

Electronic Health Records: Legal Risks of Documentation Shortcuts

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The use of electronic health records (EHRs) by physicians, hospitals, and other providers has dramatically increased in recent years. The federal government reports that 78% of office-based physicians are now using some type of EHR, up from only 18% in 2001.¹ Additionally, while only 9% of hospitals had adopted EHRs in 2008, more than 80% are now meaningfully using the technology.²

While the widespread adoption of EHRs may offer certain benefits to healthcare providers, including the increased quality and efficiency of patient care, providers should be aware that certain EHR documentation practices may expose them to serious legal implications. Specifically, providers must be cautious that the use of certain EHR documentation tools and shortcuts does not result in the creation of records that are inconsistent or inaccurate.

Copying & Pasting

One particularly dangerous EHR documentation shortcut is copying information recorded during a previous patient encounter and pasting it into the record as current documentation. This shortcut, also referred to as “cloning” or “carrying forward,” is a common practice among providers. While copying and pasting can save valuable time, it can also result in documentation errors that compromise patient safety and the integrity of a patient’s record.

The literature abounds with stories that illustrate the safety risks posed by this documentation practice. In one case, a patient was nearly subjected to an unnecessary change in medication after providers failed to update the information in his EHR to show that his abscess had been drained.³ In another case, providers continued to copy and paste a note stating that a patient was receiving vancomycin, despite the fact that the patient had been taken off the antibiotic. When the patient developed symptoms of an infection, a hospitalist read the inaccurate note and mistakenly determined that the patient was already receiving proper treatment.⁴

Coping and pasting can also lead to the creation of records that overstate the level of service provided to a patient. For example, when providers copy and paste notes from a previous patient encounter, during which the patient had undergone a complete physical, they can create a record that appears as if the same exam were performed during the current visit. Third party coders,

¹ Hsiao CJ, Hing E. “Use and characteristics of electronic health record systems among office-based practices: United States, 2001-2013.” NCHS data brief, no 143. Hyattsville, MD: National Center for Health Statistics. 2014.

² Press Release, United States Department of Health & Human Services, “Doctors and hospitals’ use of health IT more than doubles since 2012.” (May 22, 2013).

³ O’Reilly K. “EHRs: ‘Sloppy and paste’ endures despite patient safety risk.” American Medical News, February 4, 2013. Available at <http://www.amednews.com/article/20130204/profession/130209993/2/>.

⁴ Bowerman D. “Ten techniques to redeem copy-and-paste documentation.” ACP Hospitalist, July 2014. Available at <http://www.acphospitalist.org/archives/2014/07/EHRS.htm>.

who rely on the documentation to assign a CPT code to the visit, may unintentionally “upcode” the visit as a result of this practice.

Templates & “Documenting by Exception”

Another potentially-risky EHR documentation practice is the use of auto-filled templates to “document by exception.” These templates expedite the documentation of a patient’s condition by providing pre-stored data specific to a particular specialty or health complaint. Rather than starting from scratch, a provider who is seeing a patient with a UTI, for example, can rely on an auto-filled template that will populate single or multiple sections of the patient’s record with findings or other information commonly found in patients with the condition in question. If certain auto-filled data does not apply to a specific patient, as is the case with a patient who does not have the abdominal pains commonly associated with UTIs, the provider must edit the record to remove or modify the auto-filled data. This approach is called documenting by exception.

The use of auto -filled templates is another EHR feature that can save providers valuable time. However, when providers fail to review and edit the auto-filled data to ensure the accuracy of the information entered into the record, they can create serious documentation errors. For example, a provider using an auto-filled template specific to patients with hypertension may create a record that improperly notes a recommendation to take daily aspirin – a common recommendation for patients with hypertension - despite the fact that the patient is taking a medication that is a contraindication for aspirin-use. Similarly, a provider using an auto-filled template that inputs a negative review of systems, despite the fact that the provider did not review a particular system with a patient, may inadvertently create a record that documents a higher level of service than the provider actually performed.

Legal Risks of Documentation Shortcuts

Errors caused by risky EHR documentation practices can expose providers to multiple legal problems. If these practices result in errors that cause injuries to patients, providers may face malpractice lawsuits and licensing board investigations. Additionally, providers who fail to exercise caution in their use of EHR features may expose themselves to allegations of fraud and abuse. The Office of the Inspector General, which has repeatedly identified copying and pasting as a major fraud and abuse concern, has called for greater scrutiny of EHRs in order to determine whether this documentation practice has resulted in up-coding and overpayments.⁵ Similarly, the Centers for Medicare and Medicaid Services has instructed its auditors to pay close attention to EHR templates, particularly templates with check boxes and pre-defined answers, in order to

⁵ Office of Inspector General, Department of Health and Human Services. “Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology.” Memorandum Report. (Dec. 2013).

ensure that providers who use this tool are not submitting false claims resulting from inaccurate records.⁶

Documentation Best Practices

In order to reduce the risks associated with EHR documentation practices, providers should consider the following suggestions when using EHRs:

- Confirm that any copied and pasted information accurately reflects the current patient encounter
- Avoid copying and pasting whole notes
- Exercise extreme care when copying and pasting elements of a patient's history or previous examination
- Be cautious when using EHR templates with check boxes, pre-defined answers, pull-down menus, and limited space to enter information
- Make certain that any automatically-populated information accurately depicts the patient's condition and the level of service provided during the current visit
- Train staff on how to properly document using an EHR
- Verify the accuracy of all records prior to their submission

⁶ Hirsh MD. "EHR templates could cost providers reimbursement dollars." FireceEMR. Available at <http://www.fierceemr.com/story/why-ehr-templates-could-cost-providers-reimbursement/2012-12-13>.