

CORRECTIVE ACTION PLAN **Cloning of Medical Documentation - Physician Practice**

I. ISSUE / PROBLEM DEFINITION

Providers in an attempt to maintain patient volumes and RVUs are using “Cut and Paste” features of their EMR to carry forward documentation from previous visits to gain credit for current visits and to help “Beef-up” their notes to support higher levels of documentation. This practice is referred to as cloning and is a top OIG initiative in 2016 as it is for the Centers for Medicare and Medicaid Services.

II. ROOT CAUSE EVALUATION

Internal auditors from the various regions within PHYSICIAN PRACTICE as well in addition to DoctorsManagement (DM), the outside consulting firm for Physician Practice have been performing audits and pre-bill reviews and uncovered some potential issues within this area of documentation.

According to National Government Services, “Medicare providers today are faced with the challenges of providing quality healthcare while meeting ever increasing regulatory and compliance regulations. However, providers need to be aware that Electronic Medical Records can inadvertently cause some documentation pitfalls such as making the documentation appear cloned. Cloned documentation could cause payment to be denied in the event of a medical review audit of records.”

Documentation is considered cloned when it is worded exactly like or similar to previous entries. It can also occur when the documentation is exactly the same from patient to patient. Individualized patient notes for each patient encounter are required. Documentation must reflect the patient condition necessitating treatment, the treatment rendered and if applicable the overall progress of the patient to demonstrate medical necessity.

An Electronic Health Record often allows the providers to utilize default options. Defaulted documentation may cause a provider to overlook significant new findings that may result in safety/quality issues. Default data may document a more extensive history and physical exam than is medically necessary and does not differentiate new findings or changes in a patient’s condition. When documenting a service such as Diabetes, Hypertension, Asthma, Chronic Obstructive Pulmonary Disease, etc. it is important to document the status and progress of the patient and their condition. Defaulted or cloned documentation also applies to other disciplines where the documentation must demonstrate that the patient is making progress towards treatment goals, or documenting the patient’s findings or changes in a patient’s condition to meet for Medicare medical necessity.

Whether the documentation was the result of an Electronic Health Record, or the use of

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a pre-printed template, or handwritten documentation, cloned documentation will be considered misrepresentation of the medical necessity requirement for coverage of services due to the lack of specific individual information for each unique patient. Identification of this type of documentation will lead to denial of services for lack of medical necessity and the recoupment of all overpayments made.

III. ACTION STEPS

_____, **Director of Coding:** Will provide education and training back to PHYSICIAN PRACTICE coding leadership, regional executives, coders, and providers to ensure complete understanding of these documentation requirements, which will correct the current issue and prevent further errors in documentation and billing moving forward.

This is the education piece that will be prepared for PHYSICIAN PRACTICE employed providers and staff:

“Cloning” medical record documentation means copying and pasting the patient information in an Electronic Medical Record (EMR) from one date of service to another for the same patient. Documentation is also considered “cloned” when the medical documentation is exactly the same for different patients as may be documented through the use of templates. Cloned notes can make it difficult to distinguish notes from one date of service to another and may result in falsification of the medical record since the cloned note may not pertain to the visit to which it was copied. First Coast Service Options, the Medicare Administrative Contractor for Florida has indicated that “cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information.” All documentation in the medical record must be specific to the patient and his/her situation at the time of the encounter. Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Cloned documentation may lead to denial of services for lack of medical necessity and payments made by Medicare will be recouped.

"No payment will be made ... for items or services ...not reasonable and necessary for the diagnosis or treatment of an injury or illness or to improve the functioning of a malformed body member." With the use of EMR templates and copying documentation from one date of service to another, providers may "over document" and consequently select and bill for a higher level E&M code than medically reasonable and necessary. Even if a complete note is generated, only the medically reasonable and necessary services for the condition of the patient at the time of the encounter can be used when choosing the appropriate level of an E&M service. Information that is not relevant to the patient's condition at that specific time cannot be counted.

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Cloned notes can be used appropriately if the documentation is applicable to the date of service; however, the chief complaint should carry through to the exam and history, and should support the decisions made for medical necessity. Providers should always document the history of the present illness based on the patient's conversation at that visit. Providers can copy the review of systems categories that are relevant to that day's visit but should not copy the entire review of system documentation from a previous visit unless it is applicable. Further, providers can copy past medical, family and social history from a previous visit if it is reviewed with the patient and is relevant to that day's visit.

IV. IMPROVEMENT BENCHMARK(S) AND TIMEFRAME

A re-review of any provider's documentation found to be cloned should be done so within 30-days of the identified issue and education to ensure the issue is resolved.

Failure to achieve these improvement benchmarks could result in additional corrective action.

This Corrective Action Plan is effective 01/01/2016 through 12/31/2016.

V. CERTIFICATION

The undersigned have read this Corrective Action Plan and agree to its terms.

VP, Date _____

NAME Date _____
Director of Coding