

Institutional Handbook of Operating Procedures
Policy 06.03.03

Section: Compliance	Responsible Vice President: Senior Vice President & General Counsel
Subject: Coding and Billing	Responsible Entity: Office of Institutional Compliance

I. Title

Use of Scribes

II. Policy

Purpose: To define UTMB’s policy for the use of scribes to document in the patient’s medical record on behalf of the faculty physician, the APP, or the resident.

Audience: Physicians, Advanced Practice Providers, Residents, Department Administrators, Billing Managers, Billing and Coding Staff.

Every entry in the medical record that is made on behalf of a faculty physician, an Advanced Practice Provider (APP), or a resident (when his/her entry is scribed), should be authenticated by an attestation from the faculty physician, the APP, or the resident that the documentation reflects his or her performance of the service(s). A [scribe](#) can be a APP, nurse, resident, or other ancillary personnel allowed by the physician, the APP, or the resident to document his or her services in the patient’s medical record. These ancillary personnel do not have to be employed by the physician or APP performing the service(s) in order to scribe. Nurse Practitioners or Physician Assistants may not act as a scribe if they provide any portion of the service.

Violation of this policy may result in disciplinary action up to and including termination for employees; termination of the ability to utilize scribes; termination of employment relationship in the case of contractors or consultants; or suspension or expulsion in the case of a student. Additionally, individuals may be subject to loss of access privileges and civil and/or criminal prosecution.

III. Procedures

- A. Documentation and all attestations should clearly reflect what transpired during the encounter.
- B. A scribe’s entry should accurately reflect the service provided on a specific date of service. Documentation of scribed services should clearly indicate:
 1. Who performed the service.
 2. Who recorded the service.
 3. Qualification of each person (i.e., professional degree, medical title).
 4. Signed and dated by the physician, the APP, or the resident. It is recommended that the scribe also sign and date the record, but it is not required for billing purposes.
 5. The billing provider does not have to name the scribe.
- C. The practitioner is responsible for the content of the documentation even when the faculty physician, the APP, or the resident utilizes a scribe to document the medical record entry on his/her behalf.

D. The faculty physician, APP, or resident should state that the note was scribed as dictated and that it is his/her documentation. The faculty physician, APP, or resident should then sign the attestation to authenticate the entry.

- Example for Faculty, APP or Resident- “I, Dr. _____, (or APP or resident as applicable) personally performed and/or ordered the services described in this documentation, made by the Scribe in my presence, and it is both accurate and complete.”

(Signed) *Dr. Faculty, Date, Time*

- Example for Scribes- “I, _____, am scribing for, and in the presence of, Dr. _____ (or APP or resident as applicable) who performed and/or ordered the services described here-in.”

(Signed) *Scribe, Qualifications, Date, Time*

E. The authentication should take place within reasonable time after the patient encounter. Authentication cannot be delegated to another physician or practitioner.

F. The faculty physician should also include a teaching physician attestation (TPA), as required, when there is resident involvement during the encounter.

IV. References

The Joint Commission Standards FAQ Details on Scribes

[Novitas JH Scribes](#)

[CMS Provider Manual Scribes Page 44](#)

V. Dates Approved or Amended

<i>Originated: 04/20/2015</i>	
<i>Reviewed with Changes</i>	<i>Reviewed without Changes</i>
05/18/2017	
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VI. Contact Information

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