Breaking Free of Copy/Paste: OIG Work Plan Cracks Down on Risky Documentation Habit

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According to the Centers for Medicare and Medicaid Services, evaluation and management (E/M) services accounted for $28 billion in Medicare Part B payments during a one-year period.[1] And of these, 8.4 percent were billed at the wrong level-either too high or too low. Chasing these potentially inappropriate payments is now part of the OIG's new work plan and, consequently, a new focus area for HIM professionals.

A common documentation vice may be fostering the 2013 OIG work plan's focus on potentially inappropriate E/M service payments-cutting and pasting patient encounter notes within EHRs. But HIM professionals can team up with physicians, other clinicians, and IT departments to improve documentation and mitigate their audit risk.

Are EHRs the Culprit?

During random audits of patient encounter notes in medical practices, the billing of multiple E/M services for the same providers and beneficiaries was identified as a common documentation error. This problem was particularly widespread in hospitals and physician practices using an EHR, leading many to question if copy and paste functionality within EHRs for E/M documentation is the cause.

Concerns arose from multiple sources-from the Wall Street Journal to Republican leaders in Congress-regarding repeat and redundant documentation. Some have even begun second-guessing ARRA stimulus payments for the "meaningful use" of electronic record systems through the EHR Incentive Program due to fraudulent claims.

As a result, the OIG has now begun reviewing and auditing for duplication documentation resulting from copying and pasting within an EHR in their 2013 work plan.

But before the caboose derails the train, some questions must be answered. Are copy/paste practices indeed causing the increased frequency of identical documentation across services? And if so, what can HIM professionals do to help prevent these errors?

Contractors Target 'Repeat Patients, Same Specialty'

Medicare contractors have identified the use of a "new patient" E/M code for patients seen within three years by the same provider or within the same practice as an area of scrutiny. High-level E/M visits for established patients is another area of scrutiny.

In fact, the ability to copy and paste a patient note from a prior visit into a new encounter is so easy within most EHRs that providers may unknowingly fall victim to unwarranted audits.

HIM professionals should work together with their affiliated physician groups to conduct regular audits of billing and documentation. Some E/M audit tips to consider include:

- Include a broad sample of E/M services (inpatient, outpatient, new patient, follow-up visit)
- Compare each provider's results to group and national benchmarks
- Meet and discuss findings and anomalies as a team
- Use results as a learning tool to improve documentation, coding, and billing practices

Finally, with so much concern over copy and paste functionality, now is the time for HIM professionals to work with clinicians and IT departments to reassess organizational policies and procedures around this complicated and controversial documentation practice.

Rein in Copy/Paste

The first stop for HIM professionals looking to rein in misuse of copy and paste is a visit to the Copy Functionality Toolkit, published by AHIMA. This toolkit explores additional risks of copying and pasting patient encounter notes while also describing the potential billing fraud issues cited above. The toolkit includes valuable case scenarios, sample policies, checklists, and audit guidelines. While many organizations have opted to permit copy and paste functionality for E/M service documentation, many have not. Some risks associated with copy and paste are noted in the AHIMA toolkit, and include:[2]

- Information copied into the wrong patient chart adversely affecting patient care
- Inaccurate or outdated information adversely impacting patient care
- Redundant information resulting in the inability to determine current information
- Inability to identify the author or intent of documentation, or when the documentation was first created
- Inability to accurately support or defend E/M codes for professional or technical billing notes
- Propagation of false information
- Internally inconsistent progress notes
- Unnecessarily lengthy progress notes

Shore Up Outpatient CDI Efforts

The second step HIM professionals should take is to improve outpatient clinical documentation with the 2013 OIG work plan in mind. Similar to inpatient clinical documentation improvement (CDI) initiatives, an effective overall outpatient CDI plan must include phases for assessment, education, and monitoring. Findings from initial assessments and ongoing monitoring should serve to focus education and training efforts throughout. This includes physician training on the proper use of copy and paste functionality as well as the potential risks to patient safety that is created by non-compliance with organizational policies and procedures.

Hospitals that are acquiring medical practices, clinics, and groups should be particularly aggressive in implementing or expanding CDI programs into outpatient settings. Some specific areas for CDI focus should include infusions and injections, colonoscopies, incident-to visits, excision of lesions, arthroscopic knee procedures, and computer-assisted surgeries.

Specific HIM roles in improving outpatient clinical documentation include:

- Development of policies and procedures related to what is acceptable to copy and paste over from previous notes, such as ancillary services
- Provide a scribe to capture documentation while the provider is examining the patient
- Provide training on risk of return when copying information
- Develop templates that fit the provider for their specific visit types
- Every encounter must stand on its own with valid documentation to support the visit. Answer the questions:
- Can you prove the visit occurred?
- What has changed from the previous visit?
- Does the documentation demonstrate what was done?

OIG Work Plan-Copy/Paste

The section of the OIG's 2013 work plan discussing copy and paste audits reads: "We will determine the extent to which CMS made potentially inappropriate payments for E/M services in 2010 and the consistency of E/M medical review determinations. We will also review multiple E/M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments. Medicare contractors have noted an increased frequency of medical records with identical

documentation across services. Medicare requires providers to select the code for the service on the basis of the content of the service and have documentation to support the level of service reported."

Source: CMS's Medicare Claims Processing Manual, Pub. No. 100-04, ch. 12, & 30.6.1. OEI; 04-10-00181; 04-10-00182; expected issue date: FY 2013; work in progress.

Help Mitigate 'Risky' Practice

The delivery of healthcare services in outpatient settings will continue to grow in volume and revenue impact. As it does, the role of HIM professionals is critical to ensure the clinical documentation required to support accurate coding, billing, and patient care is captured and maintained. The ability to copy and paste patient encounter notes from one visit to another is a common but risky documentation practice. The review of this practice within the 2013 OIG work plan is a significant motivator for HIM professionals to get involved and help mitigate organizational risk.

Notes

1. CMS. "Evaluation and Management (E/M) Services: Complying with Documentation Requirements." April 2011. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Evaluation_Management_Fact_Sheet_ICN905363.pdf.
2. AHIMA. "Copy Functionality Toolkit: A Practical Guide: Information Management and Governance of Copy Functions in Electronic Health Record Systems". Chicago, IL: AHIMA Press, 2012.

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