Documentation Bad Habits: Shortcuts in Electronic Records Pose Risk

by Chris Dimick

Electronic documentation habits such as copy and paste save valuable time, but they can ruin the record.

As the patient's health worsened, a hospital stay of days turned to weeks. But through the various tests and physician visits, the progress notes generated in the hospital's electronic record system looked similar. Past notes were being electronically copied and pasted into current records. Old services rendered were being documented over and over again, with additions to reflect any new services.

This "copy and paste," or pulling forward of information from past visits, was meant to save time on the busy hospital floor. It resulted in a misrepresentation of the patient's stay and a fraudulent submission for reimbursement.

This specific scenario is only an illustration, but documentation auditors say they see similar practices occurring. For payers, the practice is just reaching their radar screens.

HIM professionals should be on the look out for these EHR documentation bad habits, as the consequences could harm both patients and facilities.

The Dangers of Copy and Paste

Documentation shortcuts are tempting for busy clinicians. The innovation of the EHR, which allows for easier movement of information, has made it easier to reuse previous documentation with a single click. But the practice can lead to serious consequences for both patient care and reimbursement, some auditors say.

"I see the contradictions in the records a lot. A lot more than you would expect," says Patricia Trites, MPA, CPC, CHP, HCC, CHCO, cofounder of the Advocates for Documentation Integrity and Compliance and CEO of Healthcare Compliance Resources, based in Augusta, MI. Trites has witnessed poor practices firsthand while working as an auditor. The most common is copying information from a previous encounter and pasting it as current documentation.

The practice goes by several names—copy and paste, cloning, carrying forward—but it has the same effect on the integrity of the medical record, Trites says. Carrying forward information without careful review can cause contradictions in a patient's chief complaint documentation or history of present illness.

"From the clinical point of view it has been repeatedly observed that information may be copied forward that is not accurate," says Reed Gelzer, MD, MPH, CHCC, Trites's co-founder at the Advocates for Documentation Integrity and Compliance.

"So if you are copying forward a block of information, unless the clinician reads that information word for word, line for line, and reevaluates it, they may inadvertently be copying forward information that is not accurate." Past complaints or symptoms in current documentation can lead to a host of errors, including misinformed treatment.

Copying information can go farther, as noted in a paper in the April 2008 issue of the New England Journal of Medicine. Authors Pamela Hartzband, MD, and Jerome Groopman, MD, who practice at Beth Israel Deaconess Medical Center in Boston and teach at Harvard Medical School, write, "Many times, physicians have clearly cut and pasted large blocks of text, or even complete notes, from other physicians; we have seen portions of our own notes inserted verbatim into another doctor's note. This is, in essence, a form of clinical plagiarism with potentially deleterious consequences for the patient."

The errors can ripple outward into population health studies and other data mining. It can make tracking disease outbreaks harder, Gelzer says.

Such documentation may also show physicians performing services they only performed once in the past, leading to over reimbursement. Documentation should be recorded for each specific encounter, Trites says. Anything beyond that could be considered fraud.

That's because providers are paid for the work they perform in each encounter, and that includes part of the documentation, she says. "If in their documentation they are representing that they did more than they actually do, that is considered fraud."

Once copy and paste gets into the record, its credibility is compromised. "From an auditor's standpoint, you don't know which is true and which is accurate, how much work was actually done on this visit versus last visit," Trites says. And so the auditor begins to wonder, how is the facility coding these records? she says. How does it make sure it is submitting accurate claims?

"From a medical-legal standpoint, what would a lawyer do when they saw this chart?" she asks. "They are going to rip it apart."

The Risks of Scribing and Documenting by Exception

Other misrepresentations are also facilitated through certain electronic documentation. In some instances scribing, or authenticating notes made by another person, can be a fraudulent act if not acknowledged. Scribing has long been a practice on paper charts, but it can be harder to recognize in some EHR systems.

For example, a medical assistant may complete a history and physical on a patient in totality. The supervising physician may subsequently log in to the record, evaluate only proof of positives and negatives, and electronically sign the documentation in such a way that it overwrites the presence of the medical assistant.

That overwriting misrepresents who provided the service, which could alter the amount that is billed, Gelzer says. "I don't know if there is any payer that would recognize a medical assistant as having a scope of care, and that includes a history and physical exam," he says. "So essentially by misrepresenting who provided the service and then submitting that for billing, they are committing fraud."

Using prebuilt text in an EHR or documenting by exception can also cause problems in electronic records, according to Barbara Drury, BA, FHIMSS, president of Pricare, Inc. Drury is also an EHR consultant with COPIC Insurance, a medical malpractice insurance carrier based in Colorado that offers Colorado physicians educational sessions on EHR risk management as well as chart reviews.

Through her work at COPIC, Drury has seen errors through documenting by exception. For example, she says, some EHR programs offer physicians the ability to mark a single checkbox indicating that all patient systems are either normal or abnormal. The problem occurs when the doctor mistakenly checks the wrong box, leading to improper documentation.

When Drury advises physicians on which EHR products to purchase, she at times advises against products that feature copy-and-paste functions. This can cause an uproar. However, Drury believes that if clinicians can't see the result of their point and click within a given system, the potential for misdocumentation is increased.

Stephen Levinson, MD, consults with physicians on quality and compliance issues related to electronic documentation. He warns against the confluence of time-crunched physicians and the lure of documentation shortcuts. Poorly designed systems and poor practice can speed physicians past steps in performing and documenting care.

For example, copying forward a previous review of systems without reviewing changes in the patient's health status is noncompliant, Levinson notes, and the outdated information is clinically irrelevant to the current state of the patient's health. Routinely performing automatic copy forward could even lead to an interpretation of false claims by a Medicare or OIG auditor.

"But to me that's secondary—it's just not good care," Levinson says. "The tool has taken away what the doctor is supposed to do, which is obtain information on the review of systems since the last visit. For this encounter, it isn't relevant that the patient

didn't have chest pain three months ago; the physician needs to know that the patient hasn't had chest pain during the three months since that visit."

Speed, Levinson warns, is not the same as efficiency, which requires tools that help physicians work quickly while maintaining optimal care and compliant documentation.

The Temptation of Shortcuts

Copy and paste happens for several reasons. Doing it can save time by cutting down on the amount of documentation a physician must complete. Trites points to instances where practitioners copy information from one patient's encounter and use it as a sort of boiler plate to be inserted into other records during similar encounters.

Some of these habits are being passed down to physicians during training, both by senior physicians and even EHR vendors, she says.

Some providers copy information forward to raise the level of service billed. Since EHRs make it easier to capture more documentation for the record, in turn more services can be easily billed, Trites says.

While that increased level of documentation often is justified, there are instances where the record is purposefully padded to raise the bill. "Traditionally physicians have performed a high level of service but documented a low level of service," she says. "So, they are trying to make it right, and the way they are doing it is incorrect."

Physicians may justify pulling forward information from past encounters as a way to check for errors or unnecessary information. But that doesn't always occur, and the bad information can remain, according to Trites. Most of the time doctors are just trying to conform to the system and provide adequate documentation.

"I don't want in any way to say that physicians are doing this on purpose to defraud the system," Trites says. Rather, "they are taking shortcuts that are not good."

Standards exist that help make the EHR a credible tool that produces accurate documentation. However, holes do exist in standards, Trites says.

Better audit trails would address many of the issues, but since requirements "are all over the map," Drury notes, many EHR systems lack the functionality to track some of these errors, therefore limiting accountability.

"Right now the vendors are saying, 'We can do some of that. But somebody is going to have to tell us that we have to,'" she says. "'Either our market is going to have to tell us, or the government is going to have to tell us.'"

EHRs, especially the early ones, were usually designed to be quick documentation tools, not legal records, Drury says, so that emphasis helps explain why audit functionality has often been weak.

Until standards take hold, auditing processes will remain uneven, according to Drury. She says that during an EHR demo by a large vendor, she asked to see the audit trail function. After demonstrating it, the vendor representative said that the function was a drag on the system and that providers should keep it turned off except for a couple of days a month. "So, there is a long ways to go on that," she says.

EHRs Are Not the Bad Guy

EHR developers are not necessarily at fault for including certain functionality such as copy and paste. Many clients request it. And just because some poor documentation practices are possible in an EHR doesn't mean that EHRs in general lead to overall poor documentation or promote fraud. On the contrary, EHRs and their eventual interoperability have the potential to save the industry billions of dollars through fraud prevention.

According to a 2005 report produced by AHIMA's Foundation of Research and Education for the Office of the National Coordinator, EHRs are the key to controlling fraud costs because of their audit trail capacities and other technology features. In addition, when used properly, EHRs have the potential to vastly improve documentation, Drury says.

Leading EHR vendors know the importance of documentation and do all they can to produce systems that create credible documentation, according to Justin Barnes, vice president of marketing and government affairs for Greenway Medical Technologies and board member of the Electronic Health Record Vendors Association. Leading vendors take measures to ensure that EHR systems are credible and produce accurate medical records by building in features such as audit trails, protected access, and alerts, he says.

Though he can't speak for all vendors, Barnes contends that the leaders focus on ethical standards when designing EHR systems and when training physicians on their products. Sound documentation is important to an electronic record, and vendors keep that in mind when developing systems.

"Leading EHRs always promote the utmost highest ethical standards when advising physicians and practitioners on using technology at the point of care," he says. In addition, it is much more difficult to perform fraudulent acts with an electronic medical record system than on paper records, Barnes says.

Payers Slowly Taking Note

Some payers have already enacted broad policies that condemn carrying forward documentation in any medium, electronic or paper.

First Coast Service Options, a local CMS Medicare contractor, wrote about its prohibitions on cloning information in a 2006 Medicare Part B newsletter to Connecticut and Florida Medicare Part B providers. "Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries," the newsletter states. "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."

First Coast goes on to state that discovery of this type of documentation would "lead to denial of services for lack of medical necessity and recoupment of all overpayments made." The policy is not specific to EHRs, but applies to medical documentation in any format.

Clearly defined policies against copy and paste in the electronic record have not been established at some of the major insurance providers in this country. No national policy exists for CMS. CMS spokesman Joseph Kuchler says the organization is analyzing situations in the use of electronic health records that may introduce error or potentially result in fraudulent activity. "We will initiate any appropriate action following our analysis," he says. Similar statements were made by insurance provider WellPoint.

However, specific payer policies will probably increase as more providers use EHRs. Many payers are only just beginning to comprehend what these documentation practices mean to their business, Gelzer says.

Insurance provider Aetna does not have a specific policy against electronic copy and paste, but it is keeping an eye out for fraud committed electronically. "As with many advances in technology, EHRs make some transactions easier and more efficient," says Aetna spokeswoman Tammy Arnold. "EHRs could also allow fraudulent claims to be created more quickly, thus easier, than fraudulent handwritten claims."

While Aetna feels this is a minimal problem—especially since only a small share of their providers use EHRs—it does have a special investigations unit (SIU) that monitors claims for fraudulent activities. "If a suspicious pattern of claims is identified, the SIU will investigate," she says. "Consequences of proven cases of fraud vary based on the situation, but could include reimbursement of payments, civil and criminal legal action."

A Bad Habit Hard to Break

Stopping bad documentation habits is tough. Convenience is compelling, Trites admits. Some recommend that EHR manufacturers alter their systems to make practices like copy and paste impossible. But manufacturers must cater to users who request these features, Gelzer says. Additionally, even though products may highlight the feature, copy and paste is usually a function of the underlying operating system, such as Microsoft Windows.

Vendors or IT departments that disable the ability to copy text off the screen will likely discover that determined users find workarounds all the same.

Copy and paste won't go away any time soon. It may never, unless payers forbid it. Instead, individual facilities must seek a balance of their needs for both clinical efficiency and sound documentation. That likely involves difficult negotiations. The goal is good processes around electronic documentation.

Solutions require understanding that the EHR is another tool for documentation, not an answer to documentation problems, Drury says. As Trites puts it, replicating bad paper practices electronically simply results in a "bad practice that you can do faster." Drury believes that providers must embrace a certain responsibility to prevent copy-and-paste errors and other documentation mistakes.

Awareness and education help, she says. Clearly, not a single clinician she works with is "out to hurt a patient or to commit fraud. They want to be efficient."

HIM professionals work in the middle of this complex reality. Those who notice errors should raise the issue and help find solutions. After all, Gelzer says, they are the custodians of the organization's records. Should legal action arise from improper documentation, HIM professionals would likely be the ones to testify on the record's validity in a court of law.

When it comes to copy and paste, Trites says, she hears from HIM professionals who say they see it all the time. She asks them, "Well, why aren't you doing something?"

Read more on the web

Are there "appropriate" uses of copy and paste or carry forward? Yes, with a caveat, says Stephen Levinson, MD. Read more at the new *Journal* Web site, http://journal.ahima.org.

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