THE UNIVERSITY OF CHICAGO MEDICINE
Office of Corporate Compliance

EHR Documentation Compliance Guidance

Electronic health records (EHR), such as EPIC, as well as dictation and transcription services and basic software packages such as Microsoft Word, are powerful tools that support the creation of a clear, useful, and accurate patient note. When these tools and their associated features, are used inappropriately, medical record documentation may be compromised and can lead to patient safety, billing and other compliance risks.

The Office of Corporate Compliance recognizes the value of the time saving features the EHR provides. However, it is important to ensure that these functions are used as part of a thoughtful process that assists with the accurate documentation of the specific services provided, supports medical necessity, and produces a note that enhances patient care. The patient documentation used for patient care must be valid, complete and trustworthy. This guidance is written in accordance with the Center for Medicare and Medicaid Services (CMS) coding and documentation guidelines, which serves as the regulatory authority that influences the education and audit assessments provided by the Office of Corporate Compliance.

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1   Authentication

Every individual that enters documentation into Epic should do so logged in under his/her own username and password. The basic integrity of the patient's medical record rests on the fact that each individual that enters information into the chart uses his/her own log-in credentials and password. The purpose of authentication in Epic is to support authorship and assign responsibility for an act, event, condition, opinion, or diagnosis. Entering data as a person who is already logged in, or logging in under someone else's name, even at their requests, misstates authorship and violates UCM policies. It is a violation to share passwords with anyone, and Epic passwords should not be shared.

Each note should be authenticated when completed by the clinician that served as the author. Note authentication should occur once the note is completed, and as soon as possible following the patient's visit. Patient notes should be completed prior to billing for the service to support the clinical services provided to the patient. Addendums, and corrections may be made to the patient's encounter note, but the original note should be maintained in Epic. For detailed instruction on how to addend a patient note, please (click here) to see the Epic Tip Sheet.

Providers are responsible for each element of data entered into the medical record, and must provide electronic verification of authorship/authentication. Documentation maintains a "preliminary" status until authenticated. Please note, in order to authenticate your documentation, you must select "Sign on Accept" when you have finished your note. Any other selection leaves the note unauthenticated until another action is taken. The Office of Corporate Compliance strongly advises against selecting "Sign at close encounter".

Please (click here) for the Medical Center's Medical Record Authentication policy.

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2   Copy and Other Documentation Tools

Note documentation tools, such as, Copy, NoteWriter, SmartText Templates, SmartPhrase, SmartLink and SmartList made available throughout Epic are resources that can contribute to documentation timesaving and efficiency. However, there are risks associated with using these tools and they should be used conservatively. Inappropriate use can lead to 'note bloat', cloned documentation, fraudulent billing, and quality issues for patient care.

Risks include:
- Populating a note with outdated, conflicting, incomplete or inaccurate information.
- Inability to identify the original author in the EHR.
- The original date of note creation may not be evident or may be difficult to locate.
- Notes that are repetitive, inconsistent or identical.
- Notes that are too long and contain irrelevant information. Work performed by others incorporated into your note can lead to false and misleading representation of the service(s) you performed.

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Notes that are copied forward may include refreshable SmartLinks (blue background). These links can be refreshed individually by right clicking on the link and choosing 'Refresh'; or all links can be refreshed at once by clicking the 'Refresh' button on the notes toolbar. However, please note that you cannot review or revise prompts for SmartPhrase and SmartList components of a copy forwarded note.

When using any of these note documentation tools, at a minimum the provider is expected to:

- Ensure the note is complete, accurate, and appropriate for the current service.
  - Document the current exam and evaluation of the patient.
  - Document the assessment and plan based on the patient's current condition, and/or level of severity.
- Ensure defaulted and pre-populated documentation is edited to represent the current visit.
- Review the labs and other medical tests for accuracy and omit outdated information (i.e. lab values that have changed).
- Reconcile orders relevant to the current service.
- Reconcile medication information relevant to the current service.
- Ensure the HPI and ROS agree (especially when using Templates/SmartPhrase/SmartText/SmartLinks tools and checkboxes to generate review of system documentation).
- Ensure the correct date of service is reflected on the encounter note.
- Ensure each patient encounter can serve as a standalone record. It is the provider's responsibility to ensure the documentation reflects only the level of service actually provided for a given encounter date.

Additionally providers should **<u>never</u>**:

- Copy information from one patient medical record to another.
- Copy findings or portions of a previous visit note prior to a service being provided (i.e. copying an encounter note from a patient's spring visit, and using the information to pre-populate an encounter note for a follow-up visit scheduled for the fall).
- Use defaulted language to populate the patient's Review of Systems or Exam documentation. The documentation should only reflect the systems/body areas assessed for the specific date of service.
- Use or create customized templates that result in "leading" documentation to obtain a desired billing/coding level or lack required data elements.

2.1   Note Cloning

National Government Services (NGS) the Medicare Administrative Contractor (MAC) for Illinois and other regulatory agencies including the Centers for Medicare and Medicaid Services (CMS) have taken a firm stance on note cloning. The University of Chicago Medicine in alignment with these agencies prohibits note cloning practices.   Per NGS, documentation is considered cloned when, "it is worded exactly like or similar to previous entries. It can also occur when the documentation is exactly the same from patient to patient." Cloned documentation may result in payment denials, and compromises our patients' care. Each patient encounter is required to have an individualized note, that supports the medical necessity of the service and the treatment plan outlined. NGS has stated, "cloned documentation will be considered misrepresentation of the medical necessity requirement for coverage of services due to the lack of specific individual information for each unique patient. Identification of this type of documentation will lead to denial of services for lack of medical necessity and the recoupment of all overpayments made."

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3 "Make Me the Author"

Epic, allows for a note created by one clinician (typically a Resident), to be reviewed, and modified by an authorizing provider (i.e. attending physician). When the authorizing provider opens the note that was previously created, they will be prompted to either assume authorship, or leave it under the original author. Epic records and maintains all prior versions of the note via an audit trail and are available via hyperlinks.

3.1 Residents

Teaching Physicians (TP) may assume authorship of notes created by residents. When utilizing the "Make the Author" (MMTA) functionality, the teaching physician is responsible for reviewing the note for accuracy. The teaching physician documentation rules are still applicable when using the "MMTA" functionality and at a minimum adding a TP attestation statement is required. In accordance with CMS Teaching Physician Rules, it is important to remember that the teaching physician must personally see and evaluate the patient.

For detailed steps on using the "Make Me the Author" function, please (click here) to see the Epic Tip Sheet.

3.2 Non-Physician Practitioners (NPP)

Physicians should not utilize "MMTA" functionality when collaborating with non-physician practitioners (NPPs). Please (click here) for the Office of Corporate Compliance guidance on billing and documentation requirements for physician and NPP collaboration.

4 Split/Shared Services

When a hospital inpatient/hospital outpatient or emergency department E/M service is shared between a physician and NPP from the same group practice, and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed by either the physician or NPP. In order for a service to be considered a split/share encounter, there must be collaboration between the physician and NPP. If there was no face-to-face encounter between the patient and physician, the service should be documented and billed by the NPP. A split/shared evaluation and management service performed by a physician and NPP cannot be reported as critical care services or procedures.

Please (click here) to review the Office of Corporate Compliance "Non-Physician Practitioner (NPP) - Billing and Documentation Guidance" for additional information on Split/Shared visits.

4.1 Documentation Expectations

The documentation for split/share visits should be completed and authenticated by both, the physician and NPP. Each provider should document the key and critical portions of the service they provided. The documentation for split/share encounters should support the medical necessity of the involvement of both providers and support the level of service billed. A Teaching Physician Attestation statement is not appropriate and cannot be used by the physician provider as his/her documentation.

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5   Teaching Physician Documentation

5.1   E/M Service Documentation Provided by Residents/Fellows

Medicare regulations state that for purposes of payment, documentation of E/M services billed by Teaching Physicians (TP) must demonstrate:

- That the TP performed the service or was physically present during the key or critical portions of the service when performed by the resident; and
- The participation of the TP in the management of the patient.

When residents/fellows are involved in the delivery of patient care, the TP must personally include, at a minimum, a TP Attestation statement within the documentation.

The composite of the TP's entry and the resident's entry, in Epic, together must support the medical necessity of the billed service and the level of the service billed by the TP. It is best practice for the TP to refer to the resident by name when referencing the resident's note in their TP Attestation statement. It is important to remember that it is not appropriate to reference a resident's note until it becomes available. The date and time affiliated with a TPs' Attestation statement should not precede the date and time stamp associated with the resident's signature. For billing purposes a resident's note can only be used by one TP.

Sample Attestation Epic SmartPhrases: Outpatient Attestations for Attending Physicians and Residents	
★ .ATTESTNOTPRESENTAMB	Attending sees patient separately from the resident
★ .ATTESTPRESENTAMB	Attending sees patient together with the resident
★ .ATTESTPRIMARYCAREEXCEPTION	Primary Care Exception (discussed care only)
Inpatient Attestations for Attending Physicians and Residents	
★ .ATTESTNOTPRESENTINP	Attending sees patient separately from the resident
★ .ATTESTPRESENTINP	Attending sees patient together with the resident

5.2   E/M Service Documentation provided by Medical Students

CMS allows medical students to document E/M services in the medical record. Any contribution and participation of a 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.

The teaching physician must verify in the medical record all 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.

It is best practice for the TP or Resident to create an addendum to the student note, edit the note as needed, and to verify the student's documentation using attestation statements created by the OCC. Please click here for a complete list of attestation statements.

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Please ([click here](#)) to review CMS Teaching Physician Rules at Chapter 12, Section 100 – Teaching Physician Services of the Medicare Claims Processing Manual.

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6   Epic Resources- UCM Home Page

There are many Epic resources available via the UCM intranet. Providers are encouraged to view the resource page often for tools and instructional guidance for using the Electronic Health Record. For access to the Epic support page, click ([here](#)).

7   References

- [Medicare Claims Processing Manual:Chapter 12- Physicians/Non-physician Practitioners](#)
- [AHIMA HIM Body of Knowledge: Integrity of the Healthcare Record-Best Practices of EHR Documentation](#)
- [Medicare Benefit Policy Manual: Chapter 15-Covered Medical and Other Health Services](#)
- [Association of American Medical Colleges: 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](#)
- [UCM Epic Support Training Documents](#)
- [UCM Policy A08-24: Medical Record Authentication](#)
- [NGS Policy Education:Cloned Documentation Could Result in Medicare Denials for Payment](#)

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