Decision Table

Ensuring Proper Use of Electronic Health Record Features and Capabilities

This decision table helps providers and others who use electronic health records (EHRs) become more familiar with common EHR software tools and features. Additionally, this decision table helps providers and others ensure appropriate use of these features to preserve documentation integrity and prevent fraud, waste, abuse, and improper payments. The decision table includes the following columns:

- **EHR Features and Capabilities:** Describes the features within the EHR system and its capabilities;
- **Program Integrity Issue:** Describes potential program integrity issues that result from inappropriate use of EHR features and capabilities;
- **Recommendations to Ensure Proper Use:** Outlines recommendations to ensure proper use of EHR system features and capabilities; and
- **Best Practices:** Offers examples of best practices providers should consider when using EHRs.

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Providers and others should review the information in the table and consider implementing the recommendations and best practices to protect the integrity of EHR documentation.

Table 1. EHR Proper Use Decision Table

EHR Features and Capabilities	Program Integrity Issues	Recommendations to Ensure Proper Use	Best Practices
Copy and Paste (also referred to as cloning or cookie cutter) • Enables the user to assume the content of another person's entry, (for example, by copying forward vital signs) • Selects data from an original or previous source to reproduce in another location **Copy Forward:** Replicates all or some information from a previous note to the current note. **Cut and Paste:** Removes source text or data from original location to another location.[1]	Copy and paste or cloning can lead to redundant and inaccurate information in EHRs. Using this feature can cause authorship integrity issues since documentation cannot be tracked to the original source.[2] Cloned documentation lacks the patient-specific information necessary to support services rendered to each patient. This can affect the quality of care and can cause improper payments due to: • False impression of services provided to the patient. • Coding from old or outdated information that may lead to "upcoding."	Create a policy on copy and paste and weigh efficiency against the potential for inaccurate, fraudulent, or unmanageable documentation.[3] Set policy requiring the provider to modify copied information to be patient-specific and related to the current visit. Set policy controlling and limiting the use of the copy and paste function. Include proper notation and clear attribution of copied information. [4] Set policy making clear the use of cut and paste, as it changes the original source material.[5] Monitor and audit copy and paste usage in the audit log. If possible, enable the EHR system to record the method of each data entry (for example, copy and paste or direct text entry).	Ensure providers recognize each encounter as a stand-alone record and ensure the documentation for the encounter reflects the level of service actually delivered and meets payer requirements for billing and reimbursement.[6] Validate each entry not solely authored by the user in a manner similar to bibliographic notations and include the name, date, time, and source of the data. System software design that routinely provides validation can satisfy this need.[7] Do not allow cut and paste, as it removes original source information.

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Populating via Default A feature enabling the user to generate content without selecting (as in checking a box), or typing keywords (as in using a macro). "Data is entered into a note via an electronic feature that does not require positive action or selection by author. For example, when documenting the Review of Systems in a patient history, an EHR may have functionality that enters the phrase 'all other systems negative' without requiring the author to select a checkbox, or otherwise indicate the work was performed."[8]	Populating via default may encourage overdocumentation to meet reimbursement requirements, even when services are not medically necessary or are never delivered.[9] Editing existing material is less accurate than writing new material.[10] Can cause upcoding (higher level of service than provided).	Avoid generating a note that does not require some action on the part of the provider. Set policy requiring the provider to review and edit all defaulted data to ensure recording only patient-specific data for that visit. Verify the validity of auto-populated information on entry and delete all irrelevant and unnecessary auto-populated information. Incorporate policies and control structures requiring the addition of free text when using auto-population methods.[11]	Double-check edited default text to ensure it accurately represents the services provided. Limit which users can populate by default selectively and what information they can populate by default.[12, 13]
Macros This is similar to populating by default. A macro is expanded text triggered by abbreviated words or keystrokes.[14] Macros allow users to generate much documentation with one click. The practice is also referred to as "charting by exception." [15]	Producing documentation for services not rendered, which can lead to overdocumentation and upcoding. Producing documentation for services not rendered, which can lead to overdocumentation and upcoding.	Set policy requiring the verification and the validation of information on entry. Incorporate policies and control structures requiring the addition of free text when using auto-population methods.[16]	Double-check edited default text to ensure it accurately represents the services delivered. Limit which users can use macros selectively and what information they can enter with macros.[17, 18]

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Template Documentation tools that feature predefined text and text options used to document the patient visit within a note.[19]	Use of templates may expose a physician to liability for false claims as the additional documentation may lead to upcoding. Documenting accurately can be problematic if the structure of the note is not a good clinical fit and does not reflect the patient's condition and services.[20] Overdocumenting may be encouraged by using templates to meet reimbursement requirements even when services are not medically necessary or are never delivered.[21]	Set policy requiring the use of "open-ended" templates to allow the physician to check boxes for population of some general information. Policy should require the physician to provide additional information to describe the patient in the specific episode of illness.[22] Set policy requiring providers to modify templates so that documentation clearly reflects specific conditions and observations unique to the service, and clearly identify the services.	Ensure understanding of the necessity to review and edit all defaulted data to ensure only patient-specific data is recorded for that visit, while removing all other irrelevant data pulled in by the default template.[23]
Automated Change of Note Author Automatically changing authorship of a note written by someone else to the current user of the note.	Verifying the actual service provider or the work performed by each provider may be impossible.	Adopt EHR systems allowing more than one individual to add text to the same progress note entry or flow sheet, while preserving the attribution of each entry to the correct individual. This enables multiple providers to document and sign, making it possible to verify the actual service provider or the amount of work performed by each provider.	Retain all signatures when there are multiple authors or contributors to a document, so that each individual's contribution is unambiguously identified.[24] Disable automated change of note author. Restrict ability to disable audit log to a limited set of users.[25]

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Audit Log A record of all activity that occurs within the EHR system. The audit log tracks EHR access information, including the user name, workstation, and document; event description such as an amendment, correction, or deletion; and date and time. An audit log can help detect situations in which records have been altered "to prevent the discovery of damaging information."[26]	Turning off the EHR system security features, such as the audit log, access restrictions, and warnings can result in an inadequate and incomplete audit log.	Mandate that all providers follow the HIPAA Security Rule, 45 C.F.R § 164.312(b). It requires maintaining the audit log within the EHR. Title 45 C.F.R. § 170.315(d)(2) in the 2015 Health IT final rule requires that the audit log record identify when and by whom the audit log is disabled, whether the data is encrypted, and whether the log has been altered. Additionally, the rule allows no one to change, overwrite, or delete recorded log information. Ensure institutional policy follows the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) recommendation that the EHR system's audit log should always be operational.[27] The only exception is for system performance fixes, updates, stability, and disaster recovery, and only then by an authorized administrator.[28]	Use the audit log functionality of the EHR system to identify and trend use of health records.[29]

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Dictation/Voice to Text The provider dictates notes to a recorder or scribe, or uses voice-to-text software for documenting the patient visit.	Entering documentation in to the EHR by others, through a scribe, through dictated notes, or through voice-to-text software, may not accurately identify or support the need for services provided. Not validating documentation entered by others may not support claims submitted.	Set policy requiring providers or a third party to review, edit, and approve by signature, any information entered in to the EHR on their behalf (scribes, residents, nurses) in a timely manner.[30, 31]	Set policies and procedures to ensure providers or a third party review, edit, and approve dictated information in a timely manner.[32]

Understanding the proper use of EHR system features and capabilities helps ensure the integrity in documentation and protect EHR program integrity. Implementing recommendations and best practices outlined in the decision table will help reduce fraud, waste, abuse, and improper payments with EHR use.

To see the electronic version of this decision table and the other products included in the "Electronic Health Records" Toolkit posted to the Medicaid Program Integrity Education page, visit https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

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