THE COMPLETE MEDICAL SCRIBE

A Guide to Accurate Documentation

KIM D. KWIATEK
KATERINA M. FLAMM

EDITION
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EDITION
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THE COMPLETE MEDICAL SCRIBE

A Guide to Accurate Documentation

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ABOUT THE AUTHORS

Kim Kwiatek, MD, originally trained as a Family Physician but quickly pivoted to the practice of Emergency Medicine in Dayton, Ohio. His many interests over his 40-year career included the business side of medicine and computerization of the electronic health record. These interests led him to start a medical scribe company that could help him and fellow physicians with more accurate documentation. Aptly named ABC Scribes (for Accurate Bedside Charting), the company started training scribes in its own "Scribe Academy" as well as in area universities. A textbook naturally followed. Now in its third edition, Dr. Kwiatek has collaborated with Elsevier to bring you *The Complete Medical Scribe*. Still actively engaged in medical informatics, Dr. Kwiatek makes time to travel to see his three children and three grandchildren.

Katerina Flamm, MD, began working for ABC Scribes in 2014. She rapidly mastered the documentation profession and began teaching for the company in her new role as senior medical scribe. Katerina was instrumental in helping to mature the company's curriculum and became its "Director of Education." In that role she collaborated with Dr. Kwiatek in the writing of the first two editions of this text, the first of which was published in 2017, and the second in 2019. In 2021, Katerina graduated from medical school from The Ohio State University College of Medicine. She is starting her residency at The Ohio State Wexner Medical Center and hopes to continue medical documentation education during her residency and beyond.

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This book is dedicated first and foremost to Amanda Craycraft, the "ground zero" scribe for ABC Scribes (Accurate Bedside Charting). Amanda is a force of nature who made me believe that I could build a successful scribe program way back in 2010. Without her infectious enthusiasm, our scribe program in Dayton, Ohio and the subsequent college course and textbook would never have happened.

In addition, I want to dedicate this effort to my wife, Candace, who has been the major influence in my life, teaching me by example how much can be accomplished with persistence, patience, and grace.

A shout-out goes to Larry Henry, my small business (SBA) mentor who from the get-go was brutally honest with me as I learned my way in the business world. He helped me to focus on my passion which was quality and innovation as opposed to growth for growth's sake.

Finally, this book is dedicated to the many aspiring healthcare professionals who scribed for ABC Scribes over the years. Their eagerness to learn the art of medical documentation as they began their healthcare careers was my ongoing inspiration in developing a curriculum and creating this text.

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ACKNOWLEDGMENTS

Many people contributed to this effort in numerous ways, both large and small. These are but a few.

The original college curriculum that led to this text was written with assistance from Amanda Utendorf Stegemiller. Amanda both scribed for me and cotaught our original course at the University of Dayton (the first college scribing course for credit in the nation). She provided valuable insight into the perspectives of the college student and tackled this new project with professionalism. She enthusiastically shared her scribe expertise with many budding health professionals. Amanda is now a Physician Assistant in Dayton, OH.

Katerina Flamm, MD, my coauthor, deserves special acknowledgement for the countless hours she put in writing this text with me. We collaborated on editions 1 and 2 which we "self-published" on CreateSpace (later Amazon/Kindle). These early editions served as our course text and as certification preparation for many students. The text was used in area colleges and our own "Scribe Academy." I will treasure the memory of the late nights we spent hashing things out in shared documents online, until we both were satisfied. Katerina was a scribe with ABC Scribes and a pre-med student at the time we began work on our first edition. She took a gap year to complete this project with me. We worked on the second edition together over a summer break while she was in medical school at The Ohio State University (OSU). Congratulations Katerina on your graduation from OSU and your acceptance into emergency and internal medicine residencies! You are an exemplar of what a serious scribe experience can produce. There would absolutely be no text without you.

I must particularly acknowledge Rachel E. Evans, RN, who has been by my side almost from Day One in the management of ABC Scribes. She took a chance on me and changed the trajectory of her own career throwing in her lot with ABC Scribes. Rachel has amazing qualities that she invested in our project. Daily she demonstrates how to put personal ethical values into everyday practice and how to be both confident yet humble. Only because of her handling of so many details of running the business did I have the time and energy left to devote to this book. Rachel is now the owner of ABC Scribes, a position that she has earned.

A big thank you goes to Kelly Schulte, longtime employee and manager/director at ABC Scribes, whose expertise in all things technical has been invaluable in getting early editions of this work published. Her range of knowledge is broad and her upbeat, can-do optimism is infectious. I will always be in awe of people who take lemons that life dishes out and make them into great lemonade. Kelly is such a person.

My oldest daughter, Keren Stick, was my proofreader on the first edition. She is a stickler for proper grammar and took the time to go through early versions of the book line-by-line. I will always be grateful that she did this even though it came at a time when she really did not have the time. Keren saved me from many an embarrassment, I am sure.

Finally, John Tomedi, acting as my editor for this edition, deserves special mention for his expertise in editing a medical text and his attention to detail. He was always tolerant of my lack of knowledge of the process, and I hope has succeeded in making me look like I know what I am doing. Most importantly, he tolerated my sense of humor. Thank you, John!

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PREFACE

Welcome to the third edition of our text on medical scribing. This edition is called *The Complete Medical Scribe* as it covers the vast landscape of scribing in a thorough fashion. Our intention is to have this serve as your go-to reference for all your scribing questions, both during the course and beyond.

This text has evolved over the years to include not only the technical aspects of scribing, but also elements of the art of scribing with all its nuances. Also, partnering with Elsevier has allowed us to add content and many helpful illustrations that will bring much of the material to life. In addition, the text provides you with opportunities to practice your scribing skills.

The book is divided into four parts. The first introduces the scribe's important role on the healthcare team. Two new chapters have been introduced to this edition to explore the medical-legal and health safety aspects of the job. Part II of the book delves into the heart of scribing, the healthcare note itself, and how it is constructed. Part III reviews each body system with related signs, symptoms, and problems that you, the student, will need to understand to produce accurate healthcare documentation. Finally, the last part of the book offers a practical application of your newly learned skills. Here it guides you to anticipate what may be asked or examined during the medical history and physical and what constitutes required documentation for a given problem. There is also a chapter with sample scenarios for you to practice, with answers and explanations of why we recommend the documentation as we do.

We are pleased to provide as a companion to this book several online resources for the benefit of both students and instructors. For students, this platform offers the opportunity to further practice scribing skills by observing and documenting video provider/patient encounters. There are also online templates for use throughout the course. Additionally, there are self-directed quizzes with answers and rationales explaining those responses.

For the instructor, resources include Lesson Plans and PowerPoints for classroom use and guidance for presenting the information to the class. We also are providing a test bank of over 500 questions mapped to the learning objectives in each chapter.

Good luck as you go through this course and through your scribing career. Medical scribing was born of the need to improve provider documentation to meet the needs of the many parties with an interest in the patient chart. As documentation needs have grown, the provider often has had to decide between spending time with the patient or with the chart. Neither is a perfect choice. Enter the medical scribe who is trained to create a great medical document. The provider wins. The patient wins. The other parties who use the chart win. And the scribe has created a valued spot on the healthcare team. Our hope is that you will find that spot for yourself and enjoy your time scribing while recognizing the valuable contribution that you are making.

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PART I

The Medical Scribe in Healthcare

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CHAPTER 1

Healthcare Providers and the Role of the Medical Scribe

LEARNING OBJECTIVES

1. Explain the role of the provider in patient care.
2. Differentiate the types of providers in primary care and specialty medicine.
3. Explain the role of the medical scribe.
4. Discuss the advantages of medical scribe training and certification for clinical personnel.

KEY TERMS

Acuity
Certification
Consultant
Disposition
Electronic health record (EHR)
Electrophysiology
Hard-stop
History of the present illness (HPI)
Hospitalist
Interventional cardiology
Interventional radiology
Medical scribe
Order
Physical exam (PE)
Primary care
Provider
Review of systems (ROS)
Specialty medicine
Treatment plan

Providers and the Practice of Medicine

In the delivery of healthcare there are distinct and defined roles for the variety of professionals who work together to care for patients. **Providers** are at the center of patient care. These professionals are understood to have the education, experience, and demonstrated competency to practice medicine, meaning that they can recommend and perform treatments to cure a health problem or maintain health. The legal authority to practice medicine is granted by each state. The provider examines and diagnoses patients, prescribes medications, and performs surgeries and other procedures according to the **treatment plan** he or she has developed for the patient. Every aspect of the patient's care is documented.

For the sake of simplicity, there are two types of providers: physicians and nonphysician providers (NPPs), also called advanced practice providers (APPs). By law, the physician is the only professional who is permitted to practice medicine *independently*. This is because only physicians are considered to have enough training and experience to safely treat patients and to understand when the patient requires more advanced care. That being said, physicians may delegate many responsibilities to NPPs. NPPs include nurse practitioners, physician assistants, clinical nurse specialists, and more. Depending on the laws of each state, these providers work under varying levels physician supervision; many work independently and consult with physicians when needed.

Providers may work in a variety of areas in medicine. They may work in primary care, which requires one to know a little about all areas of medicine. **Primary care** is the area of medicine that is generally considered to be the first point of contact for the patient in caring for their general needs (Table 1.1). Alternatively, they may work in **specialty medicine**, which requires expertise within a specific area of medicine. Although not a complete list, Table 1.2 describes many of the providers included in the area of specialty medicine.

Specialty medicine includes those providers who have in-depth training of one specific body system. Often these providers will have completed a residency program in a generalized area (like internal medicine or general surgery), and then complete fellowship training in their chosen specialty (like cardiology or pulmonology).

Specialists often work in the combined settings of the hospital, office, and surgery. Many specialists also may act as consultants. A **consultant** is someone who evaluates a patient and provides recommendations for a treatment plan. A specialist acting as a consultant only documents on active problems within his or her area of expertise. For example: a general surgeon might only

TABLE 1.1 ■ **Primary Care Providers**

Provider	Description
General Practitioner (GP)	Antiquated term for the doctor who "did it all." No specialty residency was required. These providers used to deliver babies, perform common surgeries, and provide care for everyone.
Family Physician (FP)	This is the "newer" general primary care practitioner. A residency in family medicine is typically completed. They may or may not deliver babies and assist in surgeries. They may take care of pediatric patients as well as adults. Family physicians generally work in offices as part of the outpatient setting.
Internist or Internal Medicine (IM)	This is a general practice physician similar to the family physician, but who usually has not trained to care for pediatric or Ob/Gyn problems. Internists typically work in an office but often also in the hospital setting (some are also called **hospitalists** if they work exclusively within a hospital; see below).
Obstetrician/ Gynecologist (Ob/Gyn)	Gynecologists are trained to care specifically for women, and are experts in women's health. Obstetricians are experts in pregnancy, and care for both the mother and the prenatal baby. Obstetrics/gynecology is one combined specialty.
Pediatrician	Specializes in the care of infants, children, and adolescents. There are many subspecialties in pediatric medicine (like pediatric cardiology, pediatric gastroenterology, etc.). Often when an individual turns 18 they must transition to a family physician for their healthcare needs.
Gerontologist	Focuses on providing care to elderly patients. This is a relatively new specialty that is now caring for a continually growing population.
Emergency Medicine (EM)	Providers are trained to care for higher **acuity** emergent issues—health problems that need to be addressed quickly or immediately—and provide lifesaving intervention if needed. Emergency medicine physicians also function as the gatekeepers of the hospital: they decide which patients are ill enough for inpatient admission, and which can be safely discharged home to follow-up in outpatient primary or specialty care.
Urgent Care	Provides urgent care for lower acuity issues (like common colds, skin infections, minor trauma, and other nonlife-threatening conditions). If a patient needs a more in-depth work-up, they are sent to the emergency department.

TABLE 1.2 ■ **Specialty Medicine**

Specialist	Description
Anesthesiologist	Cares for the patient undergoing surgery and requiring anesthesia. May also deal in pain management for patients who have chronic pain problems.
Cardiologist	Manages diseases of the cardiovascular system. Can also subspecialize into other branches of cardiology, such as **interventional cardiology** (to perform procedures using a catheter) or **electrophysiology** (to treat and manage diseases of the heart's electrical system), among others.
Dermatologist	Deals with issues related to the skin. May do in-office procedures like biopsies and excisions.
Gastroenterologist	Manages and treats diseases of the gastrointestinal tract. Can perform procedures in an office setting or in the hospital.
General surgeon	A surgeon who has not subspecialized into other types of surgery. The types of surgeries that are performed depend on the surgeon's level of training.
Hematologist/ Oncologist	Treats cancer patients and blood diseases.
Hospitalist	A branch of internal medicine which takes care of patients in the hospital only (usually after admissions from the emergency department). A hospitalist will only document on any problem that requires close monitoring or intervention while the patient is hospitalized. They will not generally address stable or old problems. After discharge, the patient will return to their primary care provider for their healthcare needs.
Nephrologist	Specializes in diseases of the kidneys, including caring for dialysis patients.
Neurologist	Provides medical care of neurological problems.
Otolaryngologist (ENT)	Provides office and surgical care relating to the ears, nose, and throat.
Ophthalmologist	Provides office and surgical care of eye problems.
Physical Medicine and Rehabilitation (PM&R)	Rehabilitates the injured, stroke victims, and others.
Plastic Surgeon	Performs reconstructive and/or cosmetic procedures.
Proctologist	Takes care of diseases in the rectal area.
Psychiatrist	Cares for patients with behavioral health problems.
Pulmonologist	Specializes in diseases of the lung. Pulmonologists may also practice critical care medicine.
Radiologist	Reads and interprets various types of imaging studies. May also subspecialize into **interventional radiology** and perform image-guided procedures.
Rheumatologist	Monitors and treats the rheumatologic autoimmune diseases (those dealing with muscles and joints, primarily). Autoimmune disease tends to have a multi-system overlap, so rheumatologists often consult with other specialists to manage autoimmune disease (like dermatology and gastroenterology, for example).
Urologist	Manages diseases of the urinary system. This would include the urinary bladder, ureter and ureters, as well as surgical conditions of the kidneys.
Vascular (Thoracic) Surgeon	Performs invasive surgeries of the heart, lungs, and blood vessels.

comment on the surgical procedure that he or she performed, and any perioperative complications. Things like hypertension or pulmonary disease would be managed by specialists on the treatment team (perhaps cardiology and pulmonology, respectively).

Many providers in different areas of medicine may participate in one patient's care. This is because they each have the training necessary to meet one or more of that particular patient's needs. For example, one patient may be following with a urologist for their recurrent urinary tract infections, a cardiologist for their hypertension, and a rheumatologist for their lupus. Generally, the primary care provider acts as a quarterback of sorts, and coordinates patient care amongst all of the other providers.

NOTE

It is always important to document the names of the providers with whom the patient follows, along with their areas of specialty. This allows the medical scribe's supervising provider to consult the other providers who are familiar with that patient. The scribe should translate the lay verbiage that the patient may use when describing a provider's area of medicine to the appropriate medical term. For example, substituting cardiologist for "heart doctor," and nephrologist for "kidney doctor" and so forth.

The Medical Scribe

A **medical scribe** is a documentation assistant to the medical provider (most commonly a physician). Documentation is recorded in the **electronic health record (EHR)**, which is a computerized healthcare platform to organize patient care information and workflow (Fig. 1.1). The EHR stores all the information about the patient and the medical care he or she receives, including the provider's **orders**, which are the directions about how to care for the patient. The scribe enters patient medical information into the EHR on behalf of the provider. Nurses and other healthcare professionals help to execute the treatment plan by following the provider's orders from the EHR.

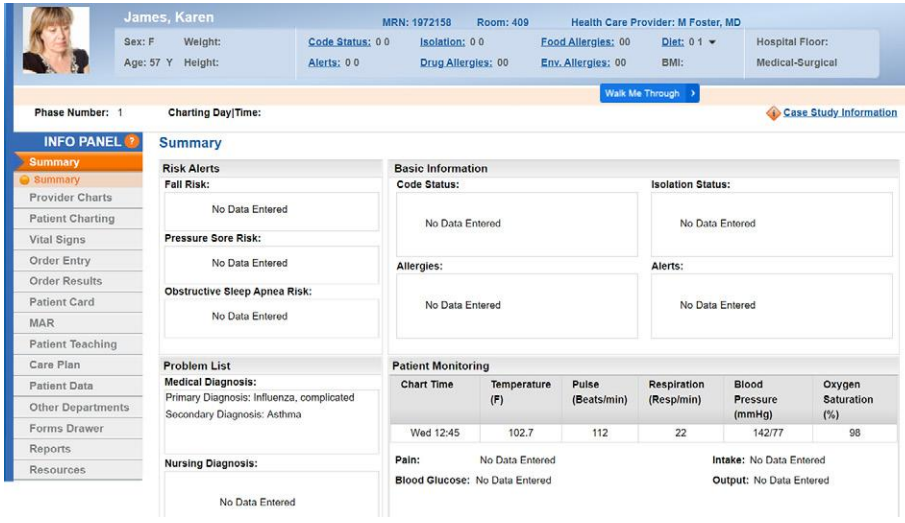

Fig. 1.1 The electronic health record (EHR) is a computerized platform to store and share patient information and to organize the work of providing patient care. (© SimChart for the Medical Office, 2021, Elsevier, Inc.)

The primary responsibility of the medical scribe is to create the **history of the present illness (HPI)** by listening to the provider while he or she is obtaining the patient's medical information (Fig. 1.2). The HPI is a coherent story, usually chronologic, describing the patient's illness or injury from the first sign or symptom to the present. The scribe may also complete the **review of systems (ROS)** after the HPI has been taken. This is a review of the symptoms that a patient may have, which is also obtained by the medical provider. A scribe may do other things if specifically told by the provider. These include recording the **physical exam (PE)**, which consists of the provider's physical findings during that patient encounter. The scribe may also enter orders for diagnostic labs, tests, or imaging into the EHR. At the provider's request a scribe may also document procedures, the results of certain tests (like electrocardiograms [ECGs]), or complete the "paperwork" for the patient's **disposition** and follow-up instructions.

Scribes are one of several solutions that allow the provider to document more accurately, more thoroughly, and more efficiently in the EHR. As an example, a provider may require 5 minutes to document on a single patient encounter. If they see 30 patients in a day, that would amount to roughly 150 minutes (or 2.5 hours) of time lost to documentation. With a scribe, the chart should be completed more or less when the provider exits the patient's room. Time and money are saved, and the chart that the scribe completes will likely be more thorough and accurate than the one the provider would create based on memory alone.

A medical scribe is the provider's partner in documentation. The scribe may have to ask questions to clarify what they did not understand, and prompt the provider to give elements of the history and physical exam that were not heard or observed (Fig. 1.3). A scribe should never be afraid to do this—at an appropriate time. This ensures accuracy and is a part of the scribe's value to the provider. A scribe should also help the provider meet billing requirements. Scribes are expected to inform the provider if billing requirements are not met, and prompt them to obtain all elements needed to complete the chart.

At the end of the day, the scribe helps to improve patient outcomes. Scribes allow the provider to spend more time with the patient and less time with the computer. They create an accurate document for other providers to consult by performing immediate documentation so details are not forgotten. They ensure that the document they create is billable to all standards so the provider will be paid. Lastly, they document details that are necessary for audits that ensure quality care.

Fig. 1.2 The medical scribe listens to the patient and provider, documenting patient care into the electronic health record (EHR). (© ABC Scribes, Inc. Used with permission.)

Fig. 1.3 The medical scribe works with the provider to ensure the documentation in the health record is complete and accurate. (© ABC Scribes, Inc. Used with permission.)

NOTE

What does it mean to be certified or to have a **certification**? In healthcare, it is important to have proof that the people working for the organization have met certain professional qualifications. A process of certification verifies that an individual has competence in a given area, and can be relied on to perform a skill. While a certification is usually voluntary, many employers prefer or require new hires to be certified by an agency or professional organization. Becoming a certified medical scribe conveys to the prospective employer that you have been trained, tested, and can be counted on to perform the job with competence.

WHAT IS A SCRIBE NOT TO DO?

A scribe is considered *nonclinical personnel*, meaning that there are a variety of clinical activities in which a scribe may not participate. The scope of a scribe's practice may vary between locations. Therefore, prior to working in a new location the medical scribe should always clarify the facility-based policies and procedures regarding limitations and expectations for a scribe. There are also things that a scribe may never do, regardless of place of employment. These will be discussed in detail.

A scribe both observes and listens to the provider prior to completing any element of the health record listed in the section above. This is because a scribe is prohibited from eliciting the HPI or ROS from the patient themselves, nor can the scribe perform a physical exam. A scribe is also not allowed to assist in performing medical procedures (other than the documentation). They also may not assist other healthcare providers in gathering supplies or administering medications. Only if the scribe has additional training or certifications that allow for it, may they be able to perform those additional functions that they are trained for.

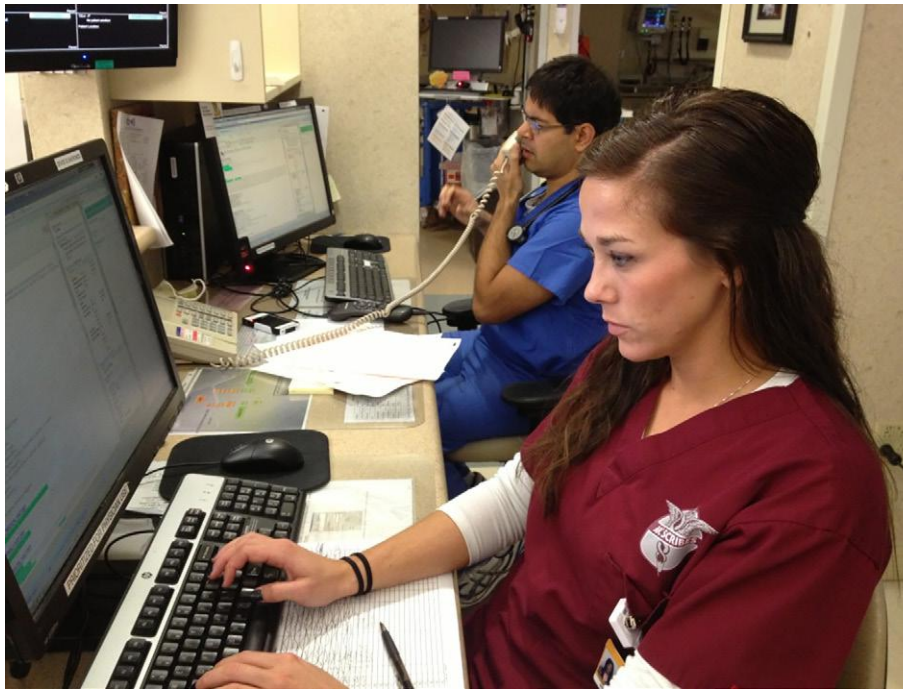

Fig. 1.4 The medical scribe's expertise is in populating the electronic health record (EHR) with the details of the patient encounter to present the most accurate record of care. (© ABC Scribes, Inc. Used with permission.)

The EHR has certain safeguards that are always in place that allow the scribe to work in the record as nonclinical personnel. These safeguards include **hard-stops** that appear after a scribe places orders or creates prescriptions. The hard-stops prevent the order or prescription from being acted upon unless the provider has reviewed, approved/amended, and signed the scribe's work. In addition to the hard-stops, the EHR should also send notifications and alerts to the provider (like medication contraindications such as allergies or drug-drug interactions), even if the scribe is the individual who entered the order.

Considering the restrictions in the EHR which are placed on a scribe, logging onto the computer using the physician's badge or user ID is never acceptable, and in fact constitutes fraud. Each individual working in the EHR must have separate login information, and different user roles and securities that depend on that individual's qualifications and required level of access. Chapter 2 will explore the security features of the EHR in detail.

A scribe must be both an excellent listener and an excellent communicator in order to be a successful part of the healthcare team. Most of the scribe's communication is written and done by documenting the encounter in the EHR (Fig. 1.4). A scribe may also communicate with other members of the healthcare team, but with certain limitations. A scribe may not call other providers to give them patient information, or transmit verbal orders to other healthcare providers. However, they can answer simple questions, such as whether the provider has been in to see a patient, or identify the provider's current location in the department or medical facility.

Occasionally the scribe may interact with patients: the patient may ask for a warm blanket or a drink, or ask questions about their healthcare. The scribe may almost always get patients warm blankets, but must ask the provider if the patient is allowed to have any oral intake ("po," or "per os,"

intake). There are a variety of reasons why this may not be allowed, including concerns for stroke (choking hazard), or the patient may be a surgical candidate (vomiting hazard). If a patient asks any questions that are medically related, the scribe should politely defer to an appropriate member of the healthcare team to provide an answer. Since a scribe is a nonclinical part of the healthcare team, they are not trained to answer these kinds of questions.

In summary, there are two general rules to heed: (1) a scribe may not touch anything that would be construed as engaging in a medical procedure or participation in a patient's care other than through documentation, and (2) a scribe should keep their communications limited to non-medical topics (other than open communication with their provider). Always use common sense, but when in doubt, ask: "is this a clinical or nonclinical function?"

Others Performing the Role of the Scribe

Although medical scribing is a nonclinical role, it can also be performed by any appropriately trained clinical personnel.

An obvious and common example of a clinical scribe would be the provider acting as his or her own scribe by "scribing" their encounter with the patient. Providers generally have extensive training and experience in this documentation. They generally know how best to convey the patient's clinical condition for later reference either by themselves or another member of the healthcare team who may need this information for aiding them in future care decisions. Often the provider is not quite as adept at documenting for other "customers" of the EHR. These customers include insurance companies, governmental bodies, quality review agencies, and legal entities.

Scribe training and certification is meant to prepare a cohort of professional scribes who are experts in documentation for all of these "customers."

Certified Nurse Assistants (CNA), Licensed Practical Nurses (LPN), and Medical Assistants (MA) are all good candidates for learning to scribe. Often even Registered Nurses (RN) are utilized as scribes in certain circumstances. Usual patient flow in an office or ED setting would, however, make it difficult to perform both scribing and clinical tasks because these generally happen simultaneously in the efficient healthcare setting.

CASE STUDY 1.1

After earning her medical assistant (MA) certification, Shawna worked for several years in a family physician's office. While she enjoyed all aspects of her work, Shawna quickly realized she liked working around the patients much more than doing the administrative tasks in the office. A colleague told her about the demand for medical scribes in all kinds of settings. "With the added skillset," Shawna's colleague said, "providers and practice managers really see the value of utilizing MAs with scribe training during patient care." With that, Shawna made up her mind to obtain certification as a medical scribe.

It turned out to be one of the best decisions she had ever made. Not long after completing her medical scribe certification, Shawna saw a job posting for a Medical Assistant/Scribe at an otolaryngologist's office. She performs all kinds of tasks at the practice, but the bulk of her day is spent with the providers—documenting exams, procedures, and postsurgical follow-ups.

QUESTIONS

1. What does the otolaryngologist specialize in?
2. What type of provider was Shawna's first employer, the family physician, and what type of patients did the office see?
3. When following the provider, Shawna's primary responsibility is to create the _____ by listening to the provider while he or she is obtaining the patient's medical information.
4. Shawna records all the information about the patient's medical care in a computer system called a(n) _____.
5. What are the professional benefits of obtaining certification?

Practice Questions

These questions are included at the end of most chapters as a self-assessment tool to gauge understanding of the materials presented. For the most benefit, we suggest that you first try and identify the correct answers without referencing the text. After checking the answer key at the back of the book, return to the text and focus on the topics or concepts of the question(s) that were missed.

1. A(n) _____ is a healthcare professional who diagnoses patients, prescribes medications, and performs surgeries and other procedures according to the treatment plan he or she has developed for the patient.

2. To loosen mucus in the patient's lungs, the provider writes a(n) _____ to instruct the nursing staff to perform chest physical therapy on the patient each morning.

3. Which physician is considered a part of primary care?
   a. radiologist
   b. gerontologist
   c. gastroenterologist
   d. proctologist

4. Which healthcare professional is not considered a provider?
   a. surgeon
   b. physician assistant (PA)
   c. unit clerk
   d. nurse practitioner (NP)

5. A(n) _____ is a physician who treats ailments of the brain and nerves.

6. A(n) _____ is a physician who takes care of heart problems.

7. A(n) _____ is a physician who manages diseases of the urinary system.

8. A(n) _____ is a physician who cares for patients with behavioral health problems.

9. A scribe is the last one leaving a patient room and the patient asks them for a drink of water. The scribe should
   a. get the patient a cup of water.
   b. review the patient's test results to ensure it is safe.
   c. politely excuse themselves from the situation.
   d. ask the provider for permission.

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CHAPTER 2

Healthcare Law and Ethics*

LEARNING OBJECTIVES

1. Explain the uses of healthcare documentation for legal and compliance purposes.
2. Differentiate criminal law and civil law and explain the role of healthcare documentation in criminal and civil cases.
3. Define consent, list the types of consent, and document patient consent for treatment.
4. Explain patient privacy and confidentiality and document patient care in accordance with the Health Information Portability and Accountability Act (HIPAA).
5. Define fraud and abuse and explain the relationship of fraud and abuse to healthcare documentation.
6. Discuss ethics and ethical concerns in healthcare.

KEY TERMS

Abuse
Accreditation
Assault
Audit trail
Battery
Breach
Business associate
Compliance
Confidentiality
Conscience clause
Consent
Continuity of care
Covered entity
Defendant
Disclosure
Emergency Medical Treatment and Active Labor Act (EMTALA)
Ethics
Explicit consent
Felony
Fraud
General consent
Health Insurance Portability and Accountability Act (HIPAA)
Implied consent
Informed consent
Kickback
Malpractice
Misdemeanor
Negligence
Office of the Inspector General
Patient Self-Determination Act (PDSA)
Plaintiff
Privacy
Privacy Rule
Protected health information (PHI)
Release of information (ROI)
Security Rule
Standard of care
The Joint Commission (TJC)
Tort
Upcoding
Whistleblower

The medical scribe is working in an industry that is heavily influenced by external forces. In healthcare, insurers and government payers have rules to follow; local, state, and federal governments create laws and regulations; accreditation bodies set standards; and professional organizations expect their members to abide by ethical codes. This chapter surveys the legal and ethical landscape as it pertains to the work of the scribe, specifically healthcare documentation.

*The editors wish to acknowledge Elsevier's *Legal and Ethical Issues for Health Professions*, 4th edition, which informs portions of this chapter.

Healthcare Documentation and Compliance

All the information the scribe and other healthcare professionals gather from the patient is recorded. The primary purpose of health record documentation is to communicate what has been done for the patient and what should be done for the patient, so that the providers of healthcare can use this information to provide quality care for the patient. For clinical staff, the health record serves as a reference for decision making and continuing care. It allows for the **continuity of care** of patients by detailing their evaluation, management, and treatments. Using the record, healthcare professionals can reconstruct each patient's medical encounters from the past to the present (Fig. 2.1).

The health record also has great importance as a legal document. Based on a legal principle called the *business record rule*, health record documentation is admissible in court. This means that if there is a dispute over the care the patient received, the health record serves as the documentation to defend the actions of the provider or healthcare facility, or to prove that the provider or facility did something wrong. The law also requires that complete and accurate documentation be kept as a record of the provider's business dealings.

In addition, the practice of medicine is regulated at all levels of government. For example:

- *Federal* agencies (who often serve as the payer on behalf of the patient) have rules about the care that can be offered to their beneficiaries.
- *States* license healthcare facilities, physicians, other providers, nurses, and other allied health professionals, and also mandate reporting of certain findings, such as child abuse or cases of infectious disease.

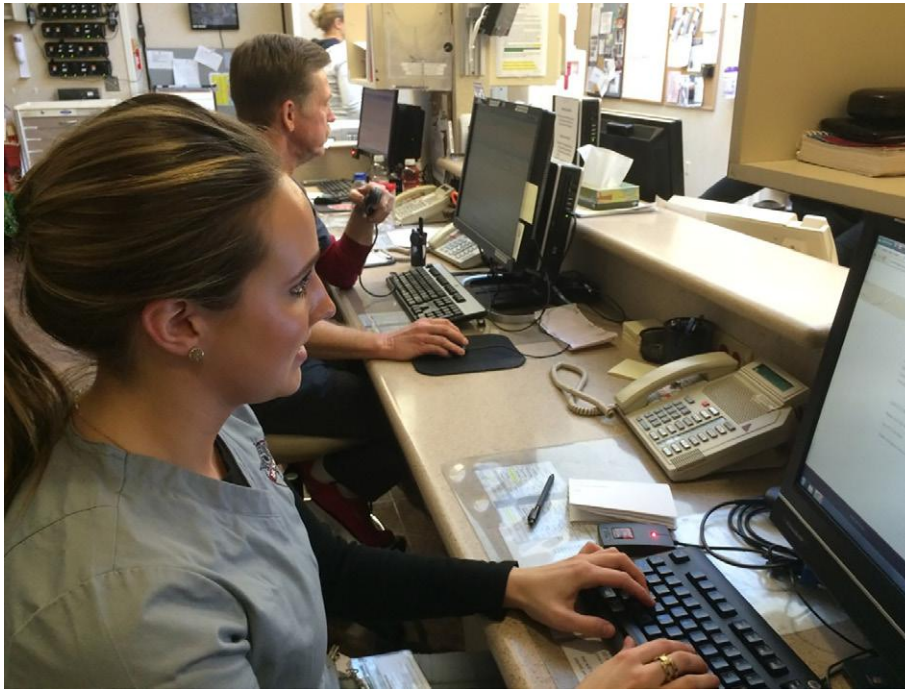

Fig. 2.1 The medical scribe documents in the electronic health record (EHR) so that others can reconstruct each patient's medical encounters from the past to the present. (© ABC Scribes, Inc. Used with permission.)

- *Local* governments can be involved with healthcare when the county facilitates certain services, or when a municipality offers tax savings to a not-for-profit healthcare entity.

At every level, regulators will use health records to monitor *compliance* with their rules. Thus, for the scribe, failure to properly document in the heath record can result in disciplinary action up to and including termination from employment. For the provider, poor documentation can result in fines and loss of licensure.

Compliance, or the adherence to a set of standards, is not only a legal matter. In healthcare, many facilities seek *accreditation* from independent accrediting organizations. **Accreditation** is voluntary, but it is valuable to healthcare facilities because it symbolizes that the organization has achieved a certain level of quality. In addition, earning some types of accreditation satisfies government requirements. There are many accrediting bodies for many different healthcare settings. The most important in the hospital setting is **The Joint Commission (TJC)**, which performs onsite surveys of the facility to monitor whether the facility is adhering to standards. During the visit, TJC surveyors examine patient records to understand how the patient is receiving care, as well as to ensure events are being documented fully and accurately. Hospitals have a *compliance officer* and a *compliance committee* to ensure providers and staff are completing documentation in accordance with regulatory and accreditation standards. Not every hospital will use TJC. There are alternative accrediting bodies such as Healthcare Facilities Accreditation Program (HFAP) that vary somewhat in their approach to ensuring compliance with federal regulations.

Types of Law

In general, there are two main categories of law: civil and criminal. *Civil law* protects the private rights of person or a person's property, whereas *criminal law* protects the rights of society based on government statutes and codes.

CRIMINAL LAW

Violations of criminal laws are called crimes. **Misdemeanors** are lesser crimes punishable usually by monetary fines established by the state, but some misdemeanors may also include imprisonment of 1 year or less. **Felonies** are more serious crimes punishable by larger fines and/or imprisonment for more than 1 year or, in some states, death. In many states, a felony conviction for a healthcare professional also includes the revoking of a license to practice in his or her profession. Two related felonies of interest to the scribe are *assault* and *battery* (Box 2.1). Healthcare professionals are at risk of a charge of assault and battery if they touch a patient without **consent**, or permission. The concept of consent is explored in detail below.

CIVIL LAW

Civil laws are laws that protect the private rights of a person or a person's property. Civil laws include the areas of contracts, property, negligence and malpractice, labor, privacy issues, and family law. A violation of civil law may prompt the supposed victim, the **plaintiff**, to bring a lawsuit to the courts to hold another party, the **defendant**, responsible for a wrongdoing. Civil lawsuits against healthcare professionals often include allegations of failure to provide care that meets the standard of care, resulting in harm or injury to the patient. Penalties in civil law are almost exclusively monetary. The court decides an amount to award for damages. In some cases, the court may order a healthcare professional to stop doing something, such as practicing medicine, to prevent further harm from occurring that money cannot remedy.

A wrongdoing or violation of civil law is called a **tort**. A tort is a private and civil wrong causing an injury. The most common tort against healthcare professionals is for **negligence**, and

BOX 2.1 ■ Assault and Battery

An **assault** is the threat of bodily harm that reasonably causes fear of harm in the victim. If the victim has not actually been physically harmed or touched, but only threatened or an attempt was made to harm, the crime is an assault. **Battery** is the unconsented physical contact on another person. For battery to occur, offensive touching is done without permission or consent or in the absence of an emergency situation. Assault and battery are separate crimes, but often occur together, with assault preceding battery.

it is the cornerstone of a *malpractice* case. Negligence does not require a specific intent to harm someone and is not a deliberate action, but is the result of an individual or party failing to act in a reasonable way where a duty was owed. **Malpractice** is an act of negligence and describes an improper or illegal professional activity or treatment, often used in regard to a healthcare professional causing an injury to a patient. The negligence might be the result of errors in diagnosis, treatment, postoperative care, or a violation of patient confidentiality. Malpractice requires proof of a breach of a *standard of care*, and the breach must cause damage or harm. In general, the **standard of care** in a medical malpractice case is defined as the type and level of care an ordinary, prudent, healthcare professional, with the same training and experience, would provide under similar circumstances. In other words, the critical question in a medical malpractice case is, "Would a similarly skilled healthcare professional have provided the same treatment under the same, or similar, circumstances?"

NOTE

Scribes are documentarians during the patient encounter, making them natural observers and recorders in the room. The scribe functions as a third-party observer in the room who can verify what the health record says is indeed what was related and what happened.

Some crimes, or violations of criminal law, are also torts, violations of civil law. For instance, a provider who has been accused of the crime of assault and battery may also be sued civilly for assault and battery.

Consent

It is illegal to touch someone without that person's consent. There are many distinct types of consent, but the two primarily related to healthcare are *general consent* and *informed consent*.

GENERAL CONSENT

General consent is an individual's permission to be touched. General consent can be *explicit* or *implied*. **Explicit consent**, also known as express or direct consent, means that an individual is clearly presented with an option to agree or disagree or to express a preference or choice, often verbally or in writing. Explicit consent is usually required when clear, documentable consent is required, and the purpose for which it is being provided for is sensitive, such as the collection, use, or dissemination of personal information. For example, all patients admitted to a hospital are required to sign a general consent form, which grants permission for employees of the hospital to "touch" the patient in order to provide medical care and treatment.

Most of the time, consent is not a formal declaration, but rather implied by the actions of the patient and the provider. This is called **implied consent**. Healthcare professionals routinely obtain implied consent when treating a patient. For example, a provider may ask a patient to roll

his sleeve up so an injection may be administered. If the patient rolls his sleeve up, this is implied consent to receive the shot.

INFORMED CONSENT

In healthcare, general consent—even if explicitly given—may not be enough to avoid the risk of a battery charge. A medical battery can be committed in specific situations in which there was consent to perform one particular procedure but a different procedure was performed instead. For example, in the case of *Pizzaloto v. Wilson*, the patient gave consent for the surgeon to perform excisions to remove adhesions and small cysts caused by ovarian endometriosis. During the surgery, the surgeon noted that the patient's reproductive organs had sustained severe damage and determined that the patient was, as a result, sterile. The surgeon proceeded to perform a hysterectomy, removing the patient's uterus and both of her ovaries. When the patient woke up from surgery, she was angry with the actions taken by the surgeon and filed a lawsuit. The court ruled that the patient (plaintiff) was entitled to recover damages and awarded her $10,000 because there was no emergency present and thus the surgeon committed battery because no consent had been given for this specific procedure.

Informed consent is a more formal consent process done before invasive procedures like surgery. In this process, the healthcare provider discusses the reason for the procedure and exactly what it entails so that the patient may make a voluntary choice to accept or refuse treatment. The healthcare provider must detail all possible risks and potential prognoses for having a treatment or procedure performed and the available alternatives. The provider must only perform the procedure as described and within the scope of the informed consent documentation. A signed informed consent form is retained in the patient's health record (Fig. 2.2).

NOTE

In emergency situations, consent—even for invasive procedures—can be implied. The situation must be life-threatening or pose a risk of significant physical injury to the patient if the procedures are not performed. Only those procedures that are absolutely necessary are authorized, and explicit consent should be obtained as soon as possible. Furthermore, only a healthcare provider, such as a physician, can make the determination that a true emergency exists that necessitates proceeding without explicit or informed consent, which will be discussed next.

Privacy and Confidentiality

Careful protection of patient health information has been central to the delivery of healthcare since ancient times. Greek physicians understood that to properly treat the patient, they needed the patient to be honest and complete about the problem and the events that led to it. Of course, the patient would be far less likely to disclose information if he or she thought the physician would tell everyone else about it, especially if the health problem was sensitive or embarrassing. Thus, **confidentiality**, or the careful safeguarding of the patient's health information, has long been a cornerstone of medicine. A similar but distinct concept is **privacy**, the patient's ability to keep health information concealed. The medical scribe is duty-bound to confidentiality, and has a responsibility to protect patient privacy.

In the 1990s, as the healthcare industry began to be computerized, providers started to store certain patient information digitally, and send information electronically to insurance companies and other payers. These new storage and communication methods prompted concerns about the privacy of health information. In 1996, the **Health Insurance Portability and Accountability Act (HIPAA)** was passed in part to address these concerns.

Tingsboro Hospital

Procedure Consent Form

Patient Label

Name

Medical Record #

DOB

Procedure: _____

I,_____, consent to the above treatment procedure as deemed medically necessary by my medical provider. My care provider,_____, has explained to me the nature of my condition, the procedure, the risks and the expected benefits of the above procedure compared with alternative approaches.

My provider has also explained to me the likelihood, and some possible complications of this procedure including, but not limited to, bleeding, infection, loss of limb or organ function, drug reactions or possibly death. I also understand that I may need a blood transfusion during or after this procedure.

I understand that Tingsboro Hospital is a teaching hospital and that students and other trainees may participate in this procedure as permitted by law and hospital policy. I also understand that tissues, blood, body parts or fluid may be removed from the body during the procedure. These materials may be used for diagnostic, therapeutic or research reasons.

Any additional comments:

_____

_____

_____

_____

_____ _____

Signature of Patient Printed Name

_____ _____

Signature of Provider Printed Name

Date:_____

Fig. 2.2 Informed consent form. (From Purtilo RB, Doherty RF: *Ethical dimensions in the health professions,* ed 7, St. Louis, 2021, Elsevier.)

HIPAA is a federal law governing all healthcare providers, insurers, and their affiliates. The law has many sections, but its provisions most relevant to the scribe regulate **protected health information (PHI)**, which is any health information that can be linked to an individual. Essentially, HIPAA forbids unnecessarily sharing any health information that can be connected to a person's identity. Furthermore, any patient information that is shared—even among healthcare professionals—is limited to only the information necessary to deliver patient care.

Understanding the HIPAA law is important for anyone who works in healthcare. Healthcare organizations are known as **covered entities**, meaning that the law directly covers their actions. A covered entity must have in place appropriate administrative, technical, and physical safeguards to protect the privacy of protected health information. The law also however extends to other companies that work closely with healthcare organizations, which are called **business associates**. If a covered entity contracts with another company that provides them with a service, and thus may have access to protected health information at any time, the covered entity must have a contract with this other company, the business associate. That contract must state what the business associate will be doing on their behalf, and that the business associate must also comply with HIPAA rules regarding protected health information. An example would be a doctor's office (the "covered entity") which is subject to HIPAA rules, that hires a scribe company (the "business associate") which will have access to protected health information and must sign an agreement outlining their role and responsibilities under HIPAA.

HIPAA legislation has resulted in two rules that are of importance to the medical scribe: the *Privacy Rule* and the *Security Rule*.

PRIVACY RULE

The **Privacy Rule** provides federal protections for any oral, written, or electronic-PHI (e-PHI), and gives patients an array of rights with respect to that information. It limits the **disclosure**, or communication of private information, of this "individually identifiable health information." Health information can be medical history, test and laboratory results, insurance information, demographics, and other data that a healthcare professional collects to identify an individual and determine appropriate care. Patient identifiers include, but are not limited to, the patient's name, birthdate, dates of service, email address, social security number, home address, phone number, and medical record number (MRN). The Privacy Rule limits who gets access to PHI without the patient's express permission. The following scenarios will illustrate this facet of the law.

Example 1: The medical scribe returns home from a long day at work and sits down for dinner with his family. He relates that Ms. Jenkins, a neighbor, was seen in the clinic for a spider bite.

The scribe's actions in this example are a violation of HIPAA, because the scribe is disclosing PHI, health information that can be connected to the identity of an individual. In this case, the health information identified with the patient's name.

Example 2: The medical scribe notices a person who attended her high school in the waiting room of the doctor's office. The scribe is not present for the patient's encounter but is curious about why her high school acquaintance is seeing the physician. The scribe asks a co-worker about the reason for the patient's visit, who tells her it is because the patient has a cold.

In this example, the co-worker is in violation of HIPAA because she disclosed information to the scribe, who did not need to know why the patient was being seen. Similarly, if the scribe had accessed the patient's health record to see why her high school acquaintance was in the office, the scribe would have committed a HIPAA violation. The scribe would have no medical or administrative need to access the patient's health record. All disclosures of PHI must be the *minimum necessary* to deliver patient care.

It is useful to consider an example of how HIPAA would work in an emergency department. A scribe will undoubtedly want to share some of the excitement that occurs in the department when they go home. It is certainly permitted to discuss certain things in a very generic way. For example, if a patient had a collapsed lung and needed a chest tube, then sharing that you got to see a chest tube insertion would be permitted as long as nothing is stated about the patient and only the procedure is discussed. In other words, health information in the absence of patient identifiers is generally not protected information under the law.

On the other hand, if a patient is evaluated for anything that may be reported in the newspapers, then the scribe may not mention anything about the case, lest it be connected with a specific person. A rape case would be an example. This is a forensic or legal case and a public record will be available for that reason, making it very likely that anything a scribe might say about the case could be tied to an individual. A celebrity seen in the emergency department would also be a case that could not be discussed, even indirectly. When in doubt, keep it to yourself.

Example 3: The medical scribe is attending a pool party with friends, and the conversation turns to the use of sunscreen. The scribe relates that he is always careful about sun protection, and that once they had a patient who was so badly sunburned that he had to be hospitalized.

Is Example 3 a HIPAA violation? Because the health information is not connected in any way to an identifier, the scribe has not broken the law.

The patient's privacy may also be violated through carelessness. Even when there is a legitimate need to communicate about the patient, healthcare professionals must be cautious not to reveal health information to others in earshot. When care needs to be discussed, the conversation should happen in private work areas, not in hallways or other public areas where others may overhear. Any printed documentation must not be left unattended. For example, a printout of a patient's laboratory results is, after all, classified as PHI: it will have many patient identifiers at the top of the page, and the rest of the document is health data. Similarly, computer screens should never be left unattended, and the scribe must log out of the system immediately after use. Should a passerby see the information on the computer screen, this would also be a HIPAA violation.

HIPAA protections of PHI extend to the patient's own healthcare providers, and even to the patient's closest friends and family. A blood relationship and even marriage does not entitle a person to the patient's health information (with certain exceptions among parents and their minor children). Of course, patients can choose to have information disclosed to whomever they choose. Patients regularly authorize disclosure to spouses, family, and other physicians. Fig. 2.3 is an example of a **release of information (ROI)** form the patient that they may sign to allow the healthcare organization to disclose his or her health record.

There are some permitted disclosures of PHI that do not require direct authorization from the patient. Some of these circumstances include sharing information in order to obtain payment or reimbursement for healthcare services, or to perform any necessary healthcare activities like the patient's treatment plan or any operation necessary for business. (Treatment, payment, or healthcare operations are collectively known as TPO.) Even though these are permitted disclosures under the law, most facilities will request that the patient sign a consent form authorizing the organization to use and disclose PHI for these purposes (Fig. 2.4).

Researchers are also allowed to access and use protected health information when necessary to conduct research. HIPAA only applies to research if the research is actively being used in patient care in such a way that the researcher is establishing a provider-patient relationship with the patient. In those cases, it crosses the boundary from pure research into the realm of treatment, which is thus covered by HIPAA.

SECURITY RULE

The second important HIPAA provision is the **Security Rule**, which requires all covered entities to enact measures to protect the confidentiality of patient health data. Covered entities must use technical and non-technical safeguards to secure electronic protected health information (ePHI). This includes:

- ***Administrative safeguards***—training for employees on HIPAA, confidentiality, and security, and disciplinary actions for employees who violate the law. These include policies for

MEDICAL RECORD | **Authorization for the Release of Medical Information**

INSTRUCTIONS: Complete this form in its entirety and forward the original to the address below:

NATIONAL INSTITUTES OF HEALTH
MEDICAL RECORD DEPARTMENT
ATTN: MEDICOLEGAL SECTION
10 CENTER DRIVE, ROOM 1N208
MSC1192
BETHESDA, MD 20892-1192

TELEPHONE: (301) 496-3331
FACSIMILE: (301) 480-9982

IDENTIFYING INFORMATION:

Patient Name	Daytime Telephone	Date of Birth

REQUEST INFORMATION: Information is to be released to the following individual or party:

Name	Telephone
Address	

The purpose or need for disclosure (charges will be determined based on purpose of disclosure): _____

Date Range of Information to be Released: from _____ to _____

Please check specific information to be released:

☐ Discharge Summary	☐ Radiology Reports	☐ EKG Reports
☐ History & Physical	☐ Radiology Films	☐ Echocardiogram Reports
☐ Operative Reports	☐ Tissue Exam Reports	☐ Heart Diagnostic Reports
☐ Outpatient Progress Notes	☐ Tissue Slides	☐ Nuclear Medicine Reports
☐ Length of Stay Verification	☐ Lab Results	☐ Nuclear Medicine Scans

☐ Other (Please Specify): _____

AUTHORIZATION: Permission is hereby granted to the Warren Grant Magnuson Clinical Center to release medical information to the individual/organization as identified above.
(Note: submission of this form authorizes the release of the information specified within one year from date of signature.)

Patient/Authorized Signature	Print Name	Date

If other than patient, specify relationship: _____

Patient Identification	Authorization for the Release of Medical Information NIH-527 (02-01) P.A. 09-25-0099 File in Section 4: Correspondence

Fig. 2.3 National Institutes of Health (NIH) release of information authorization form. (From Clinical Center, National Institutes of Health, US Department of Health and Human Services. In Pepper JK, Beik JI: *Health insurance today: a practical approach*, ed 7, St. Louis, 2021, Elsevier.)

managing user passwords, such as how often they must be changed, and disciplinary actions for sharing passwords with others.

- ***Technical safeguards***—control of access to electronic systems. Included here are user roles within computer systems that only allow a person access to certain parts of the electronic health record (EHR). Other technical safeguards are automatic logoffs

COLLEGE CLINIC
4567 Broad Avenue
Woodland Hills, XY 12345-0001
Phone: 555/486-9002
Fax: 555/487-8976

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION

I understand that this organization originates and maintains health records which describe my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information is used to:

- plan my care and treatment.
- communicate among health professionals who contribute to my care.
- apply my diagnosis and services, procedures, and surgical information to my bill.
- verify services billed by third-party payers.
- assess quality of care and review the competence of health care professionals in routine health care operations.

I further understand that:

- a complete description of information uses and disclosures is included in a *Notice of Information Practices* which has been provided to me.
- I have a right to review the notice prior to signing this consent.
- the organization reserves the right to change their notice and practices.
- any revised notice will be mailed to the address I have provided prior to implementation.
- I have the right to object to the use of my health information for directory purposes.
- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.
- the organization is not required to agree to the restrictions requested.
- I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

☐ I request the following restrictions to the use or disclosure of my health information.

_____

Date _____ Notice Effective Date _____

Signature of Patient or Legal Representative _____ Witness _____

Signature _____ Title _____

Date _____ ___ Accepted ___ Rejected

Fig. 2.4 An example of a consent form used to disclose and use health information for treatment, payment, or healthcare operations (TPO). This is not required under the Health Information Portability and Accountability Act (HIPAA), but you may find that some healthcare organizations use it. (From Smith LM: *Fordney's medical insurance*, ed 15, St. Louis, 2020, Elsevier.)

when the computer is idle for a certain amount of time, and the encryption of transmitted information.

- ***Physical safeguards***—measures taken to protect against unauthorized access and natural and environmental hazards (like floods). Computer hardware is physically locked, and equipment such as data storage servers are kept in locked rooms.

Fig. 2.5 The computer monitor on which this medical scribe is working does not face the hallway; it is oriented toward the work area. This is an example of a physical safeguard preventing others from seeing the information on the computer screen. (© ABC Scribes, Inc. Used with permission.)

Computer monitors are oriented in ways that the screen cannot be seen by others (Fig. 2.5).

Specifically, covered entities must (according to CMS) ensure the "confidentiality, integrity, and availability" of all e-PHI they create, receive, maintain or transmit. In short, the healthcare entity must take all reasonable precautions against any potential violation of the privacy of the patient's medical record that could be anticipated.

BREACHES

If there is ever a **breach** of security of a patient's protected health information, that patient must be notified. Larger breaches, such as hacks into the computer system, require notification of media outlets.

As members of the healthcare team, scribes are always subject to HIPAA laws. Violations of HIPAA may result in large fines and time in jail. Unintentional violations may include an unattended computer that is logged into the EHR, or papers with patient information left in a workspace or discarded in the waste bin (instead of the shred bin). A scribe should also avoid sharing protected health information about a patient unnecessarily, discussing protected health information in a public area, looking-up information about a patient that is not pertinent for the job, browsing through one's own medical records or the records of friends or family, or even sharing that the patient was seen in any medical facility.

PERSONAL PRIVACY

Not only should the scribe follow the rules set by HIPAA, the scribe should also be cognizant of a patient's personal privacy. In the emergency room for example, many patients are asked to change into gowns and stay in rooms separated from the rest of the department by glass doors and/or curtains. Please remember to be considerate of a patient's privacy when entering or exiting a room,

and shut the door or curtain. A good rule of thumb in respecting a patient's privacy is to consider how you would like to be treated if you were in their shoes (or wearing their gown)!

Fraud and Abuse

Fraud is the intentional act to misrepresent facts or mislead for financial gain. **Abuse** in healthcare is a reckless disregard or conduct that goes against acceptable business and/or medical practices resulting in greater reimbursement.

Fraud directly relates to medical documentation, because it is an intentional misrepresentation, deception, or act of deceit for the purpose of receiving greater reimbursement. The provider is paid based on the documented services, therefore if the documentation is falsified, a provider can receive higher levels of compensation. Examples of fraud include billing for services not provided, or **upcoding** services to gain larger reimbursement for services provided. Fraud is often obvious, but sometimes it is less obvious and providers or beneficiaries may unknowingly do things that constitute fraud. Therefore, it is important to know some of the pitfalls involved. Some examples of fraud include:

- billing for supplies not used or services not rendered
- providing or billing for unnecessary services
- upcoding, or billing for a higher level of service than that provided
- frequently incorrectly coding a service
- misrepresenting dates or duration of service
- altering medical records to hide something or otherwise falsifying information
- forging prescriptions
- waiving deductibles

It is also fraudulent to document signs or symptoms that a patient does not have in order to obtain insurance coverage for a service.

Violations of key federal fraud and abuse laws can be either civil or criminal offenses. Fraud can lead to, for example, healthcare professionals and medical billing and coding personnel incurring fines, loss of license, and even imprisonment. It is important to note that it is the attempt at deceit that is fraud, regardless of whether it is successful. As an employee in any healthcare organization, it is important to understand that the penalties for committing fraud and abuse are levied not just on the provider but may also be levied on the employer. Staff can also be subject to fines and imprisonment if they take part in a fraudulent activity, even if they were only following the provider's or employer's direction.

NOTE

As we will see in Chapter 4, The Health Record and Notes, each contributor to the EHR has his or her own unique login/credentials. Any actions performed in the EHR under this username is tracked, along with a date and time stamp. In addition, the EHR records the date and time whenever an addendum or other change is made to the record, as well as the changes that were made. Every action leaves an **audit trail**, a record of every individual who accessed the record and what they did. The audit trail is used to help identify fraud, as well as HIPAA violations.

It should be obvious that there are huge sums of money involved in healthcare. Since a large portion of that is administered by the government through Medicare and Medicaid, they have a legitimate interest in safeguarding their investment and that of the taxpayer when it comes to doling out the funds to administer healthcare. Government auditors monitor for inadequate or unnecessary medical procedures and treatments, **kickbacks** to healthcare professionals, and overcharging for Medicare and Medicaid programs.

The job of the government's auditors is to make sure that money is not lost through fraud. The **Office of the Inspector General (OIG)** is tasked with protecting the integrity of Health and Human Services (HHS) programs, like Medicare. They will often take tips from **whistleblowers** who provide the government information about fraud in the medical professions.

Other Federal Legislation for the Medical Scribe

EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

The medical scribe is likely to encounter situations that are influenced by the law known as or the **Emergency Medical Treatment and Active Labor Act (EMTALA)**. This law mostly affects care delivered in the emergency department (ED). It was enacted in 1986 to prevent EDs from refusing to treat patients presenting at the hospital with an emergency medical condition, or transferring unstable patients to another facility. Before EMTALA, some facilities were accused of "patient dumping," transferring a patient based on a potentially high-cost diagnosis, or refusing to treat a patient based on his or her ability to pay.

CASE STUDY 2.1

Devon works for a medical scribe company that has just been contracted to provide scribing services to an ambulatory surgery center. Rather than requiring the patients stay in the hospital overnight, in an ambulatory surgery center, the procedures performed are all completed within a few hours. The physicians at the facility perform many different surgeries, ranging from joint repairs, to vasectomies, to eye surgery. In Devon's job as a medical scribe, he completes the operative reports in the EHR per the physician's instructions, and checks to make sure other documentation is complete and accurate.

Since he began at the surgery center, Devon has worked hard to make sure all his documentation meets compliance standards. The facility's administrators are expecting their biannual survey from TJC any time now, and everyone wants to make sure the records are in excellent shape.

QUESTIONS

1. TJC is a(n)
   a. federal agency.
   b. state agency.
   c. accreditation agency.
   d. professional association.
2. Before undergoing surgery, the provider will explain the procedure, and the patient will be required to sign a(n) _____ form.
   a. general consent
   b. release of information
   c. informed consent
   d. privacy
3. Which is a breach of PHI?
   a. In the office workspace, Devon asks a physician for clarification about the type of suturing used during a surgery.
   b. The nurse yells out a patient's name in the waiting room to call them back for their procedure.
   c. Devon tells his grandmother that he had the chance to witness a cataract surgery a few weeks ago.
   d. One of Devon's coworkers leaves the portable computer station in the exam room without logging off.
4. A patient developed an infection after undergoing a hysterectomy at the surgical center. The patient is taking legal action against the surgeon and the ambulatory surgery center. In the court proceedings, the patient is the _____, while the provider is the _____.
5. During the trial, the patient's attorneys suggest that, although the documentation of the surgical procedure shows no wrongdoing, it is possible that someone altered the record to hide problems. What EHR function would prove that no one altered the health record?

EMTALA requires the facility perform a medical screening exam. The facility must provide stabilizing treatment and ensure the patient is in stable condition before transfer, regardless of the patient's legal status, citizenship, or ability to pay. If the facility cannot adequately treat the patient, a patient (or his or her legal representative) must agree to any intrahospital transfer and be advised as to the reason for the proposed transfer. Whenever a patient is transferred from one hospital to another, there is documentation that is required to ensure compliance with this law. The scribe may well be asked to assist in this documentation. Most hospitals will have a form that they use specifically for this purpose to ensure that all documentation requirements are met.

PATIENT SELF-DETERMINATION ACT (PDSA)

The **Patient Self-Determination Act (PDSA)** requires that adult patients be informed of their right to accept or decline any medical or surgical treatment. It also provides that they be advised of their right to have an **advance directive** describing the care they would like to receive in the event they become *incapacitated*, or unable to understand or communicate in a time of need. With an advance directive, the patient can dictate ahead of time what types of care and services he or she wishes to receive. One type of advance directive is also known as a ***living will***, which contains instructions about the types of life-sustaining treatments, such as mechanical ventilation or tube feeding, that should be administered or withheld in the case of a terminal illness. The living will may include a ***do not resuscitate (DNR)*** indicating the patient does not wish to receive CPR. Another type of advance directive is a ***durable power of attorney*** in which instead of specifying the care that they want, the patient specifies an alternate person who would be given the responsibility of making these decisions for them, often another family member (perhaps with medical training) or a trusted friend.

These forms often vary state to state. Although it would be unusual for a scribe to be involved in recording these types of documents, being aware of their existence and being able to document that a patient's advance directives were utilized in the medical decision-making process is valuable.

Ethics

Ethics are a belief system about what behaviors are acceptable. A scribe is not considered to be clinical personnel, meaning that they are only responsible for the documentation and should otherwise not function in any clinical manner. However, because the medical scribe is working within a medical environment they should expect to encounter the occasional ethical dilemma.

Some examples specific to the medical community may include end-of-life issues including, physician-assisted death. Religious affiliations may affect healthcare choices and go against the accepted community norms. For example, Jehovah's Witnesses have religious objections to receiving blood transfusions or blood products in treatment. Also there will be different choices surrounding abortion and organ donation. Although it is natural for the medical scribe to have their own opinions regarding these matters, the scribe will never be held responsible for decisions in specific cases.

The **conscience clause**, also known as medical conscience or conscientious objection, is a legislative provision that relieves a person from compliance or duty based on moral or other personal beliefs. In healthcare, the conscience clause is the refusal to perform a legal role or duty because of personal beliefs. It permits healthcare professionals—physicians, pharmacists, nurses, and other healthcare professionals—to not provide certain medical services for reasons of personal beliefs. The conscience clause constitutionally permits private hospitals and healthcare facilities—and physicians, nurses, and other employees—to refuse to perform or participate in medical procedures for "ethical, moral, religious, or professional reasons." However, in public hospitals and healthcare facilities, the conscience clause does not apply. In addition some hospitals may have their own conscience clause where a healthcare professional may refuse to perform or participate in a procedure as long as there is another staff member to take over the duty.

Practice Questions

1. A provider may have committed _____ if he or she did not obtain consent to treat the patient.

2. _____ is an act of negligence and describes an improper or illegal professional activity or treatment, often used in regard to a healthcare professional causing an injury to a patient.

3. _____ consent is neither verbalized nor written, but it is an understood agreement by both parties.

4. The unlawful communication of private information is a(n) _____.

5. Which HIPAA rule requires the organization to construct safeguards to protect the confidentiality of electronic protected health information?
   a. Security Rule
   b. Portability Rule
   c. Patient Safety Rule
   d. Privacy Rule

6. Under HIPAA, a scribe company that is employed by a hospital is considered a(n)
   a. plaintiff.
   b. covered entity.
   c. business associate.
   d. auditor.

7. _____ is a type of fraud where documents are misrepresented to bill for a higher reimbursement than the services actually provided.

8. The _____ is a legislative provision that relieves a person from compliance or duty based on moral or other personal beliefs.

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CHAPTER 3

Scribe Safety and Infection Control

LEARNING OBJECTIVES

1. Describe the measures to ensure scribe safety in the healthcare setting.
2. Discuss infection control measures in the healthcare setting.

KEY TERMS

Antiseptic
Cough etiquette
Disinfection
Don
Hand hygiene
Isolation
Pathogen
Personal protective equipment (PPE)
Respirator
Sanitization
Standard precautions
Sterile
Sterilization
Sterile technique
Transmission-based precautions

Scribe Safety

A scribe may be faced with different types of security challenges in the healthcare setting. The most dangerous area of all would be the emergency department (ED). Violent criminals, their victims, and psychotic patients all tend to come to the emergency department. Many patients have impaired behavior due to alcohol or other substances as well.

Most EDs will have some sort of security personnel present. Security personnel become involved in any dangerous situation. Be aware of your facility's security plan and any role you might be required to play. In theory, your physician will know these things. But in practice, they could be new or a *locum tenens* (temporarily in the area to fill a vacant position), and thus will not be as familiar with that ED as someone who has been there many years.

There are a few general safety rules to which a scribe should adhere. If a patient is known to be potentially dangerous, the physician should excuse the scribe from having to enter that room. As a non-essential person, the scribe ought not be unnecessarily exposed to risk. If the scribe is in a room with a psychotic or otherwise cognitively impaired or potentially violent patient, the scribe should always be standing between the patient and the door. This positioning allows the scribe to avoid "going through the patient" to exit the room. In a trauma or major resuscitation room, the scribe should be unobtrusive while recording the events and avoid being in the way of many essential clinical personnel who will be coming and going.

Infection Control

Safety in the hospital setting encompasses more than just security situations. Working in a medical setting (especially in a hospital), the scribe must be aware of exposure to infectious disease.

Healthcare facilities are home to many viruses and resistant bacterial strains. Medical settings are conducive to the spread of microorganisms because of the many sick people who are treated in them. Controlling the spread of these **pathogens** is important both to protect patients, many of whom are at higher risk because of reduced immunologic function, and also to protect healthcare workers.

STANDARD PRECAUTIONS

Accurate identification of all patients carrying infectious diseases is difficult. However, it is neither practical nor necessary to know whether each and every patient has an infectious disease. Instead, healthcare workers regularly employ **standard precautions**, infection control measures in place when caring for *all* patients. Standard precautions assume that all patients are carrying bloodborne pathogens and are therefore treated as such. The guidelines apply to

- blood
- all body fluids, secretions, and excretions except sweat, regardless of whether they contain visible blood
- nonintact skin
- mucous membranes (such as eyes or mouth)

Measures included in standard precautions are based on creating barriers between the infectious microorganisms that prevent them from entering the body of the healthcare worker, or prevent healthcare workers from transferring them around the facility on their bodies or other objects. Standard precautions use *hand hygiene*, *personal protective equipment (PPE)*, *cough etiquette*, and common-sense behavior to stop the spread of germs.

Hand Hygiene

Hand hygiene is the single most important preventive technique that healthcare workers can use to interrupt the infectious process. Hand hygiene can be traditional handwashing with soap and water, or it can be using alcohol-based foam. Handwashing is recommended when the hands are visibly soiled or after exposure to known or suspected infectious material, but the cleaning of hands with an alcohol-based hand rub or foam is preferred in most situations. This includes when entering and exiting a new patient's room ("foam-in, foam-out"; Fig. 3.1). Healthcare workers also perform hand hygiene immediately after gloves are removed, between patient contacts, and when otherwise indicated to prevent transfer of microorganisms to other patients or environments.

Personal Protective Equipment (PPE)

Standard precautions guide use of **personal protective equipment (PPE)**—gloves, masks, eye protection, and gowns—when in contact with patients. Gloves are **donned** (put on) when there is a potential for touching blood, body fluids, secretions, excretions, and contaminated items. They create a barrier between the potentially infectious material and the healthcare worker's hands. Other types of PPE are donned depending on the type of patient care encounter. For example, a healthcare worker would don a gown and eye protection if she is treating a patient with infectious diarrhea (Fig. 3.2).

Cough Etiquette

Cough etiquette is concerned with containing potentially infectious respiratory secretions. Healthcare workers and patients should cover their mouths and noses with a tissue when sneezing or coughing. Hand hygiene is performed after the hands are used to cover the mouth and nose, including after blowing the nose. If a tissue is not available, one should cough or sneeze into the elbow, remaining aware that there may now be pathogens in that location which could be spread to others.

Fig. 3.1 A healthcare worker uses alcohol-based hand rub when entering the patient's room. (Potter PA, Perry AG, Stockert PA, Hall AM: *Fundamentals of nursing*, ed 10, St. Louis, 2021, Elsevier.)

Fig. 3.2 A healthcare worker donning gloves, gown, mask, and face shield. (From Garrels M: *Laboratory and diagnostic testing in ambulatory care: a guide for health care professionals*, ed 4, St. Louis, 2019, Elsevier.)

TRANSMISSION-BASED PRECAUTIONS

Some infectious disease patients may be identified as "higher risk" and have additional safety precautions. **Transmission-based precautions** are used in addition to standard precautions around patients known or suspected to have certain types of infections, resulting in the patient being placed in **isolation**, away from other patients. The disease-specific approach falls into one of three isolation categories:

- ***Contact precautions***—pathogens transmitted by direct patient contact or by contact with items in the patient's environment
- ***Droplet precautions***—pathogens transmitted by large particle droplets
- ***Airborne precautions***—pathogens transmitted by airborne droplet nuclei

Healthcare workers may be required to wear PPE, like a gown, gloves, eye protection, and a mask while in the room. Sometimes they will also need to wear shoe covers and leggings. A **respirator** (air filtration mask) may be required in some cases. Because scribes are considered as nonessential personnel, meaning their presence in the room is not necessary for patient care, there is no reason for a scribe to enter the room of a high-risk patient.

BLOODBORNE PATHOGENS

Because the medical setting is a workplace, the federal government's Occupational Safety and Health Administration (OSHA) has established standards designed protect workers from infectious diseases. OSHA's Bloodborne Pathogen standard requires employers to supply workers with PPE. The rules also require that the employer make available vaccinations against Hepatitis B.

Hospitals will require that anyone working in the facility be vaccinated or tested for some other common illnesses (e.g. tetanus, influenza, and tuberculosis). These requirements vary between healthcare facilities, but OSHA requires that employers offer postexposure evaluation and care to any worker who experiences an exposure incident.

Although a scribe should never have to worry about touching body fluids, there is still a risk of exposure associated with being in any healthcare setting. For example, if body fluids land on intact skin, the area should be washed, but otherwise poses no concern for transmission of infectious disease. If a patient's bodily fluids come into contact with a break in the skin or with mucous membranes (like the eyes or mouth), the scribe should ask their provider or charge nurse what the policy is regarding how to proceed.

INFECTION CONTROL MEASURES

The medical setting uses different terms to describe the level of cleanliness in different areas of the facility. Although the scribe is not responsible for implementing these measures, all healthcare workers are expected to understand them.

Cleaning is the removal of foreign substances, such as soil and organic material, from objects. Generally, cleaning involves the use of water and mechanical action with or without detergents. Another word for cleaning is **sanitization**.

Disinfection is the process of destroying microorganisms. This terminology most often refers to processes that kill pathogens but not their more resistant spores. The agent used is called a ***disinfectant***. Usually, when we speak about disinfection we are talking about objects and surfaces.

Antiseptics are a means to destroy or inhibit the growth of microorganisms. An antiseptic agent is applied to the human skin or mucous membrane. Alcohol and chlorhexidine gluconate are antiseptics commonly used in healthcare.

Decontamination is the destruction of microorganisms from an object or surface so that it is safe to handle, touch, or use.

CASE STUDY 3.1

Seibei began training as a medical scribe because of his strong interest in the medical field and a desire to put his organizational skills to work. He studied hard, and it was not long before he landed a position at one of the city hospitals, working in the emergency department. There, he follows the providers in a fast-paced environment, one where people are working together to handle countless situations—including many surprises—with professionalism and flexibility. Seibei thinks he might study nursing someday soon, but for now, he cannot imagine doing anything else!

QUESTIONS

1. A father brings his son into the ED straight from a soccer game with a long laceration along the boy's forehead. Seibei accompanies the provider to collect information about the accident. What will the provider do upon entering the room?
   a. Apply a foam hand rub
   b. Lock the door
   c. Don a gown
   d. Wash his hands
2. The provider will examine the patient and likely clean the wound before suturing it shut. According to standard precautions, what PPE will the provider don before touching the wound?
   a. None
   b. Gloves
   c. Goggles
   d. Gown
3. While Seibei is in the work area finalizing the H&P note, a coworker is complaining that she has a bad cough. Which statement made by the coworker is incorrect?
   a. "I make sure to cover my mouth and nose when I cough."
   b. "I cough into a tissue and then throw the tissue in the trash."
   c. "I wear gloves when I cough to prevent spreading germs."
   d. "I wash my hands after I cover my mouth."
4. Seibei accompanies the provider to examine a patient brought to the hospital by the police. The man crashed his car into a fast food restaurant. When the police explained to the man that he was being arrested, the man said that he wanted to kill himself. Where in the room should Seibei stand while documenting the patient encounter?
   a. Between the patient and the exit
   b. At the head of the patient's bed, opposite the provider
   c. At the foot of the bed
   d. Between the patient and the provider
5. What vaccination did Seibei receive before starting his job at the hospital?
   a. Bacterial pneumonia
   b. Tuberculosis
   c. Shingles
   d. Hepatitis B

Sterilization is the process of destroying all microorganisms and their spores. This can be done chemically or by using intense heat and pressure, such as in an *autoclave*. The ***autoclave*** is a machine that sterilizes surgical instruments.

STERILE TECHNIQUE

A patient in surgery is especially prone to infectious disease because the body's natural barrier against microorganisms, the skin, is broken. The surgical incision can introduce pathogens into tissues of the body where there are few defenses against them. In the operating room and other areas where invasive procedures are performed, efforts are made to create a **sterile** environment, one that is free of all microorganisms. The methods used to destroy all microorganisms and keep them away from the exposed patient are collectively known as **sterile technique**. For example, sterile

gloves, gowns, and drapes are used to create a barrier between the environment (which includes members of the healthcare team) and the patient (Fig. 3.3). All of the surgical instruments used during the procedure are sterile.

The healthcare worker strives to avoid passage of infectious disease agents from the ill patient to the healthcare worker, and also from the healthcare worker to the patient. This is best done by observing and staying clear of areas with instruments and surgical items that are opened from a sealed package, as surgical items are always sterile prior to use (Fig. 3.4). In addition, any area of the patient that is draped in preparation for a procedure is likely to be sterile. The provider will wash hands and use packaged (sterile) gloves before approaching these areas. This should be recognized as another clue to the area and instruments being sterile. Frequently sterile equipment and areas will be identifiable by the color of the drape or packaging, surgical blue, although this is not universal. The scribe should stand back from these areas. He or she should not touch anything on the sterile field (Fig. 3.5), lean over it, or even cough or sneeze in the direction of the sterile field (use "cough and cover").

Fig. 3.3 The patient is draped for surgery to repair a broken leg. (From Sheth NP, Lonner JH: *Gowned and gloved orthopaedics: introduction to common procedures*, Philadelphia, 2009, Saunders/Elsevier.)

Fig. 3.4 Sterile instruments opened from their packages in preparation for a procedure (in this case, a vaginal birth.) (From Murray S, McKinney E, Holub KS, Jones R: *Foundations of maternal-newborn and women's health nursing*, ed 7, St. Louis, 2019, Elsevier.)

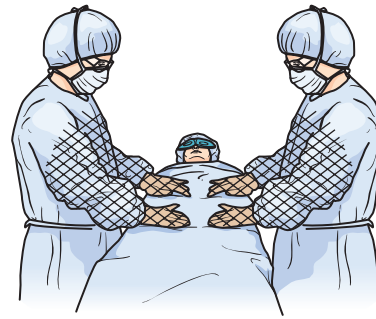

Fig. 3.5 The sterile field. (From Hornacky A, Phillips N: *Berry & Kohn's operating room technique*, ed 14, St. Louis, Elsevier, 2021.)

There are several rules that must be followed during sterile procedures to limit patient exposure to microorganisms while the skin barrier is compromised during the procedure. If a scribe is observing a procedure in which their provider is participating or leading, the scribe must also be adherent to these rules, which include the following:

1. All articles in a sterile field are sterile.
2. Persons who are sterile touch only sterile articles.
3. Persons who are unsterile touch only unsterile articles.
4. Sterile persons avoid leaning over unsterile areas and vice versa.
5. If in doubt, do not touch.

Practice Questions

1. A(n) _____ is a microorganism that causes disease.
2. Gloves, gowns, respirators and facemasks, and eye protection are all types of _____.
3. _____ are used in addition to standard precautions around patients known or suspected to have certain types of infections, resulting in the patient being placed in isolation, away from other patients.
4. The federal agency responsible for the Bloodborne Pathogen standard is the _____ _____.
5. The term _____ refers to the process of destroying all microorganisms and their spores.
6. In the surgical suite, instruments wrapped in packages are considered _____ _____.

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PART II

Health Record Documentation

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CHAPTER 4

The Health Record and Notes

LEARNING OBJECTIVES

1. Explain the importance of accurate and complete healthcare documentation and list the uses of healthcare documentation.
2. Define the electronic health record and explain its functions.
3. List and explain the components of a health record.
4. Discuss medical coding and explain the uses of various code sets.

KEY TERMS

Algorithm
Attending note
Centers for Medicare and Medicaid Services (CMS)
Claim
Clinical decision support (CDS)
Coding
Computerized physician order entry (CPOE)
Continuity of care
Current Procedural Terminology (CPT)
Diagnosis
Electronic health record (EHR)
Evaluation and management (E/M) code
Health record
International Classification of Diseases, 10th Revision, Clinic Modification (ICD-10-CM)
Level of service (LOS)
Litigation
Medicaid
Medicare
Objective
Operative note
Order
Outcome
Problem list
Problem-oriented charting
Progress note
Provider note
Quality
Reimbursement
Revenue cycle
Sign
SOAP note
Subjective
Symptom
Therapy
Third-party payer
Trauma note
Treatment plan
Value-based purchasing

Health Documentation and its Uses

As discussed in Chapter 2, medical professionals rely on complete and accurate documentation of patient care. All the data about the patient and the care he or she obtained is documented in the **health record**. The patient's identifying information, medical history, laboratory results, diagnoses, medications, problems, and procedures and other services received are all recorded here. The purpose of the health record is to communicate the services rendered and the plan of care to others.

USE IN PATIENT CARE

Primarily, the health record is used to guide patient care. For example, a physician records his findings in the record so that other physicians, nurses, and the rest of the healthcare team can refer