What's New

Documentation Requirements When Scribes are Utilized

Physicians may occasionally utilize the services of scribes to assist with documentation during a clinical encounter between the physician and patient. The scribe is present during the encounter and records in real time the actions and words of the physician as they occur. Scribes may not interject their own observations or impressions into the medical record. Physicians may rely on the review of systems (ROS) and past, family, social history (PFSH) obtained and recorded by ancillary personnel.

The physician is ultimately responsible for all documentation and must verify that the scribe’s note accurately reflect the service provided.

The Scribe’s Note Should also Include

- The name of the scribe and a legible signature
- The name of the physician providing the service
- The date the service was provided
- The name of the patient for whom the service was provided

The Physician’s Note Should Indicate

- Affirmation of that physician’s presence during the time encounter was recorded
- Verification that he/she reviewed the information
- Verification of the accuracy of the information
- Any additional information needed

Signature requirements detailed in the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.4.1.1, [PDF] (1 MB) as well as the specific documentation requirements for any service provided must be followed.

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