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Cloned notes: The time is ripe to review your practices

Office of the Inspector General initiates E&M services review

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Providers can attest to the fact that there are many benefits to utilizing an EHR. Among those benefits are increased coding accuracy, improved quality of patient care and simplified communication. But with these benefits also come some new temptations and pitfalls, such as over-documentation and cloning notes.

A specific example of overdocumentation includes recording a complete 14-point review of systems (ROS) for a limited or minor problem in a healthy patient. Cloning notes refers to copying the same text from a previous date of service or copying the same text for multiple patients. Another example would be using a comprehensive exam template with every system and body area marked as "normal" without any indication of why each element of the exam was performed.

Avoiding these pitfalls is especially important because the Office of the Inspector General (OIG) began evaluating E&M services provided to Medicare beneficiaries in 2010.[1] Once the review is complete, the OIG plans to release decisions about the appropriateness of Medicare payments for E&M services and the extent of documentation vulnerabilities.

Of course, there is a difference between the legitimate use of structured notes, which help providers complete the required elements of history and exam, and the use of automated notes or templates in the EHR system that copy and paste the elements and the findings, such as ROS and physical exam elements.

Structured notes prompt a provider to document what is required and might be beneficial in helping him or her document the necessary elements of care while preserving the integrity of the note by not including superfluous, erroneous or unnecessary information commonly seen in cloned notes. A good note should document the relevant, medically necessary history as supported by the history of present illness, review systems related to the reason for the visit, and include an examination of the symptomatic body area (BA) or organ system (OS) plus any related BA/OS examined.

On the other hand, automated notes could lead to overdocumentation and/or lack information that is related to a patient encounter. In other words, a provider does not accurately chronicle what happened in a patient visit and instead uses dummy copy. Overdocumenting is caused by documenting services that are greater than what is medically necessary and is usually the result of using the same template for each visit, regardless of the extent of the service warranted by the problem. This raises serious questions when reviewing the note, such as:

- What was really done?
- What information is relevant?
- Can this information be trusted?

> If a note was scrutinized by a lawyer or auditor, and it contained cloned or erroneous information, it could lead to a malpractice suit, denied claim or missed payment.

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This is especially pronounced when information in one section of the note contradicts another section or when something documented is implausible because of the patient's age, gender or condition, as explained in the September 2012 issue (Code of Conduct: "If it wasn't done, don't document it: Tackling E&M coding errors in the age of EHRs").

Contradictions caused by cloned notes indicate a serious problem from a medical, legal or auditing standpoint because it becomes impossible to pinpoint which information is credible. If a note was scrutinized by a lawyer or auditor and it contained cloned or erroneous information, it could lead to a denied claim or a missed payment, or even put you at a serious disadvantage in a malpractice suit. Another medical professional reviewing the records might have questions about a patient's condition due to contradictions in the record, which could result in unnecessary tests or inappropriate medications. By performing only what is medically necessary and documenting only what was done, providers protect the integrity of the medical record and help to ensure correct coding, reimbursement and patient care.

Note:

1. OIG: oig.hhs.gov/oei/reports/oei-04-10-00180.pdf.

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