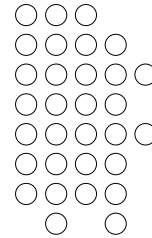


The Electronic Medical Record: Auditing the Copy and Paste Function

Presented by:
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UW Medicine Compliance
University of Washington
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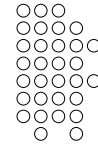


The EMR: Positive Impacts

- 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



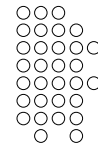
The EMR: Compliance Risks



- 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

3

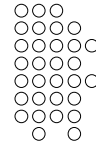
More Compliance Risks



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

4

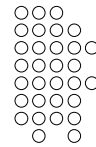
CMS Concerns



- 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

5

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.”

6

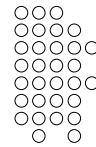
Independent Corroborating Studies



- 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

7

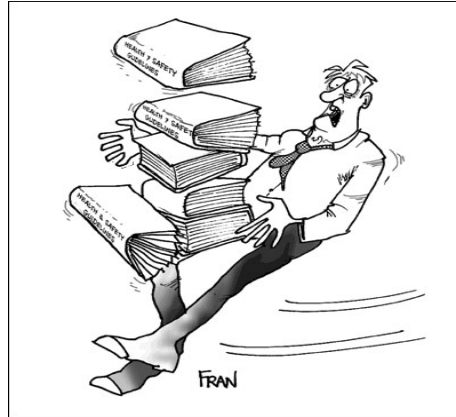
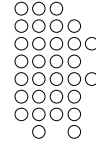
Independent Corroborating Studies



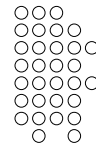
- Some Unintended Consequences of Information Technology in Health Care: The Nature of Patient Care Information System Related Errors.
 - J Am Med Inform Assoc 2004;11:104-112
- The Transition to Electronic Documentation on a Teaching Hospital Medical Service
 - AMA 2006 Symposium Proceedings page 629

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Guidelines



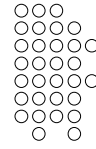
EMR Recommended Guidelines



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

www.rti.org/pubs/enhancing_data_quality_in_ehrs.pdf

EMR Recommended Guidelines

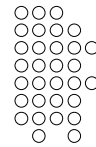


- CMS Manual System CR 3928
Pub 100-04 §100-A
- AHIMA Copy Functionality Toolkit
 - http://www.ahima.org/infocenter/practice_tools.asp

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Documentation Guidelines

History of Present Illness

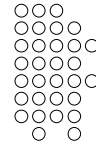


- The history of present illness (HPI) should reflect the interval of time between visits
- CMS direction: the HPI is not a description of the patient's past history over the last several years. The HPI reflects current information

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Documentation Guidelines

Review of Systems Macros

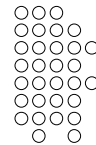


- The review of systems is a reflection of the presenting problem and any related organ systems and not a pre-populated macro of all negatives.
- CMS: Anything else in the ROS may be helpful to prevention but is considered screening and not within the medical necessity guidelines

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Documentation Guidelines

Physical Exam

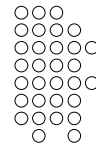


- Physical exam documentation should contain the clinical circumstances of the patient as it relates to the presenting problem and history of present illness.
- CMS: The exam is not something to be driven by a template that appears unchanged from visit to visit

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Documentation Guidelines

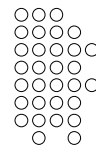
Medical Decision Making



- 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

15

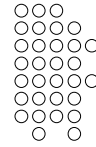
Summary of Guidelines



- 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.

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The Audit

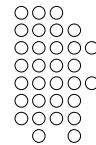


Dilbert



17

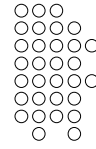
Audit Design



- 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

18

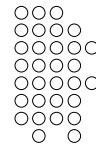
Audit Scope



- 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

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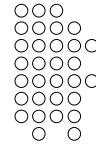
Audit Criteria Questions



- 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?

20

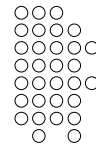
Audit Criteria Questions-2



- 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?

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Audit Template



- Date _____ Previous Date _____
- History: Same Y N
explain _____
- Physical Exam: Same Y N
explain _____
- Medical Decision Making: Same Y N
explain _____

22

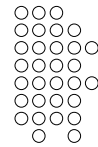
Audit Template



- 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 _____

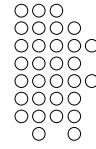
23



- 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

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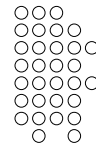
Outpatient Audit Findings



- 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

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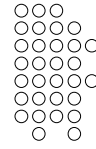
Sample Policy



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

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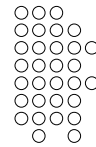
Best Practice



- 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.

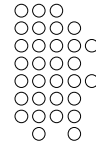
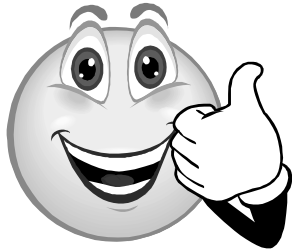
27

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

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Electronic Medical Records are a great invention as long as they are carefully used and reviewed.

