Codify
BY AAPC

Health Information Compliance Alert

Documentation: Cloned Notes Can Lead to Inaccuracies - and Trouble

Keep copying and pasting to a minimum.

Advancements and enhancements in technology like electronic health records (EHR) or electronic medical records (EMR) offer practices distinct advantages over paper records, but the convenience of dedicated software can backfire if practice employees are too tempted by the ease of templates.

Payers are on the lookout for cloned notes, or health records that are overly similar (or exactly similar) among patients and encounters.

"It's becoming an issue that you could potentially see costing you a recoupment in your practice," says **Terry Fletcher, BS, CPC, CCC, CEMC, CCS, CCS-P, CMC, CMCSC, CMCS, ACS-CA, SCP-CA,** owner of **Terry Fletcher Consulting Inc**. and consultant, auditor, educator, author, and podcaster at **Code Cast,** in Laguna Niguel, California.

Plus, if you're not careful, you could get an intentional fraud audit, she says.

Records Should Reflect Reality

Cloned notes are becoming an increasingly significant issue between providers and payers, with payers and Medicare Administrative Contractors (MACs) releasing directives reminding providers that while some diagnoses may be similar between patients, there's probably a slim chance that different patients had the exact same signs, symptoms, and received the same services during an encounter.

Watch out, too, for overdocumentation, which involves tweaking the medical record or your claim to bill for more services than your physician actually performed.

Payers contend that the practice of using cloned notes and submitting these as documentation for payment for services rendered, whether intentional or unintentional, does not meet the threshold of medical necessity, and could set up the provider for problems down the road, such as audits.

Be Careful About Software Ease of Use

Payers and MACs are zeroing in on practices whose patients' records may not be accurate because they've been copied.

"When there's no varied information, when they don't see it change, or when they start to ask to audit or ask for records from different payers from the same provider or group practice, they're looking to see if that same language is put into that same record," Fletcher says.

The software may make the documentation easier, especially by suggesting signs and symptoms that frequently correlate with a diagnosis, but you and your employees should know to avoid any temptation to cut and paste.

"Obviously, if you use the same medical software, you're going to have a lot of similarities; but, they're looking for cloned, meaning the exact same thing for different patients for the exact type of medical record of what's being submitted, and that's where it becomes a problem," Fletcher adds.

However, software can also complicate your documentation best practices.

"Some [Promoting Interoperability] PI Programs' technologies auto-populate fields when using templates built into the system. Other systems generate extensive documentation on the basis of a single click of a checkbox, which if not

appropriately edited by the provider may be inaccurate. Such features produce information suggesting the practitioner performed more comprehensive services than were actually rendered," says Part B MAC **Palmetto GBA.**

Document Only Authentic Information

Besides being scared about reimbursement issues and fraud audits, you should be motivated to ensure accurate documentation for each patient and each patient encounter so that the future of the patient's care is unblemished.

"It's inappropriate to perform clone note documentation, because it not only can damage the trustworthiness and integrity of the record for patient care, but now you're dealing with safety," Fletcher says.

For example, inaccurate information in the patient's medical record - perhaps lifted from another encounter with the same diagnosis or automatically populated by your software's template - can lead to care decisions that are dangerous for that patient.

Patients' medical records follow them, and with the electronic systems now in place, the records can often be accessed by multiple clinicians within a larger provider network. With the expanse of some of these networks, providers can no longer rely on the experiential context of remembering a particular patient's history or last visit. All providers must, instead, look to the medical record and hope that the documentation is accurate.