



I. 13.1.4 Use of Cloned Documentation in the Electronic Health Record

Chapter 13 - Clinical	Original Effective Date: October 2015
Section: 13.1 Clinical Policies	Date Last Reviewed:
Responsible Entity: Deans; School of Medicine, School of Nursing, School of Dentistry	Date Last Revised:

II. Purpose

This policy concerns the appropriate versus inappropriate use of cloned documentation in a UT Health San Antonio (UTHSA) electronic health record (EHR).

III. Scope

This policy applies to all faculty, staff, students, residents, healthcare providers, researchers, contractors, or any other individual (collectively, Workforce Member, including employees and non-employees) who has direct or indirect access to patient protected health information (PHI) created, held or maintained by any UT Health San Antonio controlled affiliate, including, but not limited to its clinics, hospitals, and research operations.

IV. Policy

This policy concerns the appropriate versus inappropriate use of cloned documentation in a UT Health San Antonio (UTHSA) electronic health record (EHR). This policy applies to all EHR users.

The term “cloning” refers to creating documentation that is worded exactly or substantially like previous medical record entries, which is never appropriate within the context of the EHR. Previously entered data, when used in a new entry, must be meticulously updated, and edited to reflect the scope of, and interval changes in, the history and physical examination findings. Therefore, a more accurate description of this process would be using a prior note as a “template” for a new note. The term template indicates a starting point for a new note that is appropriately edited to accurately describe services/activities performed during the current encounter/visit.

A. Guidelines

1. General Information/Requirements

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- a. There can be value to copying information, but it must be done selectively and thoughtfully with the goal of producing a clear, useful, and accurate patient note.
 - b. Regardless of the tools used to create the note, the individual signing it acknowledges responsibility for the entire content and is responsible for correcting any identified errors in cloned notes.
 - c. The note must accurately represent clinical work performed on the day of service, with clear attribution to the work of others.
 - d. Users should 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/Medications with the patient and have indicated any changes”.)
2. Acceptable Use of Previously Entered Data
- a. Copying and pasting or copying forward of HPI, ROS, PFSH, Physical Examination, and Plan of Care from a previous visit note by the same author must meet these conditions:
 - i. The information is reviewed with the patient and fully updated to reflect current reality.
 - ii. The information is medically necessary to support billing and coding for the current visit.
 - b. Copying and pasting or copying forward of HPI, ROS, and PFSH from a previous visit note by a different author must meet these conditions:
 - i. The original author, source, date, and location of the information are documented.
 - ii. The information is reviewed with the patient and fully updated to reflect current reality.
 - iii. The information is medically necessary to support billing and coding for the current visit.
 - c. Data linking to insert data from another part of the patient record into a progress note must meet these conditions:
 - i. The information is reviewed and updated prior to being pulled into the current note.
 - ii. The date the information was updated and the person who performed the update are documented.
 - iii. The information is medically necessary to support billing and coding for the current visit.
3. Unacceptable Use of Previously Entered Data
- a. Copying an entire previous note without appropriate edits.
 - b. Transferring information from one patient record to the record of another patient.

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- c. Medical student notes (other than the Review of Systems and Past Family Social History).
 - d. Attestation by attending.
 - e. Plan of care from a provider with another service.
4. Plan for Auditing/Monitoring for Cloned Documentation and Reporting Allegations of Inappropriate Use

Monitoring to detect inappropriate use of cloned documentation will be conducted by the Institutional Compliance & Privacy Office as a component of ongoing billing compliance audits. Separate and distinct reviews may also be conducted in the event of allegations regarding inappropriate use of cloned documentation. Identification of cloned documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made. Allegations of inappropriate use of cloned documentation may be reported to the Office of Regulatory Affairs and Compliance at 210-567-2014 or via the Hotline (877-507-7317).

5. Reporting Mechanism for Findings of Inappropriate Use of Cloned Documentation

Providers will receive feedback on unacceptable cloned documentation monitoring activities at the end of the quarter in which they are audited. Each Department Chair and Administrator will receive quarterly updates regarding unacceptable cloned documentation audit findings within their respective department. Cumulative audit findings of unacceptable cloned documentation use will be distributed to the respective school's Chief Medical Officer or equivalent on a quarterly basis

V. Definitions

When used in this document, the following words have the meaning set forth below unless a different meaning is required by context.

Copy & Paste – selecting data from an original or previous source to reproduce in another location. Examples:

- a. Progress note
- b. Narrative reports from diagnostic studies such as imaging studies

Data Linking – using shortcuts to insert data from another part of the medical record into a progress note. Examples:

- a. Past Medical, Family, and/or Social History (PFSH)
- b. Medication List
- c. Problem List
- d. Lab Data
- e. Flowsheet data (e.g., responses to PHQ-9 depression screening questionnaire)

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Copy Forward – a function that copies a significant section or entire prior note. Examples:

- f. History of Present Illness (HPI) portion of a previous note
- g. Review of Systems (ROS)
- h. Physical Examination

Automated Change of Note Author – (similar to copy forward) changes authorship of a note written by someone else to current user of the note.

Template – documentation tools that feature predefined text and text options used to document the patient visit within a note.

Populating Via Default – data is entered into a note via an electronic feature that does not require positive action or selection by author. For example, when documenting the Review of Systems in a patient history, an EHR may have functionality that enters the phrase “all other systems negative” without requiring the author to select a checkbox, or otherwise indicate that the work was performed.

Macro – expanded text that is triggered by abbreviated words or keystrokes. Not generally considered copy/paste, but rather abbreviating required keystrokes.

VI. Related References

[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](#)

UT System Model Policy “Use of Cloned Documentation in the Electronic Health Record”, August 27, 2015.

VII. Review and Approval History

The approving authority of this policy is the University Executive Committee.

Effective Date	Action Taken	Approved By	Approved Date
10/2015	Policy Origination		