

AAMC Compliance Officers' Forum

Electronic Health Records in Academic Medical Centers

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

Purpose

The ability of an electronic health record (EHR) to populate selected information into a patient's note creates many challenges. This Compliance Advisory will focus on the issues related to the use of data that can be copied and moved from one place to another within the electronic record, collectively referred to in this Advisory as "copy functionality." It recognizes that there is value to copying certain information, especially to save time, but there also are risks. The Advisory provides guidance and tools to ensure that copying occurs through a thoughtful evaluative process that assists with the accurate documentation of the specific services provided, supports medical necessity, and produces a note that enhances patient care. It also recognizes that the use of copy functionality cannot be managed solely through decisions made during the design and implementation of the EHR. Much of the mitigation of risk rests on policy and training directed at the judicious use of such tools.

The Advisory will:

- **Discuss the risks of copy functionality, with an emphasis on revenue protection and quality patient care and**
- **Provide recommendations about how to use copy functions to generate a medical record with ease and accuracy while minimizing compliance and legal risks.**

In the context of this Advisory, “copy functionality” includes: populating a note with data that already exists elsewhere in the medical record; populating a note with patient information describing work performed or findings via a template or other default function; and manually or electronically copying data that was created by a different author or created on a different date of service, or entered via default without positive action by the author of the note.

Definitions (not all terms are used in this Advisory):

Copy & Paste: selecting data from an original or previous source to reproduce in another location.

Cut & Paste: removing or deleting the original source text or data to place in another location.

Cut and Paste should never be allowed as it alters the original source material.

Copy Forward: a function that copies a significant section or entire prior note.

Automated Change of Note Author: (similar to copy forward) changes authorship of a note written by someone else to current user of the note.

Template: documentation tools that feature predefined text and text options used to document the patient visit within a note.

Populating via Default: data is entered into a note via an electronic feature that does not require positive action or selection by author. For example, when documenting the Review of Systems in a patient history, an EHR may have functionality that enters the phrase “all other systems negative” without requiring the author to select a checkbox, or otherwise indicate that the work was performed.

Macro: expanded text that is triggered by abbreviated words or keystrokes. Not generally considered copy/paste, but rather abbreviating required keystrokes.

Background:

Through the Medicare and Medicaid EHR Incentive Programs, commonly referred to as “meaningful use,” the federal government is encouraging the move to EHRs. Additionally, throughout the health care system, the effort to link payment to quality also requires an EHR as an

essential component. Although, the government has provided no specific guidance related to the risks of using the tools related to copy functionality, it seems clear that federal officials are aware of the risks. For example, the 2011 HHS OIG Work Plan includes a new targeted area of searching for identical entries among evaluation and management services in EHRs.¹

Unlike a note written on paper, a note written in an EHR can be generated by using information that already has been recorded elsewhere, and can be imported from either within or outside the EHR. The result can be a note that appears to be new and contemporaneous, but actually is a combination of pre-existing material. As will be discussed below, incorporating information that is not original to the author into a note has the potential to jeopardize patient care and expose providers and/or institutions to liability on several fronts. Little has been published to date on the compliance ramifications of an EHR. This Advisory was created to fill that void.

The Identified Risks of Inappropriate use of Copy Functionality in an Electronic Health Record

When used appropriately, copy functionality can be a valuable tool; however, if used inappropriately it may produce a flawed medical record that results in poor patient care. On the billing side, inappropriate use may suggest that services were provided when, in fact, they were not, resulting in the submission of an unsupported bill.

Risks include the following:

- **Populating a note with outdated, conflicting, incomplete or inaccurate information.**
This can result from many of the copy functions available in an EHR. For example, the ability to default or auto-populate checkboxes (primarily in review of systems and physical

¹US Department of Health & Human Services, Office of Inspector General, 2011 Work Plan
http://oig.hhs.gov/publications/workplan/2011/WP01-Medicare_A+B.pdf

exams) to “no” or “negative” upon starting a new note or closing a note may inadvertently include conflicting information in a single note; for example, a negative finding in the review of systems, and a positive chief complaint.

- **Inability to identify the original author in the EHR.**
 - This may be a risk to patient safety if the provider using the entry is not aware that additional scrutiny may be warranted because the entry was created by a medical student or RN, for example.
 - Using documentation originally authored by individuals (e.g., medical students, RNs on cost report) whose documentation is limited or barred for billing purposes.
- **The original date of note creation may not be evident or may be difficult to locate.**
 - Risk to patient safety (possible confusion as to patient status).
 - Difficulty in retrieving note for payment purposes to determine medical necessity.
- **Notes that are repetitive, inconsistent or identical.**
 - Such notes do not further the care of the patient and over time are likely to be ignored by care givers due to stagnant information.
 - This may call into question the medical necessity of the care, and result in insurance payment denials, audits, or investigations.
 - When patterns of identical notes are detected (“cloned” or “canned” notes), the documentation may not be accepted by payors to support payment.
- **Notes that are too long and contain irrelevant information.**
 - When a note is long and cluttered with “canned” text, the important parts are likely lost to the reader. This increases the risk that pertinent, new and critical information is overlooked, or may not be read by other providers, leading to poor communication, duplication of services or delay in the patient receiving appropriate care.
- **Misleading or false attribution of work performed by others, incorporated into the current note.**

- While it may be convenient to routinely import labs and diagnostic test results into a note for review, it is important that the note clearly indicate when the tests were performed, and who performed them.

Common Challenges in Current EHR Systems

- Transferring from the paper record to the EHR, the fundamental principles related to maintaining a legal medical record while incorporating the efficiencies of the electronic documentation tools must be preserved.
- Ensuring that a note that contains reused/scripted/templated/defaulted information is accurate for the patient on the specific date of service. It has been shown that the cognitive process to edit written material is different and less accurate than engaging in writing.
- Preserving the ability to identify original author(s), date and time of entry, and/or services performed during the encounter.
- Implementing the decision to selectively limit **what** may be copied by user role and/or the information being copied.
 - For example, an organization may want to restrict the ability to copy medical student notes to past/family/social/history and review of systems portions of the history in accordance with federal limitation on the use of their notes in support of a bill.
- Restricting **who** can copy, by clinical role, so that, for example, medical students have much more limited ability to copy than physicians.

Recommendations for EHR Application Architecture that is Designed to Minimize Risk and Enhance Patient Care by Directly Addressing Accountability, Attribution, Clarity, Responsibility, and Billing Compliance

- Original authorship should remain clear in both the on-line view and the printed EHR (such as through the use of italics or some other identifying font) and not be limited to viewing only by those who have access to audit trails. EHR applications must be improved to support both authorship and attribution.

- Work with EHR vendors to encourage, and ultimately require, that the base EHR application:
 - Audits documentation for inconsistencies or similarities with previous notes, previous versions of the same note where there are multiple authors, and templated notes, without requiring manual comparisons between notes.
 - Is designed for the special workflows and needs of academic health centers.
 - Contains structural controls that block copying portions of medical student documentation in accordance with federal limitations on their use for billing while allowing medical student documentation in an EHR as a teaching tool; and clearly identifies portions of the note authored by medical students.
 - Uses documentation workflows for combining notes of residents and Teaching Physicians that are in accordance with federal regulatory requirements. This would include features that permit the edit of the resident's note, retain the identification of the resident as participant in the service, and allow only the teaching physician to append his or her attestation when electronically signing.
 - Facilitates documentation workflows for combining notes of non-physician practitioners (ARNP/PAs) with physicians, and allows for easy identification of a service that meets "incident to" billing criteria or appending applicable attending physician attestations for split/shared services in a hospital environment.
 - Permits all users to easily identify the history of the note, including authorship and dates.

Recommendations for Compliance Officers

- Proactively gain an understanding of EHR tools available at your institution.
- It is important to understand the mechanics of how notes are created; training on "models" is not sufficient. Shadow physicians in clinic, on the inpatient units, floors, and procedure areas to assess how services are provided and notes are created.

- If the test results reside elsewhere in the EHR, encourage clinicians to summarize diagnostic test findings rather than copying the complete report into a note.
- Contribute to the EHR training curriculum and educate trainers on key compliance concepts that they are expected to reinforce.
- Participate in provider training courses to confirm that the information is correctly conveyed, and to respond to compliance-related questions.
- Attend vendor courses and meetings to gain an understanding of the applications purchased.
- Demonstrations with real data can be very revealing and useful in identifying risks that are not otherwise apparent. On an on-going basis compliance officers should continue to test and audit with live data.

Recommendations for Policies, Training and Partnering with Compliance

From the beginning, compliance/billing should be a partner in the selection of the EHR; decisions on features, functions and controls; and the development of policies, guidelines and user training. Failure to address compliance concerns from the beginning may result in an EHR that exposes the institution to risks related to both quality of care and legal issues. **This is a continuous process that will require refinement as the institution proceeds through selection of its EHR, implementation, roll-out, and finally full implementation.**

Policies should:

- Emphasize that:
 - **There can be value to copying information, but it must be done selectively and thoughtfully, in compliance with institutional policies, and with the goal of producing a clear, useful, and accurate patient note.**

- **Regardless of the tools used to create the note, the individual signing it acknowledges responsibility for the entire content.**
- **The note accurately represents clinical work performed each day, with clear attribution of the work of others.**
- Consider whether some copying activities may engender more risk than others.
- Provide guidance or define circumstances under which the copy tools may be used.
- Incorporate control structures such as:
 - Prohibiting the generation of a note that does not require some action on the part of the provider;
 - Providing space for the attending to enter additional notes or changes; and
 - Using strategically selected “hard stops” that require provider action.
- Determine requirements for proper notation and attribution
 - Routine duplication of medical data that resides in a separate section of the EHR, such as prior labs and testing performed by other providers, is not considered a best practice. When such duplication is used it should be accompanied by proper notation and clear attribution.
 - When it is necessary to provide a statement that data was confirmed with the patient or patient’s family, emphasize the importance of appropriate attribution to work provided by others.
- Educate providers regarding quality documentation in an EHR and the use of tools that can support it.
- Establish training requirements for all users, taking into consideration that training must emphasize the role of the policies and procedures in ensuring the integrity of the electronic note, as well as the mechanics of using the EHR.
- Prohibit the copying of
 - Notes from one patient’s record into the record of another patient;

- Medical student notes (other than the Review of Systems and Past Family Social History); and
- History of the present illness.
- Require some positive action or patient specific modification. Prohibit populating the entire note, a complete history, or complete exam.
- Provide guidance on the use of notes of registered nurses and ancillary staff and individuals included on the cost report.
- Validate the policies that are established and revise as necessary.
- Provide guidance to EHR users about where they should go when they identify a concern about a potential system error or flaw.

Sources of Information to Review Prior to Establishing a Policy

- ✓ Medicare regulations and Carrier Manual Instructions; other federal and state authoritative guidance
- ✓ Local Contractor guidance
- ✓ Joint Commission requirements
- ✓ Copy Functionality Toolkit published by the American Health Information Management Association
- ✓ The Elements of Electronic Note Style by Payne, Hirschmann and Helbig, published in *Journal of the American Health Information Management Association* 2003; 74:68, 70
- ✓ Copy-and-Paste by Robert E. Hirschtick, MD, printed in JAMA, May 24/31, 2006 Vol. 295, No. 20
<http://jama.ama-assn.org/content/295/20/2335.full>

Links to AAMC Members' Policies Related To The Use of Copy Functionality In An Electronic Health Record

The policies that are mentioned below are intended to be resources as you craft our own policy. Each institution must make its own determination about whether any specific interpretations or requirements contained in these policies accurately reflect their own views.

University of Florida College of Medicine, Gainesville

http://www.med.ufl.edu/complian/Q&A/Epic_do_and_donts.html

Policies from the following institution are available on the AAMC Compliance Officers' Forum private website and are available only to COF members:

- Johns Hopkins Medical Institution
- Northwestern Medical Faculty Foundation
- Texas Tech University Health Sciences Center
- University of California - Davis
- University of Virginia Health Services Foundation

If you would like to have your policy on copy functionality added to this list, please send a link or an electronic copy to Will Dardani, wdardani@aamc.org. Indicate whether you want the policy posted only to the private COF site.