The Legal Health Record: Copy and Paste Guidelines

Webinar
November 17, 2009

Practical Tools for Seminar Learning
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Diana Warner, MS, RHIA, CHPS

Diana Warner is a professional practice resources manager with AHIMA. Ms. Warner has nearly 20 years experience in HIM, included a variety of healthcare settings such as physician practices, acute care hospitals, nursing homes, rehabilitation hospitals, and psychiatric hospitals. She has been involved in HIPAA privacy and security, implementation and management of an electronic medical record, and managing the medical record in paper and multiple electronic environments. She was also a member of AHIMA’s Physician Practice Council and EHR Council.
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Objectives

- Identify benefits and risks of using copy/paste functionality
- Identify Auditing Best Practices
- Identify Education and Training
- Develop Policies and Procedures

Polling Question #1

Do you have an EHR?

a) Yes
b) No
Framing the Issues

- Legal Business Record
- Traditional Practices
- Documentation Practices
- Documentation Integrity

Framing the Issues

- HIM Responsibilities
- HIM and IT roles
- System Functionality
**Toolkit Overview**

- **Content**
  1. HIM Professional Responsibilities
  2. Risks associated with functionality
  3. Appropriate Use
  4. Fraud and Abuse
  5. Clinical Trustworthiness
  6. Education and Training
  7. Case Scenarios/Policy and Procedures

**Polling Question #2**

Can you audit copy/paste functionality in your system?

- **a)** Yes
- **b)** No
When is Copy/Paste Inappropriate?

- Jacobellis v. Ohio, 378 U.S. 184 (1964)
- Justice Potter Stewart’s opinion “I know it when I see it”

Copying or Collaborating?

From the WSJ Opinion Archives
TASTE COMMENTARY

Their Cheatin' Hearts
You call it copying; today's college students call it collaborating.

By CHARLOTTE ALLEN
Friday, May 11, 2007 12:01 A.M. EDT
How Common is Cheating?

2003 National Survey of Student Engagement, 87% students said peers copied from Internet

www.lib.utexas.edu/services/instruction/faculty/facultyseminar/handout/2006/Prevent_stats.pdf

Center for Academic Integrity at Duke University, “on most campuses, over 75% of students admit to some cheating”

www.lib.utexas.edu/services/instruction/faculty/facultyseminar/handout/2006/Prevent_stats.pdf
The New York Times

34 Duke Business Students Face Discipline for Cheating

By ALAN FINDER
Published: May 1, 2007

Thirty-four first-year business graduate students at Duke University cheated on a take-home final exam, a judicial board has found, in what officials called the most widespread cheating episode in the business school’s history.

The final was an open-book test in a required course in March, with students told to take the exam on their own. But many students collaborated, in violation of the school’s honor code, according to a ruling last week by the judicial board of the Fuqua School of Business at Duke.

How Prevalent is Cheating?

- Rutgers University September ’06
- 5,300 students at 54 universities (2002-04)
- 56% of business graduate students
- 54% in engineering
- 48% education
- 45% law students
SafeAssign: How Does It Work?

- Students submit papers
- Papers checked against SafeAssign's comprehensive databases of source material
- Papers delivered to instructors together with the originality reports

The Clinician’s View of the Problem

- Impact of Copy/Paste
  - Changes in document structure/content
  - Mistakes, concerns, lessened confidence

Impacts of Computerized Physician Documentation in a Teaching Hospital: Perceptions of Faculty and Resident Physicians
Embi PJ, Yackel TR, Logan R, Bower J, Cosney TG, Gorman PN
J Am Med Inform Assoc. 2004;11:300-309
Changes in Structure/Content

- Redundancy
- Formatting

Redundancy

“You will see the same information repeated over and over again in notes; you will see the same misinformation repeated over and over again in notes; to the point you can’t easily identify where the misinformation began.”
Formatting

“There’s a bunch of stuff you don’t care about and that kind of hides the stuff you do care about in the labs... and, there’s no way to like highlight what you think is important, or to put it in a prioritized fashion easily.”

Mistakes, Concerns, Less Confidence

“You’ll see exactly the same physical exam in the intern’s progress note, the resident’s progress note, the attending’s progress note, and then in subsequent subspecialist’s progress notes.”
**Mistakes, Concerns, Less Confidence**

“They’re copied and pasted from one note to another, and it’s not simply that it isn’t accurate, but probably that it’s not believable that it’s accurate.”

**Just Because It’s Legible Doesn’t Mean It’s Intelligible**

![Image of a sign with text: NEW CUYAMAS
Population: 562
Ft above sea level: 2150
Established: 1851
TOTAL: 4663]
Copy/Paste of Exams in EHR

- 15,000 VA Puget Sound patients
- 167k progress notes (1,479 patients)
- Copyfind-VA, 181k copyevent records
- 90k instances when pairs of documents contained identical 40-word sequences

Copyfind-VA

![Copyfind-VA Example]

Figure 1. Marked-up progress note showing copied text (and noted “Hernia, clinically misleading, major risk”).

Copying and Pasting of Examinations with EMR
Stephen Thielke, Kenric Hammond, Susan Helbig
Results

- 167,076 VA records
- Copying in 3% of all exams
- Copying in 25% of patient charts
- 13% authors copied ≥ 1 exam
- 3% authors copied from another

No Payment for Cloning

Requirements for the Payment of Medicare Claims—A Selection of Some Important Criteria (continued)

Cloning of Medical Notes

Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries. Cloning also occurs when medical documentation is exactly the same from beneficiary to beneficiary. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment.

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.
**Attitudes Towards Copy/Paste**

- 315 (70%) of 451 responded
- 80% wrote inpatient notes
- 90% used Copy Paste functionality
- 70% used it most of the time

Inconsistencies (71%) and outdated information (71%) were more common in notes containing copy and pasted text.
19% felt that Copy Paste Functionality had a **negative** impact on patient documentation

24% led to mistakes in patient care
80% wanted to continue to use Copy/Paste Functionality

Polling Question #3

Can you turn off the copy/paste functionality in your system?

a) Yes
b) No
Finding a Balance

1. Templates
2. Dictation
3. Scribes
4. How many clicks does it take?
5. Make it easy to do it right

Recommendations

- Teach practitioners/students that careless copying creates untrustworthy records
- Empower teachers to monitor the writings of trainees with automated methods
- Require source attribution when copied text is reused in patient records
Audit

- How do you copy/paste in your EHR?
  - Determine how this can be done
  - Is audit available for this field?
  - Is the audit turn on?

Reports

- Identify multiple notes that were edited or viewed by the provider at the same time with the same patient or different patients
- Identify copy/paste functions and if there is an audit attached use this
- Random Audits
Staff

- Compliance Staff
- Coders
- Medical Record Reviewers

Education Tools

- Legal issues surrounding the use of copy functionality
- Existing functionality within the EHR applications
- Best practices for documentation
- Ramifications of data replication
Record Integrity

- Document on each occurrence (inpatient or outpatient) at or near the time of visit
- Include information pertinent to the visit
- Ensure the note is easily attributed to the author

Quality Integrity

Accurate documentation ensures accurate:
- Patient care
- Collection of data for outcomes
- Reporting
### Coding Reliability

- Accuracy
- Determining Medical Necessity
- Validity

### Payers

- No National Policy
- Local Carriers are issuing transmittal
- Insurance Companies beginning to flag
Training

- How to Document
  - Good workflows
  - Clear understanding of what needs to be captured
  - What can be brought forward
  - Partner with medical staff leaders to address

Appropriate Use

If the following has remained the same, an organization may choose to bring forward:
- Demographics
- Medications
- Allergies
- Problems
- Ensure original author
**Inappropriate Use**

- Copying problems that are no longer active
- Copying medications that are not longer current
- Upcoding
- Not identifying author

**Avoid Copy/Paste if Possible**

- Partner with providers and IT to develop faster methods to document
- Evaluate different methods to reduce documentation time
Alternatives to Copy/Paste

- Traditional Transcription
- Voice Recognition
  - Front End
  - Back end
- Direct Charting with macros

Alternatives to Copy/Paste

- Cite data in from other parts of the record i.e. problem lists, medications
- Computer generated Forms with point and click options
- Use of scribes
Polling Question #4

Do you have policies and procedures for copy/paste functionality use?

a) Yes  
b) No

Policy Development

- Organizational use  
- System specific use  
- System selection criteria  
- Sanctions – Rules and Regulations  
- Corrections  
  - General and copy/paste
### Policy and Procedure Considerations

- Define limitations for copy/paste
- The individual performing the copy/paste is responsible for the documentation
- Reference the original source
- HIM should understand payer concerns around copy/paste
- Notification of an incorrect copy note

### Organizational Questions

- Are there alternatives to use of copy functionality?
- How will we ensure user competency?
- What copy functionality exists within the EHR including the ability to make corrections?
- What will be our process to mitigate and identify unacceptable uses?
- Who is going to enforce the policies?
**Case Scenario #1:**

- Are there specific rules for utilizing copy/paste technology within transcribed reports. A patient is admitted to the hospital for a surgical procedure. The patient was discharged three weeks prior for an unrelated case of pneumonia. The surgeon is asking the transcriptionist to copy a prior discharge summary into a current history and physical template, is that OK? What guidelines, if any, are applicable to this situation.

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**Case Scenario #1:**

- From a hospital perspective, as long as the history and physical continues the defined segments (e.g. chief complaint, review of systems, etc) and is completed prior to surgery is there a reason to be concerned with this practice? CMS has a documentation guideline that states that a history and physical utilized for a surgical case must be updated within 7 days of admission. How does that guideline fit in with the above practice? From a physician perspective, is the use of copy/paste in this scenario appropriate for their billing purposes?
Case Scenario #2:

- Is it appropriate to use copy/paste technology for demographic information. A patient is admitted to the hospital, a history and physical is dictated. The attending physician orders a consult and requests that all demographic information be copied into his report header (e.g. name, account number, medical record number). Is this an appropriate use of copy/paste technology?

Case Scenario #2:

- I think that most organizations have an ADT (admission/discharge/transfer) feed from their accounting/registration system to their EHR. If that is the case, many times this information is transferred via the system when the transcriptionist pulls up the patient’s name to begin typing the report. However, if the systems are not integrated the transcriptionist may be using copy/paste to move the demographic information into the report.
Case Scenario #3:

- Is it appropriate to use copy/paste technology for daily progress notes. A patient is admitted to the hospital. The attending physician write a progress note on day one, and then simply copies that information forward for each subsequent day. When retrospectively reviewing the record it is easy to see that the documentation within the progress notes does not change from day to day.

Case Scenario #3:

- However, when reviewing the information online in the EHR the documentation looks exactly the same and there is no reference in the progress notes to indicate that the information has been copied forward. (e.g. the font is the same, the color is the same, etc) Nor does the copied information site the source of the original text, so in fact it is difficult to determine if the original progress note was not copied itself from a prior admission.
Case Scenario #4:

- A patient is admitted to the hospital directly from their primary care physician office for congestive heart failure. The patient is followed during the hospital stay by both an attending and advanced nurse practitioner (ARNP). Each day the ARNP reviews the laboratory data and medication levels of the patient. The documentation is replicated within the progress note.

Case Scenario #4:

- In addition, the ARNP adds clinical information, treatment recommendations and changes in the patient status. The replicated data appears within the EHR is a different color font that the original text note, and the ARNP acknowledges that laboratory and medication data has been copied into the progress note. The ARNP signs the note and forwards the note to the attending for co-signature.
Case Scenario #5:

A 7 year old male is admitted from his pediatrician’s office with acute exacerbation of his asthma. The patient is admitted directly to the pediatric floor and appropriate clinical treatment is provided. Prior to admission the Pediatrician documents an extensive history and physicals examination in the EHR from his office. On day one of the hospital stay the physician completes a progress note.

Case Scenario #5:

On days two and three the physician completes his progress notes by copying the original note from day one, updates the note with the patient’s response to treatment and chest x-ray results. The physician indicates the information has been copied by inserting quotation marks around the documentation and noting “copied from day one note.” He then signs each note individually.
Case Scenario #6:

- The HIM Department at Everyday Hospital is very active in physician education. As new physicians apply for clinical privileges the HIM Manager provides system training for the physician. Dr. Jones, a new surgeon on staff, has presented to the HIM department for training. Training includes how to sign into the system, how to review ancillary data, direct document entry of progress notes and applying electronic signatures.

Case Scenario #6:

- The training does not include any guidelines or support of data replication features within the system. A clerical staff presents to the HIM Manager with two records of Dr. Jones. The clerk has noticed that Dr. Jones performed a hernia repair surgery on a patient and completed a history and physical per hospital guidelines. The patient presented to the hospital 5 days post operatively with an infection. However, Dr. Jones’ notes are exactly the same as his first admission.
Resources

- AHIMA. "Redisclosure of Patient Health Information (Updated)" Journal of AHIMA 80, no.2 (February 2009): 51-54.


- AHIMA. “Copy Functionality Toolkit.” (December 2008).

Resources

  http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_040773.hcsp?dDocName=bok1_040773

Resources


  [http://library.ahima.org/xpedio/idcplg?IdcService=GET_HIGHLIGHT_INFO&QueryText=%28Legal+EHR+Roundtable%3a+Views+and+Needs+Differ+by+Stakeholder++%29%3cand%3e%28xPublish+Site%3csubstring%3e%60BoK%60%29&SortField=xPubDate&SortOrder=Desc&dDocName=bok1_036579&HighlightType=HtmlHighlight&dWebExtension=hcsp](http://library.ahima.org/xpedio/idcplg?IdcService=GET_HIGHLIGHT_INFO&QueryText=%28Legal+EHR+Roundtable%3a+Views+and+Needs+Differ+by+Stakeholder++%29%3cand%3e%28xPublish+Site%3csubstring%3e%60BoK%60%29&SortField=xPubDate&SortOrder=Desc&dDocName=bok1_036579&HighlightType=HtmlHighlight&dWebExtension=hcsp)

Resources


**Audience Questions**

Following today’s live seminar
Available to AHIMA members at
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“Members Only” Communities of Practice (CoP)
AHIMA Member ID number and password required

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**February 23, 2010**

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Appendix

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CE Certificate Instructions
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Resource List


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http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_035123.hcsp?dDocName=bok1_035123

http://library.ahima.org/xpedio/idcplg?IdcService=GET_HIGHLIGHT_INFO&QueryText=%28Legal+EHR+Round+table%3a+Views+and+Needs+Differ+by+Stakeholder++%29+&xPublishSite%3csubstring%3e%28BoK%29&SortField=xPubDate&SortOrder=Desc&dDocName=bok1_036579&HighlightType=HtmlHighlight&dWebExtension=hcsp
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