

WEILL CORNELL MEDICAL COLLEGE OFFICE OF BILLING COMPLIANCE

Electronic Medical Record Guidelines

Policy
Effective: January 1, 2007

Electronic Medical Record Documentation

Introduction:

Electronic medical record documentation of physician services must adhere to the same core requirements for physician documentation as the traditional handwritten note. Established medical record policies such as NYPH Bylaws, JCAHO requirements, and CMS Physicians at Teaching Hospitals regulations remain in effect. The use of the electronic medical record must also be consistent with billing compliance policy.

The purpose of this policy is to establish consistent expectations as to the acceptability of electronic documentation tools and the way these are used by contributing health care providers and care givers. The electronic capabilities of all documentation systems must be used appropriately, to ensure the reliability of all of the content in each patient's medical record.

This document outlines basic EMR grounds rules that unless specified otherwise, are applicable to all service locations (inpatient, outpatient hospital including clinic and emergency department, ancillary departments, and operating room or other procedure suites). These grounds rules are also applicable to all EMR systems used to contribute to the Health Record. Because technical limitations may not allow for these guidelines to be enforced through EMR functionality, all EMR users are expected to know and comply with these rules. There are ten basic EMR rules:

1. Providers of service are required to author their own note.
2. No provider may edit or otherwise change the content of another provider's EMR note.
3. Incomplete EMR notes are not to be viewable by other users [or must be conspicuously marked as an incomplete note].
4. Timely completion of medical record entries is required.
5. Once a note is completed and made viewable to other providers, necessary changes are restricted to addendums and no content of the original completed note is to be altered by deletion or addition.
6. Multiple entries by a single provider on a single date of service are acceptable.
7. Documentation templates must conform to design guidelines.
8. Use of "Copy and Paste", "Cut and Paste", and "Copy Forward" are restricted.
9. Each EMR entry should reflect information pertinent to the current day's service that is not already documented in the Health Record and readily available.
10. All Health Record documentation is subject to review and audit.

Each of these general premises is further explained on the following pages.

EMR Ground Rules to Establish and Maintain Content Integrity:

1. Providers of service are required to author their own note.
 - a. No “sharing of passwords”: The provider is to create his/her own note by personally signing on to the system with their own logon and password and personally selecting and completing the appropriate template(s).
 - b. No provider/user may contribute to another provider’s note by entering information on their behalf under another provider’s sign-on.
 - c. When creating notes, two or more providers cannot work within one sign-on. Each contribution to a particular service note must be completed and signed-off on and closed by its author, before it is available for compilation into the composite note. Except in specific ambulatory supervision workflows, component parts of notes may not be viewable by others until completed and signed-off on by its author.
 - d. In addition to the patient’s identifying information, the record must clearly identify the name and title of the author of the note, the date of service, the date the note is prepared and the electronic signature of the individual preparing the note.
 - e. Residents providing evaluation and management services are to create a note that reflects their personal work on a particular service. A separate note linked by the attending physician is required to substantiate appropriate supervision and personal involvement as required for billing. A teaching physician note linking to a residents note for evaluation and management billing purposes are to be written on the same day (or within a 24-hour period).
 - f. **Teaching Physician Minimum Documentation Rules cannot be applied to services provided and documented by non-physician practitioners (NPP).** The NPP is to create a note that reflects their personal work on a particular service. A separate note by the attending physician is required to substantiate appropriate supervision for “incident to” ^{OFFICE} or the **specific E&M component(s) rendered** for “shared service” ^{FACILITY} billing. **The attending physician may only bill for an incident to service or a shared (E&M) service if the NPP involved is a member of their designated billing group. [Attending physicians cannot use the notes of hospital employed physician assistants and nurse practitioners as their personal documentation for billing purposes.]** (See Appendix B for more information “incident to” and “shared service” billing).
 - g. Documentation by a scribe on behalf of a physician is permitted when the scribe accompanies the physician into the patient exam room and records verbatim and real-time, the physician’s statements about the history, physical, exam, laboratory, medication, orders, diagnosis and plan. (The scribe does not perform any portion of the service being rendered and is therefore not considered to be a provider.) The scribe’s documentation will be entered as a transcribed note and include a scribe statement such as, “Note recorded by [scribe name] acting as a scribe for [doctor name]. A macro is allowed for the scribe statement. The physician follows-up by reviewing their transcribed note as entered by the scribe, making necessary edits and then finalizes the same note with a statement indicating that the scribed note was personally reviewed and edited (this statement may be a macro) and adding their electronic signature authorization.

2. No provider may edit or otherwise change the content of another provider's EMR note.
 - a. A teaching physician may not edit a resident's note. Teaching physician notes will be separate (stand alone) entries into the EMR that are authored and completed by the teaching physician.
 - b. The teaching physician entry for an evaluation and management service may be written with the minimal documentation requirements as specified by CMS and linked to the resident note by means of a "linking statement", or it may be a note with specific history, exam, and medical decision making information that is linked to the resident note, also by means of a "linking statement". A linking statement can be created using a macro or by typing in the appropriate phraseology.
 - c. Procedure notes authored by a resident who performed the service under the direct supervision of the attending may include statements by the resident indicating the presence and supervision of the teaching physician, only if the teaching was physically present for the entire procedure. Attending physicians shall write a separate note to further substantiate their level of involvement in the procedure. When the teaching physician is only present for the key or critical portions of a procedure, s/he must describe the key or critical portion in their note.
3. Incomplete EMR notes are not to be viewable by other users.

Definition of a "complete note"— A note finalized by the author's act of electronic signature authentication. The note itself may be a component note documenting just a portion of a larger service (such as only the history portion of an E&M; also see 7b). A note will not be viewable to other users unless it is completed (with electronic signature sign-off), except in specific ambulatory workflows where draft or incomplete notes are clearly marked as such.

- a. An incomplete electronic note is defined as documentation entered into the system but not finalized with the author's official electronic signature and closing of the encounter.
- b. EMR software functionality must allow for incomplete notes to be "locked out" for viewing by any user other than the author. Incomplete notes are to be stored in the author's work file or inbox until completed. Where EMR functionality is restricted to prevent this, incomplete notes must be clearly labeled as documentation that is in progress and are not to be relied upon until completed and signed-off on by the author.
- c. Preliminary diagnostic test results such as preliminary ECG, lab and radiology reports must be labeled as "Preliminary Reports". The preliminary documentation will remain in the EMR even after the separate final addendum report is issued.
- d. The author of the note may continue to update and revise their note until they complete the finalization and electronic signature steps of the EMR system.
- e. The time posted on an inpatient note that is updated multiple times throughout the day (before completion) should update accordingly and be chronologically ordered within the EMR based on the completion time.

4. Timely completion of medical record entries is required.

In general, timely completion of medical record entries is mandated by hospital and physician organization rules. The best practice is to complete the note for a patient service concurrent with or immediately following the rendering of the service. Where workflows do not permit this to happen, the following record completion deadlines must be met.

Outpatient Hospital Clinic Visits – Within two business days of the date of service.

Inpatient Admission Note -- Within 24 hours of the patient's admission time.

Inpatient Hospital Visits – Same day completion required. The deadline for completing an inpatient note is 10 AM of the next calendar date (to coincide with the resident work shift limitation [24 hrs + 3]).

Operative Reports – Dictation of the procedure is to be completed immediately following the procedure, but no more than one hour after completion of the case. The documentation may be in the form of a dictation or completion of an operative note within the electronic health record. For dictated documentation, transcription turn-around (including physician review and sign-off acceptance) is expected within 24 hours of dictation. Note: Sound-files of dictation are not retained.

Office Visits & Services – Within two business days of the date of service.

Ancillary Services – Final report within 24 hours of the availability of source data.

5. Once a note is completed and made viewable to other providers and caregivers, it is not changeable at all.
 - a. Necessary revisions or corrections to a completed note may only be made by way of a separate addendum note that will allow for the continual display of the original version.
 - i. *Definition of addendum – the inclusion of additional information to correct, update, and/or supplement a particular previously completed source document. An addendum will stand as a separate note.*
 - ii. *Definition of amendment – the alteration of health information by modification, correction, addition or deletion by its author.*
 - b. Only the author of a note may create an amendment to that note and all previously published content must remain viewable. (Physicians using scribes are considered the author of the note even though the scribe will enter it into the EMR therefore; physicians may amend the transcribed entry of their scribe. See 1G.)
 - c. Addendums must be appropriately labeled as such and clearly indicate the date and time of posting as well as reference the particular note being addended.
 - Teaching physicians will addend the resident note as required by

indicating additional information within their linking statement.

Teaching physicians should not change (amend) the note as written by the resident.

- Physicians providing direct supervision to non-physician practitioners will indicate any necessary addendums within their supervisory attestation statement. Physicians supervising non-physician practitioners should not change (amend) the note as written by the non-physician practitioner.
6. It is acceptable for a provider to make multiple entries over time within the inpatient EMR for a single patient on a single date of service, however each note must be completed individually. When the same physician makes multiple EMR entries for evaluation and management services on one day, these notes shall be used collectively to determine the level of service billing for that day. It is advisable to reference the earlier notes of that day in each subsequent entry.
7. Documentation templates utilized within the EMR are an effective tool for creating and supporting high quality documentation of medical services. Templates can allow for rapid and guided information capture pertinent to the medical encounter. Templates become part of the legal health record and must conform to various standards as set forth by Medical College policy, Hospital policy, and outside regulatory agencies (such as JCAHO rules and CMS billing rules).
- a. Template design assistance and input are available from the following:
- i. EMR technical support
 - ii. Quality Assurance and Risk Management
 - iii. Health Information Management (including the Forms Committee)
 - iv. Office of Billing Compliance
 - v. Office of General Counsel
 - vi. NYP Documentation Improvement Committee
 - vii. Information Systems Support Staff
 - viii. Vendor Representatives
- b. Templates are permissible when the template design facilitates accurate capturing of the documentation of the service as rendered, and allows for patient-by-patient variances.
- c. A template can be designed to include all of the documentation requirements in a single note or it can be designed for staging a note where components of the complete note are unique templates, each of which would be completed by the same author and timed separately. (See #6 above.)
8. Copy and Paste, Cut and Paste, and Copy Forward are generally restricted to content from previous notes of the author.

Definition: "Copy and Paste" is the act of duplicating selected content from a previously completed note and inserting it into a new note. The source note is left in its original state.

Definition: "Cut and Paste" is the act of removing selected content from a previously completed note and re-inserting it into a new note. The source note is altered through the deletion of text that is removed. This is FORBIDDEN.

Definition: "Copy Forward" is approved functionality that is programmed to allow specific content to routinely be brought forward and placed into a new note, without altering the content of any previously completed note.

CAUTION: Excessive use of the copy and paste functionality (and even copy forward) within the medical record may result extraneous, unnecessary, repetitive content that makes the medical record less succinct and more difficult and time consuming to read, and unless carefully edited may result in erroneous documentation of the current service.

CAUTION: Where the text is copied from the note of another provider and the copied text is left unchanged, (it is an exact duplicate of the source), the note may be considered plagiarized data and may not demonstrate adequate work effort for the service being documented by the current note author. This could constitute FRAUD.

It is not necessary to copy and paste or copy forward, data from the within the medical record that is intended to be shared and is easily accessible without significant system navigation. Standard shared content that is generally relative to the overall assessment and care of the patient may include medication lists, allergy lists, social history, family history, past medical history, recently documented review of systems and cumulated history statements and problem lists.

- a. Providers should refrain from copying and pasting from another provider's note.
 - b. Providers should refrain from re-entering previously recorded data or data that is readily available within the medical record (i.e., do not wholesale import lab data).
 - c. Each note is expected to be an account of the history, exam, medical decision making, counseling, coordination of care and/or procedures performed on the date of service it represents. The content of the current note needs to be specific and pertinent to that day's service(s).
 - d. The source of any information imported from a previous note should be appropriately identified when it is not a pre-approved and standardized shared list that is designed to copy-forward for ease of reference (i.e., medication charts, problem lists, and accumulated history such as past medical, family, and social history or the most recent review of systems).
9. The interval history unique to the current day's visit must be composed specific to the current day of service.
- a. The interval history in an EMR note for an inpatient evaluation and management service will serve as an indication of where the current day's service begins.
 - b. Repetitive history summaries in an inpatient note that are compiled from the daily entries and pulled forward from previous notes without indication of being relevant to the current day's service will be considered as past medical history for billing

purposes.

10. All medical record documentation (as a component of the legal health record) is subject to audit by external regulatory agencies of the federal and state government such as Medicare, Medicaid, the Office of the Inspector General, the State Attorney General's Office as well as third party payers and external peer review organizations. Routine internal auditing of EMR documentation will occur and may be conducted by Quality Assurance and Risk Management, Billing Compliance, IT security and/or Health Information Management personnel. The goal of internal audits of the EMR is to ensure adequate, timely, complete and appropriately authenticated documentation. Any of the following findings will warrant corrective action intervention:

- a. Unauthenticated documentation
- b. Missing documentation (no note where an encounter occurred)
- c. Incomplete documentation
- d. Inappropriate/inadequate template design
- e. Not meeting time standards for documentation
- f. Excessive/inappropriate copy and paste or copy forward within the medical record
- g. Insufficient documentation to meet standards of Physicians at Teaching Hospitals
- h. Submitting billing information before the documentation is completed
- i. Improperly formatted addendums
- j. Allowing another provider to add content to your note while signed-on

For additional information on this policy contact the Office of Billing Compliance or visit their intranet website – intranet.med.cornell.edu/billingcompliance

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