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[On the Cover]

Warning: Import Text Properly

Ensure clinical documentation integrity in your electronic health records.

There are advantages and disadvantages associated with the use of imported text in electronic healthcare records (EHRs). Let's explore efficient documentation practices that support the integrity of the clinical record and prevent exposure to the potential risks of this technology.

Reasons to Be Concerned

The majority of EHRs allow medical providers to enter information into the record as blocks of pre-composed text. Common methods include copying and pasting information from another external source (such as another progress note), the reuse of prior clinical notes, and the use of templates. The Centers for Medicare & Medicaid Services (CMS), members of the federal government, the media, and the Office of Inspector General (OIG) have expressed concern that these practices may contribute to fraudulent behavior among medical professionals. The use of imported text in medical records continues to be an area of focus for the OIG, as noted in its 2014 Work Plan.

Resources: For more information regarding concerns about imported text, see "Letter from Secretary Sebelius and Attorney General Holder to Hospital Chief Executive Officers," September 24, 2012 (**www.modernhealthcare.com/Assets/pdf/CH82990924.PDF**) and "Medicare Bills Rise as Records Turn Electronic," *New York Times*, September 21, 2012. To view the OIG 2014 Work Plan, go to **http://oig.hhs.gov/reports-and-publications/archives/workplan/2014/Work-Plan-2014.pdf**.

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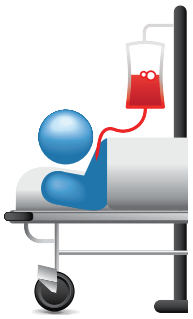


Benefits of Imported Text in Patient Care and Provider Efficiency

Imported text in any form can have significant value in medical care, when used properly. Providers have stated that this type of information can provide reminders and serve as a guide toward thorough and complete documentation. It serves as a "checklist" that may encourage clinicians to ask additional relevant questions, perform more detailed examinations, and consider additional diagnoses and management options.

Pulling information forward from a prior visit compels the provider to thoroughly review the prior encounter note while updating it to reflect findings from the current encounter. It's not uncommon for hurried providers to overlook details from prior documents that may have clinical relevance (see examples in the accompanying sidebar, **Modify Text to Warn Users of Inaccurate Information**). The pull-forward process has the potential to remind the provider of prior issues or concerns that otherwise could have been missed.

Templates have significant value as tools for patient safety and quality of care. They have the ability to instantiate clinical knowledge specific for the type of patient encounter. For example, a well-designed template for a disease process (e.g., multiple sclerosis) provides a road map for providers that can guide the history, examination, diagnosis, and management process. Clinical guidelines may be incorporated into the workflow of templates, giving them the potential to foster improvements in the overall quality of care.

The intelligent and professional use of imported text potentially can benefit patient care. A primary value of importing text within EHRs is increased efficiency of documentation over dictation and keyboard entry. Providers can create multi-page documents with a single mouse click. These large bodies of text also assist providers with meeting documentation requirements for reimbursement — a process that can actually improve the accuracy of coding, if used properly.

Human Factors and Imported Text

Human factors associated with using imported text in EHRs have led to a relatively high frequency of documen-

Definitions and Terminology

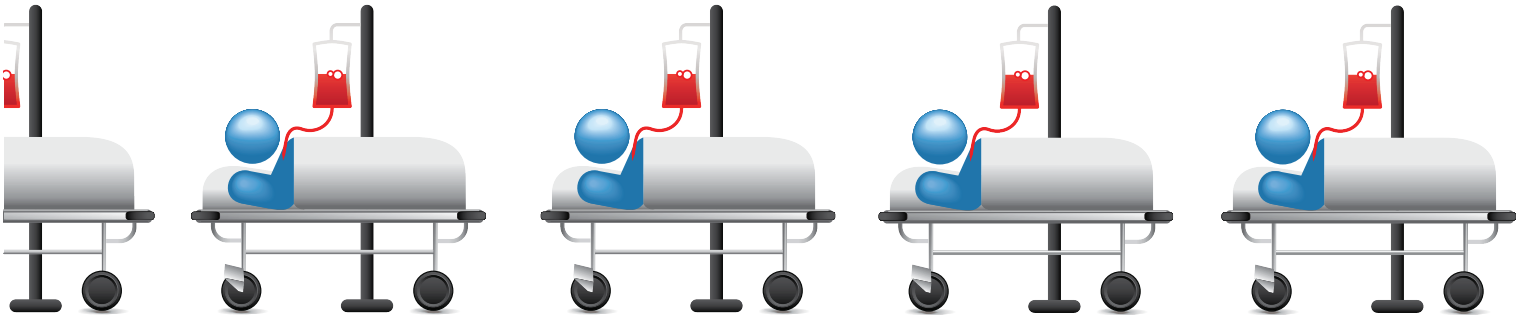
Copy and Paste: The copying of text, images, and other electronic forms of information and placing them into another document is a well known process to computer users, and is a fairly ubiquitous feature of EHRs. Blocks of text may be copied from nearly any source, such as other encounter notes, procedure notes, websites, word processing applications, etc., and "pasted" into the clinical record.

Pull Forward: This process allows the provider to make a copy of some or all of a prior visit note, and to use it as a starting point for the current visit note. It's more structured than simply copying and pasting, as the notes are pulled from a prior encounter for the same patient. This may vary depending on if the provider is reproducing an entire prior visit or pulling forward specific sections (e.g., the physical examination). More sophisticated EHR applications may "intelligently" update some of the information being pulled forward, such as the patient's age, past medical history, medications lists, etc.

Cloning: Importing text from prior records using either the copy and paste method or the pull forward method is referred to as "cloning."

Templates: Many EHRs offer extensive template libraries designed for specific uses, such as age and gender specific preventive medical examinations, symptoms, diseases, and procedures. They can be customized for new and established patient encounters. The level of sophistication in some products allows for an entire note to be populated with a template that contains default values. Templates may contain specific drop-down menus, allowing providers to modify default findings. Most of these programs allow users to add "free" text, as needed. Templates are often customized and used repetitively for documentation.

Macros: Short for macroinstruction, macros store a sequence of predetermined instructions or text in abbreviated form to make certain tasks less repetitive, such as documenting the required components of an E/M visit.



tation errors. Providers are often pressured to evaluate and manage complicated patients in short time intervals, reducing the time they have to validate accompanying documentation.

Documentation tied to reimbursement for evaluation and management (E/M) services often requires fairly extensive detail, and EHRs facilitate this process through the use of imported text. Many EHRs are specifically designed to assist providers in meeting evaluation and coding requirements and facilitate adding large volumes of free text into patient records. This has a tendency to make the documentation review process even more laborious. Given the time pressures on physicians, a tendency to accept imported text as "good enough" may arise. Unfortunately, this is a primary source of documentation inaccuracies associated with EHR use.

Preformatted text that's imported into a document, never reviewed, and used to justify an E/M level is considered fraudulent activity by CMS. Nearly every coding professional has encountered documentation errors associated with using imported text. Some striking examples include documentation of amputated extremities that subsequently have "grown back," vanishing scars, symptoms in the history of present illness that conflict with the review of systems and/or assessment, and potentially dangerous medication errors.

Identify Identical Text Blocks

For over 10 years, reviewers have been employing plagiarism detection software to identify identical blocks of text in medical documentation, and its use is increasing among auditors, as well. Audit logs provide another method for identifying imported text in medical records. Although EHR vendor products vary in their audit capabilities, some are able to track user actions, including when the user imports text into a medical record and whether the text was subsequently modified. The OIG has increased its focus on EHR audit logs to detect inappropriate documentation, and the OIG 2014 Work Plan describes reviewing multiple documents from the same provider to identify identical documentation.

Imported Text Strategies and Vendor Help

Representatives from six of the top 10 EHR vendors in the United States were interviewed confidentially in February 2014, in preparation for this article. They were asked if their current systems included features to alert providers when text has been imported during documentation review, prior to signature. None of the vendors said their EHR has this feature in place; although, one did describe having audit logs that track *when* text is imported.

Strategies to help providers identify imported text are relatively straightforward, and include font changes for imported documents (e.g., color changes, italics, underlining, shading, etc.), changes to the background of that portion of the document, and alerts and reminders. In this setting, providers have the ability to validate that the text accurately represents the encounter, after they have made necessary modifications. As of the writing of this article, few (if any) vendors have implemented such features.

Recommendations to Help Integrity

Text imported into medical records from other sources via copy and paste, pull forward, macros, or templates has the potential to benefit patient care and the efficiency of medical documentation. When used inappropriately, however, their use can adversely affect the integrity of the medical record and lead to claims denials or, in some cases, accusations of fraud.

Resource: The Legal Health Record Copy and Paste Functionality, AHIMA Seminar, September 9, 2009 (**http://campus.ahima.org/audio/2009/RB111709.pdf**)

Healthcare organizations using EHRs need to be aware of the potential pitfalls of using imported text, and of the need

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for clinicians to thoroughly review documentation before signature. They should institute policies that address the use of imported text, and test the review auditing features of their EHRs to see how the use of imported text may be recorded.

When possible, the patient record should show when imported text is used in medical documentation. In the near future, EHR vendors may offer additional features to alert providers when imported text has not been reviewed or when it may represent inaccurate information. At this time, however, providers are encouraged to increase their level of diligence when using imported text. HBM

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Modify Text to Warn Users of Inaccurate Information

Example 1a: The patient is a 47-year-old white male who presents with a three-day history of cough. The symptoms have been progressively worsening and are currently severe. The patient reports a low-grade fever. The cough is nonproductive. The patient also describes having general malaise. He denies headache.

This example shows imported text from a prior visit or template without warning enhancements. This information may or may not be relevant for the current visit; the default text is added to speed up the documentation process by anticipating what the patient "might" say. It could easily be mistaken as "real" information entered for that patient on that same day. EHRs vary considerably regarding their approach to allowing users to modify blocks of text; however, the majority do not provide warnings when imported text has not been modified or reviewed.

Example 1b: The patient is a 47-year-old white male who presents with a five-day history of cough, chest congestion, and headache. The symptoms have been progressively worsening and are currently moderate to severe. The patient denies fever. The cough is productive, with thick yellow sputum but no blood. The patient also describes having general malaise. He denies shortness of breath or lightheadedness.

This example shows how the text in **Example 1a** would be altered once the provider obtains the actual history.

Example 2: The patient is a 47-year-old white male who presents with a three-day history of cough. The symptoms have been progressively worsening and are currently severe. The patient reports a low-grade fever. The cough is nonproductive. The patient also describes having general malaise. He denies headache.

This example shows imported text that highlights the areas requiring modification and review. In this example, the user would click on each highlighted word or phrase and add the correct information via free text or drop-down menus.

Example 3:

The patient is a 47-year-old white male who presents with a three-day history of cough. The symptoms have been progressively worsening and are currently severe. The patient reports a low-grade fever. The cough is nonproductive. The patient also describes having general malaise. He denies headache.

Warning: The text contained within this box has not been edited since it was imported.

This is an example of imported text with the entire text field highlighted and a warning alert. The user would click on the text and make changes via free text or drop-down menus.