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Copy and Paste: The Real Rules Prevail

In my job, I wear many hats. I am an auditor, a physician educator, a consultant, an author, and an auditing instructor. In these roles, I hear a common concern regarding the use of electronic health records (EHRs): that of cloning, or copying and pasting records.

It is important first to consider the rules that exist regarding copying and pasting, as compared to the opinions of many in the healthcare industry.

Have you looked for published guidance on cloning/copying and pasting from the Centers for Medicare & Medicaid Services (CMS)? There is one published resource that provides rudimentary guidance. Here is an excerpt:

"This practice involves copying and pasting previously recorded information from a prior note into a new note, and it is a problem in healthcare institutions that is not broadly addressed. For example, features like auto-fill and auto-prompts can facilitate and improve provider documentation, but they can also be misused. The medical record must contain documentation showing the differences and the needs of the patient for each visit or encounter. Simply changing the date on the

EHR without reflecting what occurred during the

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actual visit is not acceptable.

This reads as a "guideline" as opposed to a rule, leaving us with no true "rules" about this practice, but be it all the same, let's break down what they say - first noting that nowhere does CMS indicate that this practice is not allowed. In fact, they have embraced the process, given its appropriate use.

First, let's define cloning/copying and pasting, as more commonly we find that complaints about it are not copy-and-paste errors at all. Above, CMS indicates that it is the practice of going to previously recorded encounters and literally copying information and pasting it into today's encounter.

Auditors often note this finding when documentation begins to appear the same from visit to visit; however, this may also be the product of incorrect use of EMR templates. Consider this: what portion of documentation is routinely the same in most encounters? In many cases it is the review of systems and the exam. Is this because they are copied from a previous encounter and pasted into a new encounter, or is it because a bunch of "normals" in the EMR were clicked to create the documentation? More typically, it is the latter.

So the next consideration is this: are those templates appropriate, according to CMS-published guidance? Again, refer to the above: *"features like auto-fill and auto-prompts can facilitate and improve provider documentation, but they can also be misused."* CMS does not define what "misused" would entail, and therefore, your organization should have a policy defining it to ensure that the providers have a clear understanding of expectations - and also that your auditors are consistent in their findings and education on this matter.

This should prompt further evaluation of CMS rules and guidance for the use of MACROs and/or templates within the medical record. CMS indicates that the use of both is certainly allowed within documentation. Additionally, there is an additional resource available from CMS, titled the Program Integrity Issues in Electronic Health Records. CMS indicates the following regarding the use of both techniques:

"Some EHR systems use templates that complete forms by checking a box, macros that fill in information by typing a key word, or functions that auto-populate un-entered text. Problems can occur if the structure of the note is not a good

clinical fit and does not accurately reflect the patient's condition and services. These features may encourage over-documentation to meet reimbursement requirements even when services are not medically necessary or never delivered."

Consider these points:

- Does CMS indicate that using MACRO and templates is not allowed or wrong? Absolutely not.
- Does CMS indicate that it will reject documentation that appears to be consistently noted as normal/negative from patient to patient, encounter to encounter, or provider to provider? No, it merely indicates that this can cause problems with the clinical fit of the note and may lead to over-documentation. But is it over-documentation if the provider truly performed those components? Should we suggest that they not include documentation of work they performed? Absolutely not.
- If CMS allows such documentation, then the auditor should as well, but understand that the purpose of an audit is to identify aberrancies and find ways to prevent them in the future.

When evaluating documentation, be sure to have a clear understanding of whether it is truly a copy/paste violation or misuse of MACRO/templates, and if the provider is meeting the necessary guidance of the use of MACROs and/or templates. Since the guidelines are minimal in nature, then, as previously mentioned, your organization should have a better-defined policy on acceptable use of MACROS and templates.

So now let's move forward to the actual portion of the rules governing copying and pasting. Well, you read it same as the rest of us: again, there is no "rule", just guidance. The guidance states that it is a problem and identifies that merely changing the date is correct, but nothing further. Therefore, should we interpret this to indicate that as long as a provider updates more than the date of service, meaning, for example, maybe some of the plan of care (no matter how minimal), we then meet CMS guidance? Well, based on what they have published, if we are updating more than the date of service and providing even minimal information regarding a new encounter, then the documentation is appropriate.

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Is there any other published guidance? CMS published some additional instruction within the Program Integrity Issues in Electronic Health Records, which for a time was not actually available on the Internet, as if it had been rescinded. According to this publication, there is minor additional guidance provided in that CMS indicates:

"Healthcare professionals have stated that copying and pasting notes can be appropriate and eliminate the need to create every part of a note and re-interview patients about their medical histories. However, HHS-OIG (the U.S. Department of Health and Human Services Office of Inspector General) identifies 'illegitimate use of cut and-paste record cloning" as a problem.

Wow! We have finally gotten somewhere. CMS clearly has indicated that there is such a thing as "illegitimate" use of copying and pasting...yet it still does not define what illegitimate use would constitute.

When we think of the term "illegitimate," we tend to think of the birth status of offspring, but there are "official" secondary and additional definitions for this term, which include, according to Merriam-Webster: "(2) not rightly deduced or inferred, (3) departing from the regular, and (4) not sanctioned by law/not authorized by good usage."

Let's put those definitions into the definition CMS has given us:

- *Identifies (the **inferred**) use of cut and-paste record cloning as a problem*
- *Identifies (**documentation verifying from the "normal" i.e., dictation (maybe))** use of cut-and-paste record cloning as a problem*
- *Identifies **(documentation not of good usage utilized as a source)** of cut-and-paste record cloning as a problem*

Take your pick, but you get the point. While each of us could derive our own opinion or interpretation of "illegitimate use" of cut-and-paste record cloning, the fact is you don't have a solid rule to reference. However (are you tired of hearing me say it yet?), unless you have your own internal policy defining an

illegitimate use of this practice, it's hard to hold providers to any specific standard.

An organization may adopt a policy that is as stringent as this: *"We allow absolutely no copying and pasting of documentation in a medical record."*

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Or in the alternative: *"We allow the use of copying and pasting within the documentation of a medical encounter, provided the reader can identify new elements specific to that day's encounter with the patient."*

Are either of these policies incorrect? Well, based on the vague wording by CMS, no. While I would defer to the likes of a noteworthy health law attorney such as David Glaser for an official opinion on how he would defend such a case in a court of law (as I am not an attorney, but a mere auditor), my guess would be he could absolutely defend this point of view. Could he be on either side of this argument, meaning could he also say, *"this COULD be defined as illegitimate use?"* ABSOLUTEY, and that is why (again) you must have a policy.

Policies are not meant to create an air of defend-ability, but rather an air of maintaining a high level of compliance. Therefore, when creating such policies, your organization should consider a "reasonable" strategy, remembering that CMS agrees that copying and pasting is an advantage of electronic documentation, and the use of it is an allowed practice.

Embrace the practice, but have rules regarding abuse.

This Week's Audit Tip
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