CU Medicine Guideline for Copy Functionality and Macro Templates in EMR Systems

Introduction:

The patient's medical record is considered to be the medical/business and legal record for an organization. As such, the medical -record should comply with legal requirements as well as business and clinical documentation standards. The Health Information Technology for Economic and Clinical Health Act (HITECH) and health information changes (HIE) have expedited the move to implement electronic health records. In this environment of new and rapidly evolving technologies, the copy/paste functionality has the potential to affect the integrity of the health record. CU Medicine is committed to maintaining the highest level of data integrity in the electronic medical record given the impact to patient care, patient safety, patient communication, clinical revenues, and legal risk. CU Medicine is also committed to recognizing the value and efficiencies that can be captured utilizing an electronic health record.

Background:

The CU Medicine Finance and Audit Committee originally created a guideline for copy/paste functionality in an electronic health record in 2008, with revisions in 2010. Since that time CU Medicine has partnered with the Association of American Medical College Compliance Officers Forum to endorse an advisory on the risks of copy functionality and provide recommendations about how to use copy functions to generate a medical record with ease and accuracy while minimizing compliance and legal risks. The identified risks of inappropriate copy functionality in an electronic health record include:

- Populating a note with outdated, conflicting, incomplete or inaccurate information that may adversely impact patient care
- Inability to identify the original author in the EHR. Using documentation originally authored by individuals (e.g. medical students, RN's on cost report) whose documentation is limited for billing purposes
- Original date of note creation may not be evident or may be difficult to locate and may impact patient safety
- Notes that are repetitive, inconsistent or identical may not further the care of the patient and may call into question the medical necessity of the care, and result in payment denials, audits or investigations
- Notes that are too long and contain irrelevant information may increase the risk that pertinent, new and critical information is overlooked, or may not be ready by other providers leading to poor communication, duplication of services or delay in the patient receiving appropriate care
- Perpetuation of errors in medication and allergy lists
- Inconsistency of documentation

Benefits of documenting in an EHR should be recognized. Benefits of an EHR include:

- Improved efficiency of documentation
- Problem list tracking
- Continuity of medical decision-making
- Completeness of encounter documentation
- Facilitated creation of paperwork and patient instructions
- Creation of searchable data for health-care research

Purpose:
To provide guidance to assure the information contained in the patient's electronic health record contains information that is accurate, trustworthy and meets all the medical, business and legal requirements. Specifically this document will provide guidance on the use of copy functionality when documenting in an electronic medical record so that:

- Documentation meets all federal/state mandated and CU Medicine mandated documentation compliance standards
- Each record provides evidence of the patient's medical evaluation, treatment, and change in condition as appropriate.
- Encounter specific documentation establishes the medical necessity of all services rendered by the billing provider
- Note accurately represents clinical work performed each day, with clear attribution of the work of all providers involved in the care of a patient.
- Benefits of documentation assist features can be appropriately utilized to improve the efficiency of data capture, timeliness, legibility, consistency, and completeness of the patients record

Definitions:
For the purposes of this guideline the term copy means any one of the following synonyms: copy cut & paste, copy/forward, re-use, carry forward, predetermined text, cloning, auto-populated and save note as a template.

- *Cut & Paste*: removing or deleting from the original source text or data to place in another location.
- *Copy & Paste*: selecting data from an original or previous source to reproduce in another location.
- *Copy Forward*: a function that copies a significant section or entire prior note.
- *Template*: documentation tools that feature predefined text and text options used to document the patient visit within a note.
- *Populating via Default*: data is entered into a note via an electronic feature that does not require positive action or selection by author. For example, documenting Review of Systems in a patient history, EMR functionality that enters the phrase "negative" without requiring the author to select a checkbox, or otherwise indicate that the work was performed.

- *Macro*: expanded text that is triggered by abbreviated words or keystrokes.
- *Automated Change of Note Author*: changes authorship of a note written by someone else to current use of the note

Teaching Physician Rules

- The performing/billing provider must follow all regulations as related to the teaching physician guidelines when documenting encounters performed with a student or resident. **The guideline for copy functionality DOES NOT supersede the teaching physician guidelines.**
  - Teaching physician guidelines in an EHR determine WHAT may be copied by user role and/or the information being copied.
  - Teaching physician guidelines in an EHR determine WHO may be copied.
  - Signature requirements for all providers documenting in an EHR must meet CMS signature requirements.

Guideline Recommendations:

- The billing provider is responsible for the entire content of the documentation/note including its accuracy, communicative value, pertinence to the episode of care, and appropriate attribution including copied information, if any.
  - The billing provider should 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, complete notes in a timely manner
- When using an EHR it is acceptable for the performing/billing provider to use copy functionalities when the provider has confirmed the following:
  - The identically replicated text and findings are integral and relevant, and medically necessary to the current encounter, and are not solely used to support a level of billing.
  - The performing/billing provider actively reviews and confirms with the patient at the current encounter, all elements of the copy/paste, copy/forward, auto populated text. The performing/billing provider must edit and document customized history elements relevant to the current encounter on the specific date of service.
  - If you did not author copied information, you must attribute the author, including naming the previous author and date of the original notes.
    - If the author is unknown, do not copy the information
  - If the work of the identified author is “not billable” given the role of the author or the nature of the clinical setting, the billing physician is responsible for reviewing, verifying, modifying, editing all information in a secured EHR environment such that the elements authored by the non-billable provide become billable elements.

- The performing/billing provider must follow all regulations related to the teaching physician guidelines when documenting encounters performed with a student or resident. The above guidelines for copy functionalities**,** and predetermined text and predetermined findings DO NOT supersede the teaching physician guidelines.
- A teaching physician may use a macro as the required personal documentation if he or she personally adds it in a secured or password protected system. In addition to the teaching physician's macro, either the resident or the teaching physician must provide customized information that is sufficient to support a medical necessity determination. The note in the EHR must sufficiently describe the specific services furnished on the specific date. It is considered insufficient documentation if both the resident and the teaching physician use macros only,
- The performing/billing provider must actively perform all physical exam elements of the replicated text findings. The performing/billing provider must edit and document all new findings unique to the current encounter.
- The attestation a performing/billing provider has actively reviewed, confirmed, performed, updated, and edited the copied functionality documentation is supported by:
  - The performing/billing provider signature in a secured (password protected) system.
  - The CU Medicine billing documentation attestation statement as signed by the billing provider.
- The performing/billing provider must report in addition to the identically replicated text and findings customized information specific to the services furnished on the specific date
  - Customized information is defined as information that is written in a distinct and differentiated format which differs from that of the copy functionalities utilized. It is expected that customized information will always be obtained during a current encounter. Customized information is required for elements that are age/time sensitive, or are subjective and would be expected to vary with time - such as reported onset, location, duration, severity, aggravating and associated symptoms, and items in the plan of care.
  - When using a copy functionality to replicate data from a billable or non-billable provider, the billing provider MUST at a minimum document the History of Present Illness and Medical Decision Making sections of the medical record with customized documentation. In addition, when using copy function to replicate data from a billable or non-billable provider, the billing provider is required to actively perform all elements of the replicated text findings and provide documentation of new findings as referenced above.

- In the outpatient setting, customized information is further defined as information that clearly reflects the events or changes that have occurred since the previous visit. Customized information must always reflect medical necessity, and provide distinct evidence that the documentation reflects the billing providers work product.
- In the inpatient setting, customized information is further defined as information that clearly reflects patient progress and events over the interval since the last encounter. Evidence that customized information has been obtained should be verifiable comparing the billing providers copied documentation with the documentation from other care providers on the same date of service.
- Customized information must always reflect medical necessity and provide distinct evidence that the documentation reflects the billing providers work product.

▪ History of Present Illness and Plan of Care data documented by a non-billable provider (including the patient) using a physician guided template, customization must be supported by:
  - Billing provider actively reviews and confirms the data elements
  - Billing provider edits the template guided responses where appropriate for time-sensitive or subjective responses.
  - History of Present Illness: Fixed items reflecting medical/surgical complexity (e.g. review of relevant PMH, recent events) that are cut/paste, copy/forward that are reported in the HPI, may appear unchanged over multiple encounters.
  - The attestation that a performing/billing provider has customized information by actively reviewing, confirming, updating, and editing the HPI data that has been copy/paste or copy/forward from a physician guided HPI template is evidenced by:
    - The performing/billing provider signature in a secured (password protected) system.
    - The CU Medicine billing documentation attestation statement as signed by the billing provider.

- Do not copy information from one patient to another
- Do not pre-populate defaulted normal/negative findings or “standard language” into a note
  - Documentation should be provided by positive action, not default.
  - Services documented must be pertinent to the episode of care and be clear as to services provided that day

  - After documenting pertinent findings, (positive action) you may indicate all other systems are negative by a single positive action but only when all system documented was reviewed during the visit and it was medically necessary to do so.
  - Documentation of a physical exam should be a positive action for only the systems examined. Providers should not populate the remainder of the physical exam template with defaulted language.
- Medical student notes should be considered for teaching purposes only. At most the student ROS and PFSH may be copied to support a level of service
- Do not copy information without referencing the information by author or source, date/time and location.

Enforcement of Standards

Providers are responsible for the total content of their documentation, whether the content is original, copied, pasted, imported, or reused.

Exact duplication of notes across multiple encounters; unchanged without customized information, notes without a clear indication that all copied findings have been reviewed, confirmed, performed and edited, excluding fixed history or data items, or "minimally changed" not meeting the above requirements, will be subject to a formal audit. Evidence that customized information has been obtained should be verifiable comparing the billing providers copied documentation with documentation from other care providers on the same date of service. Customized information must always reflect medical necessity, and provide distinct evidence that the documentation reflects the billing providers work product.

CU Medicine ACE is also responsible for working with affiliate HIM managers to encourage where appropriate the installation of software that allows audit tracking.

The CU Medicine Audit, Compliance & Education Department is responsible for evaluating cases of inappropriate copying and pasting. The cases will be referred to the CU Medicine Compliance Committee for final review and action. The CU Medicine Compliance Committee is responsible for recommending corrective action and disciplinary action when continued inappropriate use of copy technology is identified. Failure to comply with the organizational policy regarding copy functionality may be deemed a violation of the CU Medicine Member Practice Agreement.

References:
AHIMA Copy Functionality Toolkit 2012
AAMC Compliance Advisory 2 – Copying/Importing/Scripts/Templates 2011
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Approved by CU Medicine Board of Directors: Aug. 19, 2014

[i] **Revised Nov. 18, 2010, July 17, 2014**