PROVIDER RELATIONS

NEWSLETTER **April 2023**

CHD Provider Portal

With our Provider Portal, you have the convenience of helpful online services such as reviewing claim status and submitting non-urgent prior authorization requests.

Community Health Direct Provider Portal

***Please note, if you previously had an ePower login and password, you will need to set up a new login and password for the updated Community Health Direct provider portal.**

Review the Provider Portal registration guide for helpful instructions on how to register for the new provider portal.

Please contact us at CHDProviderRelations@ecommunity.com or 317-621-7581 if you need further assistance.

VISION: We strive to simply deliver an exceptional experience - with every life we touch.

IN THIS ISSUE:

Monthly Provider Roster Updates:

MARCH

- NEW providers joining Community Health Direct—Click HERE
- TERMED Community Health Direct providers—Click HERE

APRIL

- NEW providers joining Community Health Direct—Click HERE
- TERMED Community Health Direct providers—Click HERE

Credentialing of NEW Providers:

Credentialing through Community Health Direct for ALL new providers takes anywhere from 90 to 120 days from notification until completion. You can find helpful forms and answers to frequently asked questions on our website.

Provider Credentialing Website

Copy/Paste, Copy/Forward and Pre-charting Guidelines for Healthcare Providers/Clinical Staff Documentation in Electronic Health Record

PERFORMED BY:
Providers, scribes, and clinical staff documenting in the electronic health record.

STATEMENT OF PURPOSE:
This policy provides guidance for the safe, proper and effective use of the copy/paste and copy forward functionality and pre-charting guidelines in the Electronic Health Record (EHR). It is intended to align the use of the documentation assist functionality with the Community Health Network (CHNw) precepts of high quality and safe patient care, integrity and accuracy of the health record and assure compliance with governmental, regulatory and industry standards. This policy addresses;
Acceptable use of copy/paste, copy forward, and pre-charting, including limitations on use.
Identification of origin and author of copied information

POLICY STATEMENTS:
Providers/Clinical Staff documenting in the EHR through use of copy/paste or copy forward functionality must reference (or link to) the original source of the information, including its author, date, and time of entry. This is automatically completed through the audit trail in EPIC with the exception of pasting outside information.

1. Providers/Clinical staff are responsible for the total content and medical necessity of their documentation, whether that content is original, copied and pasted, copied forward or pre-charted.
2. It is critical that only accurate and properly documented services be billed. Any information that results in inconsistencies within the documentation will not be allowed in support of services billed.
3. Copy/paste, copy forward or pre-charting of an entire note is not allowed.
4. Providers are solely responsible for:
    a. Reviewing, attesting and appropriately updating each area of each encounter note or documenting “reviewed and verified” if no changes have occurred.
    b. Checking for contradictory information in the medical record documentation.
    c. Ensuring the accuracy and medical necessity of any information from a prior note.
    d. Ensuring that significant abnormalities which are copied into the chart are also documented in the Assessment and Plan section of the note (e.g., an elevated potassium level copied into a note should have a plan to address the abnormality).
    e. The accuracy of the information copied/pasted or copied forwarded by signing/attesting to the encounter/documentation and adding smart phrases of reviewed and verified.

Providers, Clinical staff and Scribes MAY NOT copy forward documentation/visits that has originally been marked as blocked/not shared even for historical purposes.

Clinical staff may only copy/paste, copy forward or pre-chart documentation they are allowed to document in a medical record. Pre-charting may only be completed in a reasonable timeframe. Staff MAY NOT copy /paste, copy forward or pre-chart the following:

1. Diagnoses
2. Exam
3. Medical decision-making components
4. Plan of care in an encounter note

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Scribes may only copy/paste, copy forward or pre-chart documentation that a provider has directed them to do.

Pre-charting must be completed within a reasonable time frame. Pre-charting a week in advance is not acceptable.

Documentation for medical necessity of an encounter, is only counted towards a level of service if it is documented during or after the visit (unless accompanied by a smart phrase that stated the documentation was reviewed and verified during the visit.)

Copy Forward can only be used within the same patient record. Information from one patient's medical record cannot be copied into another patient's medical record.

The History of Present Illness (HPI) must contain new subjective findings such as patient complaints and new symptoms or lack thereof.

Past, Family, Social Histories (PFSH) and Review of Systems (ROS) are reviewed and updated by the provider/ clinical staff as appropriate. This can be documented by adding a smart phrase such as: " *ROS was reviewed during the visit and the proper additions/corrections were made".*

The Exam may be copied from a previous encounter. Changes/updates to the information are made for the current visit, or a notation that it has not changed from the previous visit should be captured in a smart phrase by the provider stating the documentation was *"reviewed and verified"*.

Diagnoses may be copied by the provider if unchanged from a previous visit; however accurate acuity of the condition must be considered (i.e. chronic vs acute in the diagnostic statement).

Assessment/Plan of care may be copied by the provider with changes to information pertinent to current visit to show the status of existing conditions "today" and the medical necessity of the encounter.

Providers/Clinical staff should be thoughtful in copying/pasting images, including scanned images, photographs, or tables into the EHR or into a transcribed report(s) as these could create storage, printing, release, and readability issues.

Therapy note information (PT, OT, ST) may be copied from one provider to another for consistency and continuity of care but must contain visit day documentation as well and a smart phrase stating the plan of care/ assessment has been reviewed and updated.

DEFINITIONS:

Copy/paste - The manual process of copying text from one source and moving the copied material into the same or an entirely different document via keyboard commands.

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"Cloned" notes — Notes that appear identical for different visits; these may not reflect the uniqueness of the encounter or the patient's description of their chief complaint.

Copy forward – Tools within the EHR that allows duplication of text and/or data from one area in the EHR to another area.

Pre-charting — Documenting information beforehand in order to prepare for the patients' visit.

Clinical Staff – Individuals approved to document in the EHR and are not able to bill separately for their services. This includes licensed and unlicensed staff.

Provider – Licensed individual with an NPI and able to bill for their services

Scribe — A scribe or documentation assistant may be an unlicensed, certified, (MA, ophthalmic tech) or licensed person (RN, LPN, PA, NP) who provides documentation assistance to a physician or other licensed independent practitioner (such as a nurse practitioner) consistent with the roles and responsibilities defined in the job description, and within the scope of his or her certification or licensure. There are individuals with the official title of "scribe" for whom documentation assistance is their only role, and there are individuals who perform dual roles that include clinical responsibilities as well as documentation assistance. Both are classified as Scribes.

GENERAL INFORMATION:

Providers/Clinical staff are accountable for compliant use of documentation assist tools.

It is preferred that Providers use a Smart Link to pull lab data, pathology reports, or radiology reports into a note rather than copying and pasting this data or reports into their note.

Data copied and pasted into the EHR from sources outside of the EHR may be incompatible and as such may not display as in the original source. Such data may be impossible to print or appear distorted and illegible when printed. This includes multiple file formats such as word processing and spreadsheets.

Forms created using word processing, spreadsheets, or other software programs that may include special formatting templates such as checkboxes or tables will not view or print properly when copied and pasted into the EHR.

Paper documents from sources outside of the EMR will be scanned into the EMR. For most inpatient areas, the paper documents will be kept in the hard chart and scanned post discharge by Health Information Management.

The Medical Staff Office, in coordination with Health Information Management and Internal Audit, will monitor compliance to this policy. Repeated inappropriate use of copy/paste and copy forward functionality may result in corrective action.

Providers utilizing documentation assistants such as scribes should reference the Scribe policy.

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PROCEDURES:
None

EQUIPMENT:
None

DOCUMENTATION:
None

REFERENCES:
The original policy was approved by MECs (Howard 3/15/22, CHE/CHN 3/8/22, CHS 3/8/22, Anderson 3/17/22)
OIG 2014"Copy-Pasting. Copy-pasting, also known as cloning, enables users to select information from one source and replicate it in another location. When doctors, nurses, or other clinician. Clinical staffs copy-paste information but fail to update it or ensure accuracy, inaccurate information may enter the patient's medical record and inappropriate charges may be billed to patients and third-party health care payers. Furthermore, inappropriate copy-pasting could facilitate attempts to inflate claims and duplicate or create fraudulent claims."

The CY 2019 PFS final rule expanded current policy for office/outpatient E/M visits starting January 1, 2019 to provide that any part of the chief complaint (CC) or history that is recorded in the medical record by ancillary staff or the beneficiary does not need to be re-documented by the billing practitioner. Instead, when the information is already documented, the billing practitioner can review the information, update or supplement it as necessary, and indicate in the medical record that she or she has done so.

MLN906764_Evaluation_and_Management_Services_Guide_2022-06 (cms.gov)
Jurisdiction J Part B - Medicare Providers: What You Need to Know About Signatures and Documentation (palmettogba.com)

Our region's MAC, WPS also has some information on pre-charting: WPS Pre-charting Guidelines
CMS and Its Contractors Have Adopted Few Program Integrity Practices To Address Vulnerabilities in EHRs (OEI-01-11-00571; 01/14) (hhs.gov)

Electronic Health Records Provider (cms.gov)

Association of American Medical Colleges, Compliance Officers' Forum. 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. July 11, 2001.

Managing Copy Functionality and Information Integrity in the EHR - Retired (ahima.org)

How To Submit A Change

COMPLETING A CHANGE OF INFORMATION IN SHAREPOINT (Employed CHNw practices ONLY)

- Go to InComm, from the Tools menu, select Provider Onboarding. Click that link to the Provider Onboarding site.
- Once there, you will go the Change of Information link, found on the left side of the page, about 2/3rds down.
- From there, at top left of screen there is a plus sign that says “add new item”. Click the plus sign once and a fillable form asking for all of the details will appear.
- Select the provider and type of change and enter any notes about the change and submit.
- This kicks off the process of changing the information with the payers and it typically take 30—45 days before all payers approve and enter the change.

Feel free to share his information with any practice leadership in any Community employed group, as it’s the same process for many practice changes. If you are an operations leader and do not have access to this site for some reason, SharePoint you can contact Shawn Miller in IT and request access.

VALUES: Patients first. Relationships. Integrity. Inclusion. Diversity. Excellence.

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