_1_CPOE_MedicationOrders.pdf).

when orders are written by an unlicensed person, they should not be acted upon until authenticated.

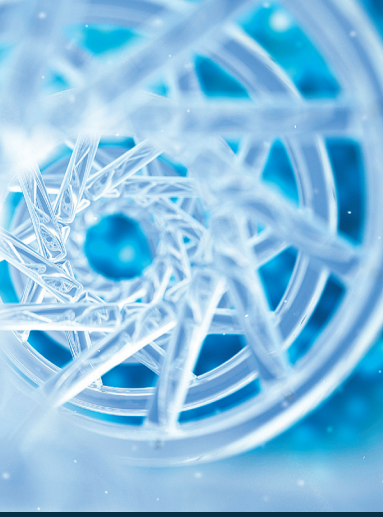
It is also worth noting that the Joint Commission's position is that scribes should not be utilized for order entry because it presents too much risk for error. Specifically, in a July 12, 2012 FAQ, the Joint Commission instructed surveyors to look for:

- A job description that recognizes the scribe's unlicensed status and clearly defines the scribe's qualifications and job responsibilities;
- Scribe orientation and training, competency assessment and performance evaluation;
- The scribe's compliance with HIPAA, confidentiality and patient rights standards;
- Performance improvement review that ensures scribes are not acting outside the scope of the job description; and
- Proper authentication of all scribe entries:
  - Signature stamps are not permitted with scribe entries;
  - Authentication must occur *before* the physician and scribe leave the patient care area; and
  - Authentication cannot be delegated to another physician.

Although the Joint Commission does not recommend against or prohibit the use of scribes in a hospital setting, it does expect that the practice be closely regulated and monitored in the hospital setting.

#### **4. Risk Management Issues.**

There are two main risk areas when using scribes in the hospital setting. First, there is risk that the scribe may exceed the scope of their role (e.g. lay hands on the patient or do more than acting as a recorder on behalf of the physician). Second, there is risk that the scribe will make an incorrect entry into the medical record which results in harm to the patient. To limit these risks, hospitals would benefit from clear policies that: (i) delineate the role of the scribe; and (ii) require the responsible practitioner to authenticate every entry made by the scribe in a prompt manner. To further reduce risk, hospital policies should clearly state that scribes are acting on behalf of the physicians and are not agents of the hospital. A certification by the physician and the scribe that the scribe is not an employee of the hospital is also recommended and could most appropriately be administered through the hospital's medical staff office before the scribe is issued a hospital identification badge. Finally, physicians who are accompanied by scribes in the hospital should provide a certificate of insurance evidencing that the scribe is covered under the physician's professional liability insurance.



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## **5. Policies Addressing Scribes.**

If hospitals embrace the practice of using scribes in the hospital, they should develop a hospital-wide policy that addresses the: (i) the role of the scribe, including the orientation, health care clearance and training that each scribe must receive; (ii) a clear statement that unlicensed scribes may not have physical contact with the patient even if they are assisting the physician; (iii) a clear statement relating to entries by the scribe in the legal medical record, including the fact that all entries must be authenticated by the practitioner responsible for the patient; (iv) a statement that unlicensed scribes may not enter orders in the medical record, or in the alternative, if the unlicensed scribe enters an order, a statement that it may not be acted upon by others until properly authenticated by the practitioner responsible for the patient; (v) whether or not your hospital imposes certain physical restrictions regarding the permissibility of scribes entering certain physical areas, such as the operating room or procedure rooms; and (vi) a statement that scribes working on behalf of private physicians are agents of the physician, not employees or agents of the hospital and must be covered by the physician's professional liability coverage. To further address the presence of scribes in the hospital, the hospital may want to also consider requiring, as part of its policy, that the physician introduce the patient to the scribe upon entry to the patient's room, along with explaining the role of the scribe. Finally, the hospital may want to consider stating in its notice of privacy practices that scribes are used in the hospital to assist physicians with documentation and performing other medically related administrative tasks.

## **6. Scribes Who Are Licensed.**

Some physicians will round with their employed physician assistants and nurse practitioners and to the extent that these licensed individuals are functioning as scribes, it is important that all entries clearly indicate whether or not the physician assistant or nurse practitioner is making entries in the medical record in his/her capacity as a scribe or as an ordering person.

If you have any questions about scribes, please contact Joan Feldman, Chair of Shipman & Goodwin LLP's Health Law Practice Group at (860) 251-5104 or [jfeldman@goodwin.com](mailto:jfeldman@goodwin.com).

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