

Institutional Handbook of Operating Procedures Policy 06.03.01	
Section: Compliance Policies	Responsible Vice President: Senior Vice President and General Counsel
Subject: Billing Compliance	Responsible Entity: Office of Institutional Compliance

I. Title

Use of Cloned Documentation in the Electronic Medical Record

II. Policy

- A. This policy describes the appropriate use of cloned documentation in **the University of Texas Medical Branch’s (UTMB)** electronic medical record (EMR). This policy is based on guidance from The University of Texas System, best practices identified at other academic health centers, and the rules and regulations governing appropriate coding, billing and health care operations, including regulatory guidance from the Centers for Medicare and Medicaid Services (CMS), the Office of the Inspector General (OIG), Texas Medicaid, and the Joint Commission. Medicare Administrative Contractors for other jurisdictions outside Texas (e.g., National Government Services, First Coast Service Options, Palmetto GBA) have issued formal policies indicating cloned documentation does not meet Medicare’s medical necessity requirements for coverage (i.e., payment) of services.

- B. It is the expectation of UTMB that any documentation, including cloned documentation contained within or incorporated into the medical record represents services actually performed or reviewed on the indicated date of service by the indicated author. All services billed to a third-party payer or patient must be based on medical necessity and the actual services performed or rendered during the encounter/visit, and not on the volume of documentation contained within the medical record. Failure to comply with this policy may result in disciplinary action, up to and including termination, loss of appointment, or employment.

- C. This policy applies to all UTMB EMR users, including, but not limited to, teaching physicians, residents, medical students, advanced practice providers (e.g., nurse practitioner, physician assistant, etc.), nurses, technicians, medical assistants, and other individuals.

III. Risks Associated with the Inappropriate Use of Cloned Documentation in the EMR

- A. *Patient Safety.* The inappropriate use of cloned documentation may result in several risks to patient care. These risks include critical patient or treatment information being overlooked as a result of unnecessarily lengthy provider documentation, misinterpretation of the chronology of a patient’s illness and the services rendered to address that illness, and inconsistencies among current symptoms, examination findings, and treatment plans. Additionally, the inability to accurately identify each medical record author may bring into question the credibility of medical entries and has the potential to have a negative effect on patient care.

- B. *Professional Billing.* All provider documentation must comply with all federal, state, and local laws and UTMB's policies and guidelines. Provider documentation must support medical necessity and the appropriateness of services provided. Cloned documentation that is not appropriately edited and updated to reflect patient and visit-specific information does not, in most instances, meet the medical necessity requirements established by third-party payers for coverage or payment of services. All entries in the medical record must be patient- and visit-specific and only reference the actual data collected or services performed at that encounter or visit by the documenting provider. Providers must make every effort to avoid over-documenting by inserting irrelevant or unnecessary documentation into the medical record, or by not appropriately editing and updating system-generated templates and information. Providers may reference other providers' (e.g., residents) entries in the patient's record when that information is pertinent to the reason for the current visit and done in accordance with applicable federal and state rules and the guidelines included in this policy.
- C. *Patient Privacy.* Each note must be unique to the individual patient. Cloning documentation from one patient's record into another patient's record puts the patient's privacy and the institution at risk for potential violations of the Health Insurance Portability and Accountability Act (HIPAA) privacy rules.

IV. Documentation That May be Appropriate to Clone

- A. *Authorship and Attribution.* The provider who authors a note is ultimately responsible for the accuracy and content of the entire note, including any attestations and/or template information, whether the content is original, cloned, or based on templates/macros/dot phrases. In addition, the provider who authors, or attests to a note, is responsible for correcting any errors identified in cloned notes, and alerting Health Information Management (HIM) of the error, as needed.
- B. *Cloning from Provider's Own Prior Note into a Current Note.* Generally, a prior note does not have to be attributed (i.e., identified as being created by the involved provider). However, the note must be attributed if the provider is practicing in multiple non-UTMB facilities/locations which each have a unique EMR, and the source of the cloned note is different than the ultimate destination of the final EMR entry. In these instances, the cloned information originating from the other EHR system must be separately identified, and the provider must attribute/identify the original source of the information.
 For Example: Dr. John Smith, a UTMB faculty member, sees Patient X at his UTMB clinic and at Bayshore Hospital. Dr. Smith has access to the EMR at both facilities. Dr. Smith clones appropriate information on Patient X from the Bayshore Hospital's EMR into UTMB's EMR. Dr. Smith must attribute/identify his cloned documentation as originating from Bayshore Hospital's EMR.
- C. *Information That May Be Acceptable to Clone from Prior Notes.*
 It may be acceptable to clone information from prior notes created by the provider or resident him/herself or created by another provider or resident. **However, discretion must be used to ensure the cloned information is specifically required for assessment of the identified patient problem or complaint being addressed during the current encounter or visit.** The documenting provider or resident must also ensure that the cloned information is accurate, that all appropriate updates and changes are made, and that the information reflects actual services performed or rendered during the current encounter or visit.

The types of documentation that *may* be appropriate to clone from a prior note include:

- (a) Review of systems (ROS);
- (b) Allergies;
- (c) Historical procedures and surgeries;
- (d) Developmental history;
- (e) Immunizations;
- (f) Past, family, and/or social history (PFSH); and
- (g) Dates of scheduled appointments and procedures.

Although it may be appropriate to clone other types of previously recorded information, providers are ultimately responsible for ensuring that the cloned information is the most current information that accurately describes services or activities actually performed during the current encounter/visit. All cloned history and other previously recorded information must accurately reflect information obtained and services performed during the current encounter or visit.

PFSH and ROS information cloned from a prior visit must be reviewed, verified, and confirmed as accurate and complete by the provider or resident via verbal confirmation by the patient or patient's representative. The cloned information may only be used to the extent the information is medically necessary for the current encounter or visit.¹

Medication lists may be cloned if the use of each medication is reviewed and verified by one or more of the following:

- (a) Patient;
- (b) Family member;
- (c) Inspection of medication containers;
- (d) Review of orders or pharmacy records;
- (e) Pharmacist; or
- (f) Physician, nurse or appropriate health care team member.

Current medications not on the original (cloned) list must be added and linked to the condition for which they were prescribed. If the accuracy of the medication list cannot be verified, the source of the list should be identified, and a statement should be added that the medication list could not be verified.

D. *Guidelines for the Use of Templates/Macros/Dot Phrases.*

The use of EMR templates, macros, or dot phrases may be a more effective, efficient and appropriate mechanism for ensuring the information documented in the current encounter or visit note is completely accurate. Templates, macros, and dot phrases should allow for a full and complete collection of information to demonstrate that individual services have actually been rendered by the indicated provider, as well as to demonstrate that the applicable third-party payer coverage and coding criteria have been met. Use of a template, macro, or dot phrase is

¹Per CMS, MLN evaluation and management service guide (ICN006764)

An ROS and/or a PFSH obtained during an earlier encounter do not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his or her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:

- Describing any new ROS and/or PFSH information or noting there has been no change in the information; and
- Noting the date and location of the earlier ROS and/or PFSH.

appropriate if the provider or resident can enter or edit information in the template, macro, or dot phrase to reflect actual services performed during the current encounter, as well as applicable results, or can update information in the template, macro, or dot phrase by removing information not reviewed or which is inconsistent with information obtained or services actually performed during the current encounter/visit. The use of templates, macros, or dot phrases in an electronic medical record must allow the involved provider or resident to enter or edit encounter or visit-specific information for the current patient encounter.

E. *Guidelines for All Cloned Information.*

Providers and residents are strongly encouraged to include a statement in the medical record to support cloned information if no changes are made to the prior/original information (i.e., “I have reviewed the ROS/PFSH with the patient and have indicated any significant or relevant changes.”). Any information included in the current encounter or visit’s EMR entry must accurately and completely reflect services actually provided or performed during that encounter or visit.

V. Documentation That is Inappropriate to Clone

A. *Chart-to-Chart Information.*

Because documentation must accurately describe the current condition of an individual patient, cloning *any* information from the medical record of one patient to the medical record of a different patient is strictly prohibited.

B. *Assessments and Plans.*

Assessments and plans must not be cloned and must be based on the clinical evidence obtained during each encounter.

C. *Documentation by Medical Students.*

Medical student notes must be clearly identified as such to all users and/or reviewers of the medical record. Any contribution and participation of a medical student to the performance of a billable service (other than the review of systems and/or past family/social history, which are not separately billable, but are taken as part of an E/M service) must be performed in the physical presence of a teaching physician or physical presence of a resident in a service meeting requirements set forth for teaching physician billing. Medical students may document services in the medical record. However, the teaching physician must verify in the medical record all medical student documentation or findings, including history, physical exam and/or medical decision making. The teaching physician must personally perform or re-perform the physical exam and medical decision-making activities of the E/M service being billed, but may verify any student documentation of them in the medical record, rather than re-documenting this work. Providers should utilize one of the following attestations as applicable:

Attestation with Faculty and Medical Student: I have verified the medical student documentation and/or findings, including the history, physical exam and medical decision making. Additionally, I have personally performed or re-performed the physical exam and medical decision-making activities of this patient’s evaluation and management service.

Attestation with Medical Student working with Resident Team and/or Faculty. Resident Attestation: I have verified the medical student documentation and/or findings, including the history, physical exam, and medical decision making. Additionally, I have personally performed

or re-performed the physical exam and medical decision-making activities of this patient's evaluation and management service.

Faculty Attestation: I personally examined the patient and agree with the resident's note as written, including any changes or additions that the resident may have made to the medical student's note. I actively participated in the decision-making process. Please see the resident's note for additional details.

Documentation and attestations must accurately reflect what occurred during each encounter.

D. *Documentation by Medical Assistants (MAs) and Ancillary Staff.*

Any part of the chief complaint (CC) or history [history of present illness/HPI, past family social history/PFSH, or review of systems (ROS)] that is recorded in the medical record by ancillary staff or the beneficiary does not need to be re-documented by the billing practitioner. Instead, when the information is already documented, the billing practitioner can review the information, update or supplement it as necessary, and indicate in the medical record that he or she has done so. Providers should utilize one of these two attestations, as applicable, when utilizing MAs or ancillary staff documentation:

I have reviewed and confirmed the medical history as documented by the medical assistant.

I have reviewed and confirmed the medical history as documented by the medical assistant. However, it is also noted that... {Provider fills in further details as appropriate}.

E. *Documentation by Scribes.*

To the extent Scribes are utilized at UTMB, any information cloned by a Scribe is considered to be cloned by the responsible provider.

F. *Pre-Constructed Physical Examination Templates.*

The use of pre-constructed physical examination templates, which reflect the exact same physical examination elements (i.e., body areas or organ systems) and results from encounter to encounter, may lead an external auditor to believe the physical examination was not actually performed (or performed as documented). Therefore, physical examination templates which do not afford the involved provider with an opportunity to include case-specific information and/or results for the current visit or encounter, and which do not accurately reflect the actual physical examination performed during the current encounter, are strictly prohibited.

G. *Cloning Documentation from Outside of EPIC EMR.*

It is generally prohibited for a provider to "bring over", copy and paste, or clone documentation from outside UTMB's EPIC EMR. Occasionally, and only applicable to certain clinical areas where the required documentation for new patients may be extensive, providers may be allowed to create the note outside EPIC EMR by utilizing a UTMB computer or logging in to the UTMB system to compile the note. Unless the documentation is created and then copied to EPIC from a secure, UTMB protected word processing system, no documentation should be brought over into a patient's medical record. An attribution statement or an attestation should always be included under these circumstances to support where the documentation outside of EPIC originated.

Sample Attestation/Attribution Statement: “This documentation is my own and was copied from a UTMB protected word processing source originating outside of Epic.”

Example: Physician sees and examines the patient and compiles notes about the encounter for a visit lasting over an hour. The physician logs into UTMB from home or from his/her office and compiles the extensive note in Microsoft Word. Physician then copies the note from Microsoft Word into EPIC and utilizes the attestation/attribution statement listed above.

Please Note: Appropriate attestations can help to prevent entries from being flagged as “findings” during reviews or audits. Attestations/Attributions provide a clear picture of how the documentation was compiled and prevents unnecessary dialogue between providers and auditors in determining how the documentation appeared in a patient’s chart.

H. *Exception for Chronic Conditions*

Cloning information other than that identified in Section IV.C. from a provider’s or resident’s own prior notes may be acceptable when a provider or resident regularly treats a patient for a chronic condition (a condition lasting longer than three months). This may be acceptable when documenting for patients who are under active treatment and are seen repeatedly and frequently during the treatment phase of their care. These visits may be daily (*e.g.*, radiation therapy, high-dose chemotherapy protocols in stem cell transplant), biweekly (*e.g.*, intense dose chemotherapy regimens), or weekly (*e.g.*, visits to monitor laboratory results for all other chemotherapy protocols). A provider or resident that elects to clone information in these situations is responsible for reviewing the cloned information to ensure its accuracy, ensuring appropriate updates and changes have been recorded, and ensuring the information accurately reflects the actual services performed or provided during the current encounter or visit. Providers and residents are strongly encouraged to include a statement in the medical record if no changes were made to the prior/original information (*i.e.* “I have reviewed the note above and have indicated any significant or relevant changes.”)

I. *Exception for Special Circumstances.*

Special circumstances may necessitate cloning information not listed in Section V. An example of a special circumstance under this policy may include a patient who is no longer able to provide updated or current history information during the current encounter or visit, or during a subsequent encounter or visit. If information is cloned in these special circumstances, providers and residents must specifically identify the source of the originally documented information, clearly indicate the information has not been updated, and clearly document the special circumstances that exist (*e.g.*, “patient is unable to speak and provide history information during today’s visit.”).

VI. **Auditing and Monitoring Use of Cloned Documentation**

- A.** All personnel at UTMB who enter into the electronic medical record, or routinely access the medical record should be vigilant concerning inappropriate utilization of cloned documentation. The Office of Institutional Compliance, Health Information Management, Care Management/Utilization Review, Revenue Cycle Operations (coders and audit personnel), and Clinical Documentation Improvement will actively look for inappropriate utilization of cloned documentation when reviewing charts as part of their routine job responsibilities. More specialized reviews may be conducted to ensure compliance, or if necessitated for cause.

- B. Allegations of inappropriate use of cloned documentation should be reported to the Office of Institutional Compliance. The Office of Institutional Compliance, with the assistance of the Compliance Oversight Committee (COC) and the Executive Billing Compliance Committee (EBCC) will conduct and coordinate investigations of alleged violations of this policy. In the event of a finding of inappropriate use of cloned documentation, the Office of Institutional Compliance will make recommendations regarding disciplinary action and/or the need to submit refunds to payers. The Office of Institutional Compliance will communicate regularly with the COC and EBCC regarding significant violations of this policy. The COC is comprised of members from the Office of Institutional Compliance, Health Information Management, Care Management, Revenue Cycle Operations, Clinical Documentation Improvement, Contracts Management, Physician Advisors, and Government Reimbursement. At the monthly committee meeting, the COC will review suspected instances of inappropriate cloned documentation and will make a recommendation to the Executive Billing Compliance Committee (EBCC) for action to be taken.
- C. If a provider is found to have inappropriately used cloned documentation in the medical record, appropriate disciplinary actions may be taken, up to and including termination, loss of appointment, or loss of employment.
- D. Documentation determined to be inappropriately cloned will not be considered in the level of the billable and/or payable service.

VII. Provider Responsibility

- A. Providers who elect to clone information as permitted under this policy, are responsible for thoroughly reviewing the cloned information to ensure its accuracy, to ensure appropriate updates/changes have been recorded, and ensuring the information accurately reflects the actual services performed or provided during the current encounter or visit.
- B. Providers must participate in, and successfully complete, all applicable required EMR training prior to utilizing the EMR System for documentation purposes.

VIII. Definitions

Attributed to: The term “attributed to” refers to the process by which the author of an entry into the electronic medical record is appropriately identified. In order to appropriately attribute a prior or current note/medical record entry, the following items must be included:

- a) Author’s name and credentials;
- b) Date of original note and, if appropriate, the note type (e.g., Evaluation and Management, Procedure, Clinic Note, Progress Note, etc.); and
- c) Location of the record.

Cloning: The term “cloning” refers to documentation that is worded exactly like or substantially like previous medical record entries. For purposes of this policy, the term “cloning” includes “copy/paste,” “copy/forward,” “cut/paste,” automated change of author functions (e.g., “sharing”, “make me the author, etc.), and/or the use of system-generated templates (e.g., physical examination template).

Medical Student: A student enrolled in an accredited medical school and working toward an MD, DO, or equivalent degree.

Provider: Includes physicians, psychologists, advanced practice professionals (e.g., physician assistant, nurse practitioner, etc.), licensed nurses, medical assistants, pharmacists, and fellows, respiratory and

other types of therapists, and technicians who document health care items or services in the EMR system as part of providing services.

Resident: Includes any individual enrolled in a post-graduate medical training program.

Templates/Macros/Dot Phrases: Formats for recording information or pre-formed text that may be placed into a patient's record and then modified with patient-specific information, as needed. Templates, macros, and dot phrases allow for consistency in recording useful information and serve as a reminder about important elements that should be incorporated into a given document.

IX. Relevant Federal and State Statutes

[HIPAA Administrative Simplification, 45 CFR Parts 160, 162 and 164.](#)

[Social Security Act, 42 USC Chapter 7, Section 1862 \(a\) \(1\) \(A\).](#)

[Texas Medical Board, Board Rules, Texas Administrative Code, Title 22, Part 9, Chapter 165 \(Medical Records\), §§165.1 – 165.6.](#)

X. Additional References

[American Health Information Management Association \(AHIMA\), *Appropriate Use of the Copy and Paste Functionality in Electronic Health Records*, 2014.](#)

[Association of American Medical Colleges \(AAMC\), AAMC Compliance Officers' Forum, *A Challenge for the Electronic Health Records of Academic Institutions: Physicians Combining Documentation or Using Information Documented by Others When Billing for a Professional Service*, 2012.](#)

[Association of American Medical Colleges \(AAMC\), AAMC Compliance Officers' Forum, *Compliance Advisory: Electronic Health Records in Academic Health Centers, Topic 1: Medical Student Documentation*, 2011.](#)

[Association of American Medical Colleges \(AAMC\), AAMC Compliance Officers' Forum, *Electronic Health Records in Academic Medical Centers, Compliance Advisory 2, 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*, 2011.](#)

[Centers for Medicare & Medicaid Services, *Medicare Claims Processing Manual, Transmittal 2303, Teaching Physician Services*, September 14, 2011 \(effective October 14, 2011\)](#)

[Centers for Medicare & Medicaid Services, *Medicare Program Integrity Manual, Transmittal 455, Progress Notes and Forms*, March 15, 2013 \(effective December 10, 2012\).](#)

[Centers for Medicare & Medicaid Services, *Medicare Claims Processing Manual*, Pub. No. 100-04, Chapter 12, § 30.6.1.](#)

[Preventing Copy-and-Paste Errors in the EHRs, The Joint Commission Quick Safety Advisory on Safety and Quality Issues, Issue 10, February 2015](#)

[Texas Medicaid & Healthcare Partnership, *Provider Procedures Manual, Section 1.6.10 General Medical Record Documentation Requirements*, Updated March 2016.](#)

[U.S. Department of Health and Human Services, Office of the Inspector General, CMS and Its Contractors Have Adopted Few Program Integrity Practices to Address Vulnerabilities in EHRs. January 2014 OEI-01-11-00571](#)

[U.S. Department of Health and Human Services, Office of Inspector General Work Plan for Fiscal Year 2014](#)

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4068CP.pdf>

[Centers for Medicare & Medicaid Services, Medicare Claims Processing Manual, Pub. No. 100-04, Chapter 12, § 100.1.1.](#)

[Evaluation and Management \(E/M\) Visit Frequently Asked Questions \(FAQs\) Physician Fee Schedule \(PFS\)](#)

Novitas, JH, Frequently Asked Questions, Evaluation and Management Services, Key Components, History

XI. Dates Approved or Amended

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<i>Reviewed with Changes</i>	<i>Reviewed without Changes</i>
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XII. Contact Information

Office of Institutional Compliance
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