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The Detrimental Pitfalls of Provider Documentation

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THE DETRIMENTAL PITFALLS OF PROVIDER DOCUMENTATION

Copying and Pasting

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23 April 2015

Abstract

Electronic Health Records hold many benefits and clearly is a cut above maintaining paper records. Although, over the years we have learned that there are potential drawbacks that come with having an electronic health record. This review on EHR's, is what could be, considered detrimental pitfalls of provider documentation (copying and pasting) and how this may affect the safety and quality of the physician documentation and patient care.

Table of Contents **Page**

Abstract ii
List of Tables

Table 1A – Survey Methods 8
Table 1B – Survey Methods 8
Table 1C – SWOT Analysis 16

Chapter 1 – Introduction 4
Chapter 2 – Review of Literature 6
Chapter 3 – Methodology 7
Chapter 4 – Results 10
Chapter 5 – Analysis and Discussions 12
Chapter 6 – Conclusions and Recommendations 14

References 17

Electronic Health Records hold many benefits and clearly is a cut above maintaining paper records. There are potential drawbacks that come with having an electronic health record. This review is on EHR's, and what could be, considered detrimental pitfalls of provider documentation (copying and pasting, cloning) and how this may affect the safety and quality of the physician documentation and patient care. The copy and paste functionality has many names "cloning," "carrying forward," and "identical documentation" all which should not be used unless you have strong technical and administrative controls, this would include organization policies, training and education.

VA Medical Records managers and clinicians first began to notice issues with copying of text from one clinical document into another using Windows® copy and paste functions in the late 1990s. Copying and pasting was convenient to make notes among records belonging to a single patient. The concern arose when it was, realized there was potential erroneous information placed in wrong record, a lapse in professional ethics, billing irregularities, and potential liability exposure. They considered disabling the copy and paste function but at the time felt, this was impractical. In 2000, they developed policies for electronic records, which is an ongoing process even today. Even in 2014, as coders, we often come across accounts where the provider has copied information from one record to another. We see information where a male/he, is later identified as a female/she in the body of the discharge summary or operative report or vice versa. We also see where the provider has copied an entire section of information and placed it in the wrong patient record. This is a safety and HIPAA issue.

According to Butler (2014), “Clinician use of copy and paste functionality in EHRs is widespread, in part because it saves users time by reproducing lengthy progress notes and narrative patient data. This functionality unfortunately used within the same person’s chart as well as across multiple patients’ charts. According to research cited in the position statement, as many as 90 percent of physicians use copy and paste in their documentation.”

This can lead to errors such as:

- Inaccurate or outdated information
- Redundant information
- An inability to identify when the documentation was first created
- Unnecessarily lengthy progress notes
- The false information

The practice of copy and paste unfortunately, is also be used to perpetrate fraud. (Butler, 2014), “A desired outcome of EHR implementation is to increase the quantity and utility of data available to clinicians about each patient,” the paper states. “While increased availability of this information is useful for informed clinical decision-making, too much information can lead to difficulties in navigation and synthesis.”

In its position statement, AHIMA aimed its recommendations to four distinct groups—industry stakeholders, healthcare provider organizations, EHR system developers, and the public sector.

Chapter 2 – Review of Literature

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Method

The literature used was from various electronic articles and publications from the Journal of General Internal Medicine, PubMed, Family Practice News, and The American Health Information Management Association (AHIMA). Other relevant articles used were found in Ovid Medline using the key word searches: ‘copy and paste’ and ‘computerized physician documentation’ as well as the subject headings: ‘copying processes,’ ‘user computer interface,’ ‘documentation,’ ‘medical records systems, computerized,’ ‘attitudes to computers’ and ‘attitudes of health personnel’ were reviewed.

Chapter 3 - Methodology

Population Studied

Each article conducted very different methods when measuring how physicians document in the EHR. The first review was from the article by O’Donnell, Kaushai, Barron, Callahan, Adelman, and Siegler, (2009). The population used for the study came from 451 eligible residents and physicians within two affiliated medical centers that are currently using a computerized system.

The second, review was from an article by Hammond, Helbig, Benson, and Brathwaite-Sketoe (2003). The population used for this study was electronic records from the VA facility in Puget Sound. One of the main studies previously used was computer software called (Copyfind-VA) that’s used by the VA to capture copying and pasting used in electronic records.

The purpose of this study is to show the detrimental pitfalls in provider documentation that copying and pasting can cause when it comes to the quality and safety of patient care. This has been an ongoing issue from the time computers came on the scene, and it's going to get worse if there aren't some strict guidelines put in place to eliminate or limit the use of copying and pasting.

The survey used will have approximately 8-questions that will ask specific questions in regards to copying and pasting and how it affects the quality and safety of patient care. There are approximately 25 participants in this survey that work in the areas as an HIM Operations Manager, Records Analyst, Coding/CDI Analyst, HIM Manager, Compliance, and Other. Data from the survey will come from the following information:

- Participants
- HIPAA violations
- Legal cases/12 months
- Facilities with Policies
- Errors/12 months

Survey Method

Methods previous used were the results from a self-administered surveys. The surveys were over an 8-week study period between June and August 2007. The previous plan used was good and provided good results, but the survey that used for this project will provide results that are more current. The time used for this survey will cover the last 12 months of the calendar year. Once all surveys have been received I will break them down by job titles/positions, how many responded, the number of HIPAA violations, number of Legal cases in the past 12 months, and the number of facilities with a policy.

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Table 1A.

Comparison			
Author's, Year	Participants/Survey Method	Variables	Results
	-Voluntary -HIM Operations Manager -HIM Record Analyst -HIM Coding/CDI Analyst -HIM Manager -Compliance -Other	**7/25** **1/7** **1/7** **2/7** **0/7** **3/7**	-28% responded - 100% Legal cases/12 months - 37%used HIPAA violations - 27%accuracy and quality - 100% Facilities that have Policies - 18% Risks - 57% Hinder - 0% Benefit

Table 1B.

Comparison			
Author's, Year	Participants/Survey Method	Variables	Results
O'Donnell, Kaushai, Barron, Callahan, Adelman and Siegler, 2009	-Voluntary -Residents and Physicians -Affiliated Academic Medical Centers	-specialties -residency year -gender -usage	-70% responded -90% used CPF -70% always used CPF when writing daily progress notes -80% wrote their inpt note electronically

Hammond, Helbig, Benson, Brathwaite-Sketoe (2003)	-VA Puget Sound patients (electronic records) -Random Sample -Software resources	-at least one progress note recorded between 15 May – 15 June 2002 -Severity -Categories of duplicated information	-Cases: 243. -Time frame: 1993–2002. -Total (copied and uncopied): 29,386. -Notes containing copied text: 2,645 (9.0% of total notes*). -Copying Risk 5: 294 (1.0 % of total notes). -Copying Risk 6: 44 (0.15 % of total notes). -Prevalence of human copying: 63% of copied notes; 5.2% of total notes.

Chapter 4 - Results

Results/Findings

The use of the CPF will be an ongoing issue until standards have been put in place nationally that will either remove the function or limit its use. According, to the survey results by, O'Donnell, Kaushai, Barron, Callahan, Adelman and Siegler, (2009) "showed that out of the 451 eligible physician's only 315 responded. Ninety percent of the 253 electronic note writers reported they used CPF when writing daily progress notes. Among the 226 CPF users, 177 (78%) were high CPF users (used CPF usually or most of the time when writing progress notes). Residents were almost three times more likely to be high rather than low CPF users compared with faculty physicians (OR = 2.9, 95% CI = 1.5, 5.7), while age, gender, hospital, specialty and comfort writing notes electronically were not independently related to frequency of use. CPF users frequently copied notes written by other physicians (81%) and notes written during past visits or admissions (72%). Forty-seven percent of CPF users at Hospital B with the copy forward function and 69% at Hospital A (p = 0.002) copied either the entire note or part of the note, including the physical exam".

When the VA survey/review ended, out of the 243 patients, reviewed there were 6,322 copy events (1.6% of the one-month sampling cohort). According to Hammond, Helbig, Benson, and Brathwaite-Sketoe (2003), "Despite only scratching the surface, the yield of information was sufficient enough to show the pervasiveness of the copying phenomenon." The total (copied and uncopied) notes for cases between 1993 and 2002: were 29,386, out of those 2,645 (9.0% of total notes*) contained copied text.

These results revealed a behavior that cannot be, ignored. Authors of the documentation were responsible for 63% of the copying found in notes containing copied material (after filtering). Human copying is hard to detect without proper technical aid. Without Copyfind-VA, it would have been very difficult to distinguish valid from invalid records. With it, many innocent-appearing records raised doubts.

After the VA conducted their study, they had many concerns as well. Once, the study is complete, there will be a discussion, with the current Interim HIM Manager who is also the HIPAA and Operations Officer about the results. This will be a good opportunity to discuss and develop the best course of action to correct any issues identified. This would also be the perfect time, to identify any negative impact; the survey may unveil on patient safety or security of their information due to these incidents.

The survey conducted did not yield the results anticipated due to the fact there was low participation, but the results received did show a pattern that all that did participate had some of the same concerns when it came to copying and pasting.

The results show that although many of Health information Managers and Compliance officers have been in the career field for a quite some time not many of them have had the pleasure of experiencing going to court and witnessing providers trying to explain why their documentation is not complete or legible in a medical record.

As you will see from the survey results some of our key managers and HIPAA personnel have not dealt with many violations when it comes to copying and pasting, but we know it's happening. So that tells us one thing that it's not being identified as it should be. But from some of the articles I've read lately that's going to change in the very near future. Providers and nurs-

ing staff need to be educated on the dangers of copying and pasting and how it can affect not only the facility but the welfare of the patient as well.

Chapter 5- Analysis and Discussion

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The use of the copy and paste functionality is being, used more as more facilities move forward towards using electronic health records. Copying and pasting is a valuable tool if used correctly it can ease clinician workflow and improve the consistency of health information, an example would be a patient's past medical history. The problem comes when this function is, used incorrectly, and it affects the patient in a negative way.

As coder's we see first-hand the dangers of copying and pasting documentation errors on a consistent basis. According to a September AHIMA article, 74-90 percent of providers use the copy and paste functions. The most serious of the errors we encounter is when the information has been, copied from one patient's record to another. This can lead to incorrect medical information (diagnosis, history, etc.) being stored in a patient's EHR record, it can also lead to HIPAA violations if any of the information from the original patient is mistakenly stored in another patient's chart. When this function is misused, it can lead to redundancy, misleading and nonessential documentation.

Copying information can go farther, as noted in a paper by Hartzband & Groopman (April 2008) they wrote, "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."

Copy and pasting can lead to a patient or insurance company being, billed incorrectly lead to payer audits and fraud lawsuits. An example of this, is when a physician using the physical exam documentation for breast cancer, provided by another provider. Unfortunately, when this occurs the medical billing does not know the difference and will bill the patient or insurance company for a new physical. Another example is once the provider has completed his/her copy-forward and the information copied states patient has history of breast cancer. This could lead to the patient losing their insurance coverage because the medical documentation states the patient has cancer. This practice is clearly unethical, and this behavior gives the patient or insurance company grounds to investigate for fraud or file a lawsuit.

Some insurance providers have already taken the first step and moved forward with restricting or prohibiting the practice of copying and pasting (cloning) documentation. One provider that we are familiar with here in Florida is First Coast Service Options. First Coast is a local CMS Medicare contractor. In a 2006, in a Medicare Part B newsletter to all providers, CMS wrote, “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.” First Coast also stated that this type of documentation would lead to the denial of services due to the lack of medical necessity.

Chapter 6 – Conclusions and Recommendations

Summary – Finding out that this was an issue back as early as 1990 and is still an issue today was shocking. Copying and Pasting can be a useful function if used correctly. As team lead Coder there are several opportunities to speak with several providers on this subject and the majority of them agree that there is an issue with copying and pasting, and there should be national guidelines/standards set. At the same time, over half of them believed that education on using CPF should be, provided to all physicians. The physicians were not particularly fond of the idea of limiting their CPF use or removing it all together.

Conclusions/Implications - As we advance, in technology we need to remember that EHR's is not the enemy. According to Drury (2005), "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."

Recommendations- I believe that the key to having a successful EHR is to have a standardized national guideline/policy for all facilities to follow. We need to establish clearly defined policies that would prevent against negligent copying and pasting. At, the present time CMS does not have a national policy. According, to CMS spokes-man Joseph Kuchler he states; "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." Unfortunately, as long as guidelines or policies are up to each individual facility, we are going to continue to encounter documentation issues.

SWOT ANALYSIS

STUDENT FULL NAME : Rosalind Crook-Duckett

Potential Future Research Topic: Provider Documentation Improvement

Table 1 c

MY **STRENGTH'S** IN THIS RESEARCH	MY **WEAKNESSES** IN THIS RESEARCH
-Strong commitment to facility mission -Extensive knowledge of medical documentation and coding -Experience in provider documentation training -Flexibility – open minded to suggestions from providers—get a feel of what their concerns are -Ability to make decisions that will benefit the facility	-Not as strong of a communicator as I should be -Need to be more outgoing to ensure the job is being done correctly -Resistance from professional staff -Limited education training funds -Lack of interest --provider staff -Lack of support by leadership; chief of staff -Not enough face-to-face interaction between coders and clinical departments-it's good to put a face to the voice or email.
MY **OPPURTUNITIES** IN THIS RESEARCH -Build confidence—work on weaknesses -Explore techniques/lessons from other facilities and organizations -Conduct quarterly audits/evaluations to monitor status -Create easy to read/follow tools or internet site to assist with questions on documentation and coding -Communicate, Communicate, Communicate with providers, leadership and co-workers -Make learning fun for providers -Improve patient safety --	MY **THREATS** IN THIS RESEARCH -Strict timelines – need to prepare now for ICD 10 -Low physician support -Loss of provider/professional staff

References

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AHIMA. "Data Quality Management Model (Updated) (2012)." *Journal of AHIMA* 83, no.7 (July 2012): 62-67.

Butler, Mary. (24 March 2014) "AHIMA Position Statement Warns of EHR "Copy and Paste" Dangers, Journal of AHIMA. http://library.ahima.org/xpedio/groups/ public/documents /ahima/bok1_050621.pdf

Benson, C., MS; Brathwaite-Sketoe, B., BS; Hammond, K.W., MD; Helbig, S., MA, RHIA (2003) Are Electronic Medical Records Trustworthy? Observations on Copying, Pasting and Duplication; AMIA Annu Symp Proc. 2003; 2003: 269–273. PMCID: PMC1480345 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1480345/

Committee on Data Standards for Patient Safety (2003). *Key Capabilities of an Electronic Health Record System: Letter Report*. Board on Health Care Services and Institute of Medicine, 2003. http://www.nap.edu/catalog.php?record_id=10781

CMS, *Medicare and Medicaid Incentive Provider Payments by State. Program Type: January 2011-March 2013.* Accessed at http://www.cms.gov on April 25, 2013. [5] See §§ 1848(a)(7), 1853(l)(4), and 1886 (b)(3)(B), as enacted in ARRA. See also CMS, *CMS Finalizes Requirements for the Medicare EHR Incentive Program*. Accessed at http://www.cms.gov on Jan. 3, 2012.

Dimick, Chris. (June 2008) "Documentation Bad Habits: Shortcuts in Electronic Records Pose Risk." *Journal of AHIMA* 79, no.6: 40-43.

Groopman, Jerome, MD, and Hartzband, Pamela, MD, April 2008; Issue of the New England Journal of Medicine.

Hipp, Elizabeth ; July 1, 2012; How copy and paste in electronic medical records affects patient care, http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_038463.hcsp?dDoc Name =bok1_038463

Kuchler, Joseph, **EHRs Are Not the Bad Guy** http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_038463.hcsp?dDoc Name=bok1_038463

O'Donnell HC, Kaushal R, Barrón Y, Callahan MA, Adelman RD, Siegler EL (Jan 2009). Physicians' attitudes towards copy and pasting in electronic note writing: J Gen Intern Med. 2009 Jan;24(1):63-8. Epub 2008 Nov 8