Cloning and Other Compliance Risks in Electronic Medical Records

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Acumen. Agility. Answers.

AGENDA

- Basic definitions and stories
- Identify where risk is associated with specific functions in an electronic medical record
- Present methods to audit and monitor the controls of the electronic record

FROM TESTIMONY OF LEWIS MORRIS, OIG

"For example, electronic health records (EHR) may not only facilitate more accurate billing and increased quality of care, but also fraudulent billing. The very aspects of EHRs that make a physician's job easier—cut-and-paste features and templates—can also be used to fabricate information that results in improper payments and leaves inaccurate, and therefore potentially dangerous, information in the patient record. And because the evidence of such improper behavior may be in entirely electronic form, law enforcement will have to develop new investigation techniques to supplement the traditional methods used to examine the authenticity and accuracy of paper records. "

http://oig.hhs.gov/testimony/docs/2011/morris_testimony_07122011.pdf

CLONING

- Cloning
  - Cut & Paste = Blocks of text or even complete notes from another MD
  - Copy & Paste = Carry forward of prior notes
  - Other terms used =
    - Copy forward,
    - Re-use, and
    - Carry forward

TWO MACS' POLICIES ON CLONING

First Coast Services Options, Inc.

- Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information. All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter. Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

Cahaba Government Benefit Administrators LLC

- The medical necessity of services performed must be documented in the medical record and Cahaba would expect to see documentation that supports the medical necessity of the service and any changes and or differences in the documentation of the history of present illness, review of system and physical examination

LCD GUIDANCE ON TEMPLATES

- Noridian Administrative Services, LLC

  Documentation to support services rendered needs to be patient specific and date of service specific. These auto-populated paragraphs provide useful information such as the etiology, standards of practice, and general goals of a particular diagnosis. However, they are generalizations and do not support medically necessary information that correlates to the management of the particular patient. Part B MR is seeing the same auto-populated paragraphs in the HPIs of different patients. Credit cannot be granted for information that is not patient specific and date of service specific.

  Source: https://www.noridianmedicare.com/shared/partb/bulletins/2011/271_jul/Evaluation_and_Management_Services_-_Documentation_and_Level_of_Service_.htm

DOCUMENTATION RISKS
AHIMA AREAS OF CONCERN

- **Authorship integrity risk:** Borrowing record entries from another source or author and representing or displaying past as current documentation, and sometimes misrepresenting or inflating the nature and intensity of services provided
- **Auditing integrity risk:** Inadequate auditing functions that make it impossible to detect when an entry was modified or borrowed from another source and misrepresented as an original entry by an authorized user

Guidelines for EHR Documentation to Prevent Fraud
http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_033097.hcsp

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DOCUMENTATION RISKS
AHIMA AREAS OF CONCERN

- **Documentation integrity risk:** Automated insertion of clinical data and visit documentation, using templates or similar tools with predetermined documentation components with uncontrolled and uncertain clinical relevance
- **Patient identification and demographic data risks:** Automated demographic or registration entries generating incorrect patient identification, leading to patient safety and quality of care issues, as well as enabling fraudulent activity involving patient identity theft or providing unjustified care for profit

Guidelines for EHR Documentation to Prevent Fraud
http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_033097.hcsp

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COPY AND PASTE

- **Two varieties:**
  - Word (Ctrl C)
  - Computer generated
- **Concern**:
  - Copying and pasting is **not** noncompliant. It is how the information is used or "counted."
  - For example, per Trailblazer's September 30, 2002, bulletin, Medicare is also concerned that the provider's computerized documentation program defaults to a more extensive history and physical examination than is typically medically necessary to perform, and does not differentiate new findings and changes in a patient's condition."

COPY AND PASTE

- Real examples:
  - Nurse was updating her resume (using Word) and copied a portion of her resume into a patient chart
  - ED nurse had two records open. She copied part of Patient A's record into Patient B's record—drug use and bi-polar diagnoses showed on Patient B's medical record and billing information

In an EMR, the error never truly goes away

COPY AND PASTE EXAMPLES

- A note was copied "in total" to include the PREVIOUS performing provider's name
- NO original documentation by the 'today' provider; just an electronic signature with 'today's date and time'.
- Reviewed 10 visits over a year period for a provider....every exam finding was the same despite current complaints to the contrary. Found to be copying and pasting exam.....forgot to 'edit' for today's findings.

TEMPLATES: A NECESSARY EVIL

- Reminders for important “red flag” questions
- For example, strep throat template would have the prompts below:
  - Fever? HA? Rash? Heart Valve? Kidney Problem?
  - Consistency and medical/legal liability coverage
- Despite the well-intended questions, all the visits look exactly the same

TEMPLATES: CHALLENGES

- Generate canned phrases, may lose uniqueness.
- Multiple consecutive canned statements causes a poor read that may misconstrue the intended meaning.
- One-size-fits-all templates are incomplete, not comprehensive enough, and only work for one problem.
- Subjective observations go undocumented.
- Templates drive more unnecessary documentation. Many times they cannot be closed until all boxes are checked, which then drives higher E&M levels than medically necessary.

OTHER RISK AREAS

Structured Data

- **Advantages**: Enables stated values to be supported for specific variables so as to provide standard meaning for reporting purposes (all entries are reportable data).
- **Disadvantages**: Predetermined display names and consistently structured phrases appear the same in all charts; does not allow for descriptions in the clinicians own thoughts or style.
    - The classic completely "canned text" note

OTHER RISK AREAS

Free Text

- **Advantages**: Preserves the narrative component of the medical record. Each visit appears different because the clinician created it specifically for the individual patient.
- **Disadvantages**: Typing and/or dictation must be done for each patient by a clinician who would rather be seeing patients than typing. This typing, dictating or filling out templates can be onerous to the provider.

OTHER RISK AREAS

- Monitoring of coding by EMR is not done
- Assume EMR coding matches billing system
- Coding "assistance" via the EMR product itself (CPT & ICD)
- Coding in EMR is valid although based on pre-determined design
- My "99214" template
- My standard procedure template

OTHER RISK AREAS

- Tracking of user's changes, deletions or modification to a specific subsystem
- Lack of policies and procedures related to coding and documentation related to EHR
- Lack of EHR retention policies
- Lack of continuous monitoring with feedback to providers
  - Who owns this—Coding? Medical Directors? Quality?

FOLLOWING YOUR ORGANIZATION'S COPY AND PASTE POLICY AND PROCEDURE

- If you have a policy and procedure in place and you are not following it what are the consequences?
  - MHS has a Physician Handbook with the industry best practices for our medical staff to follow
  - Our audit found that we were not following our own handbook policy and procedures
  - Interviews were conducted with key stakeholders and end users
  - The information gathered was measured against the MHS Physician Handbook and the AHIMA Copy Functionality Toolkit

MULTICARE IDENTIFIED EXCELLENT PROCESSES IN PLACE

- Collaboration between physicians in the ambulatory setting is occurring
- The coding team is attending the new physician orientation and providing training
- Coding audits the documentation of newly hired physicians
- Coding helps physicians with development of smart phrases
- Revenue cycle clinical appeals has a well defined process for handling additional documentation requests for medical necessity requirements
- Identified services who have standardized their templates

CUT & PASTE / COPY & PASTE

- Audit difficulty:
  - Identifying if function was used
- Documentation integrity risks:
  - Bringing forth information which is not specific to patient
  - Failure to edit information not applicable to subsequent encounter
- Can use software originally designed to detect plagiarism at universities
- Using encounter data, compared the following EHR
  - Same provider, same primary diagnosis
  - All visits for one day for a provider

Plagiarism software download: http://plagiarism.phys.virginia.edu/
AHIMA article: http://library.ahima.org/xpedio/groups/public/documents/ahima/bok3_005520.hcsp

MAKE ME THE AUTHOR

- Audit Difficulty: Identifying when this function was used
- Test EMR system controls by creating a patient encounter using another provider user ID (or RN) and create documentation
- Review EHR documentation & audit logs to ensure that test documentation is attributable to the correct provider
- Turn off / remove this functionality if the EHR does not have the capability to attribute an entry, modification or deletion to a specific individual

TEMPLATES

- Identify a sample of patient encounters where a template was selected for the encounter documentation (frequent template users – GI, cardiology, urology, respiratory, and primary care)
- Review EMR documentation to ensure that any default information was verified or updated (patient name, symptoms, medication, etc.)
- Review the EMR audit logs to ensure that the defaulted information was edited (inquire how this should look prior to examination)

EHR TOOLKIT – TESTING POLICY

- Testing for copy functionality in your existing electronic health record
- Comprehensive testing in test environment or using "dummy" patients
- Work with your EHR vendor and the information services department to determine copy functionality options, e.g., copy forward, blocking or disabling, audit records, date/time of entry, attributions, etc.

EHR TOOLKIT – CHECKLIST OF ORGANIZATIONAL QUESTIONS

- Duty to ensure the integrity of the health record
- Questions you need to ask…
  - Is there a better means than copy functionality to accomplish the clinical objectives, such as through the use of forms or templates that are more readily standardized and auditable?
  - If your EHR uses smart tools, then your providers have the option to create smart phrases and smart lists based on their individual preferences. What is the scope of this?

EHR TOOLKIT – QUESTIONS…

- Can you be assured that the ongoing training and education you have provided to your medical staff is sufficient to address cloning risks?
- How do you monitor to ensure providers are following the organization's copy and paste policies and procedures?

EHR TOOLKIT – QUESTIONS…

- Does the organization know how its systems copy functions can be used within the EHR?
- Does the organization have a process for identifying and mitigating unacceptable functions or uses?
- Has the organization identified how copy will be utilized within the EHR?
- Has the medical staff approved copy policy and procedures?

EHR TOOLKIT – QUESTIONS…

- Who is responsible for ensuring that all copy policies and procedures are enforced?
- Who will perform ongoing audits of provider documentation for appropriate use of copy?
- What audit trails are available?

EHR TOOLKIT – SAMPLE PROCEDURE

- Providers are responsible for the entire content of their documentation, whether the content is original, copied, pasted, imported or reused
- The provider is responsible for the accuracy and medical necessity of the note whether it is copied, pasted, etc.
- Providers are responsible for correcting any errors identified and alerting the HIM professional
- Providers must reference or attribute any documentation brought forward
- When referencing prior documentation the provider must attribute who and where he/she brought information forward
- Providers are required to follow all state, federal, and local laws, including the medical staff bylaws, rules and regulations
- Failure to comply will result in disciplinary action being taken

EHR TOOLKIT – SAMPLE SANCTION POLICY

- Title: Copy Function Sanction Policy
- Purpose: To provide guidance for action in the event of inappropriate use of copy functionality in the EHR
- Policy: Provider documenting in the EHR must avoid indiscriminately copying and pasting another provider's documentation. The process of copying forward information from previous notes, without clear attribution in an effort to increase documentation in a current visit is prohibited.

EHR TOOLKIT – SANCTION PROCEDURE

- Procedure: "Who" is responsible for referring cases of inappropriate copying and pasting to "whom" for corrective action, review, and facility wide trending.
- "Who" is responsible for reviewing the corrective action and facility wide trending report. "Who" shall make recommendations on disciplinary action in which continued inappropriate use of copy technology is identified.
- Failure to comply with the organizational policy regarding copy functionality may be deemed as violating hospital policy.
- Disciplinary action may be taken.

COPY FUNCTIONALITY AUDIT PROCEDURE EXAMPLE

- Identify responsible party
- Determine how and when audits will be conducted
- Determine who will perform these ongoing concurrent audits
- Establish frequency for performing the audit
- Establish time period covered by the audit
- Identify how the sample size if determined
- Identify a description of the outcome indicators
- Determine how copy functionalities within the record are identified
- Design a corrective action plan based on findings
- Maintain and provide a detailed list of copy functionalities as they exist within the electronic system
- Provides testing of copy functionalities prior to implementation and prior to version updates
- Identifies copy functionalities and categorizes by whether they are retained as auditable events or otherwise identifiable as copied

EXAMPLE OF COPY AND PASTE CHALLENGES FOUND

- Outdated histories
- Outdated labs
- Entire chart note
- Patient is stable but is an inpatient
- Taking credit for interpretations
- Spelling errors, formatting issues
- Attributions not documented
- Orders authentication (verbal and phone)
- Use of abbreviations (texting in the EMR)

EXAMPLE OF DUPLICATIVE DOCUMENTATION CHALLENGES FOUND

- Copy error– 2 charts open at one time
- Physician – copied and pasted the office visit into the next 10 visits
- 60 page chart note
- Chart note documentation not unique to visit
- Bill multiple times for one procedure
- Consistency of "place" in the EMR for documentation (provider orders in nurses notes)

AND….

- Joint Commission requirements
- Use of audit trails/audit logs

RECOMMENDATIONS

- Train and educate providers to review the note for accuracy before authentication
- Document attributions
- Draft and implement education policy and checklist
- Draft and implement an audit policy related to the EHR
- Perform chart audits
- Learn and know your EHR system
- Partner and collaborate with education department, coding departments, Quality Management, and Compliance in the training of providers

RESOURCE/REFERENCE LIST

- AHIMA Copy Functionality Toolkit – A Practical Guide: Information Management and Governance of Copy Functions in Electronic Health Record Systems, AHIMA Updated 2011
- CMS Documentation Requirements
- Local Medicare and Medicaid Carriers

QUESTIONS?

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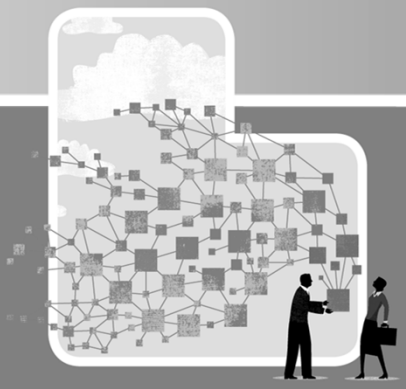

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