“Copy / Paste” Guidelines
Guidance for Appropriate Use of Electronic Health Record (E.H.R.) Functions

Purpose:
To establish standards for the appropriate use of copy / paste functionality and to avoid cloning risks within the electronic health record (E.H.R.). Quality documentation supports patient care, continuity of care, record integrity, and accurate coding for professional fee and facility billing consistent with the complexity of a patient’s clinical conditions.

Standard:
All entries in the E.H.R. must be patient- and visit-specific and contain the actual data collected and/or reviewed and confirmed by the provider based on medical necessity and personally rendered services. Providers may reference their own prior entries and/or other providers’ entries in the patient’s record (by noting the specific date and time of the referenced entry), such as when the information is pertinent to the reason for the visit, the patient’s history, test or imaging results, etc. Providers should avoid: (1) inappropriate use of copy / paste functionality; (2) over-documentation of clinically irrelevant information (not medically necessary); or (3) copying redundant information (provided in other parts of the legal medical record). The term “provider” includes attending physicians, residents, nurse practitioners, physician assistants, and any other health care professional who is licensed and credentialed to provide patient care services at UC San Diego Health.

Definitions:
1. Copy. For purposes of this standard, “copy” shall be understood to include: copy / paste, copy forward, imported documentation, “roll-in”, pull-forward, auto-populate features, and any other intent to move documentation from one part of the record to another section of the health record (or to another patient’s record).
2. Cloned. Cloned documentation refers to medical record documentation that is identical or unreasonably similar to the previous entries for a patient (or another patient’s record)

Examples:
   a. Identical entries – Entries that are exactly alike between visits or between providers. The visit note contains the exact same history of present illness, review of systems, physical exam and/or care plan.
      i. Same patient with identical notes, unchanged from one visit to the next.
      ii. Different patients with identical entries regardless of the patient involved.
      iii. Care team notes that are the same and make it difficult to determine who provided the service, e.g., teaching physician’s note is identical to the house staff note; attending physician’s note is identical to the mid-level provider’s note.
   b. Unreasonably similar entries – such as entries that are almost identical to previous entries within an individual’s medical record.

Provider Responsibilities & Good Practices:
1. Authenticate notes. Signed notes are “final” and become part of the patient’s legal medical record. Additional information may only be included as an addendum or a new entry. The provider’s signature shall serve as his/her attestation that the information (whether the content is original or copied) is accurate, and that any copied information is current and represents the provider’s services for that date of service.
2. Identify the source of information copied from a prior note (i.e., date, time, prior note’s author). Reconfirm and update as necessary to accurately reflect the care you provided during the current encounter.
3. Cite and summarize clinically applicable test results (labs, imaging, consult reports, etc.) by date and time, rather than copying the entire report into the current entry.
4. Avoid copying one patient’s medical record into a different patient’s medical record.
5. Discuss the review of systems (ROS) and past, family and social history (PFSH) with the patient and comment upon pertinent updates to the current encounter, e.g., “ROS and PFSH are unchanged from previous encounter on
MM/DD/YYYY” – rather than copying / pasting the entire ROS and PFSH entry from a previous note. Importing up-to-date content from PFSH-related sections of the E.H.R. is legitimate.

6. Use the approved teaching physician documentation template (GC templates / SmartText) in Epic to document teaching physician services, rather than copying the supervisee's note in its entirety. The GC templates can be found as follows: (a) Start a note; (b) Locate the “Insert SmartText” search box in the toolbar above the white rectangle where the note text will appear; (c) Enter "GC"; (d) Select the appropriate attestation SmartText for supervisee type (e.g., fellow, PA, etc.) and visit types (consult, H&P, etc.).

7. Correct errors identified within your documentation. Refer to policy, MCP 325.1, "Correcting Errors / Amending the Medical Record", for record correction and amendment procedures. http://mcpolicy.ucsd.edu

8. Consult with Health Information Services if it is necessary to delete an incorrect note (i.e., entered in error under the wrong patient MRN).

Risks associated with the misuse of “Copy / Paste” E.H.R. functionality:

Quality of Care and Patient Safety:
1. Inaccurate, contradictory, duplicative, inapplicable, erroneous, misleading information.
   Examples:
   a. Chief complaint of “knee pain” vs. review of system indicating “no musculoskeletal pain”
   b. History of present illness refers to a married person vs. social history of “single person”
   c. Incorrect diagnoses could be relied upon by other care providers

2. Over-documentation of clinically irrelevant or inaccurate facts.

3. Questions regarding the validity of entries. Information included via the “copy forward” function raises questions as to the origin and accuracy of the information (who is the author, was the information verified as still current).

4. Burdensome processes associated with correcting or amending multiple entries of the same information.

Billing Risks:
1. Inaccurate billing claims such as where the billed CPT code reflects a different level of service than was provided; or where the medical necessity of the billed CPT code is not supported by the billed diagnosis code (ICD10) for services provided.

2. Lack of individuality of entries from one visit to the next could result in payers questioning whether the service is legitimate and medically necessary.

3. Inappropriate linkage by the teaching physician to the trainee’s note, in that the copied note makes it appear as if the teaching physician personally performed the entire service.

Teaching Physicians: Billing Reminders & Resource Information on Documentation:
1. Resident notes: Teaching physicians must document personal performance of the key / critical portions of the service and may refer to the resident’s note for details.

2. Medical student notes: Teaching physicians may only utilize student documentation related to ROS and PFSH.

3. Scribes: The use of scribes by UC San Diego Health teaching/attending physicians is acceptable, but use of scribes is limited to individuals who are trained for scribe functions. Scribes must meet the minimum requirements and documentation procedures outlined in policy, MCP 562.3, “Use of Scribes”. The billing provider who has elected to use the services of a scribe is ultimately responsible for the content and accuracy of the scribed note. http://mcpolicy.ucsd.edu


Questions? Call or email the UCSD Health Compliance Program at 858-657-7487 or hsc comply@ucsd.edu.