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	EFFECTIVE DATE: 08/17/2020	REVISION DATE(S):
SUBJECT: Copy/Paste and Copy/Forward Functionality In Electronic Documentation Policy		

OBJECTIVE/BACKGROUND:


A new note written in an electronic health record (EHR) can be generated by using information that has already been recorded electronically 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can be a note that appears to be new and contemporaneous, but actually is a combination of pre-existing and possibly outdated material. While there can be value to the selective and careful copying of information within a patient's chart, the use of copy functionality (namely copy/paste and copy/forward) must be done selectively and thoughtfully, in compliance with institutional policies, and with the goal of producing a clear, accurate and useful note.

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. The UMMS electronic medical record contains a recommended control to monitor copied documentation and provides an audit trail to identify where and when the documentation originated, and who copied it, and when it was copied.

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 due to the inappropriate use of copy/paste and copy/forward functionality include the following:

- Populating a note with outdated, conflicting, incomplete or inaccurate information.
- Difficult to identify the original author in the EHR.
- Original date of note creation may not be evident or may be difficult to locate.
- Notes that are repetitive, inconsistent or identical.
- Notes that are too long and contain irrelevant information.
- Misleading or false attribution of work performed by others into the current note.
- Adverse audit findings, non-billing of services and/or repayment of previously submitted claims.

The University of Maryland Medical System (UMMS) prohibits the practice of "cloned" documentation. Cloned documentation exists when the entire set of documentation is worded exactly like a previous entry, without appropriate annotation to the patient's current condition or plan.

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DEFINITIONS:

Copy and Paste	Duplicating text found in an original document and placing that copied text into a new document.
Copy Forward	An EHR tool that allows the function of copying a significant section or an entire prior note and forwarding that copied information into a new document.
Attribution	<p>The identification of the original note parameters that includes reference to the date, time and author of the original entry.</p> <p>When the copy and paste occurs within the Epic system, hovering over the content will provide the note attribution information.</p> <p>A manual attribution should occur when the copying of information occurs from outside of the Epic system. For example, <i>The (type of note) from (date/time) by (insert original author) indicates (insert copied information).</i></p>
Authentication	The identification of the author of a medical record entry by that author and confirmation that the contents are accurate what the author intended.


POLICY:

To establish a policy which provides guidance to UMMS providers on the compliance related limitations applicable to "copy/paste" and "copy/forward" functionality and documentation within an electronic health record (EHR). This guidance should be construed as applying to any feature within the respective EHR systems which allows a provider to document a series of typed characters or other keystrokes in order to quickly document portions of a medical note.

PROCEDURE:

Copy/Paste and Copy/Forward Functionality Guidelines


- 1) Providers must use extreme caution when utilizing copy/paste and copy/forward functionality within any UMMS EHR system. Sections of notes may be copied forward for a patient encounter, but should contain appropriate attribution and modification(s) to reflect the patient condition on that given day.
- 2) Regardless of the tools used to create the note, the individual signing it acknowledges his/her responsibility as the owner of that note as well as for the accuracy of the content of that note.
- 3) The note entered into the EHR should accurately reflect the clinical work performed on each separate occasion of service, with clear attribution, completed manually or with embedded attribution workflows, to denote the work of others as applicable.
- 4) Although providers may utilize copy/paste and copy/forward functionality within the UMMS EHR, and within a particular patient's chart, the following practices are to be followed:

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- a) Do not copy forward or copy/paste information in a manner that could make it appear that you provided services that you did not personally provide
 - b) Only copy forward or copy/paste information that you have read and/or have edited for accuracy.
 - c) Only copy forward or copy/paste information that is pertinent to the current encounter.
 - d) Do not copy information that identifies a provider as involved in care in which they were not involved.
 - e) Copy/paste entire laboratory findings, radiology reports, and other information verbatim into progress notes or other reports only when clearly pertinent and germane to the care provided.
 - f) Do not copy forward or copy/paste documentation from another provider, only your own, unless required for continuity of care purposes, with active attribution (i.e., as detailed in the note from...).
 - g) Any clinical documentation used from a prior encounter of the same patient should reference the date of the previous note from which the information was copied.
- 5) The copying of information from one patient record to a different patient's record is prohibited, with the exception of the following:
- a. When the family history is copy forwarded between family members.
 - b. When documentation is entered in error on the incorrect patient and needs to be moved to the correct patient's record. See Health Information Management Chart Correction policy (CHIM-003).
- 6) The author must not use the copy functionality from a medical student's documentation for evaluation and management services, unless the attribution indicates the medical student documentation was verified and attested to by the supervising physician.
- 7) Medical students are not permitted to copy forward or copy/paste.
- 8) Once a note has been entered into the patient's record and is signed, it will be considered final. Any additional information must be added as an addendum.

Reference and "refer to" Guidelines

- 1) The provider should reference the origin of the information and indicate the continuing validity of the information.
- 2) Previous documentation to which a reference is made should be available for review. If the document is not available for review, it should not be referenced.
- 3) Specific dates or version of the documentation included in the note should be properly referenced.
- 4) A provider should not refer to the documentation of a medical student except for the documentation of the review of systems and past medical family social history.

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REFERENCES:

- A. CMS Medicare Learning Network Fact Sheet: "Guidelines for Teaching Physicians, Interns and Residents," ICN 006347, December 2011
- B. Palmetto GBA (J11, Part B), "Medical Record Cloning," 12/06/2011
- C. 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
- D. HIM Chart Correction Policy: <http://intra.umms.org/umms/policies/health-information-management-policies>

POLICY OWNER:

Health Information Management reserves the right to alter, amend, modify or eliminate this policy at any time without prior written notice.