UPI Guideline Statement for Macro Templates and Previously Created Text in EMR Systems

**Purpose:** The purpose of this guideline is to insure EMR clinical documentation submitted by UPI billing providers meets the following goals:

- EMR documentation meets all federal/state mandated and UPI mandated documentation compliance standards
- EMR documentation of clinical care reflects an accurate record of all new/relevant findings and the clinical services rendered by the billing provider at every clinical encounter
- Encounter specific documentation establishes the medical necessity of all services rendered by the billing provider
- EMR documentation of clinical care accurately reflects the quality of care provided at every clinical encounter
- EMR documentation maximizes efficient data capture and recording without jeopardizing establishment of medical necessity by the billing provider

**CMS statement regarding macro templates in the EMR.**

- A macro, per CMS, is “a command in a computer or dictation application in an electronic medical record that automatically generates predetermined text that is not edited by the user.”
- A billing physician may use a macro as the required personal documentation if the billing provider personally adds the macro in a secured or password protected system. In addition to the macro, the billing provider (or resident who is documenting the majority of the encounter) must provide customized information that is sufficient to support a medical necessity determination. The note in the EMR must sufficiently describe the specific services furnished to the specific patient on the specific date.
- In a teaching physician clinic, if both the resident and the teaching physician use macros only, this is considered insufficient documentation. One or both of the physicians (teaching or resident) must provide customized information that is specific to the services furnished on the specific date.

**Teaching Physician Rules**

- The performing/billing provider must follow all guidelines related to the teaching physician guidelines when documenting encounters performed with a student or resident. The guideline for copy/paste, copy/forward, auto population, and
predetermined test and predetermined findings DO NOT supersede the teaching physician guidelines.

Macro Templates in EMR Systems

- A macro, per CMS, is “a command in a computer or dictation application in an electronic medical record that automatically generates predetermined text that is not edited by the user.”.
- When using an EMR, it is acceptable for the performing/billing provider to use automatically generated predetermined text/findings, for the purposes of billing, when all of the following occur:
  - The predetermined text/findings are integral and relevant to the current encounter, and are not solely used to support a level of billing.
  - The performing/billing provider actively reviews and confirms with the patient at the billing encounter, ALL elements of the predetermined text/findings. The attestation that a performing/billing provider has reviewed and confirmed the predetermined text/findings is evidenced by:
    - The performing/billing provider signature in a secured (password protected) system.
    - The UPI billing documentation certification statement “I certify that (1) all services on this form were personally provided and/or personally supervised by me and hereby approved for billing. (2) I understand the medical record must be documented for these services, and (3) the rendering of the services and the documentation in the medical record are in accordance with UPI guidelines”.
  - The performing/billing provider actively edits the predetermined text/findings based on the unique patient data acquired during the encounter so that any macro templates remaining in the EMR documentation at the time of billing are medically necessary for the reason for the specific encounter.
  - Billing should be based on the medical necessity of the services provided during the encounter. Billing must NOT be based solely on the level of the unedited, predetermined text.
  - Billing providers are expected to actively remove predetermined text/findings that are no longer active/relevant or applicable to the patient at the time of the encounter.
  - Exploding macros that may alter a billed level of service may only be used if all findings within the exploding macro are personally performed by the documenting provider,
Copy/Paste, Copy/Forward Auto population in EMR Systems

- Copy/paste, copy/forward, and auto population are functionalities that exist in EMR systems that allow performing/billing providers to **identically replicate previously created text and findings** into a current encounter. Previously created text and findings may be created by billable providers, non-billable providers, or by ancillary staff depending on the unique specifications of an EMR system and the defined roles within a clinical system.

- **When using an EMR it is acceptable for the performing/billing provider to copy/paste, copy/forward, auto populate for the purposes of billing,** identically replicated text and findings from any billable provider, non-billable provider, or ancillary staff when all of the following occurs:
  - The identically replicated text and findings are integral and relevant, and medically necessary to the current encounter, and are not solely used to support a level of billing.
  - The performing/billing provider actively reviews and confirms with the patient at the billing encounter, **ALL elements** of the copy/paste, copy/forward, auto populated text. The **performing/billing provider must edit and document customized history elements** relevant to the billing encounter for the specific patient on the specific date of service.
  - The performing/billing provider must follow all guidelines related to the teaching physician guidelines when documenting encounters performed with a student or resident. The above guidelines for copy/paste, copy/forward, auto population, and predetermined test and predetermined findings DO NOT supersede the teaching physician guidelines.
    - A teaching physician may use a macro as the required personal documentation if he or she personally adds it in a secured or 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 EMR must sufficiently describe the specific services furnished to the specific patient on the specific date. If both the resident and the teaching physician use macros only, this is considered insufficient documentation.
  - The **performing/billing provider must actively perform all physical exam elements of the replicated text findings.** The performing/billing provider must edit and document all new findings unique to the billing encounter.
  - The attestation that a performing/billing provider has actively reviewed, confirmed, performed, updated, and edited the copy/paste, copy/forward is evidenced by:
The performing/billing provider signature in a secured (password protected) system.

The UPI billing documentation certification statement “I certify that (1) all services on this form were personally provided and/or personally supervised by me and hereby approved for billing. (2) I understand the medical record must be documented for these services, and (3) the rendering of the services and the documentation in the medical record are in accordance with UPI guidelines”.

The performing/billing provider must report in addition to the identically replicated text and identically replicated findings customized information that is specific to the services furnished on the specific date. Customized information is defined as documented information that is written in a distinct and differentiated formatted from that of the copy/paste, copy/forward, auto populated replicated text and replicated findings. It is expected that customized information will always be obtained during a unique encounter. Customized information is required for elements that are age/time sensitive, or are subjective and would be expected to vary with time - such as reported onset, location, duration, severity, aggravating and associated symptoms, and items in the plan of care. When identically replicated text is replicated from a billable or non-billable provider, the billing provider is required at a minimum in the History of Present Illness and Medical Decision Making sections of the medical record to provide customized documentation that is written in a distinct and differentiated formatted from that of the billable or non-billable provider. When identically replicated findings are replicated from a billable or non-billable provider, the billing provider is required to actively perform all elements of the replicated text findings and provide documentation of new findings as referenced above.

- In the outpatient setting, customized information is further defined as information that clearly reflects the events or changes that have occurred since the previous visit from which the text is being replicated. Customized information must always reflect medical necessity, and provide distinct evidence that the documentation reflects the billing providers work product.

- In the inpatient setting, customized information is further defined as information that clearly reflects patient progress and events over the interval since the last billing encounter. Evidence that customized information has been obtained should be verifiable comparing the billing providers cut/paste, copy/forward
documentation with documentation from other care providers on the same date of service.

- **Customized information must always reflect medical necessity, and provide distinct evidence that the documentation reflects the billing providers work product.**

  - History of Present Illness data obtained/submitted by a non-billable provider (including the patient) that is documented using a physician guided HPI template, and Plan of Care data that is submitted by a non-billable provider this is documented using a physician guided care plan template, customization is evidenced by:
    - Billing provider **actively reviews and confirms** the data elements
    - Billing **provider edits** the template guided responses where appropriate for time-sensitive or subjective responses.
    - History of Present Illness: Fixed items reflecting medical/surgical complexity (e.g. review of relevant PMH, recent events) that are cut/paste, copy/forward that are reported in the HPI, may appear unchanged over multiple encounters.
    - The attestation that a performing/billing provider has customized information by actively reviewing, confirming, updating, and editing the HPI data that has been copy/paste or copy/forward from a physician guided HPI template is evidenced by:
      - The performing/billing provider signature in a secured (password protected) system.
      - The UPI billing documentation certification statement “I certify that (1) all services on this form were personally provided and/or personally supervised by me and hereby approved for billing. (2) I understand the medical record must be documented for these services, and (3) the rendering of the services and the documentation in the medical record are in accordance with UPI guidelines”.


Enforcement of Standards

Exact duplication of notes that are unchanged without customized information, or those notes without a clear indication that all replicated, copy/forward, copy/paste text and findings have been reviewed, confirmed, performed and edited, excluding fixed history or data items, across multiple encounters, or “minimally changed” not meeting the above requirements will be subject to a formal audit. Evidence that customized information has been obtained should be verifiable comparing the billing providers cut/paste, copy/forward documentation with documentation from other care providers on the same date of service. Customized information must always reflect medical necessity, and provide distinct evidence that the documentation reflects the billing providers work product.

Approved by UPI BOD September 2008