TITLE: Usage of Copy/Paste, Copy/Forward and Prepopulated Narrative Functionality in Provider Notes in the Electronic Medical Record

POLICY/PURPOSE: The purpose of this policy is to provide guidance on the use of copy functionality when documenting in the Electronic Health Record, to align with the Office of the Inspector General (OIG) and the Medicare Administrative Contractor's (MAC) view on copy/paste and template usage. The OIG's view: Inappropriate copy-paste is the common cause for inaccurate medical records, inflated claims and over billing. Auto-populating fields when using templates or creating extensive documentation after a single click of a checkbox, can result in inaccurate medical records if unedited.[1]

Medicare's view: cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.[2]

There can be value to copying information, but it must be done selectively and thoughtfully, in compliance with our institutional policies, and with a goal of producing a clear, concise, and accurate patient note. It is important that notes accurately describe the work performed for the specific episode of care and do not inadvertently include extraneous or inaccurate information that may misrepresent services provided.

DEFINITIONS:

Copy and Paste – the process of copying existing text from one electronic document and pasting it into a new destination to create a document at a later date. It is also known as copy forward, cloning, cut and paste, pull in and carry forward.

Templates – customizable forms that are short, easy to use and include positives and negatives.

Auto-population – to populate information on a form automatically.

Macro – a single instruction that expands automatically into a set of instructions to perform a particular task.
• CMS only allows the teaching physician (TP) to use a macro as the required personal documentation if the TP adds it personally in a secured (password protected) system like Teaching Physician Attestation Statement (TPS).

Smart Lists – a predefined list of choices.

Smart Texts – templates or blocks of text.

Smart Phrases – long words, phrases, or paragraphs.

Smart Links – information from another part of the chart.

PROCEDURE:

1. **Provider Responsibility**

   A. Regardless of the tools used to create the note, the provider acknowledges via signature his or her responsibility for all content.

   B. It is the billing provider's responsibility to ensure that copied information has been appropriately updated to reflect the current patient status.

   C. If you did not author copied information, you must attribute the author, OR source including naming the previous author and date of the original note (includes when copy/previous note functionality is used).

   D. If the author is unknown, do not copy the information or indicate that the author is unknown.

2. **Author Responsibility**

   A. The following tasks are the responsibility of the Author.

   - Review notes for accuracy, completeness and relevance;
   - Confirm/authenticate that all information is current and pertinent and occurred on that date of service;
   - Communicate their medical judgment and assessment;
   - Strive for concise, articulate, clear communication; and
   - Complete notes in a timely manner.

   B. Additional caution and consideration of patient safety and reasonableness should be exercised when copying information that is not recent.

   C. Copying information already available in other parts of the medical record is discouraged. Referencing the information by author, date/time, and location is

encouraged. Alternatively, utilize EPIC "bookmarks" to reference key elements of the medical record.

D. Copying entire laboratory or radiology reports already recorded in the medical record is discouraged. Summarizing findings and medical judgment is encouraged. The use of collapsible and refreshable links in EPIC is encouraged.

3. Prohibited Use

A. Do NOT copy information from one patient to another.

B. Do NOT copy information where the author is unknown.

C. Be careful about defaulted normal findings or "standard language" in Evaluation and Management services (E&M) documentation to ensure accurate information about the patient at the time of the encounter.

D. Do NOT copy notes written by students, including medical students (exception: the Review of Systems or Past, Family, Social portion of history may be used in documentation in support of a bill). Do utilize all portions of medical student notes in support of a bill IF the history was obtained in the presence of a resident or attending, the physical examination and medical decision making was completely performed (or re-performed) by a teaching physician, who then verified all medical student documentation through the use of an approved addendum.

E. Do NOT copy others' signature blocks to avoid confusion on note authorship.

F. Do NOT copy without editing the History of Present Illness (HPI, the subjective portion of the daily progress note). HPI must be original to each episode of care.

4. Templates

A. Do not prepopulate findings that are not known in advance of the service. A template that prepopulates the narrative portion of E&M services, including the History, Exam and/or Medical Decision Making, is prohibited.

B. Any documentation where options are represented with a preset default must be individually reviewed and confirmed as to the accuracy of the default documentation for the particular episode. Services documented must be pertinent to the episode of care and be clear as to services provided that day.

C. E&M services, Review of Systems: After documenting pertinent findings, you may indicate all other systems are negative by single positive action (click), but only when all systems documented were reviewed during the visit, and it was medically necessary to do so.

D. E&M Services, Exam: Depending on the specialty of the service provider, a physical examination may or may not vary from patient to patient or from encounter to encounter. However, providers must take care when using templates, macros, or smart phrases by reviewing the documentation, editing it where appropriate, and removing any information for service elements not performed.

5. Questions/Information

- Physician Billing Compliance Services Gainesville (352) 265-8359
- Physician Billing Compliance Services Jacksonville (904) 244-2158

REFERENCES:

[1] H.H.S. O.I.G OEI-01-11-00570. "Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology." December 2013.
[2]. First Coast Service Options, Inc. Medicare B Update. "Requirements for the Payment of Medicare Claims—A Selection of Some Important Criteria." 3rd Qtr. 2006.

APPROVED BY: Robert Michalski, Chief Compliance and Privacy Officer