Electronic Health Record (EHR) Compliance – An Update on the Government’s Position regarding “Cloning” and the Copy-Paste Function

By Connie Eckenrodt, RHIT, CHCA, CHC

While the government has been incentivizing physicians to implement EHRs, the Office of Inspector General (OIG) indicated “cloning” as a concern and initiated a focus on EHR documentation practices as early as 2011 in its Work Plan for Physicians and continues as a “work in progress” in 2014, with every indication that scrutiny will continue for several years to come. In fact, Medicare contractors continue to see increased numbers of records with identical documentation across services, especially among EHR users. Most EHR systems provide the ability to copy and paste documentation from an earlier patient encounter or from one patient’s medical record to another. Per Medicare, documentation is considered cloned when each entry in the patient medical record is worded exactly alike or is similar to the previous entries. Cloning also occurs when medical record documentation appears the same from patient to patient. EHR functions which may be used to clone documentation for the same or different patients include: a) copy & paste; b) copy forward; and c) save note as template.

It’s important to note that copying and pasting in itself is not noncompliant. It is in how the information is used or “counted” toward substantiating the service performed and billed. There is concern that the cloned documentation may misrepresent what actually occurred in the patient encounter. Does the information that is copied and pasted into the note accurately demonstrate provider work and fully support the medical necessity of the claim? Is the information accurate? Does it pertain to this patient and his/her presenting problem? Whereas the old saying among coders used to be “If it’s not documented, it wasn’t done,” with the proliferation of electronic health records, the saying has transitioned to “If it’s documented, it might not be pertinent,” or “If it’s documented, it might not have been done.” From the payer perspective, cloned documentation has the potential to misrepresent the complexity of the service and result in overpayment.

The copy-paste function of the EHR can be an effective tool for easing the documentation burden for the provider. However, physicians and non-physician practitioners should ensure the documentation accurately reflects the service provided and supports medical necessity. It would not be expected that every patient have the exact same documentation on any given date. The documentation in the medical record must be specific to the patient’s presenting problems or concerns for that encounter. The provider’s signature is attestation that the information is accurate, and that any cloned information is current and represents the provider’s services for that date. If the provider signs the encounter note, they are attesting to, “This is what the patient said, this is what I found, this is what I did and this is what I told the patient to do.”

By the same token, healthcare organizations that employ providers should ensure that their providers are accurately and comprehensively documenting the patients’ care.

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The Centers for Medicare and Medicaid Services (CMS) E/M Documentation Guidelines specifically allow certain portions of the note — for example, the Review of Systems (ROS) and Past Medical, Family and Social History (PFSH) — to be recorded by someone other than the billing provider or reviewed from a previous note and credited as provider work. However, the provider must review these portions with the patient and not simply copy them into the note in order to be given credit for the work. Healthcare organizations are accountable for auditing and monitoring the providers’ work product, not only for compliance with coding, billing and documentation guidelines, but to ensure quality of patient care and appropriate utilization of resources.

CMS has no national policy on cloning and/or copy-paste, but a recent recommendation from the Office of Inspector General to CMS to develop a policy (which CMS has agreed to do) indicates even greater scrutiny to come in this area. From a medico-legal standpoint, healthcare organizations that employ billing providers would be well-served to develop their own internal compliance policies and procedures for ensuring the integrity of their patients’ medical record documentation within their own systems. Without measures to safeguard documentation integrity, the organization is hard-pressed to protect its interests and the interests of its providers should documentation come under patient and/or payer scrutiny.

To date, there have been multiple references (read: warnings) to the action that may be taken by the government and its Medicare Administrative Contractors, or MACs, when documentation is suspect for the medical necessity for coverage of services:

**Department of Health and Human Services**

Secretary Kathleen Sebelius and US Attorney General Eric Holder, Jr. warned the American Hospital Association, 3 other hospital industry groups, and the Association of American Medical Colleges in a letter that it would “pursue healthcare providers who misuse electronic health records to bill for services never provided. *A patient’s care information must be verified individually to ensure accuracy; it cannot be cut and pasted from a different record of the patient, which risks medical errors as well as overpayments*,” Holder and Sebelius wrote.

**Noridian Administrative Services, LLC (now Noridian Healthcare Solutions), MAC — LCD Guidance on Templates**

“*Documentation to support services rendered needs to be patient specific and date of service specific. These auto-populated paragraphs provide useful information such as the etiology, standards of practice, and general goals of a particular diagnosis. However, they are generalizations and do not support medically necessary information that correlates to the management of the particular patient. Part B MR (medical review) is seeing the same auto-populated paragraphs in the HPIs of different patients. Credit cannot be granted for information that is not patient specific and date of service specific.*”

**National Government Services (NGS), MAC**

“*Cloned documentation will be considered misrepresentation of the medical necessity requirement for coverage of services due to the lack of specific individual information for each unique patient. Identification of this type of documentation will lead to denial of services for lack of medical necessity and the recoupment of all overpayments made.*”

**Cahaba Government Benefit Administrators LLC, MAC**

The medical necessity of services performed must be documented in the medical record and Cahaba *would expect to see documentation that supports the medical necessity of the service and any changes and or differences in the documentation of the history of present illness, review of system and physical examination.*

**First Coast Services Options, Inc., MAC**

*Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information.* All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter. *Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.*

**Palmetto GBA, MAC**

The word “cloning” refers to documentation that is worded exactly like previous entries. This may also be referred to as “cut and paste” or “carried forward.” Cloned documentation may be handwritten, but generally occurs when using a...
preprinted template or an Electronic Health Record (EHR). While these methods of documenting are acceptable, it would not be expected the same patient had the same exact problem, symptoms, and required the exact same treatment or the same patient had the same problem/situation on every encounter. Cloned documentation does not meet medical necessity requirements for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

Healthcare organizations that employ, submit claims and accept reimbursement on behalf of providers are accountable and responsible for ensuring those providers adhere to official coding, billing and documentation guidelines and payer regulations. To avoid pervasive use of cloning and mitigate the risks associated with the copy/paste function, it is in the best interests of the organization to establish corporate policies and procedures to address appropriate use of copy-paste functionality and cloning of medical record documentation in the EHR. Corporate policy should insist that EHR entries be patient- and visit-specific and contain the actual information collected by the provider based on medical necessity for that date of service. For example:

- Address how cloned documentation is identified and how it may/may not be considered for submitting claims for service---
  - ROS copied and pasted from a previous note should include only those systems reviewed with the patient and pertinent to the current encounter. Avoid copying the whole ROS and revise the documentation to reflect any changes since the previous encounter.
  - PFSH copied and pasted from a previous note should be reviewed with the patient and included in the note only if it is pertinent to the current encounter.

When a corporate copy-paste/cloning policy is established, perform regular auditing and monitoring of documentation to ensure the accuracy of submitted claims. Experienced, certified coding auditors--- internal and/or external --- should be utilized to perform this function. Information obtained through these compliance activities should be used to develop corrective action plans and processes which may include further provider education, and continued auditing and monitoring of coding and documentation in demonstration of an effective compliance program.

References:


National Government Services: [http://www.ngsmedicare.com](http://www.ngsmedicare.com)


First Coast Services Options: [http://medicare.fcsso.com/Publications_A/2006/138374.pdf](http://medicare.fcsso.com/Publications_A/2006/138374.pdf)


Connie Eckenrodt RHIT, CHC, CHCA has over 15 years in the HIM field. Focusing on outpatient coding, with particular emphasis on professional fee coding and documentation improvement, Ms. Eckenrodt’s areas of expertise include: new provider coding orientations; individual and group coding education for providers and professional fee coders; pre-bill and retrospective coding audits; and risk assessment and focus review audits for internal compliance initiatives and compliance initiatives pursuant to federal investigations. Consulting has been provided in myriad settings, from small practices to large multi-specialty practice groups.
What’s the Big Deal about Designated Record Sets?
By Chris Apgar, CISSP

In the preamble to the Omnibus Rule published last year HHS was pretty clear that allowing patients to request their designated record set (DRS) sent to a third party did not require an authorization. Today if I requested an e-copy of my DRS and in turn sent it to my attorney, it accomplishes the same thing but with a bit more hassle for the patient. I’ve seen covered entities deny a patient a copy of his or her DRS because the patient stated at the time of the request the patient intended to send it to a third party. The covered entity required the patient sign an authorization - this is, in and of itself, a violation of a patient's privacy right to get a copy of a DRS.

It has been theorized that now third parties would send that request for a copy of a DRS posing as the patient and the final rule would allow such activity. I don't agree that if a third party sends a request as the patient for a copy of the patient's DRS that the new rule would allow such action. To me that represents a violation of the HIPAA Privacy Rule if the covered entity sends the DRS to the third party. Covered entities are required to authenticate the requestor even if the requestor is the patient. As far as the third party, I would say that is fraudulently accessing the patient's DRS.

I recently read a post that this change permitting the patient to request an electronic copy of his or her DRS be sent to a third party is an end run around the authorization requirement. I don't agree. It makes it easier for the patient to legitimately access his or her DRS and have that record sent to a third party of the patient's choosing rather than get that DRS and then forward it on to a third party. I think this actually provides greater protections for the patient. Hopefully the covered entity has implemented sufficient security to make sure the electronic DRS makes its way to the intended recipient.

The change also makes it easier for the covered entity to assist patients exercise their right to access their DRS by removing some of the requirements associated with authorization construction and handling. In the end I see this as an added patient protection, improving the ease with which a patient can use his or her DRS for patient related activities outside the doctor's office and makes it easier to support the patient's rights.

It may be helpful to give a live example. One of my clients had implemented a practice requiring patients to fill out a template requesting a copy of the patient's DRS. It later became an unwritten practice to require the patient sign an authorization in cases where the patient said he or she intended to share the patient's DRS with a third party. The covered entity wasn't sending it to the third party but the patient was.

If a patient mailed a DRS copy request and intended to share the patient's DRS with a third party but didn’t state that on the request form, that patient was treated differently than the patient who showed up in person to request that DRS and just happened to mention he or she intended to share it with a third party. You really can’t treat two patients differently when it comes to privacy rights. Also, it appears the Omnibus Rule prohibits requiring patients sign an authorization when requesting a copy of their DRS to a third party. You do need to authenticate the requestor, get it in writing and make sure the information regarding where to send the DRS is clear, though. In the end, that’s the needed documentation versus that sometimes complicated authorization form.

Chris Apgar, founder of Apgar & Associates is a Certified Information systems Security Professional (CISSP). He is one of the country’s foremost experts and spokespersons on healthcare privacy, security, regulatory affairs, state and federal compliance and secure and efficient electronic health information exchange. Chris has more than 19 years of experience in regulatory compliance and is a leader of regional and national privacy, security and health information exchange forums. As a member of Workgroup for Electronic Data Interchange, and serving on the Board of Directors since 2006, Chris is an honest, reliable, trustworthy expert in the field of privacy and security. Email capgar@apgarandassoc.com for more details.
RMC provides the following brief coding exercises for our readers to continue honing their ICD-10-CM coding skills. The answers to the exercises can be found below.

**Practice Exercise #1:**


A: Normal gyn exam.

P: RTC 1yr.

**Practice Exercise #2:**

S: 55 year-old female presents to ER with acute asthma episode. Pt has had asthma since childhood. Allergic triggers include cold weather, pollen and mold. She uses oral and inhaled steroids extensively.

O: Patient is SOB and very anxious. Wheezing can be heard without stethoscope. O2 sat was 92% on RA but increased to 95% after initiation of O2 4L/m via NC. Nebulizer treatment given.

A: Moderate persistent asthma with acute exacerbation most likely due to weather change.

P: Admit for overnight breathing treatments and IV steroids.

**Practice Exercise #3**

S: 50 year-old patient here with complaints of right middle finger pain. The pain is moderate and constant. Patient jammed it with the ball while playing basketball with his buddies at the gym.

O: Right hand is mildly swollen. Normal alignment on extension. Palpation and flexion do cause pain. X-ray negative for fractures.

A: Right index finger sprain.

P: RICE and buddy taping. NSAIIDs for pain. RTC 2 weeks or sooner if pain persists or worsens.

**Answers:**

Practice Exercise #1:

Z01.419 Encounter for gynecological examination (general) (routine) without abnormal findings  
*Look-up: Examination, gynecological*

Z80.49 Family history of malignant neoplasm of other genital organs  
*Look-up: History, family, malignant neoplasm (of), genital organ*

Z97.5 Presence of (intrauterine) contraceptive device  
*Look-up: Presence (of), intrauterine contraceptive device (IUD)*

Practice Exercise #2

J45.41 Moderate persistent asthma with (acute) exacerbation  
*Look-up: Asthma, moderate persistent, with exacerbation (acute)*

Z79.51 Long term (current) use of inhaled steroids  
*Look-up: Longterm (current) (prophylactic) drug therapy (use of), steroids, inhaled*

Z79.52 Long term (current) use of systemic steroids  
*Look-up: Longterm (current) (prophylactic) drug therapy (use of), steroids, systemic*  
*Continued on following page...*
Modifiers for HCPCS and CPTs are a necessary part of correct facility and physician coding. Modifiers are two character codes added to HCPCS and CPT codes to modify the circumstances of the service coded or billed. They may add extra information regarding a procedure or change the description of the procedure performed. For example, modifier 50, bilateral procedure, is added to surgical CPTs to indicate that a procedure was performed on each side of a paired organ. Modifiers should improve the accuracy of the coding.

HIM coders are not the only ones responsible for the billing of HCPCS and CPT codes. Some modifiers are placed by ancillary departments (radiology, cath labs, etc) or billing departments. Modifiers can definitely affect how reimbursement is paid. The correct application of modifiers is a very important step in avoiding compliance and possible fraud and abuse issues. To complicate the subject, however, there are times when the CPT modifier information published by the AMA is different from what CMS (Medicare) has in place. Coders should strive to keep up with CMS and other regulatory agency updates when new modifiers are announced or changes are made throughout the year.

Level I or CPT modifiers are updated annually by the American Medical Association. They are two digit numerical codes. Each year’s current modifiers are listed in Appendix A of the CPT manual. Certain modifiers apply to physician and other qualified health care providers while others only apply to ASC and hospitals for billing of facility services. Some of the modifiers apply to both professional services and facility services.

Level II (HCPCS/national) modifiers are also updated annually but this is done by the Center for Medicare and Medicaid Services (CMS). They are alpha modifiers, AA through VP. There are many Level II modifiers covering various areas ranging from PT (colorectal screening test converted to diagnostic procedure) to digits (TA, great toe, left foot) to CS modifier that is applied to a condition caused or exacerbated by the 2010 oil spill in the Gulf of Mexico.

Current lists of modifiers should be available through your fiscal intermediary or on the CMS website. Although many modifiers pertain more to the billing process in your facility rather than the coding function, HIM departments and coders are responsible for multiple modifiers every day. Physician office and clinic coders are also responsible for multiple modifiers describing physician services. RMC is presenting an audio conference in March titled “Modifiers – Physician or Facility.” The 2014 modifiers commonly used by physicians and facilities will be reviewed.

Jane Barta, RHIA has worked in hospitals both small (5 bed) and large (350+ beds) in Colorado, Montana and Idaho before joining RMC 2000. Her past experience covers Quality Assurance, Utilization Review and departmental management in addition to Coding Quality. With RMC, Jane concentrates on the areas of Ambulatory Surgery, Emergency and Urgent Care coding. During the last 10 years, she has worked with over 38 hospitals in addition to multiple physician offices and insurance companies.
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