



- (2) 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) Providers are responsible for the total content of their documentation, whether the content is original, copied, pasted, imported, or re-used.
- (4) Providers will avoid indiscriminate use of copy/paste and other documentation aides. Examples of such documentation aides include but are not limited to functions that allow providers to mark every item in a section normal, pulling forward information from prior visits, using pre-prepared templates or copying/pasting/pulling forward other providers' notes. If these documentation aides are used it is expected that the provider will edit the document to ensure abnormal findings are documented accurately and the provider will de-select items not performed. See section E(4)
- (5) Providers are responsible for the accuracy and medical necessity of any information that is imported or re-used from a prior note.
- (6) Providers are responsible for correcting any errors identified within documentation and clearly noting that this is a correction of previously inaccurate information.
- (7) Providers must notify Health Information Management immediately regarding any erroneous entries that cannot be corrected by the provider (e.g. wrong patient, wrong record, outside media which cannot be altered).
- (8) Providers are responsible for citing the outside or third party source when external data is documented in a note.
- (9) Providers are responsible for clearly identifying the individual who performed each service documented within the note and 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 credential (e.g. RN, PA,MA).

(E) Acceptable Use of Documentation Aides:

- (1) Providers may copy relevant portions of the patient's previous notes or use EHR functionality to pull forward data from prior notes, 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) Review of System information copied from a prior visit must be verified and confirmed as accurate by the Provider and may only be used to the extent the Review of Systems is medically necessary for that visit.

- (3) 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.
- (4) 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 1/1/2013.”
- (5) Providers are responsible to check for contradictory information in the medical record documentation.
- (6) If using a general date reference (e.g. post op day 1, hospital day 1) assure the date references are accurate.
- (7) Providers are responsible for ensuring significant abnormalities that 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).
- (8) Providers are responsible for reviewing, updating and marking as “reviewed” the Problem List. Providers are to ensure only current problems/diagnosis assessed during their current office encounter are documented in the Assessment / Plan.
- (9) If the Assessment / Plan are copied and are unchanged from the previous note, providers are responsible to attest that there has been no change.

#### (F) Definitions

*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. One or more of the following function may be used within an EHR to clone: (a) copy & paste; (b) copy forward; (c) save note as template; (d) or any other function that allows an individual to copy information from one patient visit note to the current visit date for either the same or different patient.

*Provider* includes attending physicians, resident physicians advance practice nurses, certified nurse midwives, physician’s assistants, licensed nurses, pharmacists, respiratory or other types of therapists, dietitians, and technicians who may create clinical notes.

*Advanced practice provider* includes Nurse Practitioner, Advanced Practice Nurse, Physician Assistants, and Certified Nurse Midwives

#### (G) Discipline

Failure to comply with this policy could result in discipline up to and including loss of privileges or dismissal from your applicable program and termination of employment.

Approved by:

/s/  
Rick Swaine, Chief Executive Officer

/s/  
Date

\_\_\_\_\_  
Michael Ellis, M.D.  
Chief of Staff

\_\_\_\_\_  
Date

*Review/Revision Completed by:*  
*HAS*  
*UT Physicians*  
*Chief of Staff- Medical Executive Committee*

Policies superseded by this policy:  
none

Initial effective date: July 2, 2013  
Review/Revision Date: 7/1/2016  
8/1/2020  
Next review date: 08/01/2023