The Electronic Medical Record: Auditing the Copy and Paste Function

Presented by:
Kathleen Enniss CPC CHC
Compliance Analyst
UW Medicine Compliance
University of Washington
kenniss@uw.edu

The EMR: Positive Impacts

- Saves charting time
  - Templates
  - Copy and paste functions
  - “Make it my note”
- Allows real time access to previous notes from other providers and diagnostic studies
- Legibility
- Optimizes Reimbursement
  - “Suggests” the E/M level
  - Advises that you are just one element or 2 clicks away from a higher code
The EMR: Compliance Risks

- Who’s the author?
  - And how old is that copied information?
- Inflated Documentation
  - Higher E/M visit selection by a coder
  - EMR prompts; “missing one physical exam element for a 99214 level four visit”
  - Current visit has irrelevant data imported

More Compliance Risks

- Erroneous, contradictory, or cloned information
  - Potential for fraud
  - Lack of medical necessity
  - Patient care issues
- Data Integrity
  - Accuracy, consistency, reliability
CMS Concerns

- Providers are liable to include more data than is reasonable and necessary leading to up-coding especially of E/M visits
- Templates are meant to prompt physician documentation

- Cloned notes may meet coding criteria but are not medically necessary if nothing changes from visit to visit

Local Part B Carriers

- “Default documentation is a problem because it is difficult to tell what work was actually provided for the current visit.”

- “Medical necessity documentation is a cognitive process that is difficult to document with templates and macros.”

- “The volume of documentation should not influence the selection of the visit code.”
Independent Corroborating Studies

- Impacts of Computerized Physician Documentation in a Teaching Hospital: Perceptions of Faculty and Resident Physicians
  - J AM Med Inform Assoc. 2004; 11:300-309
  - Also known as the Peter J Embi Study

- Are Electronic Medical Records Trustworthy?
  - AMIA 2003 Symposium Proceedings – page 269

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Independent Corroborating Studies

- Some Unintended Consequences of Information Technology in Health Care: The Nature of Patient Care Information System Related Errors.
  - J Am Med Inform Assoc 2004;11:104-112

- The Transition to Electronic Documentation on a Teaching Hospital Medical Service
  - AMA 2006 Symposium Proceedings page 629
Guidelines

EMR Recommended Guidelines

- Office of the National Coordinator for Health Information Technology
  “Recommended Requirements for Enhancing Data Quality in Electronic Health Record Systems.”
  Final report June 2007

EMR Recommended Guidelines

- CMS Manual System CR 3928
  Pub 100-04 §100-A

- AHIMA Copy Functionality Toolkit

Documentation Guidelines

History of Present Illness

- The history of present illness (HPI) should reflect the interval of time between visits

- CMS direction: the HPI is not a description of the patient’s past history over the last several years. The HPI reflects current information
Documentation Guidelines

Review of Systems Macros

- The review of systems is a reflection of the presenting problem and any related organ systems and not a pre-populated macro of all negatives.

- CMS: Anything else in the ROS may be helpful to prevention but is considered screening and not within the medical necessity guidelines.

Documentation Guidelines

Physical Exam

- Physical exam documentation should contain the clinical circumstances of the patient as it relates to the presenting problem and history of present illness.

- CMS: The exam is not something to be driven by a template that appears unchanged from visit to visit.
Documentation Guidelines
Medical Decision Making

- Medical decision making is more than a list of problems.

- Relevant impressions, tentative and confirmed diagnoses, and all therapeutic options chosen should relate to every problem that is clearly demonstrated in the history and exam.

Summary of Guidelines

- Accurate, Complete, and Concise

- Structured (macros and templates) and unstructured data need to meet quality standards

- Each note should contain individualized data that supports the medical necessity of the visit or procedure.
The Audit

Dilbert

I'll make your life miserable! I'll thwart your every move!

Hi. I'm the new sadist.

What happened to the old one?

He went to Sadist paradise.

The auditing department?

Audit Design

- Identify issue(s)
  - Repetitious use of copy and paste
  - Contradictions
  - Inconsistencies
- Gather supporting documentation, e.g. regulations, policies
- Define Sample
  - All clinic providers who saw a single patient at least 10 times in the last 15 months; or
  - All patients on a single day; or
  - Daily inpatient notes for a specific patient
Audit Scope

- Define Scope
  - Review each note and compare it to the previous and subsequent note
  - Compare notes between different providers
  - Is copy and paste being used to excess?
  - Review signatures and dates for accuracy and timeliness

Audit Criteria Questions

- Does the HPI relate the circumstances surrounding the current visit?
- Does the physical exam change to reflect any new presenting problems?
- How does medical decision making compare to the history and exam findings?
Audit Criteria Questions-2

- Are there contradictions in documentation and patient care?

- Are diagnostic test results relevant to the current visit?

- Are signatures and time/date stamps done in a timely manner?

Audit Template

- Date_____ Previous Date_____
- History: Same Y N
  explain_______________________________
- Physical Exam: Same Y N
  explain______________________________
- Medical Decision Making: Same Y N
  explain______________________________
Audit Template

- Document any contradictions in EMR

- If copied from another source, is the original author, date, and time documented?  
  Y N

- Timeliness standards are met:
  - Note Y  N  explain____________________
  - Signatures Y  N  explain________________

- The history of present illness was repetitious instead of an update of the patient’s health between visits
- Review of system macros always stated as negative while the HPI held contradictory answers
Outpatient Audit Findings

- Exams appeared to be exactly the same from visit to visit and did not always reflect the chief complaint or HPI
- The assessment and plan was a problem list that remained the same from visit to visit and contradicted the history and exam
- Contradictory information was carried forward over several dates of service
  - Sometimes caused erroneous diagnosis coding

Sample Policy

- Commitment to Compliance
- Purpose
- Definitions
- Authentication
- Copy/Paste function
- Template/Macro function
- May add or refer to independent policies
  - Documentation timeliness
  - Amendments
Best Practice

- Involve Coders and/or Compliance in developing macros and templates
- Develop macros that can be reviewed, amended, and re-used instead of pre-populated negatives
- The use of accurate drop down menus encourages active selection of E/M elements, especially the physical exam.

Best Practice, cont.

- Caution physicians against boosting productivity by excessive copy and paste
  - Teach that careless copying results in untrustworthy records
  - Adopt a policy against unethical copying
- Require source name and date when copied text is pulled forward
  - Discourage plagiarism
Electronic Medical Records are a great invention as long as they are carefully used and reviewed.