EHR Compliance Issues you didn't know you had - The crisis and the challenge

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Financial Disclosures

David E. Silverstone is a practicing ophthalmologist and has no financial interest in the subject matter.

Kevin Corcoran is a consultant for the Corcoran Consulting Group and acknowledges a financial interest in the subject matter of this presentation.

Agenda for Today's Presentation

- Compliance program overview
- Government initiative for electronic health records (EHR)
- Why do compliance issues come up?
- What special compliance challenges are presented by EHR?
- Medico-Legal issues, risks and benefits of EHRs
- Action items
Your Handout

- Available on ASCRS/ASOA Meeting Site
- Available at Corcoran Consulting Group Website

CMS Fraud Prevention Initiative

- Recovered ~ $4 billion in fiscal year 2010
- Affordable Care Act expands efforts to prevent and fight fraud, waste, and abuse
- CMS efforts include:
  - Prevention
  - Detection
  - Reporting
  - Recovery

Source: CMS Top Ten Facts, Fraud Prevention Initiative

Medical Review

- Comprehensive Error Rate Testing (CERT)
- Recovery Audit Contractors (RAC)
- Medicare Secondary Payer Recovery Contractor (MSPRC)
- Zone Program Integrity Contractors (ZPIC)
Recovery Audit Contractors

- Diversified Collection Services, Inc.
  - www.dcsrac.com
- CGI Technologies and Solutions, Inc.
  - http://racb.cgi.com
- Connolly Consulting Associates, Inc.
  - www.connollyhealthcare.com/RAC
- HealthDataInsights, Inc
  - http://racinfo.healthdatainsights.com

Source: CMS website

OIG Demands More

- OIG Report "Addressing Vulnerabilities Reported by Benefit Integrity Contractors" December 2011
- No resolution or significant action by CMS to resolve 77% of vulnerabilities reported in 2009
- Coding and/or billing vulnerabilities most common type reported by PSCs and ZPICs
- Estimated impact was $1.2 billion
- CMS lacks procedures to ensure resolution

Source: OIG Report OEI-03-10-00500

New Technology Fighting Medicare Fraud

- CMS implements new tool July 1, 2011
- Predictive Modeling Technology
- Similar to tool used by credit card companies
- Provides real time data to spot suspect claims and providers

Source: CMS Press Release 6/17/11
Target for Scrutiny
E/M: Potentially Inappropriate Payments

“We will assess the extent to which CMS made potentially inappropriate payments for E/M services and the consistency of E/M medical review determinations. We will also review multiple E/M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments. Medicare contractors have noted an increased frequency of medical records with identical documentation across services. Medicare requires providers to select the code for the service based upon the content of the service and have documentation to support the level of service reported.”

Source: HHS OIG FY 2012 Work Plan

OIG Guidance

- Office of Inspector General (OIG), HHS
- Published “Compliance Program Guidance for Individual and Small Group Physician Practices”
- Broadly applicable
  - Federal health care programs
  - Private payers’ health plans
- Not mandatory but advisable
- Likely will become mandatory soon

Source: Federal Register Vol 65, No 194, October 5, 2000

7 Elements of an Effective Compliance Program

- Conducting internal monitoring and auditing
- Implementing compliance and practice standards
- Designating a compliance officer or contact
- Conducting appropriate training and education
- Responding appropriately to detected offenses and developing corrective action
- Developing open lines of communication
- Enforcing disciplinary standards through well-publicized guidelines
Benefits of a Voluntary Compliance Program

- Speed and optimize proper payment of claims
- Minimize billing mistakes
- Reduce the chances that an audit will be conducted by CMS or the OIG
- Avoid conflicts with the self-referral and anti-kickback statutes
- Demonstrates good faith effort to comply with laws and regulations
- Indicates that staff have an affirmative, ethical duty to report billing errors or fraudulent conduct so it may be corrected

Advancing Medical Care through Information Technology

The Federal EHR Initiative

- Start of HIT initiative by George W. Bush in 2004
  - Bipartisan effort
  - Set up ONC (Office of the National Coordinator for Health Information Technology)
  - Goal: Universal EHR by 2014
- HITECH – Health Information Technology for Economic and Clinical Health Act
  - $19 billion for HIT (Health Information Technology)
  - Two incentive opportunities: Medicare or Medicaid
  - Carrot and stick approach
  - Requires purchasing and using a “certified EHR”
  - Requires demonstration of “Meaningful Use”
  - Penalties start in 2015
**Benefits of EHRs:**

- Data is generally readable
- Data is either present or not present
- Quantity of information increases
  - Good for supporting coding
  - Good for medico-legal reasons
- Altering the medical record is more difficult
- Chart records are easier to find; fewer are missing

**Problems introduced by EHRs:**

- Data always looks real even if it isn’t
- Charting by default can hide medical problems
- Copy forward can copy legacy data not relevant to today
- Quantity of information increases and can produce information overload

**Focus on the Potential of EHRs**

**“Meaningful Use” vs. Meaningful to Me**

- Provide better patient care
  - Care plans
  - Care coordination
  - Personalized care
- More efficient care
  - Efficient entry of data
  - Easy access to data
  - Better communication
- Engage patients in their care
Insuring Information Integrity in the Electronic Medical Record

How are Chart Errors Created?

- Copy and Paste, Copy Forward
- Use of Normal Defaults
- Inserting Templates with Prepopulated Data
- Selecting the wrong choice in a Pick List
- Inadvertently marking or failing to mark a Check Off Box
- Inserted outdated data objects

Chart Errors characterized by type:

- Temporal
- Contradictory
- Authorship confusion

Editorial

Insuring Information Integrity in the Electronic Health Records: The Crisis and the Challenge

David E. Silverman, MD - New Haven, Connecticut
Michelle C. Lin, MD - San Mateo, California
on behalf of the American Academy of Ophthalmology Medical Information Technology Committee

The electronic health record (EHR) was introduced in part to improve patient safety. However, despite the Federal mandate for EHRs, the Institute of Medicine (IOM) reports that safety concerns are wide-spread and widespread. A specific type of health IT can improve patient safety under the right conditions, but these conditions remain to be defined. Several factors are involved in the design and implementation of EHRs, which determine the potential benefits.

The IOM has identified fundamental changes in the way that healthcare is delivered and received, and these changes have the potential of leading to new advances in patient care. However, in the process of achieving improvements, EHRs have created various unintended consequences that need to be identified and addressed.

Software tasks are copied forward, cut and pasted, and added to various patient notes. To “ensure” that these tasks are not inserted into other databases, some software is designed to ensure that information is entered into the correct database. However, this process may result in the creation of tables and even complex diagrams.

1. Temporal: Time elements of the patient record are not accessible (e.g., “patient died” does not change the data or the previous note).
2. Contradictory: The information is not consistent with the patient’s record at another point (e.g., “complaint is noted in the oral examination and not the electronic medical record at this point).
3. Authorship confusion: It may be unclear as to who wrote the previous note.
4. Insuring isolated data objects (laboratory data, patient demographics, imaging results, etc.)

The ability to copy previous notes or sections of notes and enter these data into the patient examination may result in greater efficiency of EHR. It is thus recommended that these notes are clearly noted.
General Principles for Achieving Information Integrity in the EHR

- Document what you do and only what you do
- Use shortcuts carefully; edit final notes
- Never copy from one patient’s chart to another
- At the end of an exam, review the data, sign the note, and lock the note
- Each office should establish rules and policies for entering data into a medical record
- EHRs should have an auditing function to monitor who enters and modifies data.

Questions about Data Integrity have led to the CMS Fraud Prevention Initiative

- Billions of Dollars are recovered each year
- Affordable Care Act expands efforts to prevent and fight fraud, waste, and abuse
- CMS efforts include:
  - Prevention
  - Detection
  - Reporting
  - Recovery

Source: CMS Top Ten Facts, Fraud Prevention Initiative

HITECH: Achieving “Meaningful Use”
### Stages of “Meaningful Use”

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“Meaningful Use” Demonstration: First Year, 90 days; Subsequent Years, Full Year

### Achieving “Meaningful Use”

#### 1. Use Certified EHR Software
(Vendor must obtain certification)

- Objective - focus certification criteria on meaningful use and provide assurance to providers that EHR technology is capable of meeting meaningful use requirements
- Certifications are software version specific
- May be for complete EHRs (fulfills all criteria) or modular EHRs (fulfills some criteria)
- Certified Health IT Product List
  - ≈1,300 certified products
  - [http://oncchipl.force.com/ehtren/CHPLHome](http://oncchipl.force.com/ehtren/CHPLHome)

### Achieving “Meaningful Use”

#### 2. Demonstrate “Meaningful Use”
(must be by the provider)

Stage 1 Reporting Requirements:
- 1. Report all 15 CORE SET OBJECTIVES AND MEASURES
  - Have thresholds that have to be met
  - Core Measure 8 – Record and Chart Vital Signs – can have a scope of practice exclusion
- 2. Report 5 of 10 MENU SET OBJECTIVES AND MEASURES
  - Have thresholds that have to be met
  - At least one must be one of the 2 Public Health Measures
- 3. Report 6 CQMs – CLINICAL QUALITY MEASURES
  - 3 Core CQMs – may be replaced with Alternate Core CQMs
  - 3 Additional CQMs from a list of 38 PQRS Measures
  - 4 are Ophthalmology Specific

Stage 2 Reporting Requirements – Start in 2014
Stage 3 Reporting Requirements - ? Start in 2015 – TBD
Stage 1 “Meaningful Use” Core Set

Objectives

1. Demographics recording
2. Vital signs recording
3. Problem list
4. Medication list
5. Allergy list
6. Smoking status
7. Provide patients with clinical summary
8. On request, provide electronic clinical summary

Stage 1 “Meaningful Use” Core Set

Objectives – continued

9. e-prescribe
10. Use computer to enter medication orders
11. Drug-drug and drug-allergy interaction checks
12. Demonstrate that you can electronically exchange information with an authorized data center
13. Implement a decision support rule and show you can track it
14. Use certified technology to protect data privacy and security
15. Report clinical quality measures

HITECH “Meaningful Use” Menu Set

Objectives and Measures (need to choose 5 of 10)

1. Implement drug formulary checks
2. Incorporate lab test results as structured data
3. Generate lists of patients by condition
4. Use EHR to provide patient education material
5. Perform medication reconciliation
HITECH “Meaningful Use” Menu Set
Objectives and Measures – continued
(need to choose 5 of 10)

6. Provide summary of care for patient referrals
7. Submit electronic immunization data to registries
8. Submit electronic syndrome surveillance data to agencies
9. Send reminders to patients for flu and preventive care
10. Provide patients with timely access to their health information

CQM – Clinical Quality Measures
Core Measures

- Three core measures
  - Hypertension: Blood Pressure Measurement
    - Percentage of patient visits for patients 18 and older with a diagnosis of hypertension who have been seen for at least 2 office visits with blood pressure recorded.
  - Preventive Care and Screening: Tobacco Use
    - Percentage of patients 18 and older (who have been seen for at least 2 office visits) queried about tobacco use and percentage of patients 18 and older identified as tobacco users (who have been seen for at least 2 office visits) who received cessation intervention
  - Adult Weight Screening and Follow-Up
    - Percentage of patients 18 and older with a calculated BMI in the past 6 months documented in the medical record with a follow-up plan, if necessary

Clinical Quality Measures
(Core Measure Alternates)

- Three alternate core measures (if denominator of any of the core measures is “zero”)
  - Weight assessment and Counseling for Children and Adolescents
  - Preventive Care and Screening: Influenza Immunization for Patients 50 Years Old and Over
  - Childhood Immunization Status
- No allowed exclusions, but reporting “zero” values acceptable
Additional Clinical Quality Measures (need to choose 3 of 38)

4 of the 38 apply to OPHTHALMOLOGY

12. (PQRS Measure 12) Primary Open Angle Glaucoma: Optic Nerve Evaluation
13. (PQRS Measure 18) Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Retinopathy
14. (PQRS Measure 19) Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
21. (PQRS Measure 117) Diabetes: Eye Exam

2014 Changes in Stage 1 Requirements

- Computerized provider order entry (30%)
- Vital sign exclusion allowed for “scope of practice”
- Requirement to demonstrate exchange of key clinical information is eliminated
- Require reporting of ambulatory quality measures
- Requirement to give patient an electronic copy of their health information change to give online access to patients’ information within 4 days (would necessitate a patient portal) – would start in 2014

MU Stage 2 Requirements

- Core Measures
  - Increased to 17 (from 15)
- Menu Set Measures
  - Decreased to 3 of 5 (from 5 of 10)
- CQMs
  - PQRS Measures
HITECH Stage 2 Core Objectives

1. Computerized provider order entry (60%)
2. eRx (65%)
3. Record demographics (80%)
4. Vital signs (80%)
5. Smoking status (≥13 y/o) (80%)
6. Use clinical decision support for 5 measures
7. Clinical lab tests as structured data (55%)
8. List patients by a specific condition
9. Identify patients who need reminders (10%)

HITECH Stage 2 Core Objectives (cont.)

10. Give online access to patients’ info within 4 days (50%)
11. Give patients clinical summaries within 24 hrs (50%)
12. Provide patient-specific education via EHR (10%)
13. Use secure electronic messaging (10% of patients)
14. Perform medication reconciliation (65%)
15. Provide summary care record in transitions (65%)
16. Report to immunization registries
17. Encrypt electronic health information

HITECH Stage 2 Menu Set Objectives

1. Incorporate imaging results in EHR (40%)
2. Record Electronic Notes in Patient Records
3. Family health history as structured data (20%)
4. Send syndromic data to public health agencies
5. Report cancer cases to registry
6. Reporting to specialized registries
Stage 2 Clinical Quality Measures

- Beginning in 2014, all providers will report CQMs the same regardless of Stage; all beyond the first year must report electronically
- Must report on 9 of 64
- At least 3 of 6 key “domains” must be covered
  - Patient and family engagement
  - Patient safety
  - Care coordination
  - Population and Public Health
  - Efficient use of Healthcare Resources
  - Clinical Processes/Effectiveness
- A complete list will be posted on: www.cms.gov/EHRIncentivePrograms

CMS EHR Incentive Program Payment Schedule

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<td>12,000</td>
<td>8,000</td>
<td>4,000</td>
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*Bonus payment is made to each eligible provider, not to group.
*Total maximum payment through Medicaid program is $63,750 over 6 years.

Medicare vs. Medicaid Reimbursement

- Must select either Medicare or Medicaid incentive program – cannot participate in both
- One time switch between incentive programs allowed
- Consecutive participation/payment years required for Medicare, but not for Medicaid
- Incentive payments are per provider
- Online registration via EHR Incentive Program website
  - Must have NPI
  - Must be enrolled in PECOS
  - Must attest to use of certified EHR
  - Select Medicare or Medicaid
  - Select state for Medicaid providers
Can I double dip?

- Pick only one program:
  - Medicare HIT or Medicaid HIT
  - (allowed to switch once but must notify CMS of the switch)
  - HITECH bonus or E-Rx (decreases to 1% for 2011 and 2012 and 0.5% for 2013)

Incentive determined by when you start demonstrating “Meaningful Use”?

- If you started in 2012
  - Had to demonstrate meaningful use for 3 months then for one year in 2013
  - Would be entitled to full $44,000 potential incentive
- If you started in 2013
  - Had to demonstrate meaningful use for 3 months
  - Potential Incentive dropped to $39,000
- If you start in 2014
  - Must demonstrate meaningful use for ONE QUARTER (not any 3 consecutive months)
  - Potential Incentive drops to $24,000

Penalty if “Meaningful Use” is not achieved

- Penalties start in 2015
- Must Demonstrate “Meaningful Use” in 2013 or have achieved and attested to the first year of “Meaningful Use” by October 1, 2014 and report to CMS by October 3, 2014
HITECH EHR Bonus Eligibility – Eye Care Considerations

- Eligible Provider (EP) is either ophthalmologist or optometrist under Medicare and "physician" under Medicaid (state specific as to whether optometrist qualifies as "physician")
- Patient volume requirements for Medicaid – 30% (or 20% for pediatricians)
- Hospital based providers who furnish at least 90% of services in an inpatient setting or emergency department not eligible for incentives under either Medicare or Medicaid
- Providers who work at multiple locations must have at least 50% of total patient encounters at location(s) with certified EHR

EHRs and HIPAA Issues

- Celebrities – patient confidentiality
- Controlled access to PHI by staff
- Breaches: failure to keep PHI protected
- HIPAA compliant computer screens
- Patient access to data
- Business Associate Agreements for vendors

Medico-Legal Issues and Electronic Health Records

- Risk during implementation of an EHR
  - Documentation gaps if partially on paper and partially electronic
  - Systemwide errors in EHR software
  - Inadequate training may lead to errors
  - Inadequate support during implementation may lead to loss of patient information and/or errors in documentation or e-prescribing
Medico-Legal Issues and Electronic Health Records

- Risk as EHR use matures
  - E-prescribing mistakes
  - More extensive documentation and information increases discoverable evidence for plaintiffs
  - "Metadata"
  - Departure from clinical decision support can support a plaintiff's case
  - The provider may be overly focused on the computer and not on the patient


Medico-Legal Issues and Electronic Health Records

- Risk as EHR use matures
  - Email advice can increase risk if given without patient examination
  - Slow or non-response to email can constitute negligence, anger patients
  - Email contact may establish a "duty of care" relationship between physician and patient

EHRs can help Medico-Legal and Compliance Issues

- Data is generally readable
- Data is either present or not present
- Quantity of documentation increases, so too little information is less frequent
  - Good for supporting coding
  - Good for medico-legal reasons
- Altering the medical record is more difficult
- Chart records are easier to find; fewer missing
**Action Items**

- Ensure physician performs HPI; attestation
- Ensure recalled data is reviewed and edited before it is accepted
- Ensure every chart entry is signed
- Establish a HIPAA protocol
  - Monitors
  - Breaches in security
  - Late editing of charts
  - Patient access to and modification of data
- Perform regular chart audits

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**Questions and Discussion**
Official CMS EHR Website

- Description of Incentive Program
- Calendar of important dates
- Official information
- CMS.gov → Regulation & Guidance → EHR Incentive
Ensuring Information Integrity in the Electronic Health Record: The Crisis and the Challenge

David E. Silverstone, MD¹ - New Haven, Connecticut
Michele C. Lim, MD² - Sacramento, California

on behalf of the American Academy of Ophthalmology Medical Information Technology Committee

The electronic health record (EHR) was introduced in part to improve patient safety. However, a report by the Institute of Medicine from 2012 suggests that safety outcomes are hard to show and noted that “specific types of health IT can improve patient safety under the right conditions, but those conditions cannot be replicated easily and require continual effort to achieve.”¹ One category of safety is the integrity with which we document the medical examination. The EHR has introduced fundamental changes in the way we record medical examination data and these changes have the potential of leading us to new advances in patient care. However, in the process of facilitating improvements, EHRs have created serious unintended consequences that need to be identified and addressed immediately.

Software tools, such as copy forward, cut and paste, and text generation buttons (or “macros”), have facilitated the efficient documentation of more complete examination records and the creation of better and more complete notes. They have become a vital and indispensable part of the EHR by ensuring avoidance of omissions in documentation leading to incomplete descriptions of the patients’ conditions or status. Because there are plenty of descriptors that change rarely, these tools are a reasonable approach for documentation. However, when not used carefully, these same tools can lead to the generation of unintended documentation errors in the medical record. Furthermore, these errors, when copied and pasted into future notes, may be propagated throughout the patient’s medical record, even if the original error is corrected. This phenomenon has brought the accuracy of some physician’s medical records into question. In 2011, the American Health Information Management Association noted that, despite high expectations for EHRs to improve patient healthcare, “the use of the copy functionality has the potential to negatively affect the integrity of the health record.”²

It is important to understand how chart note errors can be created to prevent them. Errors can be categorized by their mechanism of creation:

1. Copy and paste or copy forward.
2. Use of “normal” defaults.
3. Inserting templates prepopulated with information that is not carefully edited.
4. Inadvertently selecting the wrong choice in a pick list.
5. Inadvertently marking or failing to mark a check-off box.
6. Inserting outdated data objects (laboratory data, patient demographics, imaging results, etc).

They can also be categorized by the type of error created:

1. Temporal: Time elements of the patient note are incorrect (e.g., “patient received laser retinopexy in the right eye today” when in fact the laser was performed at the previous visit).
2. Contradictory: Information in one part of the patient note contradicts another part (e.g., cataract is noted in the eye examination portion of the note but a diagnosis of pseudophakia is listed under impression).
3. Authorship Confusion: It may be unclear as to who wrote the patient note.

The ability to copy previous notes or sections of notes and insert that data into the present examination note is a great efficiency of EHRs. In fact, attempting to use an EHR without this functionality is difficult and it can lead to incomplete examination records. Yet, when done carelessly, copy and paste is a prime mechanism of documentation error. Often when data are copied forward, they are outdated and no longer accurate. If the data are irrelevant to the current examination, this creates great masses of redundant data or “chart bloat,” which can obscure the important data and make it difficult to follow the care of the patient. In a 2008 study, Hartzband and Groopman³ commented that “many times, physicians have clearly cut and pasted large blocks of text, or even complete notes, from other physicians; we have seen portions of our own notes inserted verbatim into another doctor’s note. This is, in essence, a form of clinical plagiarism with potentially deleterious consequences for the patient.”³

If discussions are copied from one patient to another, there is a potential both for adding irrelevant and inaccurate data into a patient’s chart and for creating HIPAA violations. Tools that default to normal or to abnormal findings enable the efficient generation of more complete examination data, but require editing and review to ensure that the correct and intended data are recorded. If editing is not done, incomplete or contradictory data may be entered.

Authorship confusion is another potential problem. In the EHR, documentation has become a group function and in some systems, the entries of the physicians, nurses, assistants, and technicians are merged into one note for the encounter. Often it is impossible to know who entered what data. Yet only one person can own and be responsible for the note.
addition, until the encounter is locked (to prevent additional data from being inserted), changes can be made to the note by anyone with access to the chart. Therefore, depending on the software, the chart might be changed after the provider completes the note. Although these problems exist with paper documentation, authorship can often be inferred in paper charts by cues such as differences in handwriting.

Documentation errors in the EHR such as those described not only affect the integrity of the patient note, but they may also negatively affect the finances of our health care system. Because the EHR often generates billing codes and supporting documentation for these codes, inaccuracies in these elements may lead to submitting higher level billing charges than what is appropriate. Legally, this constitutes fraud. The Office of Inspector General of the Department of Health and Human Services performed a study to investigate coding trends of Evaluation and Management (E&M) codes between 2001 and 2010 and found a significant increase in higher level code submissions. These findings engendered a letter of warning by the Obama Administration to health care organizations on September 24, 2012, which noted “troubling indications that some providers are using this technology to game the system, and “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.” As part of its work plans for both 2012 and 2013, the Office of Inspector General is reviewing “multiple E&M services for the same providers and beneficiaries to identify EHR documentation practices associated with potentially improper payments…. Medicare contractors have noted an increased frequency of medical records with identical documentation across services.”

So now that we know we have a problem, how do we solve the problem? Without question, there is a need to harness the power of the electronic environment to optimize usefulness of data charted while maximizing efficiency. Documentation aids such as copy and paste/copy forward cannot and should not be eliminated, because these are efficient functionalities that can enhance the quality of documentation and the quality of care when used properly; most clinicians using an EHR could not survive a busy clinic day without them. The challenge is using these capabilities appropriately.

We need to examine this problem on both ethical and functional levels and make changes in our workflow and in the software we use to ensure information integrity in the EHR. Individuals working alone cannot solve this problem, but rather a community of health care providers, health care organizations, and EHR vendors will need to participate together to craft a solution. EHR vendors, with assistance of physicians, will need to assume more responsibility and accountability for resolving this problem.

We hope that such a meeting can be organized and take place sooner rather than later. However, the first step in solving the problem is to create guidelines to promote accurate clinical documentation. What follows are some suggestions developed by the Medical Information Technology Committee of the Academy for beginning this process.

**General Principles for Achieving Information Integrity in the EHR**

1. Document what you do and only what you do. You are responsible for everything in your examination record. Your documentation must reflect your thought processes.
2. Shortcuts that we have now and will develop in the future, such as copy/paste, copy forward, templates populated with normal data, pick lists, text generation tools, and check-off boxes generating discussions are important tools for producing documentation. However, the final patient note must be edited carefully to ensure accuracy and relevance to the current visit.
3. Never copy information from one patient’s chart into another patient’s chart.
4. When an examination record is completed, data should be reviewed, the examination must be signed, and the encounter should be locked to prevent alteration.
5. Every office or facility should have rules and policies for entering data into a medical record including copying and pasting data and employees need to receive ongoing education about these policies. Documentation must be able to stand up to the scrutiny of auditors, insurance companies, and attorneys.
6. The EHRs should have an auditing function to monitor who enters and modifies data.

**References**

5. Sebelius K, Holder E. Letter to Chief Executive Officers of the American Hospital Association, the Association of Academic Health Centers, the National Association of Public Hospitals and Health Systems, the Federation of American Hospitals, and the Association of American Medical Colleges. 2012.
Financial Disclosures

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Financial Disclosures:
The authors have no proprietary or commercial interest in any of the materials discussed in this article.