American Health Information Management Association

COPY FUNCTIONALITY TOOLKIT

A Practical Guide: Information Management and Governance for Copy Functions in Electronic Health Record Systems

RIGOROUS, YET EASY-TO-READ INSTRUCTION MATERIALS:

- Educate HIM professionals
- Enhance classroom learning
- Advance HIM careers

AHIMA PRESS

COPY FUNCTIONALITY TOOLKIT

ISBN: 978-1-58426-567-2
AHIMA Product No.: ONB182016
AHIMA Staff:
Chelsea Brotherton, Assistant Editor
Jewelle Hicks, Publications Manager
Pamela Woolf, Director of Publications, AHIMA Press
Anne Zender, Senior Director, Periodicals

For more information about AHIMA Press publications, including updates, visit
http://www.ahima.org/education/press?tabid=Updates

American Health Information Management Association
233 N. Michigan Avenue, 21st Floor
Chicago, Illinois 60601

AHIMA.ORG

TABLE OF CONTENTS

FOREWORD

Whether in paper or electronic form, the health record represents the legal business record of the healthcare organization. Federal initiatives such as the Health Information Technology for Economic and Clinical Health Act (HITECH) and health information exchange (HIE) have expedited the industry wide implementation of electronic health records (EHRs). In this rapidly changing environment, the use of technologies, such as copy functionality, has the potential to affect the integrity of that health record. In accordance with AHIMA's Information Governance Principles for Healthcare—specifically the principles of Accountability, Integrity, and Compliance—this toolkit identifies best practices regarding data replication in EHR systems.

The implementation of EHR systems has substantially increased the amount of electronically created and stored information. As clinical providers become more familiar with the capabilities and the technology surrounding documentation, questions about both the legal robustness and demonstrable integrity of the EHR continue to be a challenge, and the technology that facilitates these documentation practices is under increased scrutiny.

In order to knowledgably incorporate and appropriately manage the copy functionality of an EHR, organizations must have sound documentation integrity, auditing, and training practices. This toolkit is designed to support and guide organizations, HIM professionals, providers, and information technology (IT) professionals to examine the issues and circumstances in which the healthcare industry needs to define, support, and execute best practices managing copy technology in the EHR. This toolkit is intended to assist in developing policies and procedures surrounding this functionality. This toolkit will reaffirm that a trustworthy EHR system begins with technology but succeeds only with appropriate and effective information management and governance.

AUTHORS

Reed Gelzer, MD, MPH, CHCC
Terri Hall, MHA, RHIT, CPC
Elizabeth Liette, RHIA
Diana Warner, MS, RHIA, CHPS, FAHIMA
Lou Ann Wiedemann, MS, RHIA, CPEHR, FAHIMA

ACKNOWLEDGMENTS

Cecelia Backman, MBA, RHIA, CPHQ
Amber Bartlett, RHIA
Jan Barsophy, RHIT
Sue Bowman, RHIA, CCS
Jill Clark, MBA, RHIA
Angela Dinh, MHA, RHIA, CHPS
Michelle Dougherty, MA, RHIA, CHP
Pamela Heller, MSHI, RHIA, CCS-P, FAHIMA
Barry Herrin, CHPS, FACHE
Priscilla Komara, RHIA, CCS-P
Lydia Washington, MS, RHIA, CPHIMS

ORIGINAL AUTHORS

Reed Gelzer, MD, MPH, CHCC
Terri Hall, MHA, RHIT, CPC
Elizabeth Liette, RHIA
Mary G. Reeves, RHIA
Jennifer Sundby, MA, RHIA
Anne Tegen, MHA, RHIA, HRM
Diana Warner, MS, RHIA, CHPS
Lou Ann Wiedemann, MS, RHIA, CPEHR
Student: **Kelly McCormick**

AHIMA PRESS

INTRODUCTION

A patient's health record is considered to be the business and legal record for the healthcare organization. As such, it must be maintained in a manner that complies with legal requirements as well as business and clinical documentation standards. In order to thoughtfully and appropriately manage copy functionality, organizations must have sound documentation integrity policies. This is especially important when EHR software implementation changes operational processes and documentation and workflow practices within the healthcare environment.

The HIM professional is an integral participant in the process of ensuring that accurate documentation practices exist and are implemented in the organization. HIM professionals should take a leadership role within their organizations, listening, educating, collaborating, and reviewing documentation workflows with other professionals (including IT) in order to ensure sound HIM principles are included as EHR systems are developed and implemented.

HISTORY

The term "cut and paste" is derived from the traditional practice in manuscript-editing, in which people literally would cut paragraphs from one page with scissors and paste them onto another page. This practice remained standard as late as the 1960s and did not necessarily affect documentation within a health record.

In 1974, Lawrence G. Tesler first transferred the manual "cut and paste" process into a computer-based text-editing process while working at the Xerox Corporation Palo Alto Research Center. The term copy refers to the simple method of reproducing text or other data from a source to a destination. This differs from the term cut and paste in which the original source text or data is deleted or removed from the documentation.

ISSUES TODAY

Copy functionalities that do not meet the organization's data and documentation integrity policies may leave the organization open to malpractice law suits. According to a 2016 *Journal of AHIMA* article, "Most health information management (HIM) professionals would not be shocked to learn that errors caused by 'copy and pasting' portions of a record into other parts of the record contributed to the malpractice lawsuits."[1]

When evaluating copy functionality, there needs to be a determination if it will even be used. The functionality should be assessed and if the appropriate metadata and tools for monitoring are not available, an organization may choose to turn it off at the system level.

Previously common but risky documentation practices are no longer acceptable. Every member of the healthcare team is responsible for ensuring documentation integrity within the healthcare record. Nonauditable copy functionalities that do not support transparency of authorship or origination present risks to documentation integrity.

In 2014, AHIMA wrote a position statement "Appropriate Use of the Copy and Paste Functionality in EHRs" that "The use of copy/paste functionality in EHRs should be permitted only in the presence of strong technical and administrative controls which include organizational policies and procedures, requirements for participation in user training and education, and ongoing monitoring. Users of the copy/paste functionality should weigh the efficiency and time savings benefits it provides against the potential for creating inaccurate, fraudulent, or unwieldy documentation."[2]

Copy and paste continues to have unintended consequences. To address this concern, both The Joint Commission[3] and ERCI Institute[4] have published information regarding the risks of copy and paste.

HIM PROFESSIONALS

HIM professionals must have sufficient knowledge of the copy functionality in the organization's EHR and must, where applicable, identify gaps within the current electronic systems and provide strategies for auditing documentation that is copied from elsewhere in the EHR. Any deviations that prevent tracking and auditing need to be documented as known issues within the system.

HIM professionals are not only responsible for helping to ensure overall documentation integrity; they are also directly affected by documentation practices. For example, information that is inconsistent and ambiguous in the documentation directly affects the coding professional's ability to accurately assign the diagnosis and procedure codes based on the information documented.

The HIM professional is obliged to know, understand, and manage copy functionality to support EHR documentation quality. The HIM professional must also work closely with the organization's IT department and technical system vendors. Availability and management of the copy functionality are, in turn, based on the individual EHR system's functionality, and may be further determined by the unique way that a given organization has implemented that system.

Accordingly, the HIM professional can help ensure that appropriate organization-wide governance policies and procedures are in place to manage the EHR's copy functionality. (For a sample organizational copy and sanctions see appendices A and B.) HIM professionals must lead their organizations in developing policies and procedures on the utilization of copy functionality that address:

- Acceptable uses
- Operational processes
- Documentation guidelines
- Responsibility
- Auditing and reporting
- Sanctions

RISKS

Certain risks are always inherent in the use of copy functionality. For example, copying information into the wrong patient health record could adversely impact patient care. And overuse of disk space, created by storage of redundant copied information, can affect overall system response time. Specific risks to documentation integrity of using or misusing copy functionality include:

- Inaccurate or outdated information that may adversely impact patient care by compromising interaction among healthcare team members
- Redundant information, which causes the inability to determine current information
- Inability to identify the author or intent of documentation
- Inability to identify 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/documenting services not rendered
- Internally inconsistent progress notes
- Unnecessarily lengthy progress note
- Potential for fraud and abuse allegations
- Compromised integrity of legal EHR

APPROPRIATE USE

If copy functionality is used appropriately, it can assist providers in working efficiently while maintaining optimal care and compliant documentation. Copy functionality can be a time saver for providers who want to complete patient documentation quickly. In that regard, copy functionalities may be appropriate when copied information is based on external and independently verifiable sources, such as basic demographic information, e.g., name, date of birth, that does not change over time. Copy functionality is used appropriately when the information is clearly and easily distinguished from original information, such as automatic summaries that populate data fields, are clearly identified as non-original, and cannot be mistaken for original information. Finally, information is auditable for identifying actual origination.

Ensuring appropriate citation and verifying that the information is still current are both critical. There are times that copied information is no longer relevant, which can affect patient care. Other times, too much information is copied, such as multiple pages of labs, making it difficult to identify the relevant information.

When used appropriately, copy functionality can be an effective tool for providers to quickly and accurately complete their documentation. HIM professionals should work proactively to ensure that guidelines for appropriate use are in place, keeping in mind that the execution of quality and timely patient care depends on clear and effective documentation.

SOLUTIONS THAT PROMOTE QUALITY DOCUMENTATION

Offering alternatives is one way to mitigate the risks of using copy functionality. As the organization assesses the use of the copy functionality, provider workflows must be examined to ensure best practices for documentation. Taking an inadequate paper process and replicating it in the EHR creates frustration for the providers and increases the likelihood of frequent errors. When the workflow is slow and cumbersome, providers will look for shortcuts to make documentation easier and quicker, thereby creating risks that may negatively impact patient safety. There are several alternate tools to copy functionality that should be considered to increase provider productivity while maintaining the integrity and compliance of the EHR.

1. Dictation or transcription
2. Voice recognition
3. Scribes
4. Citing
    - Active problems from problem list
    - Current medication from medication list
    - Allergies
    - Current labs
5. Templates
    - Drop down menus
    - Check boxes
6. Macros
    - Phrases that are used routinely and can be populated automatically

As with any documentation, these alternatives also carry their own risks with respect to documentation integrity and compliance and should be thoughtfully implemented.

Workflows that allow for citing current health information may seem logical; however, the information must be easily accessible and available. Providers will not use workflows that are not effective; they may regress to the copy functionality to ensure the note is completed easily. Developing workflows, such as enhancing the problem list function to allow citing, is a better alternative to copying text lists.

Templates for direct chart entry may utilize drop-down menus and data fields which allow for quick entry into the health record. EHR systems must not allow templates that have been populated with patient information and finalized to be saved as a template that may be reused again. Templates that automatically populate the last 24 hours of laboratory/medications may be developed, but there must be a method for the provider to update information that is not relevant and indicate that the remaining information was reviewed. Templates often use positive or negative check boxes. All templates must meet accreditation standards and the Centers for Medicaid and Medicare Services (CMS) documentation requirements, and the forms committee needs to approve all template designs and standardize the content. It may be advisable to create a template for each specialty using the EHR.

The organization must assess the costs and the risks for these alternatives when considering the options. HIM professionals can assist in determining the best method or combination of methods to reduce the risks of copying information.

FRAUD AND ABUSE

BILLING CONCERNS

CMS Medicare Claims Processing Manual, Pub. No. 100-04, ch. 12, § 30.6.1, states that providers are to "select the code for the service based upon the content of the service" and that "documentation should support the level of service reported."

In June 2016, CMS released a Fact Sheet on the Documentation Integrity in Electronic Health Records.[5] The fact sheet noted that when appropriately used functions such as copy and paste may facilitate efficient documentation. However, the Office of the Inspector General has identified that features such as copy and paste were used to facilitate fraud, waste, and abuse.

Though the copy and paste function itself may be a compliant function, the way the functionality is used may be noncompliant. Providers must create accurate and complete documentation for medical necessity as proof is required that the diagnostic tests, services rendered, treatments provided, or procedures conducted were ordered appropriately based on the patient's illness, injury, prevention of diseases, or other patient specific needs and documentation in the health record meet that criterion. Providers need to appreciate that the volume of documentation is not the primary reason that a level of service is selected and reported. Rather, documentation should support the level of services rendered. Documenting a comprehensive history and physical for a minor problem would not justify reporting a higher level of service if that service was not warranted by the patient's condition.

Inconsistent and ambiguous documentation can directly affect coding and reporting. This may result in an inaccurate diagnosis code or present on admission assignment. It also may decrease productivity of the coding process for various reasons, such as time to determine what really happened at the visit or an increase in physician queries seeking clarification. Reporting of inaccurate codes may be misconstrued as fraud. A pattern of inaccurate reporting, even without intent to defraud, may be considered abuse.

It must be recognized that there can be actual violation of the law that can result in disciplinary or other adverse action. The authors of copied entries are liable for the content of copied items within the notes they authenticate. As part of the health record review function, use of copy and paste functionality must be monitored, and where violations occur, findings must be reported to the appropriate Medical Staff Committee for disciplinary or other adverse action. It should be noted that criminal charges may be filed when in violation of Federal laws such as the Privacy Act requirement (5 U.S.C. Section 552a(e)(5)); or Standards of Ethical Conduct for Employees of the Executive Branch (5 CFR Part 2635).

CLINICAL TRUSTWORTHINESS

A major underlying concern regarding the use of copy functionality is that the use can damage the clinical trustworthiness and integrity of the health record. From a clinical point of view, copying information that is not current, accurate, or applicable into the record of a more recent patient encounter may have a direct impact on patient care. If indiscriminate use of copy functionality results in the inclusion of the health record of medical conditions that were resolved in the past, physical findings and symptoms may be inconsistent within the healthcare record. Other providers and organizational staff may become confused by the inconsistent documentation.

Misuse of copy functionalities can also create unanticipated risks. In one instance, an oncologist falsified patient encounters to create the appearance that he was meeting quality care guidelines. These fictitious encounters were only discovered when the organization began to investigate the physician's complaint under the equal opportunity laws that he had been passed over for promotion. If not for this investigation, the records would have stood as valid in the system. False records of this sort most certainly undermine the clinical trustworthiness of the record.

EDUCATION AND TRAINING

Once an organization chooses an EHR system, the copy functionality of the system must be analyzed and the organization must develop a detailed education and training plan for all users. Organizations must determine how the copy functionality works within the system, and then define how this will be used, prior to the EHR implementation. Training should include appropriate hospital staff, providers, and HIM staff that may use or audit the use of the functionality. Each training session should be tailored to meet the needs of the end user. In addition, the training should include a review of organizational policies and procedures regarding appropriate use of the tool. (For a sample organizational education policy, see Appendix C.)

PROVIDER TRAINING

Organizations must strive to create workflows that are meaningful. Copy functionality is often used as a shortcut or workaround when the workflow is cumbersome. To deter the unauthorized use of the copy functionality, a thorough provider educational training program and organizationally sanctioned policies must be developed and implemented. Provider training and education should be designed to promote:

- The importance of accurate documentation for patient care
- The importance of documentation integrity within each visit
- Trust by other clinicians who will rely on the documentation generated
- The ability for documentation to stand up to scrutiny by auditors, attorneys, and state and federal regulators
- The importance of notifying the appropriate staff (e.g. the HIM department) in the event of incorrect information in order to ensure the information is properly corrected
- The importance of adhering to organizational policy for proper use of the copy functionality

Providers should attend system training prior to receiving a user identification number to access the organization's system. At that same time, and annually thereafter (or at the time of reappointment), providers should undergo extensive training regarding system functionality with specific emphasis on copy functionalities. All providers, including nurses, physical therapists, case managers, and social workers who document within the health record, must be trained. Other staff may enter important patient-specific information in the record such as patient communications or instructions that if duplicated without care, may cause errors. As a result, these staff members must also be required to attend routine organizational training and education on copy functionality. Training should be defined by the end user access and control parameters and should address all appropriate state and federal rules. Training should focus on using alternatives to using the copy functionality as applicable.

RISK MANAGERS AND LEGAL COUNSEL

Because the health record is the business record that organizations can be required to produce in litigation, the accuracy and integrity of that record must be credible and sustainable over time. Risk managers and legal counsel should understand the implications of the inappropriate use of copy functionalities as well as a failure to meet defined organizational policies and procedures. Risk managers and legal counsel must be in a position to understand and support the appropriate use of copy functionality within the EHR. When the copy functionality is inappropriately utilized, patient safety can be put at risk. Redundancy in the health record makes it difficult to identify what information is pertinent to care for the patient. There is a risk for propagating misinformation, inadvertently entered, throughout the health record, which can also lead to patient safety errors. Copy functionality can also lead to a large volume of data in a single note making it visually hard to determine the assessment, plan, and course of action.

The organization has a duty to ensure the integrity of the health record when using any new functionality of an EHR. HIM professionals are well-equipped and positioned to assist in the maintenance of record integrity. Healthcare organizations are at risk if they do not identify and mitigate systems compliance gaps. HIM should work with risk management to identify organizational questions and vendor questions to be addressed in EHR systems. See Appendix D for a Checklist of Organizational Questions and Appendix E for a Checklist of Vendor Questions.

HIM STAFF

As stated earlier, ensuring documentation integrity within the health record is the responsibility of the HIM department. This includes ensuring the integrity of any information entered within the record, whether handwritten or created electronically. Therefore, HIM staff must have extensive education in copy functionality and must test this function in the EHR prior to its implementation. In addition, some organizations may choose the HIM staff to be responsible for training organizational staff or providers on this functionality.

AUDITING FOR COMPLIANCE

The organization has a duty to ensure that copied documentation follows all appropriate organizational, state, and federal requirements. Keys to accomplishing this include system tracking (audit trails), observation of organizational use, and testing of system capabilities.

When an EHR system supports copy functionality, the organization must decide how to monitor and measure appropriate use. Organizations must determine if the use of copy functionality is tracked by the system. If the system cannot detect when the functionality has been utilized, compliance must be handled differently than if the system can show retrospectively how and when the functionality was employed and who employed it. (For a sample copy audit policy, see Appendix F.)

There should be a corrective action plan if there is an issue identified with a provider, such as additional education to the provider, follow up, disciplinary action if it continues.

DEVELOP AN AUDIT PLAN

Organizations utilizing copy functionality must develop an audit plan by first determining the ways the copy functionality works in each system. If the intention is to allow the copy of documents from one system to another (e.g., from transcription import system to the EHR, from one progress note to another, from one assessment to another, across encounters, within encounters, or template to template), the auditing may be complex.

Testing should be conducted not only for the approved methods, but also for all the ways the functionality works in each system. Testing may require thorough investigation to systematically identify what can and cannot be audited. An interdisciplinary approach, including HIM professionals, IT staff, and even system vendors, is recommended to ensure audit methods effectively capture and report copy functionality. See Appendix G for a Sample Checklist for Auditing for Copy Functionality.

BUILD IN STATE AND FEDERAL REQUIREMENTS

The HIM professional has extensive knowledge of essential state, federal, organization-specific, and Joint Commission documentation requirements. As a result, the HIM professional can help ensure that all these standards are identified, reviewed, and met in conjunction with the proper implementation of the copy functionality. Failure to consider these key documentation requirements can result in inaccurate or erroneous information within the health record and in extreme cases, even a deficiency finding from an accreditation body.

Timely reporting is also a key part of the process. Audit results must be reported to the appropriate organizational committee, and review of these results should be a part of the ongoing oversight and compliance process. Violations of the copy policy should be identified, validated, and rectified through factual documentation. Such action should take place in an appropriate time frame but as promptly as possible so as to minimize the number of errors and inappropriate uses.

CREATE A WORK LIST

Organizations should recognize the existence of copy functionality within their EHRs. Developing a simple initial work list to introduce the audit concept will help with the due diligence process. Basic questions to address are:

- Can a copy event be identified retrospectively?
  - Different color font used
  - Original author identified
  - Original date and time noted
- Is an appropriately detailed audit log generated when a copy event occurs in the course of documentation? Basic information to include is:
  - Name of user performing the copy function
  - Identification of what information was copied
  - Identification of where copied information originated
- Name of document/data field
- Date of original data
- Time of original data

A compliance-oriented EHR system will have rules that feed an auditing work list. For example, many systems can provide the HIM department with a list of incomplete notes. Similarly, the system may be able to generate a list of encounters where providers have used the copy function. Understanding exactly what the system does and what the options are for retrospective analysis is valuable knowledge in supporting appropriate practices and eliminating improper ones.

Organizations can consider the following reports or work lists:

- If utilization of copy functionality is available as an auditable event, review a sample of its use over a prior interval by one or more individual users.
- A listing of patients re-admitted within a certain amount of time (for example, within 30 days, 3 months, 6 months). This report can be used to randomly audit documentation (for example, review re-admissions history and physicals or assessments within a certain period of time).
- A report that compares discrete data elements in the electronic record (for example, pain score and the comment area of the pain assessment for the entire patient length of stay).
- Consider using coders or clinical documentation specialists to identify copy practices when reviewing for completeness of physician health record documentation to support coding and billing.

- Review patients on a "teaching service" to verify original documentation by residents and medical students.
- Where copy use is not auditable, consider commercially available software to analyze documents and identify duplicate phrases.

As the implementation of EHRs increases, organizations may consider changing the focus of their audit strategies to real-time audits to promote accurate and complete health record documentation. Performing concurrent health record audits as the encounter occurs allows organizations to determine if documentation is complete and appropriate, and provides an opportunity for the organization to address best practice immediately. (For sample testing activities, see Appendix H.)

There can be value to copying information, but it must be done selectively and thoughtfully, in compliance with institutional policies, and with the goal of producing a clear, useful, and accurate patient note. The development of organizational policies surrounding the use of copy functionality is extremely important. Policies and procedures set the basis for how an organization defines the use, management, and maintenance of this functionality and should not be considered lightly. Policies should address the limits on what type of information can be copied, provider responsibility for copied information, notification of errors, and corresponding sanctions or disciplinary action.

Risk management, compliance, HIM, and the medical staff must work together to identify how the organization is going to approach copy functionality. Guidelines must clearly outline how to use and identify the origin and author of the health information. Developing and implementing policy, then training, and auditing based on organizational policy will mitigate the risks of using the copy functionality. See Appendix I for Checklist Notification Procedures for Inappropriate Use of the Copy Functionality.

CASE SCENARIOS

The following case scenarios, representing both potentially appropriate and inappropriate use, can help organizations understand how copy functionality may work in their settings. The scenarios can also serve as a teaching tool.

CASE SCENARIO 1

Jane Doe presents to a hospital emergency room for a laceration. While washing dishes, this 35-year-old female cut her hand on a knife in the dishwater. She presents to the ED, is triaged, and moved to examination room 1. Following evaluation from the physician, the patient receives 10 sutures with instructions to follow up in 10 days for suture removal. The physician documents his emergency room encounter for this visit, including a complete history and physical and system evaluation. In 10 days the patient returns with no complaints, and her sutures are removed. The physician examines the patient and finds no signs of infection and instructs the nurse to remove the stitches. The physician then pulls up his prior ED note, highlights the history and physical and system evaluation sections, and copies that information into the new visit history. The ED coder reviews the documentation and bills for a Level 5 ED visit.

Result: The first visit was reported consistent with facility E/M guidelines. However, the second encounter was inappropriately reported at the same level as the first visit because the physician pulled forward documentation of services that were not actually performed on the second encounter. The ED coder could not determine that the documentation within the record was from a previous encounter.

What should have happened? If the physician utilized the copy functionality the physician should have noted the original source document and updated the note with the specific information from this encounter. System functionality would allow the user to confirm that the physician copied an entry. The ED coder would recognize the information that was pulled forward, and could then establish the ED level for the second encounter based appropriately on the services performed during that encounter only.

CASE SCENARIO 2

A 55-year-old male is admitted through the emergency department of a large academic medical center following a motor vehicle accident. The patient is admitted to the intensive care unit for a left temporal bone fracture, left femur fracture, grade-2 spleen laceration, and multiple cuts and bruises. In the course of his hospital stay, the patient is followed by the trauma service, neurosurgery service, and orthopedic service, all of which have attending physicians, residents, and physician assistants in addition to medical students. The patient remains in ICU for five days before he is transferred out to the surgery unit to be followed by the trauma service. During his stay in ICU, the trauma medical student initiated daily progress notes for the trauma service, which were expanded upon by the trauma resident and physician assistant within the electronic record. Each progress note was then co-signed by the attending physician. The orthopedic medical student copied forward diagnostic information from the previous day's documentation, added new documentation, and then forwarded it to the orthopedic attending for co-signature. Both wrote new progress notes each day, which were signed by the attending physicians. The neurosurgery medical student used the copy functionality to copy the neurosurgery progress note from the previous day and add his follow up. The neurosurgery resident simply added his information below the medical student's. The attending co-signed each note without noticing that the student had used copy functionality and selected a level of service based on the entire note.

Result: The trauma service was writing new notes each day that were then co-signed by the attending service. No documentation issues were identified. The orthopedic service used copy functionality to bring forward diagnostic information only. In addition to this diagnostic information, the medical student and resident wrote different clinical information and updates. The orthopedic attending co-signed each note; therefore, no

documentation issues were identified. The neurosurgery service, however, used copy to pull forward information from the initial progress note, thus implying that the neurosurgery service was providing the same level of detail in the examination on subsequent visits as on the initial visit. If that is not in fact occurring, the neurosurgery service may be at risk for fraud related to the level of service.

What should have happened? The neurosurgery service should have indicated which information was pulled forward from previous notes and which information was new information. The attending physician is ultimately responsible for the progress notes within the patient record and should ensure that any resident utilizing copy functionalities has been adequately trained in a manner consistent with organizational policies.

CASE SCENARIO 3

A 65-year-old woman is a direct admission from her primary care physician (PCP) for pneumonia. She is admitted to the hospital under the care of her PCP to a general medicine floor. The PCP documents an extensive history and physical examination in the EHR and orders the appropriate tests. On day one of the hospital stay, the physician completes a progress note. On subsequent days two and three, the physician completes progress notes updating the patient's progress and documents the results of all tests. On day four, the patient is discharged home. The PCP copies forward the chief complaint and physical examination from the progress note on day one. The PCP indicates that the information is copied by inserting quotation marks around the documentation and noting "copied from day 1 note." He notes on the final progress which phrases have been copied forward and then adds new content underneath.

Result: The physician appropriately used the copy functionality.

NOTES

1. *Journal of AHIMA* Staff. "Copy and Paste Run Amok—EHRs and Malpractice." *Journal of AHIMA* 87, no.9 (September 2016): 76. http://bok.ahima.org/doc?oid=301866.

2. AHIMA. "Appropriate use of the Copy and Paste Functionality in Electronic Health Records." 2014. http://bok.ahima.org/PdfView?oid=300306.

3. The Joint Commission. "Preventing copy-and-paste errors in EHRs." Quick Safety, Issue 10 (February 2015). https://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_10.pdf.

4. ECRI. "Health IT Safe Practices: Toolkit for the Safe Use of Copy and Paste." February 2016. https://www.ecri.org/Resources/HIT/CP_Toolkit/Toolkit_CopyPaste_final.pdf.

5. CMS. "Documentation Integrity in Electronic Health Records Fact Sheet." June 2016. https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/ehr-docintegrity-factsheet.pdf

REFERENCES

"Legal EHR Roundtable: Views and Needs Differ by Stakeholder." *Journal of AHIMA* 79, no. 2 (2008): 32-36.

AHIMA. "The Legal EHR: Trials and Errors." *AHIMA Advantage* vol. 11, no. 4 (2007): 1–5.

AHIMA. "Developing a Legal Health Record Policy: Appendix A." *Journal of AHIMA* vol. 78, no. 9 (2007): web extra.

AHIMA. "Guidelines for EHR Documentation to Prevent Fraud." *Journal of AHIMA* vol. 78, no. 1 (2007): 65–68.

AHIMA. "Update: Maintaining a Legally Sound Health Record Paper and Electronic." *Journal of AHIMA* vol. 76, no. 10 (2005): 64A–L.

Amatayakul, M., M. Brandt, and M. Dougherty. "Cut, Copy, Paste: EHR Guidelines." *Journal of AHIMA* vol. 74, no. 9 (2003): 72–74.

Boodman, S.G. "Do Electronic Records Impede Care?" *Washington Post,* May 13, 2008.

Centers for Medicare and Medicaid Services. "State Operations Manual: Appendix A—Survey Protocol, Regulations and Interpretive Guidelines for Hospitals" Rev. 1, 05-21-04. www.cms.hhs.gov/manuals/downloads/som107ap_a_hospitals.pdf.

Fox, L. and W. Imbiorski. *The Record That Defends Its Friends,* 6th ed. Chicago: Care Communications, 1994.

Hartzband, P. and J. Groopman. "Off the Record Avoiding the Pitfalls of Going Electronic." *New England Journal of Medicine* vol. 358, no. 16 (2008) :1656–58.

Health Level Seven. 1997. Ann Arbor, MI: Health Level Seven. Sections 9.4.5-9.4.11, 9.5.5-9.5.10.

Hirsh, H.L. "Will Your Medical Records Get You into Trouble?" *Legal Aspects of Medical Practice* vol. 6, no. 9: (1978):46–51.

Indian Health Services, Veterans Administration, and Vanderbilt University Hospital. Sample policies and procedures.

Johnson, M.L. *Electronic Medical Record Playbook.* Revised December 2010. http://www.ttuhsc.edu/billingcompliance/documents/EMR_Playbook_12_10.pdf.

Quinsey, Carol Ann. "Policies and Procedures for a Legal EHR." *Journal of AHIMA* 78, no. 4 (2007): 62-63.

Shepherd, A. "The Perils of Copy-Paste." *For the Record* vol. 23, no. 5 (2011): 14.

Sturgeon, J. "EMR and the Coder: The Dark Side of the Force." *For the Record* vol. 19, no. 7 (2007): 6.

APPENDIX A

SAMPLE COPY POLICY

Utilization of Copy Functionality for Documentation within the Health Record

PURPOSE: The purpose of the health record is to provide a basis for planning patient care and for the continuity of such care. Each record should provide documentary evidence of the patient's medical evaluation, treatment, and change in condition as appropriate. The purpose of this policy is to provide guidance on the use of copy functionality when documenting in the EHR. For the purpose of this policy, the term copy means any one of the following synonyms: copy and paste, cloning, copy forward, re-use, carry forward, and save note as a template and any intent to move documentation from one part of the record to another.

POLICY: Providers documenting in the EHR must avoid indiscriminately copying and pasting another provider's progress note, discharge summary, electronic mail communication, and redundant information provided in other parts of the health record.

PROCEDURE:

1. Providers are responsible for the total content of their documentation, whether the content is original, copied, pasted, imported, or reused.
2. If any information is imported or reused from a prior note, the provider is responsible for its accuracy and medical necessity.
3. Providers are responsible for correcting any error identified within documentation. (INSERT HOSPITAL CORRECTIONS POLICY)
4. Providers must notify (INSERT JOB TITLE; e.g.; HIM Director) immediately regarding any error(s) in the source note. All notes from the original source that contain errors must be corrected.
5. If the provider uses information from a prior note, he/she must reference the date of the previous note. (ORGANIZATION POLICY SHOULD DEFINE TIME LIMITS.)
6. Providers are responsible for citing and summarizing applicable lab data, pathology, and radiology reports rather than copying such reports in their entirety into the note.
7. Providers are responsible for clearly identifying who performed each service documented within the note. When entering patient data into the health record that the provider did not personally take or test, the provider must attribute the information to the person who did.
8. If the provider references a prior section within the record (e.g., review of systems), he or she must reference the note with sufficient detail to uniquely identify the source. Example: "For review of systems see note dated 1/1/11."
9. Providers are required to document in compliance with all federal, state, and local laws as well as Medical Staff Rules and Regulations.
10. Once a note has been signed as final, additional information may only be added as an addendum.
11. Failure to comply with this procedure subjects the provider to corrective disciplinary action per (INSERT HOSPITAL SANCTION POLICY NUMBER OR REFERENCE HERE).

(INSERT SPECIFIC DEPARTMENT OR JOB TITLE, e.g., HIM Department):

1. Shall be required to monitor provider compliance with organization policy
2. Shall forward reports and trends to the appropriate Committee

See also (LIST RELATED HOSPITAL POLICIES HERE)

APPENDIX B

SAMPLE SANCTION POLICY

Copy Function Sanction Policy

PURPOSE: To provide guidance for action in the event of inappropriate use of copy functionality in the EHR. For purposes of this policy, copy shall be understood to include cutting and pasting.

POLICY: Providers documenting in the EHR must avoid indiscriminately copying and pasting another provider's documentation as well as the process of copying forward information from previous notes, without clear attribution in an effort to increase documentation in a current visit. Indiscriminate use of copying and pasting lengthens the note, may lead to fraudulent provider billing, adds redundant information that may be unnecessary, and may increase organizational liability.

PROCEDURE:

1. (INSERT APPROPRIATE PARTY, e.g., HIM Department) is responsible for referring cases of inappropriate copying and pasting to the (INSERT APPROPRIATE PERSONNEL) for corrective action, review, and facility-wide trending.
2. The (INSERT THE APPROPRIATE HOSPITAL COMMITTEE) is responsible for reviewing the corrective action and facility-wide trending report. This committee shall make recommendations on disciplinary action in which continued inappropriate use of copy technology is identified.
3. Failure to comply with the organizational policy regarding copy functionality may be deemed a violation of hospital policy. (INSERT HOSPITAL POLICY NUMBER OR REFERENCE REGARDING PRIVACY VIOLATIONS OR SANCTIONS)
4. Further disciplinary action may be taken by the (INSERT HOSPITAL PRIVACY OR SECURITY COMMITTEE) if violations of this policy are substantiated. (INSERT MEDICAL STAFF RULES AND REGULATIONS OR HOSPITAL POLICY REFERENCE).

See also (LIST RELATED HOSPITAL POLICIES HERE)

APPENDIX C

SAMPLE COPY FUNCTIONALITY EDUCATION POLICY

Education Policy for the Use of Copy Functionality

PURPOSE: To provide guidance on the required education that a provider must attend prior to the use of any copy functionality. For the purpose of this policy, the term copy means any one of the following synonyms: copy and paste, cloning, copy forward, re-use, carry forward, and save note as a template and any intent to move documentation from one part of the record to another.

POLICY: Providers documenting in the EHR must attend organizational education training on the copy functionality with the electronic health system.

PROCEDURE:

1. Any provider utilizing copy functionality within the EHR must attend training prior to his/her initial use of such technology.
2. Providers must demonstrate their understanding of all applicable state and federal rules regarding appropriate documentation.
3. Providers must demonstrate their ability to appropriately use the functionality, including but not limited to copy forward, copy, cutting, note identification, note authorization, and identifying source information.
4. Providers must attend annual training.

(INSERT APPROPRIATE PARTY; e.g., HIM Department):

1. Provides for annual provider training
2. Documents provider demonstration of understanding of functionality
3. Ensures providers understand how to appropriately identify, cite source document, copy from other media (e.g., e-mail), and identify original ancillary test (e.g., laboratory)
4. Ensures new providers are trained
5. Ensures that appropriate audit trails identify providers who may be using copy functionalities who have not attended training

See also (LIST RELATED HOSPITAL POLICIES HERE)

PROVIDER EDUCATION TRAINING FORM CHECKLIST

Date:_____
Provider:_____
User Identification:_____

1._____ Provider demonstrated understanding of copy functionality.
2._____ Provider demonstrated understanding of applicable state and federal regulations.
3._____ Provider received copies of all related organizational policies and procedures.
4._____ Provider demonstrated understanding of how to cite source document.
5._____ Provider demonstrated understanding of cut functionality.
6._____ Provider verbalizes understanding that he or she is responsible for the content of his or her documentation whether the content is original, copied, pasted, imported, or reused.

7._____ Provider verbalizes understanding documentation must clearly identify who performed each service.
8._____ Provider attests to understanding that once a note has been signed as final, additional information may only be added as an addendum.
9._____ Provider verbalizes understanding of the requirement for annual training.

Trainer Name:_____

Trainer Signature:_____

Trainee Signature:_____

Original Form: Medical Staff Credentials File
Copy: (INSERT APPROPRIATE PARTY; e.g., HIM Department)

APPENDIX D

SAMPLE CHECKLIST OF ORGANIZATIONAL QUESTIONS

The organization has a duty to ensure the integrity of the health record in using any new functionality of an EHR. HIM professionals are well-equipped and positioned to carry this out. Healthcare organizations are at risk if they do not identify and mitigate systems compliance gaps. Organizations should, at a minimum, use the following checklist as a guide.

Organizational Question	Organizational Solution	Comments
1. Is there a better means than copy functionalities to accomplish the clinical objectives, such as through the use of forms or templates that are more readily standardized and auditable?		
2. Can the organization ensure that EHR end users have been trained and understand the organization's expectations when it comes to accurate, timely, and thorough documentation for the care that was rendered to each patient?		
3. Does the organization know how its systems' copy functions can be used within the EHR?		
4. Does the organization know how copy functionalities should be used within the EHR?		
5. Does the organization have a process for identifying and mitigating unacceptable functions or uses?		
6. Has the organization identified how copy will be utilized within the EHR?		
7. Has the medical staff approved copy policies and procedures?		
8. Who is responsible for ensuring that all copy policies and procedures are enforced?		
9. Who will audit the provider's documentation for appropriate use of copy?		

APPENDIX E

SAMPLE CHECKLIST OF VENDOR QUESTIONS

When implementing an EHR system or a module within the system, the HIM professional should be prepared to ask a series of questions that will aid in appropriately implementing the functionality. For the most part, better auditing capabilities may address some of the concerns with copy technology that healthcare providers have. Defining accountability is a key requirement of the electronic system when inquiring about copy functionality. Sample questions to ask a vendor include:

System Function	How System Works	Comments
1. Does the system allow for "soft" copy forward? (Or does it require re-validation of the copied information?)		
2. How are health record corrections identified and corrected and by whom?		
3. What audit trails are available that would indicate a report has been edited?		
4. Is information that is copied forward brought forth in a distinct color or otherwise easily identified?		
5. Are blocks of content individually authenticated, allowing for original and copied information within the same note?		
6. How is re-authenticated information identified?		

APPENDIX F

SAMPLE COPY FUNCTIONALITY AUDIT POLICY

Auditing for Copy Functionality

PURPOSE: The purpose of the health record is to provide a basis for planning patient care and for the continuity of such care. Each record should provide documentary evidence of the patient's medical evaluation, treatment, and change in condition as appropriate. The purpose of this policy is to provide guidance on the audits required in conjunction with the copy functionality within the EHR. For the purpose of this policy, the term copy means any one of the following synonyms: copy and paste, cloning, copy forward, re-use, carry forward, and save note as a template, and any intent to move documentation from one part of the record to another.

POLICY: In order to protect the integrity of the health information record and to provide quality patient care, copy functionality within the EHR should be used in conjunction with all applicable state and federal regulations. Noncompliant use of copy functionalities is considered a sanctioned offense in accordance with the organizational policies.

PROCEDURE: (INSERT RESPONSIBLE PARTY; e.g., HIM Department):

1. Determines how and when audits will be conducted
2. Determines who will perform these ongoing concurrent audits
3. Establishes frequency for performing the audit
4. Establishes time period covered by the audit
5. Identifies how the sample size is determined
6. Identifies a description of the outcome indicators
7. Determines how copy functionalities within the record are identified
8. Designs a corrective action plan based on findings
9. Provides a detailed list of copy functionalities as they exist within the electronic system
10. Provides testing of copy functionalities prior to implementation and prior to version updates
11. Identifies copy functionalities and categorizes by whether they are retained as auditable events or otherwise identifiable as copied (such as date and time stamps, showing that a large number of data elements or a large block of documentation was generated in the system concurrently and instantaneously)

See also (LIST RELATED HOSPITAL POLICIES HERE)

APPENDIX G

SAMPLE CHECKLIST FOR AUDITING COPY FUNCTIONALITY

From a mitigation standpoint, organizations or providers are sued because they did not follow their own policies and procedures. A basic mitigation risk management strategy is to identify the risk from the organizational level, vendor level, and legal level. The copy functionality is a high-risk area; organizations will be best served by developing procedures for auditing the copy functionality.

Audit	Process	Comments
1. How will audits be conducted?		
2. Who will conduct the audits?		
3. How often will the audits be conducted?		
4. What time period will be covered?		
5. How will the audits be selected? • Population • Group • Service • Location		
6. How will sample size be identified?		
7. Audit Report		
8. Description of analysis technique		

APPENDIX H

SAMPLE COPY FUNCTIONALITY TESTING POLICY

Testing for Copy Functionality

Purpose: As with any new technology, comprehensive testing of functionality should occur prior to implementation. This toolkit recommends three copy functionalities for testing. Ideally the system has a test environment or other means to make sure that testing does not have problematic impact on the actual patient information system.

Policy: Review EHR Systems for copy functionality abilities and document findings, risk, and mitigation.

Procedure: While they are not comprehensive tests, the following three points provide a first set of screening questions to apply and to target areas for further investigations:

Questions	How the System Works	Comments
1. Copy functionalities that originate in software other than the EHR, such as copy in Microsoft Windows • Can this be blocked or disabled for use in your EHR system? • Is there a way to monitor or otherwise identify its use? • If there is no way to automate use monitoring and the functionality cannot be disabled, what other alternatives are available to ensure proper documentation?		
2. Copy functionalities that permit duplication of sections of a patient record for use in new documentation, such as medication or problem lists • Is the original source (date, time, and author) of the information visible in the record? • Is the original source of the information traceable in the audit functionalities? • Does the system require sufficient review of the copied documentation to ensure it is reviewed and intended by the clinician?		
3. Copy functionalities that duplicate an entire prior encounter record from a different date, and possibly from a different author or different patient, and represents it as today's documentation. • Is the original source (date, time, and author) of the information visible in the record? • Is the original source of the information traceable in audit functionalities? • Does the system require sufficient review of the copied documentation to assure it is reviewed and intended by the clinician?		

APPENDIX I

SAMPLE CHECKLIST FOR NOTIFICATION PROCEDURES FOR INAPPROPRIATE USE OF COPY FUNCTIONALITY

Procedures to notify the health information management (HIM) department must be in place to report the incorrect use of copy functionality. HIM will collaborate with the provider to correct the information and will also investigate to determine if the incorrect copied information was copied into other places in the record. If the incorrect copied information went to other systems, HIM will determine if the incorrect information was released outside the system and ensure the updated information is sent. Organizational policy should clearly define:

Notification	Procedure
1. How should incorrect information be reported?	
2. Who is responsible or reporting incorrect information?	
3. Who will be notified of incorrect information?	
4. Who has permission to correct information? What is the procedure for correcting the information?	
5. Who finalizes corrected information?	
6. Who investigates how the incorrect information was entered?	
7. What is the process for ensuring corrections are made in all systems and updated to all providers?	
8. How are providers notified when they have incorrectly entered information?	
9. When is a corrective discipline plan initiated?	
10. What is the process for education?	