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Policy on Copy/Paste, Other EHR Documentation

Alvin Gore, M.D., physician advisor and director of utilization management at St. Joseph Health System in Santa Rosa, California, developed this policy on the use of copy and paste and other electronic health record practices. "We made it clear the physician of record is responsible for everything in the chart," he says. Contact Gore at alvin.gore@stjoe.org.

ELECTRONIC HEALTH RECORD (EHR) DOCUMENTATION STANDARDS AND GUIDELINES

MANUAL: MEDICAL STAFF POLICIES AND PROCEDURES

Effective Date: 6/28/2016

Approval _____

Reviewed/Revised:

I. VALUES CONTEXT

Our values call us to respect the inherent dignity and worth of every individual and develop systems and structures that attend to the needs of those at risk of discrimination because of age, gender, lifestyle, cultural or ethnic background, religious beliefs or socioeconomic status.

II. DEFINITIONS

Electronic Health Record (EHR) patient-related electronic documentation which provides an accurate depiction of treatment surrounding a specific date of service.

Cloning documentation refers to medical record documentation that has been cut and pasted from another source location and, consequently, may or may not accurately reflect information specific to the individual patient encounter once it is completed in its cloned location.

Automatic Data Recall shall be understood as electronic functionality that automatically pulls in information from other areas of the electronic record or electronic text or templates that pull in preset information.

Physician Providers include any attending physicians (MD, DO, DPM or dentists).

Non-Physician Providers include nurse practitioners, certified nurse midwives, and physician's assistants, who may create clinical notes.

Providers will mean both Physician Providers and Non-Physician Providers.

III. SCOPE

All Santa Rosa Memorial (SRM) EHR users, including, but not limited to, Physician Providers and Non-Physician

Providers, who document health care items or services and any EHR system as part of providing services on behalf of SRM.

IV. PURPOSE

The purpose of this Policy is to establish the standards and criteria for the appropriate use of the EHR in order to meet Federal and State rules and regulations regarding appropriate Provider documentation and the integrity of the patient record, including the use of Automated Data Recall and Cloning in the Electronic Health Record.

V. POLICY STATEMENT

The EHR's quality and integrity shall be maintained by adhering to identified standards in entering complete, concise, accurate and updated information that produces clear and useful medical record. The EHR should document clinical work performed on each patient each day. Copy and pasting may occur only through a thoughtful evaluative process that assists with the accurate documentation of the specific services provided, supports medical necessity, and produces a record that enhances patient care.

VI. PHYSICIAN'S RESPONSIBILITY AND EXPECTATIONS

1. The Physician Provider is ultimately responsible for the accuracy of the health record for each patient under the physician's care.
2. Physician Providers are required to document in compliance with all federal, state, and local laws, Hospital policies and procedures, and Medical Staff Bylaws, Rules, and Regulations.
3. Physician Providers are solely responsible for:
    a. The total content of their documentation, whether the content is original, copied, pasted, imported or re-used.
    b. Correcting and dating any errors identified within documentation and clearly noting in the EHR that this is a correction of previously inaccurate information.
    c. Citing outside or a third-party source when external data is documented in a note.
    d. Reviewing, attesting and appropriately updating the Assessment/Problem List of each note.
    e. Attesting and dating that there has been no change, if the Assessment and/or Plan are copied and are unchanged from the previous note.
    f. Checking for contradictory information in the medical record documentation.
    g. Ensuring the accuracy and medical necessity of any information that is imported or re-used from a prior note.
    h. Ensuring that significant abnormalities which are copied into the chart are also documented in the Assessment and Plan section of the note (e.g., an elevated potassium level copied into a note should have a plan to address the abnormality).
    i. Clearly identifying the individual who performed each service documented within the note. When entering patient data into the medical record that the Provider did not personally take or test, the Provider must attribute the source and their credentials (e.g., PA, NP, CNM).

4. Providers are discouraged from:

    a. Indiscriminate use of copying or use of the data recall, particularly use which results in redundant information from other parts of the EHR, which makes it difficult to identify current information (e.g., other Provider's progress notes, prior Discharge Summaries, diagnostic test findings).

    b. Indiscriminate use of "Normal Limits" shortcut: if the "Normal Limits" shortcut is used, the Provider will de-select items not performed and ensure that abnormal findings are documented correctly.

5. Providers must notify hospital's Health Information Management immediately regarding any inaccurate entries that cannot be corrected by the Provider (e.g., wrong patient, wrong record, outside media which cannot be altered).

6. In addition to a general date reference (e.g., post-op day 1, hospital day 1), the use of a calendar date is encouraged in order to clearly discern when a particular service was delivered.

7. Once a note has been signed as final, additional information may only be added as a separate addendum that is clearly marked with dates and times.

VII. ACCEPTABLE USE OF COPY AND PASTE

1. Providers may copy relevant portions of the patient's previous notes or use the Automatic Data Recall, entered by the same Provider, to the extent it represents the level of work performed by the Provider during the current visit and is revised to reflect any changes in the information. Historic conditions or services will be clearly differentiated from present conditions or services. In such cases, the Provider's signature shall serve as his/her attestation that the information is accurate, and that all information is current and represents the Provider's services for that date of service.

2. While some portions of medical information may be copied and pasted, the Chief complaint, Review of Systems, Physical Examination, Assessment and Plan sections of the patient's record should not be copied from another author, except in circumstances when information is not obtainable directly from the patient. Interval history, subjective HPI, Physical Examination, Assessment and Plan should not be copied from another author without updating each section of the note with dated current information.

3. If test results are located elsewhere in the EHR, Providers are encouraged to summarize the diagnostic test findings rather than copying the complete report into a note. When the entire report is used, it should be accompanied by proper notation and clear attribution.

4. Notes from other Providers can only be used as reference information and cannot be copied into a current note. Providers are responsible for ensuring notes copied from another Provider retain date, time, and original Provider notation. For example: "Per Progress Note of Dr. X dated 1/1/2015." Notes copied from other Providers will have no impact on the scoring of the current entry.

5. Automatically pre-populated data, such as Lab results or "Shared queries," that are not attributable to a specific Provider.

VIII. PHYSICIAN ATTESTATIONS

The Physician Provider will apply the appropriate attestation to accurately reflect their involvement in the care and treatment of the patient and documentation of the visit in compliance with physician guidelines.

IX. NONCOMPLIANCE PROCESS

1. Noncompliance with documentation standards and guidelines can be identified by any authorized EHR user or patient who reviews the EHR.

2. When a potential documentation compliance issue is identified, the Medical Record Number (MRN), name of the Health Care Provider, and a description of the error shall be forwarded to the Chief Medical Information Officer (CMIO) for review with the Provider.

3. If documentation practices remain unchanged following CMIO intervention, the CMIO will escalate to the Chief Medical Officer (CMO) for review and recommendation.

4. If further escalation is required, the CMO will refer to the Chief of Staff, who will initiate appropriate procedures to address and resolve any incident(s) of noncompliance, including, but not limited to, Education, Monitoring and Corrective Action pursuant to Medical Staff Bylaws.

X. APPROPRIATE DOCUMENTATION BY NON-PHYSICIAN PROVIDERS

1. Physician Assistants, Nurse Practitioners and Certified Nurse Midwives can document the reason for visit, past medical history (PMH), past surgical history (PSH), social/family history (SH/FH), or review of systems (ROS), as long as the physician reviews and revises as needed, including the information and documentation of services provided.

2. The Physician Provider or Non-Physician Provider must perform and complete the documentation of the Chief Complaint, History of Present Illness (HPI), Physical Examination (PE) (except for vital signs) and Assessment & Plan (medical decision-making) entries.

3. If any documentation within these sections was started by someone other than the physician, an attestation statement entered by the physician (separate from the original note template) should reflect the Provider reviewed and edited these sections.

References

Author/Department: Dr. Alvin Gore, HIM Committee

1. Center for Medicare & Medicaid Services, CMS Manual System, Pub 100-08, *Medicare Program Integrity Manual*, Transmittal 445, March 15, 2013.

2. Center for Medicare & Medicaid Services, CMS Manual System, Pub 100-08, *Medicare Program Integrity Manual*, Transmittal 442, December 7, 2012.

3. The Joint Commission, *Quick Safety: Preventing copy-and-paste errors in EHRs*, Feb. 15, http://bit.ly/38Cyn86.

4. Center for Medicare & Medicaid Services, *Medicare Program Integrity Manual*, Chap. 3, "Verifying Potential Errors and Taking Corrective Actions," Rev. 634, 01-22-16, https://go.cms.gov/2GjS0p2.

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