The Dangers of Record Cloning

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The use of electronic health records (EHR) has made the review of a patient's history and previous findings easier than with paper records. With the push of a button, we can pull all previously entered information into the current record – patient history, previous examination findings, and even the previous Assessment and Plan. However, there is a real danger in this ability called medical record cloning.

Record cloning is defined by Medicare as *"…documentation that is worded exactly like previous entries. This …generally occurs when using a preprinted template or an Electronic Health Record (EHR). While these methods of documenting are acceptable, it would not be expected the same patient had the same exact problem, symptoms, and required the exact same treatment or the same patient had the same problem/situation on every encounter*".

While the 2021 E&M Guidelines eased the requirements for the amount of history and number examination elements, this change did not substantially change the issue of medical record cloning. The revised code descriptors require history and physical exam performance only to the extent medically necessary and clinically appropriate. However, these components must still be present and must still be unique to the patient and the particular visit.

Using your EHR to its full potential is a real time-saver and is fine as long as you are careful to ensure that EVERY encounter for EVERY patient is documented to reflect what actually occurred during that encounter. Your documentation should have a unique chief complaint for that encounter. Your findings should reflect exactly what is found during that encounter. Your assessment and plan must be unique to that encounter reflecting changes in any condition and any changes to the treatment plans.

EHR's that automatically fill in findings on a patient should be carefully reviewed to ensure that the automatic documentation accurately reflects the condition of that patient. Many programs fill in a lot of words that do not really say much about that patient. For example, only listing a cataract for the right eye, the documentation should indicate the type and degree of that cataract on that visit. The Assessment should reflect that change. The plan should be updated as necessary. If every encounter for that patient or every encounter for that day says the same thing, then your records will be deemed, in an audit, to be cloned.

Example:
Good: Cataract +3NS OU worse - Monitor for complications, not ready for surgery
Questionable: Cataracts- Monitor (and wording was the same for the last visit as well)

CMS further states: "*Cloned documentation does not meet medical necessity requirements for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.*" As well, the OIG considered record cloning a form of Medicare abuse at the very least, and fraud at the worse.

Each provider should carefully review the documentation for every encounter prior to finalizing to ensure that record accurately reflects the encounter to avoid any appearance of record cloning.

In the 2020, CMS established a general principal to allow the physician/NP/PA to review and verify information entered by physicians, residents, nurses, students or other members of the medical team. This was covered in the article Signatures and Record Authentication in the June 2023 coding article.

Happy Coding….

https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-ehr-providerfactsheet.pdf