Managing Copy Functionality and Information Integrity in the EHR - Retired

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There are high expectations for electronic health records (EHRs) to improve patient healthcare. However, as the industry implements EHRs, it is recognizing that adoption and implementation alone do not guarantee data integrity. In this rapidly changing environment, the use of the copy functionality has the potential to negatively affect the integrity of the health record.

The copy functionality in an EHR works much like the copy functionality in word-processing programs. It enables providers to copy health information from a section of a patient's health record to another section or record.

This practice brief identifies best practices to ensure the clinical integrity of EHR systems through appropriate and effective copy functionality practices. It is designed to support and guide organizations, HIM professionals, providers, and IT professionals to define, support, and execute best practices managing copy technology in the EHR environment.

Information Integrity

EHR systems have the capability of storing large amounts of electronically created information. As clinical providers become more familiar with an EHR system's documentation functionalities and capabilities, questions about data integrity and clinical trustworthiness are increasing.

The functionalities that facilitate documentation in the EHR are under increased scrutiny. One such functionality is copying documentation from one record to another. Indiscriminate use of copy functionality can damage the clinical trustworthiness and integrity of the health record. Not knowing if the functionality was used correctly leads to distrust of the record. However, providers who do not trust the information that was copied will continue to use the function when workflows are not in place.

From a clinical point of view, copying information that is not current or accurate may have a negative impact on patient care. Other providers may become confused by the inconsistent documentation and not understand what care is needed to treat the patient.

Risks of Copy Functionality

Using copy functionality presents risks. Copying information that is no longer relevant into a current encounter of the patient health record could adversely impact patient care. Some examples of risks to documentation integrity include:

- Inaccurate or outdated information
- Redundant information
- Inability to identify the author or the thought process
- Inaccurate coding
- Propagation of false information
- Inability to follow the care of the patient
- Unnecessarily lengthy and redundant progress notes

Take for example an oncologist who inadvertently copies only a part of a patient's family history. The patient's mother had a history of breast cancer and when this information was copied to a new note, it was copied as the patient had a history of breast cancer.

This information was then copied multiple times into multiple notes. Copies of the patient record were sent to the insurance company for billing purposes, and the patient was denied insurance based on the history of breast cancer. The patient reported the error to the organization.

If it had not been for the insurance denial, the patient's health records would still have the incorrect information. Not only did the records within the organization have to be corrected, but all records supplied to providers and insurance companies with this erroneous information had to be corrected.

This type of incorrect information in patient records certainly undermines the clinical trustworthiness of the record.

Legal Liability

Implementing an EHR does not necessarily decrease an organization's liability risks. On the contrary, the risk of liability may actually rise in the short term. This is especially true where poor documentation practices can affect data integrity.

The American Medical Association noted that among the issues of increased liability risks were autopopulated fields that propagate incorrect or false information and copying information from one clinical note to another.[1] Copying information forward may also lead to omitting new information that is needed to treat the patient.

The EHR system does not change the fact that a patient's health record is considered to be the business and legal record for the healthcare organization. The EHR must be maintained in a manner that complies with legal requirements as well as business and clinical documentation standards.

In order to thoughtfully and appropriately manage copy functionality, organizations must develop and implement policy imperatives for effective management of health data and information. Copy functionalities that do not meet the organization's data and documentation integrity policies should be considered unacceptable.

Previously common but risky documentation practices that took place in the paper records-such as using a prefilled Word document for a bariatric evaluation, changing only the patient name, and printing it out-are no longer acceptable in the EHR system.

Focus of Federal Review

The copy and paste function in the EHR continuously makes headlines due to the potential for negative patient care outcomes. Due to the many copying issues that various articles and experts have outlined, the Office of Inspector General (OIG) incorporated the review of duplicate documentation in its FY 2011 work plan.

Medicare defines duplicate documentation as multiple entries in a patient's health record that are exactly alike or similar to other entries in the same patient's health record or another patient's health record.[2] Terms used for duplicate documentation include cloning, copy and paste, copy forward, macros, and save note as a template.

OIG audited for multiple evaluation and management services for the same providers and the same beneficiaries.

Because Medicare contractors continue to voice concerns about an increase in the number of patient records with identical documentation across services, OIG will continue to audit for duplicate documentation as part of its 2012 work plan. In order to review for potential duplicate documentation OIG will identify copied information from the review of evaluation and management services.

OIG considers the use of copied information a health record documentation practice that may be associated with improper payments.

In addition, the Centers for Medicare and Medicaid Services' "Medicare Program Integrity (MPI) Manual" directs zone program integrity contractors (ZPICs) and Medicare administrator contractors (MACs) to identify cases of suspected fraud, including inappropriate copying of health information. Under the "Benefit Integrity/Medical Review Determinations" section, the manual directs these government auditors to look for duplicate medical documentation:

The medical records tend to have obvious or nearly identical documentation

- In reviews that cover a sequence of codes (evaluation & management codes, therapies, radiology, etc.), there may be evidence of a trend to use the high end codes more frequently than would be expected
- In a provider review, there may be a pattern of billing more hours of care than would normally be expected on a given workday

MACs have begun to deny payments based on improper provider use of the copy functionality to create duplicate or identical entries. As noted by MAC First Coast Services Options, copied documentation is a misrepresentation of the medical necessity requirements for services rendered.[3] The lack of specific individual information for the encounter will not only lead to denials, but recoup of overpayments.

Cahaba Governmental Benefit Administrators, another MAC, also has policies expecting to see documentation that supports the medical necessity of the service, including changes in documentation that demonstrate changes or differences from the history and physical.[4]

HIM Professional's Role

The HIM professional is an integral participant in ensuring that accurate documentation practices are implemented and followed in the organization. It is crucial for HIM professionals to be involved with the documentation practices at their organizations.

In order to make certain HIM principles are at the foundation of any EHR system implementation, HIM professionals must take a leadership role within their organizations, listening, educating, collaborating, and reviewing documentation workflows with doctors, nurses, other healthcare givers and IT professionals to ensure data integrity and clinical trustworthiness.

The HIM professional is obligated to understand and ensure the proper use of copy functionality to support EHR documentation quality and integrity. HIM professionals must also work closely with IT vendors to clearly articulate the expectations of the copy functionality and how it may be used within the EHR systems at their organizations.

Appropriate organization-wide governance policies and procedures must be in place to manage the EHR's copy functionality. HIM professionals must lead their organizations in developing and implementing these policies and procedures. Policies must address acceptable uses, processes, responsibility, auditing and reporting, and sanction for improper use.

In addition, it is critical for HIM professionals to be involved in the design of forms and template documentation and workflows for documentation to ensure compliance with governmental, payer, and organizational rules and policies on copy functionality

HIM professionals and organizations should not assume that certified EHRs are in compliance with copy functionalities. At this time, the Certification Commission for Healthcare Information Technology does not require copy functionalities of any type to be auditable events. HIM professionals must investigate their organizations' EHR systems to see if the auditing of copy functionality is available.

The HIM professional's role is to ensure the information integrity of the EHR system. HIM professionals must knowledgably incorporate and appropriately manage the copy functionality of an EHR. This will be accomplished by ensuring their organizations have sound documentation integrity, auditing, reporting, and training practices.

Training and Education

Training and education must be included in policies for copy functionality. Organizations must ensure all users receive thorough and detailed training on the proper use of the copy functionality.

Training must include clear expectations of how the copy functionality will and will not be used. The training should address:

- Accurate documentation
- Integrity of the healthcare information
- Trust that the information is accurate and up to date
- Risks for copying information incorrectly
- Risk for omitting information when notes are copied
- Ability of notes to stand up to scrutiny by auditors, attorneys, and regulators
- Liability for not following training and organizational policies

Monitoring

The use of the copy functionality should be monitored to ensure that it is used appropriately. Organizations must implement strategies for auditing the copy functionality.

In addition, audit plans should be developed based on how the functionality is employed in the organization's EHR. Additional audits should be developed to review notes that may not follow the copy policy, such as reviewing consecutive notes in patient records or reviewing notes by providers who see patients with specific diagnoses.

Utilizing staff who review records routinely such as coders, transcriptionists, internal quality staff members, or outcome reviewers to identify and report duplicate or identical documentation is yet another method the organization may employ.

Notes

1. "Do Electronic Medical Records Decrease Liability Risk?" www.kevinmd.com/blog/2009/12/electronic-medical-records-decrease-liability-risk.html.
2. Department of Health and Human Services, Office of Inspector General. "Work Plan Fiscal Year 2012." http://oig.hhs.gov/reports-and-publications/archives/workplan/2012/Work-Plan-2012.pdf.
3. Youngstrom, Nina. "Medicare Watchdogs, Compliance Officers Investigate 'Carry Forward' (with Two MACs' Policies on Cloning Electronic Medical Records)." Health Business Daily, August 30, 2011. http://aishealth.com/archive/rmc081511-03.
4. Ibid.

Resource

AHIMA. *A Practical Guide: Information Management and Governance of Copy Functions in Electronic Health Record Systems*. Chicago, IL: AHIMA Press, 2011.

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