

**TECH UNIVERSITY HEALTH SCIENCES CENTER
OFFICE OF BILLING COMPLIANCE**

ELECTRONIC MEDICAL RECORD PLAYBOOK

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The information contained in this document is a resource for Texas Tech University Health Sciences Center (TTUHSC) to utilize during the on-going implementation of electronic medical record (EHR) systems at TTUHSC. The primary purpose of this document is to educate providers and their staff on potential risks that may arise when implementing an EHR and provide some initial recommendations from the . With this knowledge base, providers and their staff can seek further guidance from their Billing Compliance Office staff to minimize the risk of improper documentation that could result in fraud/abuse liability. This document includes best practices as outlined by professional associations, the Center for Medicare and Medicaid Services (CMS) as well as lessons learned from other academic institutions that have EHR systems in place as well as our own experiences.

Some of the recommendations stated in this document will be the basis of future written compliance policies and procedures from the Billing Compliance Office (BCO) at which time this Playbook will be updated to reference those policies.

I. EVALUATION AND MANAGEMENT (E/M) CODE SELECTION & PROMPTS

This is an important issue if the campus decides to use tools within the EHR system to identify the level of E/M code based on the provider's documentation in the EHR. Exclusive use of the 1995 or 1997 Documentation Guidelines (DG) for E/M services may not accurately reflect the true level of service provided. Also, and as a best practice, the Compliance Office will establish parameters/guidelines for the proper use of code selection tools to ensure that E/M levels are coded based on medical necessity rather than the amount of documentation.

A. E/M CODE SELECTION TOOLS

An important aspect of coding E/M services is **medical necessity** as it is supported by the documentation to code a particular level of E/M service. While a computer may calculate history and exam components, it cannot calculate medical necessity based on the presenting problems(s) which must be taken into consideration for every encounter.

Code selection tools can create a trap for the unwary provider who relies solely on the code selector without evaluating the medical necessity supporting the reason for the visit (Chief Complaint and History of Present Illness) and the type of documentation in the EHR. **DOCUMENTATION THAT IS NOT MEDICALLY NECESSARY MUST NOT BE COUNTED TOWARD THE LEVEL OF SERVICE.**

- Preventive Services (including well baby visits). Preventive visits have required elements that must be completed, not based on medical necessity, but rather established criteria that may allow for the use of a one-click option to populate the medical record with the standard preventive service elements, with the provider taking responsibility for performing all of those elements that are documented via the EHR. This may be acceptable as long as the EHR allows the provider the ability to comment on any abnormal or unusual findings during the well visit exam.
- Problem Focused/Sick Visits. E/M codes for problem focused/sick visits must ultimately be selected based on medical necessity, not on the volume of documentation in the EHR for that visit. **MEDICAL NECESSITY** is a cognitive process and cannot be easily quantified. Trailblazer, our CMS Medicare Advantage Contractor (MAC), has stated that medical necessity is based on the information captured in the History of Present Illness¹ (HPI). Trailblazer will be focusing more on ambulatory EHRs, especially looking for increases in higher levels of E/M services that may not be supported by medical necessity, thus resulting in higher levels of denials. The key to any payment under the Medicare program is that payment is only made for medically necessary services. Thus, it essential that someone objectively evaluate the E/M sick visit code selected by the EHR to confirm that it is supported by medical necessity based on the reason for the visit (Chief Complaint) and the provider's assessment/plan.

EHR SELECTION OF E/M LEVEL – BILLING COMPLIANCE POLICIES

1. [BC Policy 7.3, Code Selection and Prompt Functions](#)
2. [BC Policy 7.2 EHR Cloning \(Copy & Paste\) Functions](#)

Copy-and-pasted or cloned documentation (see more details below) that is not medically necessary must not be counted towards the level of service billed.

B. E/M CODING PROMPTS

Some EHR systems include a feature that notifies the provider when one or more history/exam elements are missing that, if documented, would increase the level of E/M service. While EHR system prompts can add value by providing guidance and alert the provider to possible inconsistencies, it is important that controls are in place to identify upcoding resulting from documentation that does not accurately reflect the services provided, but is merely there to bill a higher code.

The Certification Commission for Healthcare Information Technology (CCHIT) has recognized the value of E/M code selection tools as a means of assisting the provider in calculating an E/M code from an encounter based on data entered into the system to show the basis of the calculation. However, it would be inappropriate to utilize a code prompt

¹ Provider Outreach Education Material, "Tips for Preventing Most Common Evaluation and Management Service Coding Errors" at <http://www.trailblazerhealth.com/Publications/Job%20Aid/tips%20for%20preventing%20most%20common%20e-m%20coding%20errors.pdf>

from the EHR to suggest that additional data be added for the sole purpose of increasing an E/M code level without being medically necessary. In a final report to the Department of Health and Human Services, Research Triangle Institute (RTI) International set forth various recommendations to enhance data quality in the EHR, including E/M coding requirement 5.2, which states:

Prompts that are driven by E/M administrative processes shall not explicitly or implicitly direct a user to add documentation. This does not apply for additional documentation for E/M levels already achieved, for medical necessity or for quality guidelines/clinical decision support².

E/M CODING PROMPTS – BILLING COMPLIANCE POLICIES

1. [BC Policy 7.3, Code Selection and Prompt Functions](#)

C. 1995 VERSUS 1997 DOCUMENTATION GUIDELINES - WHICH WILL BE USED TO CALCULATE LEVEL OF SERVICE?

1. The **1995 DG** for a Comprehensive Exam (Levels 4/5 for Office Visits and Consults and Level 2/3 for Hospital Admits) require 8 body areas and/or organ systems³ for a general multi-system exam. Currently, there are no specific criteria to determine what constitutes a complete single organ exam under the 1995 DG and therefore limiting the EHR to 1995 DG may result in lower levels for specialist providers (i.e., Cardiologists, Ophthalmologists, Obstetrician/Gynecologists, and Orthopedic Surgeons).
2. The **1995 DG** Expanded Problem Focused (EPF) and Detailed (D) Exam both require documentation of 2 to 7 body areas and/or organ systems. According to our Carrier⁴, the difference between these two levels of service is not the number of body areas and/or organ systems examined, but the detail in which the examined body areas/systems are described. This will require evaluation by either the provider and/or coder to verify if the exam is sufficient in detail to support a Detailed Exam rather than an Expanded Problem Focused Exam.
3. Limiting the EHR to 1997 DG may not be advantageous to general practitioners and general internal medicine providers because the criteria for reaching a general multi-system exam are more stringent under the 1997 DG.

² Recommended Requirements for Enhancing Data Quality in Electronic Health Record Systems, May 2007 at http://www.rti.org/pubs/enhancing_data_quality_in_ehrs.pdf

³ Trailblazer's E/M pocket reference card states that 8 body areas or organ systems can satisfy the requirements under the 1995 DG for a comprehensive exam. <http://www.trailblazerhealth.com/Publications/Job%20Aid/coding%20pocket%20reference.pdf>. Correspondence from Trailblazer Medical Director notes body areas can be counted if an exam element does not fit within an organ system, such as examination of "thyroid", "breast", etc.

⁴ Provider Outreach Education Material, "Tips for Preventing Most Common Evaluation and Management Service Coding Errors" at <http://www.trailblazerhealth.com/Publications/Job%20Aid/tips%20for%20preventing%20most%20common%20e-m%20coding%20errors.pdf>

DOCUMENTATION GUIDELINES - RECOMMENDATION OF BCO:

The BCO does not anticipate issuing any policies at this time to address this item unless it is requested by the Schools. At this time, the BCO follows CMS' standards, which are that either the 1995 or 1997 DG may be used to code E/M services. A way to do this would be to input both 1995 and 1997 DG into the EHR system and let the provider and/or coder select the Documentation Guideline that is most advantageous based on the specialty of the provider (i.e., that will properly identify the level of documentation based on medically necessary documentation).

A provider and/or coder must evaluate the E/M code level when the 1995 DG are used and the exam is Detailed to verify that the exam is sufficient enough in detail to support that level of E/M code.

II. E/M TEMPLATES

EHR templates can make documentation faster and easier, but template features, such as “exploding” notes, “auto-population”, “pre-population”, “default documentation” and “cloning” and “macro⁵” features can result in too much information being replicated from one encounter to the next with little to distinguish patient encounters and failing to support medical necessity which can raise compliance concerns. Documentation automatically entered by way of template functions that is not relevant to what was performed or what was medically necessary is not counted for billing purposes. Therefore, it is important that the EHR does not take over the documentation for the provider, but that the provider is in control of the type and extent of information available through the EHR system that needs be included in the patient's medical record for each visit to identify the actual services provided and the medical necessity to in support of each service.

Template features should be utilized by the provider to prompt documentation of medically necessary information, not do the “lion's share” of the documentation. The focus of the BCO is to encourage providers to use the information available through the EHR to customize the patient's medical record so that the integrity and accuracy of the information cannot be put into question, whether it is for billing purposes or patient care. It is the provider's responsibility when using these features to customize the visit note to the greatest extent possible to reflect the unique problems evaluated and services provided so it is obvious to auditors (internal or external) that the visit notes are not “carbon copies” records.

A. EXPLODING/PRE-POPULATED ELEMENTS

“Exploding notes” or “exploding macros” or “pre-populated elements” refers to the functions of clicking or checking “normal” or “negative” which then populates documentation of a complete element within the history or exam even though that level

⁵ In this context a “macro” is a series of commands grouped together as a single command that are recorded and saved under a short key code or macro name. A macro can be used to add “blocks of text” that is used over and over again.

of service may not have been provided. This function, if not properly utilized by the provider, can take over the documentation and result in erroneous information in the final record.

EXAMPLE: The provider selects GI exam and the patient's medical record automatically places in the medical record all GI descriptions, such as "abdomen soft and non-tender, normal bowel sounds, not distended, organomegaly", etc., with no further input by the provider even though the provider may not have examined all of those GI areas.

If the provider does not perform each of these elements or fails to delete those items not performed, it not only raises billing compliance risks, but also raises quality of care and malpractice liability concerns.

EXPLODING ELEMENTS – RECOMMENDATION OF BCO:

- Ideally, the EHR should require that the provider verify and click on each item within a specific element, whether it be in the History, Exam or Medical Decision Making sections to ensure that the documentation is patient specific and accurately reflects the service provided. The chief complaint should carry through to the type of information documented in the history and exam. In the absence of such a mechanism, then it is the provider's responsibility to review and verify information auto-inserted into the medical record.
- Ideally, each campus should consider establishing a committee (to include the Billing Compliance Office) to review and approve EHR templates to ensure that they are not only accurate, but complete for purposes of capturing the necessary information and are populated based on patient specific information selected by the provider.

B. DEFAULTS TO NEGATIVE

Similar to the exploding elements, some EHR systems allow for all the items within an element (i.e., ROS, PFSH, Exam) to be recorded in the medical record as negative unless the provider specifically documents otherwise. Defaulted information can lead a provider to overlook documentation of positive and/or pertinent negative findings. Also, defaulted language can lead to documentation of a more extensive history and/or examination that is medically necessary to perform based on the patient's presenting problem(s). It can result in inaccurate or incomplete information in the patient's medical record.

DEFAULTS TO NEGATIVE – RECOMMENDATION OF BCO:

Ideally, each element of the patient encounter should be selected and verified by the provider.

C. CLONED/COPY AND PASTE FUNCTION

A feature of most EHR systems is the ability to copy and paste (i.e., clone) documentation from a previous patient encounter or from another patient's medical

record. Cloned documentation refers to medical record documentation that is identical regardless of the patient involved; or in the case of the same patient, regardless of the date of service. EHR system features that may exist include, among others: (a) copy and paste functions; (b) copy note forward; and/or (c) save note as template option.

The transition to an on-line medical record in the VA system resulted in the growth of copying and pasting along with its attendant risks, including inaccurate information and larger records containing redundant information already located in the EHR⁶. More recently, the Office of Inspector General (OIG) has included in its Fiscal Year 2011 Work Plan⁷ an audit of electronic medical records to determine if there is inappropriate use of cloning/copy & paste functions that result in improper claims and payments.

Basically, the documentation looks acceptable until you compare it to other charts for the patient and/or created by the provider and they all look the same, except the name or date, as applicable, has been changed. This type of activity can lead to inaccurate and sometimes contradictory information in the medical record and raise questions as to the validity of the service provided.

Example #1:

Chief Complaint (Documented by Nurse/ancillary staff/medical student): Nausea and vomiting for 3 days.

ROS (Copy and Pasted by Nurse/ancillary staff from previous visit): No complaints of nausea or vomiting.

Example #2:

Patient was seen in the family medicine clinic for 4 visits over the course of 5 months. Each visit documents performance of a pap smear (due to copying and pasting of information from previous visits without reviewing the information).

Entries into the EHR must be patient and visit specific and contain the actual data collected by the provider based on medical necessity on that date of visit. Use of copy and paste functions from one note to another can lead to cloned documentation if the provider fails to update the information and make it specific to the patient for that date of service. Trailblazer has expressed concerns about the use of cloned documentation in the EHR setting.⁸

Another concern that arises with copy and paste functions (also referred to as pull forward function) is the ability to identify information that has been copied from another part of the record, not only to confirm the origin of the information (the author and date), but also to remind the provider that it needs to be reconfirmed and revised as necessary to

⁶ Hammond, et al. "Are Electronic Medical Records Trustworthy? Observations on Copying, Pasting and Duplication" AMIA 2003 Symposium Proceeding. (2003): 269-273

<http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1480345&blobtype=pdf>

⁷ OIG Work Plan, Fiscal Year 2011 at: <http://oig.hhs.gov/publications/workplan/2011>

⁸ Trailblazer Bulletin, September 20, 2002.

accurately reflect the visit on that new date of service. Studies have indicated that providers who copy and paste information from a previous encounter (or another patient) have unwittingly or erroneously signed off or authenticated information that was duplicative, inapplicable and in some instances, erroneous or misleading.⁹ A wrinkle in the academic setting is the potential ability of the Resident and/or Teaching Physician to copy a medical student's HPI, Exam or Medical Decision Making and paste it into the note to become part of the Resident's or Teaching Physician's documentation. (See C.2 below) However, it is not acceptable for either the Resident or Teaching Physician to use the medical student's documented HPI, Exam or Medical Decision Making for patient care and/or billing purposes, including copy & paste.

Another issue that can arise with the use of copy and paste functions is the inability to identify the original source of the information, thus creating legal and quality of care risks to the individual provider. Ideally, the EHR should be able to identify all entries. Data pulled (copy and pasted) from other sources (i.e., previous visits) should be identified within the medical record (i.e., different color font) and identifiable as to the author, source and original date of the copied/pulled information; however, not all EHR's have the same functionality and; therefore, functionality can be limited on that basis. CMS¹⁰ and Texas Medicaid require that the documentation include the identity of the individual making the entry into the medical record.

AHIMA's Guidelines for EHR Documentation to Prevent Fraud includes a helpful resource (Appendix B) presenting good and bad cases of the copy and paste function to borrow data from another source¹¹.

CLONED/COPY AND PASTE – RECOMMENDATIONS OF BCO:

The BCO recognizes the value of allowing copy and paste functions to ease documentation burdens for the provider. However, as outlined above, there should be specific methodologies in place to ensure that this functionality is used properly. More details are found in these policies:

1. [BC Policy 7.2, Cloning \(Copy & Paste\) Functions](#)

III. TEACHING PHYSICIAN DOCUMENTATION

A. EHR TEACHING PHYSICIAN MACROS

In its November 2002, revision of the Teaching Physician regulations, CMS specifically addressed use of computer generated macros by teaching physicians to personally document their participation/presence for E/M services involving residents. The teaching physician rule now states in its definition of documentation the following:

⁹ AHIMA, Guidelines for EHR Documentation to Prevent Fraud;

http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_033097.hcsp?dDocName=bok1_033097

¹⁰ The Five Step Process (Trailblazer) <http://www.trailblazerhealth.com/Publications/Job%20Aid/five-step%20process.pdf>;

¹¹ Id, Appendix B

In the context of an electronic medical record, the term 'macro' means a command in a computer or dictation application that automatically generates predetermined text that is not edited by the user.

When using an electronic medical record, it is acceptable for the teaching physician to use a macro as the required personal documentation if the teaching physician adds it personally in a secured (password protected) system. In addition to the teaching physician's macro, either the resident or the teaching physician must provide customized information that is sufficient to support a medical necessity determination. The note in the electronic medical record must sufficiently describe the specific services furnished to the specific patient on the specific date. It is insufficient documentation if both the resident and the teaching physician use macros only.¹²

Since the teaching physician must personally document his/presence for E/M services, it is important that the teaching physician macro for E/M services be established so that only the teaching physician can add it to the medical record. In those cases where residents or others can documentation teaching physician presence (i.e., surgeries, etc.), then it is acceptable to allow residents, nursing staff as well as the teaching physician the privilege to use those macros.

TEACHING PHYSICIAN MACROS – RECOMMENDATION OF BCO:

- Approved Macros: The Billing Compliance Office has approved teaching physician macros for TTUHSC EHR systems which are attached as Appendix A. These may be updated or revised from time to time. They should be used in any TTUHSC EHR system, with any requested changes pre-approved in writing by the Billing Compliance Director and/or Institutional Compliance Officer.
- Teaching Physician Macros: The EHR must only allow the teaching physician to add the teaching physician macro for those services that must be personally documented by the teaching physician. This includes E/M services, time-based services, psychotherapy services (along with any additional documentation required) via a secured password. In the hospital setting, it would also include anesthesia services and overlapping surgeries. These macros or supporting documentation cannot be added by residents or other office staff members. This will likely require role-based access to various areas within the EHR.

IV. MEDICAL STUDENT DOCUMENTATION – BILLING ISSUES

While the medical student's documentation of clinical care is an important educational tool, the use of the medical student's documentation to support a billable service is very limited. The medical student's documentation of HPI, Exam or Medical Decision

¹² CMS Internet Only Manual, 100-04, Chapter 12, Section 100;
<http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>

Making cannot be used to support an E/M service. Therefore, it is very important that the EHR system distinguish the medical student's documentation from that of the resident and/or teaching physician in determining the level of E/M services for billing purposes.

MEDICAL STUDENT DOCUMENTATION – RECOMMENDATION OF BCO:

The medical student's documentation of HPI, Exam and Medical Decision Making must not be captured (including any copy and pasted information by the resident and/or teaching physician) when determining the level of E/M service for billing purposes. The Billing Compliance Office audits will focus on this aspect of the EHR to ensure that billable E/M services are documented by authorized individuals. The medical student's documentation of HPI, Exam and/or Medical Decision Making, whether original or copied by the resident or teaching physician, shall not be counted for billing purposes.

V. OTHER DOCUMENTATION ISSUES

A. TIME-BASED CODES

Medicare has specific documentation requirements for time-based codes in the ambulatory setting. In particular the EHR should allow appropriate documentation of psychotherapy time as well as counseling/coordination of care when it constitutes more than 50% of the E/M service.

1. Counseling/Coordination of Care: When counseling and/or coordination of care dominates more than 50% of the total face-to-face time with the patient and/or family encounter, then the E/M level may be selected based on time. In order to do this, the medical record must reflect the total time spent with the patient and describe the counseling/coordination of care activities¹³. In order to verify that more than 50% of the time was related to counseling/coordination of care activities, we strongly suggest that the provider also document the time spent in counseling/coordination of care activities. The best practice is to have the EHR not only prompt total time, but also time spent in counseling/coordination of care activities.
2. Psychotherapy Services and Prolonged Services: These services are billed based on time and therefore the medical record must reflect the time spent. Time should be reflected as time in and time out.

TIME-BASED CODES - RECOMMENDATION OF BCO:

1. Counseling/Coordination of Care: The EHR should have a location for the provider to indicate total time in the medical record along with a description box when counseling/coordination of care constitutes more than 50% of the time spent with the patient. We strongly favor also including space to allow the provider to document time spent counseling/coordinating care AND the total time along with the description box, such as:

¹³ 1995 and 1997 DG; http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf

“I spent [insert total time] with the patient, of which [insert time counseling coordination care] was devoted to discussing the following issues: [insert general description of items discussed]”

2. Psychotherapy Services and Prolonged Services: There should be a location in the EHR that allows the provider to document time-based services, such as psychotherapy and prolonged services, using a time-in and time-out methodology.
3. Teaching Physician: Only the teaching physician’s time can be used to bill for services. It is important that only the teaching physician be able to enter time into the medical record when a resident is involved. There should be role-based access to ensure that only a teaching physician can enter time for time-based codes. See more details above on teaching physician issues in the EHR.

B. AUTHORSHIP

An EHR must allow various individuals to make entries into the record. This not only includes ancillary personnel who may document preliminary information such as demographics, chief complaint and vitals, but also corrections to the medical record. In such situations it is vital that the author of the documentation be tracked, retained and displayed. Systems with only a single authorization for a visit note may create compliance risks if there is no ability within the system to identify who the author is of each entry. This is especially true when the service is a shared visit involving care provided by both a non-physician provider (PA, NP, etc.) and a physician.

In its report to DHHS, RTI International recommends the use of date/time/user stamp identification for each entry and that this information is retained when data is entered into the medical record on behalf of the provider.¹⁴ For example, the record should be able to distinguish between information obtained and entered by staff as opposed to information entered into the record by staff on behalf of a provider.

AUTHORSHIP – RECOMMENDATION OF BCO:

1. Ideally, the EHR system should have some means of identifying the author and date of each entry into the patient’s medical record. The EHR system should have a back-end audit trail to verify who entered each item into the medical record, including the date of such entry.
2. The provider under whose name the services will be billed (billing provider) must sign off on the medical record before it is billed to the payer.
3. Staff entering information into the EHR, either transcription, scribing or copying information from dictated note, must identify the role in entering the information and the billing provider must sign off on the entry and be identified as the true author of the information.

¹⁴ Recommended Requirements for Enhancing Data Quality in Electronic Health Record Systems, May 2007 at http://www.rti.org/pubs/enhancing_data_quality_in_ehrs.pdf (Requirements 4.2.4 and 4.2.6)

C. CORRECTIONS/AMENDMENTS AND AUDIT TRAILS

Amendments and changes to the medical record must be accurately reflected and traceable to avoid improper alteration of the medical record. Such corrections must be dated, timed and authenticated. After the encounter has been authenticated by the provider, there should be a mechanism to amend and/or change the record that can be easily audited to prevent fraudulent, untraceable, alteration of the record. RTI International, standard 4.2.7 states that entries after the signature event should be retained as the original document and any changes/additions to the record thereafter must be handled as amendments that can be tracked through the system.¹⁵ This audit function of the EHR system should always be activated in order to identify legitimate changes from improper changes. The audit trail should include the identity of the user as well as the date and time of the amendment/change.

CORRECTIONS/AMENDMENTS – RECOMMENDATION OF BCO:

All entries into the EHR should include the author's credentials, electronic signature as well as a date and time. All entries into the EHR should be auditable by provider (i.e., author) as well as by date and time of entry. Once the record has been authenticated by the provider, corrections/amendments must be separately entered and noted in the EHR, with the identity of the author as well as the date and time of the corrected/amended entry. There should never be the ability to erase or otherwise obliterate information in the EHR system that has been authenticated.

RESOURCES

1. AHIMA e-HIM Workgroup: "Guidelines for EHR Documentation to Prevent Fraud" Journal of AHIMA 78, no. 1 (January 2007).
http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_033097.hcsp?dDocName=bok1_033097
2. Tips for Preventing Most Common Evaluation and Management (E/M) Service Coding Errors, by Trailblazer Health Enterprises, LLC, August 2010.
<http://www.trailblazerhealth.com/Publications/Job%20Aid/tips%20for%20preventing%20most%20common%20e-m%20coding%20errors.pdf>
3. Medical Necessity for Evaluation and Management Services, by Trailblazer Health Enterprises, LLC, August 2010.
<http://www.trailblazerhealth.com/Publications/Job%20Aid/medical%20necessity.pdf>
4. Articles on Compliance Strategies, Compliance Risks Grow with Electronic Medical Record Systems, reprint from the May 28, 2007 issue of REPORT ON MEDICARE COMPLIANCE;

¹⁵ Recommended Requirements for Enhancing Data Quality in Electronic Health Record Systems, May 2007 at http://www.rti.org/pubs/enhancing_data_quality_in_ehrs.pdf

http://www.aishealth.com/Compliance/ResearchTools/RMC_Compliance_Risks_EMRs.html

5. Recommended Requirements for Enhancing Data Quality in Electronic Health Records, Final Report, June 2007 prepared by RTI International for the Department of Health and Human Services. http://www.rti.org/pubs/enhancing_data_quality_in_ehrs.pdf
6. Foundation of Research and Education. “Report on the Use of Health Information Technology to Enhance and Expand Health Care Anti-Fraud Activities” (September 30, 2005) ONC Health Care Anti-Fraud Project Task Order HHSP23320054100EC http://library.ahima.org/expedio/groups/public/documents/ahima/bok1_031699.pdf
7. Hammond, et al. “Are Electronic Medical Records Trustworthy? Observations on Copying, Pasting and Duplication” AMIA 2003 Symposium Proceeding. (2003): 269-273 <http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1480345&blobtype=pdf>
8. Hirschtick, Robert F. “Copy-and-Paste” JAMA Vol. 295, no. 20 (May 23/31, 2006): 2335-2336. <http://jama.ama-assn.org/cgi/content/full/295/20/2335>

Teaching Physicians Electronic Medical Record Macros Only

TEACHING PHYSICIAN MACRO TITLE	TEACHING PHYSICIAN MACRO STATEMENT	ACCESS RIGHTS
E/M: Teaching Physician with Resident	I was present with the Resident during the history and exam. I discussed the case with the Resident and agree with the findings and plan as documented in the note except for my comments if noted below.	Teaching Physician
E/M: Teaching Physician and Resident Perform Separately	I saw and evaluated the patient. I reviewed the Resident's note and agree with the findings and plan as documented in the note except for my comments if noted below.	Teaching Physician
E/M: Primary Care Exception (99211-99213; 99201-99203; IPPE)	I have discussed the patient's care with the Resident. I have reviewed the patient's history and Resident's findings on exam, the patient's diagnosis/differential diagnosis and treatment plan. I concur with the treatment plan as documented by the Resident, except for my comments if noted below.	Teaching Physician
Minor Procedure (< 5 min)	I was physically present for the entire procedure.	Teaching Physician
Present for Entire Single Surgery (Includes Endoscopic Surgery)	I was physically present for the entire surgery.	Teaching Physician
Present for the Key/Critical Portions of Single Surgery/Endoscopic Surgery and Immediately Available	I was physically present for the key/critical portions of this surgery and immediately available throughout the rest of this procedure.	Teaching Physician
2 Surgeries - Key/critical portions DO NOT overlap (Each Case)	I was physically present for the key/critical portions of this case which were: [insert key/critical portions]. Dr. [Teaching Physician] was immediately available at all other times during this procedure.	Teaching Physician
Time Based Codes (Individual Medical Psychotherapy, Counseling/Coordination of Care, Critical Care, Discharge, etc)	I was personally present for [____] minutes for this service.	Teaching Physician
Psychiatric Services (Excluding individual medical psychotherapy)	I was physically present during the psychiatric service or concurrently observed the psychiatric service by use of a one-way mirror or video equipment. [Time]	Teaching Physician
Anesthesia: One-on-one with Resident	I was physically present during all key/critical portions of this procedure.	Teaching Physician
Anesthesia: Two Concurrent Cases Involving Residents (For each Case)	I was physically present with the Resident through the pre and post anesthesia care of this case and all other key/critical portions of the procedure which represented [Time].	Teaching Physician
Interpretation of Diagnostic Tests (Other than Pathology)	I personally reviewed the image and the Resident's interpretation and agree with the findings except if noted below:	Teaching Physician
Interpretation of Pathology Tests	I personally reviewed the slide and the Resident's interpretation and agree with the findings except if noted below:	Teaching Physician
Endoscopic Diagnostic Procedures (Not Surgeries)	I was personally present during the entire viewing, including insertion and removal of the endoscope.	Teaching Physician