Philadelphia Medicine

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EMR Cloning: A bad habit

Convenient computer function may prompt patient care concerns, payment denials and legal questions

Widespread adoption of electronic medical records (EMRs) in hospitals has resulted in a shift from the traditional clinical narrative writing style to an unintended reliance on the computer function known as copy and paste. It is also referred to as a save as macro, or carry forward, or most descriptively—EMR cloning.

Hospital attendings may have observed how medical residents and younger hospitalists, who grew up with computers, have assumed the liberty of writing and organizing their electronic hospital notes with minimal direction and no clear-cut hospital or professional standards.

The EMR function called copy and paste allows physicians to easily incorporate lab tests, round the clock vitals, and every conceivable report in a single progress note. While the feature is handy, it creates risks for the patient, the hospital and the physician.

But these risks can be mitigated if physicians develop a writing style, tailored to the EMR, which makes use of the long-established hospital narrative. This narrative style is essentially storytelling that relays the particulars of the patient's illness, with events sequenced chronologically, along with appropriately inserted clinical commentary and discussion of treatments.

In contrast, when a physician relies on copy and paste in EMR charting, vast amounts of clinical data and whole

See EMR cloning *on page 3*

Some important tips for avoiding the pitfalls of cloned or identical notes

- Always document the history of present illness based on the patient's description that day. Never copy it from a previous visit.
- Only document those reviews of systems (ROS) elements that are relevant to that day's visit. ROS elements are intended to describe the patient's answers to the practitioner's questions about that day's chief complaint.
- Use only medical, family, and social history from a previous date of service if it is reviewed with the patient and relevant to that day's visit.
- Double-check that the diagnoses in your assessment are only those addressed at that visit.
- Some EHRs allow copying of all diagnoses in the problem list, even those that have been resolved or aren't the reason for that day's patient visit.
- Use templates with care, editing them thoroughly, including medication and diagnosis "favorites" that you have set up previously.
- Be careful with information you copy and paste from a previous visit or another physician's visit. The documentation must be medically necessary,and you must have performed the work. Remember, the volume of documentation does not determine the level of care at which you bill.
- When your EHR vendor offers a way to duplicate another practitioner's documentation (for example, copying another physician's interpretation or consultation), remember that he or she has already billed for this work, and understand that your review is just a review of this information.

PCMS NEWS

Politics and the Future of Medicine: Register today for Advocacy Day

The Pennsylvania Medical Society (PAMED) holds Advocacy Day each spring to give medical students, residents and fellows a first look at how they can positively effect change on the state level. Recent funding increases to Pennsylvania's loan forgiveness and additional residency slots serve as examples of the difference advocacy can make.

This year's Advocacy Day will take place May 4-5, 2015, in Harrisburg. It is free for member students, residents and fellows, but we encourage them to register in advance at *www.pamedsoc.org/advocacyday2015.*

MOC Summit

On March 6, PAMED hosted an MOC Summit at PCMS that brought together state medical society leaders and several national partner groups to discuss next steps to address physician concerns. Learn more: *www.pamedsoc.org/MOC-summit.*

Telemedicine Task Force

At its first meeting on Feb. 26, PAMED's Telehealth Task Force determined legislation is needed to address barriers to telemedicine in Pennsylvania. Learn more: *www.pamedsoc.org/telehealthtaskforce.*

March 24 Medical Marijuana Hearing

PAMED member physicians testified in opposition to proposed legislation (Senate Bill 3) that seeks to legalize medical marijuana in Pennsylvania. Learn more: *www.pamedsoc.org/medmarijuanahearing.*

Health Policy Intern

PAMED is currently accepting applications for the 2015-2016 intern, who can choose to complete the program in the fall of 2015 or the spring of 2016. The deadline to apply is April 10. Learn more: *www.pamedsoc.org/policyintern.*

SAVE THE DATE
Saturday, June 20, 2015
President's Installation and Awards Night
Celebrating the Inauguration of
Michael DellaVecchia, MD
PCMS 154th President
The Philadelphia Country Club, Gladwyne, PA

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Let's all work to re-emphasize physician-led, team-based care

By Anthony M. Padula, MD

On March 3, 2015 the *Philadelphia Inquirer* published a letter to the editor from the Pennsylvania State Nurses Association titled "Nurses can be as effective as doctors." The letter notes that current law prevents some providers, such as advanced practice registered nurses, nurse practitioners, midwives, nurse anesthetists and clinical nurse specialists, from practicing to the full scope of their education and licensure.

As physicians, our number one priority is the health and welfare of our patients. At the end of the 2014 legislative session in Harrisburg, the General Assembly unanimously approved legislation establishing the Patient-Centered Medical Home Advisory Council (Act 198 of 2014). This Council will advise the Department of Human Services on how Pennsylvania's Medicaid program can increase quality of care while containing costs by implementing the patient-centered medical home (PCMH) model of care delivery.

As physicians, we have long embraced the team-based approach to patient care, which emphasizes coordination and integration among healthcare providers, rather than physician autonomy. Despite universal acceptance of the benefits of team-based care, however, the Pennsylvania Coalition of Nurse Practitioners is promoting legislation that would eliminate the collaborative ties between certified registered nurse practitioners (CRNPs) and physicians. In contrast to the concepts of physician-led, team-based care promoted by Act 198, CRNP proposals would fragment care and eliminate the team's most highly trained member—the physician.

There are substantial differences in the education and training of a physician and a CRNP, in terms of scope and duration. Upon completing an academically rigorous undergraduate course load in order to gain acceptance into medical school, physicians receive four years of postgraduate education, followed by 3-7 years of residency, for a total of 12,000-16,000 hours of supervised patient-care training. In stark contrast, CRNPs receive just 2-4 years of graduate level education and 500-720 hours of patient-care training.

While CRNPs are integral and valuable members of the healthcare team, the depth and the breadth of their education and training does not sufficiently prepare them for the wide array of challenges that confront the independent medical practitioner. Physician and CRNP collaboration brings the best of both providers' training to the care of patients and the cure of disease.

Our state-elected officials are being asked to cosponsor and support legislation that moves away from team-based care by removing the requirement for collaborative agreements between CRNPs and physicians. This change would grant a CRNP the same authority and clinical autonomy as a physician, without the education and training the Commonwealth mandates for physicians.

Physicians have long embraced the team-based approach to patient care, which emphasizes coordination and integration among healthcare providers, rather than physician autonomy.

The collaborative agreement currently in place serves to ensure that patients have direct access to a physician when their care requires a more highly trained professional. Eliminating this network of support would not only be contrary to team-based medicine, but has the potential to jeopardize patient care.

PCMS and PAMED strongly support the team-based model of care in which healthcare professionals with unique and complementary—not interchangeable—skills coordinate care to help patients get better. Allowing CRNPs to diagnose, treat, and prescribe without any physician involvement will not solve the current issues within our healthcare system; and lowering the standard of experience required to practice independently would not be in the best interest of patients.

Dr. Padula is president of PCMS.

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text from previous notes or the initial history and physical, regardless of author, or even the original patient, can end up being pasted into the new note. EMR cloning quickly makes yesterday's note into today's note but the story of the patient is muddled with a deluge of clinical information.

Worse yet, EMR cloning has resulted in Medicare and other insurance companies denying payments, thus inviting case review and new legal liabilities. Recent studies have also established EMR cloning as a potential factor in poor patient outcomes, such as when the cloning of glucose labs in hospitalized diabetics becomes harmful.

Of course, as a platform for hospital communication, EHRs have advantages, such as legibility, simultaneous access to records, and endless data storage space.

Although multi-page EMR notes can be assimilated by the reader, the lack of narrative order often impedes clarity. What is now being diminished, or even eliminated, is the 100-year-old tradition of hospital narrative writing that tells the story of the patient's condition in a manner that is easy to understand and remember. Even longtime physicians have abandoned the clinical narrative and simply click a line or two in the EMR.

While EMR cloning may appear to save time, the US Office of the Inspector General (OIG) is currently reviewing duplication standards in hospital charting and has stated that the use of duplicate entries "may be associated with improper payments."

Medicare defines cloning as multiple entries in a patient chart that are identical or similar to other entries in the same chart. The independent Medicare administrative contractor (MAC) who reviews charts for appropriateness of service has been directed by the Centers for Medicare and Medicare Services (CMS) to identify "suspected fraud, including inappropriate copying of health information" under the Benefit Integrity/Medical Review Determinations mandate.

MACs have started to deny payments on the grounds that cloning is a "misrepresentation of the medical necessity required for services rendered." This is an absence of explicit, individual information. One MAC contractor has established policies for its reviewer to assure that medical necessity of hospital services includes documentation demonstrating that physician notes are different and not merely a copy of the initial history and physical entry. The Center for Government Services (CGS) states, "For Medicare, the medical necessity of a service is the overarching criterion for payment," but necessity is considered fraudulent if cloning of past medical services, lab and x-ray results, and medical notes from previous days, are simply reinserted into a new day's progress note to justify need.

FDA releases new draft guidance for compassionate use program

The Food and Drug Administration (FDA) responded to physicians' and patients' concerns that the process for gaining access to an unapproved drug outside of a clinical trial for "compassionate use" is too complex; and so it has proposed a new application form.

The proposed draft Form—FDA 3926—is intended to provide a streamlined alternative for submitting an Investigational New Drug Application (IND) for use in cases of individual patient expanded access. If finalized, it would replace the current Form FDA 1571.

The FDA commissioner estimates that physicians will be able to complete the finalized version of the form in just 45 minutes, as compared to 100 hours for the previous form.

The proposed changes, including the draft form, are outlined in draft guidance, which was announced in the Federal Register on Feb. 10, 2015. Those who want to submit comments must do so during the 60-day comment period ending on April 13, 2015. Instructions for submitting comments are included in the Federal Register.

All events are posted on the PCMS website. These include CME programs and seminars from outside sources. If you would like to post your event on the website, call 215-563-5343, Ext. 102

AMA and CDC launch new physician prediabetes practice tools/resources

Eighty-six million American adults have prediabetes, which means it is likely that you have patients with this common but treatable condition. To help these patients and improve outcomes for your practice, without adding to your workflow, you can take advantage of new physician practice tools and resources from the American Medical Association (AMA) and the Centers for Disease Control and Prevention (CDC).

On March 12, 2015, the AMA and CDC launched a national, multi-year initiative called "Prevent Diabetes STAT: Screen, Test, Act – Today".

The goal of Prevent Diabetes STAT is to raise awareness about prediabetes and to increase physician screening, testing and referral to evidence-based diabetes prevention programs that are part of the CDC's National Diabetes Prevention Program.

Visit *preventdiabetesstat.org*, the new web page where physicians and the general public can find helpful content.

The first phase of the initiative is focused on providing physicians and care teams with easy-to-use tools and resources to help them identify people with prediabetes and refer them to community-based or virtual diabetes prevention programs.

Using Prevent Diabetes STAT screening, testing and referral tools can help your practice achieve Patient Centered Medical Home Recognition, as well as Meaningful Use of your electronic medical record.

The AMA and CDC are calling on physicians and care teams to screen patients for prediabetes, using the CDC Prediabetes Screening Test or the American Diabetes Association Diabetes Risk Test; and if a CDC-recognized in-person or virtual diabetes prevention program is not available, patients with prediabetes should be referred for alternative nutrition and physical activity counseling services.

Change of address?
Phone 215-563-5343, Ext. 102 with any change of address, phone, fax number, or e-mail address.

pcms people

Herb Greene and Richard Bunt from Prescription Advisory Systems & Technology [PAST] with Anthony Padula, MD, FACS

Anthony Padula, MD, FACS with Pam Clarke of HealthShare exchange of Southeastern Pennsylvania

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Want to read more about your fellow PCMS members and medical history in Philadelphia? Check out our new Facebook page ***www.facebook.com/PhilaMedSoc***

Left to right: Drs. Padula, Baron, VanDecker and Christopher at the PCMS MOC debate

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