

Policies and Procedures:
Copy and Paste Functionality in Electronic Documentation

Section: Compliance
Chapter: Administration
Policy: Copy and Paste Functionality in Electronic Documentation

I. PURPOSE

To establish a policy which provides guidance to WVUPC providers on the compliance related limitations applicable to “copy and paste” functionality and documentation within an electronic health record. This guidance should be construed as applying to any feature within the Epic system which allows a provider to document a series of typed characters or other keystrokes in order to quickly document portions of a medical note.

II. APPLICABILITY

This policy applies to all WVUPC providers who enter documentation into a WVUPC clinical record within the Epic system.

III. BACKGROUND

1. Unlike notes written on paper, a note written in an electronic health record (EHR) can be generated by using information that has already been recorded elsewhere, and imported into the EHR. The result can be a note that appears to be new and contemporaneous, but actually is a combination of pre-existing material.
2. When used appropriately, copy functionality can be a valuable tool; however, if used inappropriately, it may produce a medical record that contains an inaccurate summary of work actually performed. From the billing perspective, inappropriate use of copy functionality could suggest to third party reviewers that services were provided when, in fact, they were not, resulting in the submission of an unsupported bill.
3. Incorporating information that is not original to the author into a note also has the potential to jeopardize patient care and to expose providers and/or institutions to liability on several fronts. Risks include the following:
 - i. Populating a note with outdated, conflicting, incomplete or inaccurate information;
 1. This can result from many of the copy functions available in an EHR. For example, the ability to default or auto-populate checkboxes (primarily in review of systems and physical exams) to “no” or “negative” upon starting a new

note or closing a note may inadvertently include conflicting information in a single note; for example, a negative finding in the review of systems, but a positive chief complaint.

- ii. Inability to identify the original author in the EHR;
 - iii. The original date of note creation may not be evident or may be difficult to locate;
 - iv. Notes that are repetitive, inconsistent or identical
 - 1. Such notes do not further the care of the patient and, over time, are likely to be ignored by care givers due to stagnant information;
 - 2. Repetitive documentation may call into question the medical necessity of the care, thus triggering insurance payment denials, audits and/or investigations;
 - v. Notes that are too long and contain irrelevant information
 - 1. When a note is excessively long and cluttered with “canned” text, the important parts are likely lost to the reader. This increases the risk that pertinent, new and critical information is overlooked, or may not be read by other providers.
 - vi. Misleading or false attribution of work performed by others into the current note.
4. Palmetto GBA prohibits the practice of “cloned” documentation. Cloned documentation exists when documentation is worded exactly like previous entries, and will be considered misrepresentation of the medical necessity requirement for coverage of services by our Medicare Administrative Contractor.
5. While there can be value to the selective and careful copying of information within a patient’s chart, copy functionality must be done selectively and thoughtfully, in compliance with institutional policies, and with the goal of producing a clear, useful and accurate patient note.

IV. POLICY/PROCEDURE

- 1. Providers must use the utmost caution when utilizing copy and paste functionality within Epic or any other EHR system.
- 2. Regardless of the tools used to create the note, the individual signing it acknowledges his/her responsibility for the accuracy of the content of that note.

3. The note entered into the EHR must accurately reflect the clinical work performed on each separate date of service, with clear attribution of the work of others as applicable.
4. Although providers may utilize “copy and paste” functionality within Epic and within a particular patient’s chart, the following are prohibited practices: (a) copying notes from one patient’s record into the record of a different patient; (b) copying/pasting of medical student notes (other than review of systems and past family and social history); and (c) history of present illness.
5. If the provider uses information from a prior encounter with the same patient, the author should reference the date of the previous note that the information was copied from.
6. Do not copy documentation from another author without proper notation and attribution to the original author. This includes reference to the date, time and author of the original entry. Failure to properly attribute authorship has the potential to trigger false claim exposure and liability.
7. Providers should refrain from copy/pasting entire notes from a prior encounter, since this practice leads to the appearance of prohibited “cloned” documentation, and also increases the potential for errors in documentation accuracy to occur.
8. Providers are encouraged to cite and summarize applicable lab data, pathology and radiology results, rather than copying such reports in their entirety into progress notes and documentation.
9. Once a note has been entered into the patient’s record and is signed, it should be considered final. Any additional information should be added as an addendum.
10. Careless use in the use of “copy/paste” functionality within Epic may result in adverse audit findings, non-billing of services and/or repayment of previously submitted claims.

V. Amendment or Termination of this Policy

This policy may be amended or terminated at any time.

VI. References

- CMS Medicare Learning Network Fact Sheet: “*Guidelines for Teaching Physicians, Interns and Residents*,” ICN 006347, December 2011
- Palmetto GBA (J11, Part B), “*Medical Record Cloning*,” 12/06/2011
- AAMC Compliance Officers’ Forum, “*Appropriate Documentation in an EHR: Use of Information That is Not Generated During the Encounter for Which the Claim is Submitted: Copying/Importing/Scripts/Templates*,” 7/11/2011
- <http://jama.ama-assn.org/content/295/20/2335.full>

POLICY/PROCEDURE NO.: B-28

Effective date: August 23, 2012

Date(s) of revision: _____