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cloning:
ADDRESS THE ELEPHANT IN THE ROOM

DON'T FORGET MEDICAL RECORD INTEGRITY AS YOU STRIVE TO IMPROVE PRODUCTIVITY.

BY KELLIE S. HALL, CPC, CPCO, CCS-P

Electronic health records (EHRs) offer providers many benefits, but using the technology in compliance with government standards takes a bit of know-how. One such compliance risk EHRs facilitate is called "cloning." Recognizing cloning and discouraging its use is an affirmative action toward protecting your practice from charges of healthcare fraud.

RECOGNIZE CLONING

Per the Centers for Medicare & Medicaid Services (CMS), "Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries" (Medicare B Update, third quarter 2006 (vol. 4, No. 3)).

Per the Office of Inspector General (OIG):

> *Copy-pasting, also known as cloning, allows users to select information from one source and replicate it in another location. When doctors, nurses, or other clinicians copy-paste information but fail to update it or ensure accuracy, inaccurate information may enter the patient's medical record and inappropriate charges may be billed to patients and third-party health care payers. Furthermore, inappropriate copy-pasting could facilitate attempts to inflate claims and duplicate or create fraudulent claims.*
>
> *Overdocumentation is the practice of inserting false or irrelevant documentation to create the appearance of support for billing higher level services. Some EHR 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 can produce information suggesting the practitioner preformed more comprehensive services than were actually rendered.*
>
> Source: OIG, December 2013, "Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology"

In other words, copying and pasting, pulling forward information, and the use of macros could all be defined as cloning.

CLONING PLAGUES MEDICAL RECORD INTEGRITY

Many physicians consider nothing amiss with cloning. They argue, "It saves time. I could never see this many patients if I had to rewrite everything." But before the EHR, physicians were not copying previous encounters, changing the date, adding a line or two, and placing it in the medical record as the documentation for that day. Such actions would compromise the integrity of the patient's note, and fall under the category of fraud and abuse.

EHRs are supposed to cut healthcare costs and improve patient care, but something has gone terribly wrong. Evaluation and management (E/M) payments have actually increased 48 percent from 2001 to 2010 (OIG, December 2012, "Coding Trends of Medicare Evaluation and Management Services"). The media has picked up on this trend. As seen in The New York Times ("Medicare Bills Rise as Records Turn Electronic," September 21, 2012):

> *... the move to electronic health records may be contributing to billions of dollars in higher cost for Medicare, private insurers and patients by making it easier for hospitals and physicians to bill more for their services, whether or not they provide additional care. ...*

Some experts blame a substantial share of the higher payments on the increasing widespread use of electronic health record systems. Some of these programs can automatically generate detailed patient histories, or allow doctors to cut and paste the same examination findings for multiple patients with the click of a button or the swipe of a finger on an iPad, making it appear that the physicians conducted more thorough exams than, perhaps, they did.

Office notes that were once one or two pages are bloated to six or eight pages, filled with irrelevant information carried over from a patient's initial visit.

On the billing side, inappropriate use of EHRs may suggest that services were provided when they were not, resulting in the submission of an unsupported bill. Documentation is part of the work a physician is paid to do, and cloning is shortchanging that work.

From an auditing perspective, gleaning relevant information from a documented note in an EHR can be like a scavenger hunt. Sometimes, it's almost impossible to identify who authored the note (i.e., medical assistant, nurse or physician), compromising the medical record. And in the end, something has been lost: Chart integrity.

OIG ON THE LOOKOUT

Who's to blame for the negative outcomes EHRs have created? Some say the government is at fault for mandating EHRs in the first place. Some say the developers who created EHRs per government guidelines are to blame. And others point to the vendors, for promising things for which there was no proof.

Stephen Levinson, MD, in his May 23, 2013 presentation, "Advanced E/M Coding for EHRs," suggests that, due to government requirements, the EHR development has been focused on meaningful use issues—for instance, e-prescribing and HIPAA security—rather than on documentation and coding compliance.

To entice providers to adopt EHR technology, developers promised increased productivity and, to that end, created components such as:

- Templates with check boxes used in a review of systems (ROS)
- The ability to pull forward problem lists from a patient's previous date of service
- Macros that automatically enter predetermined entries of history or examination, without requiring clinician documentation
- Copy-paste functionality

In essence, EHRs have created the point, click and swipe era of the patient encounter.

In 2013, the OIG reported that Medicare administrative contractors have seen an increase in instances of "identical documentation across services" (OIG 2013 Work Plan). This elephant in the room has led the OIG to set its sights again this year on physician documentation.

DON'T FALL INTO CLONING TRAPS

There are ways for physicians, who see patients with chronic conditions, to avoid government scrutiny for cloning.

1. Don't clone the whole note. Cloning the entire note makes you vulnerable for error and creates too much information to review, creating a greater likelihood of contradictory information in the record.
2. A physician's documentation should paint a picture of the current encounter. Always document the history of present illness (HPI) based on the patient's current information, adding notes such as, "since last seen, he reports ..." If the previous HPI is pulled forward to use as a reference, date it. This will identify it as past history, not to be added into the history component for E/M leveling.
3. It's acceptable to pull a ROS forward from a previous encounter; however, use only those items that are relevant to the present. A complete ROS may not be medically necessary at every visit. When an auditor sees a trend, red flags go up.
4. The exam component is based on exam findings for that specific date of service. Although it may seem beneficial to copy a previous exam as a reminder of abnormal findings, this can easily lead to over-documenting. A comprehensive exam may not be medically necessary at every visit.
5. If a provider's notes contain a laundry list of the patient's chronic and acute conditions, the structural integrity of the note—which is supposed to represent what happened during the specific visit—becomes compromised. The assessment and plan should reflect the problems addressed that day, with a status update. The documentation guidelines before EHRs did not allow using and updating a previous assessment and plan. Until CMS updates or changes the guidelines, the rules still stand (CMS 1995 and 1997 Documentation Guidelines for Evaluation and Management Services).
6. To avoid contradictions in the note, it must be carefully reviewed. Cloned information from a previous encounter may contradict information documented that day. It's the physician's responsibility to review the medical documentation.
7. Authorship matters. There are EHRs with the ability to identify who is entering the information (i.e., ROS, etc.). For those systems that do not have this capability, it may be good practice to have ancillary staff initial their entries.

STEER CLEAR OF THE ELEPHANT IN THE ROOM

Time is the enemy here. Physicians want to take shortcuts to save time and increase productivity. But saving time by cloning may cost the physician in government audits and potential fines. Knowing the pitfalls in EHRs will help you to avoid them, as you travel down the road to meaningful use.

Kellie S. Hall, CPC, CPCO, CCS-P, has been in the healthcare industry for over 14 years with a background in physician coding, billing, and education. She is the compliance billing/coding analyst for Akron General Health Systems. Hall presents coding workshops for physicians and residents, and is a presenter at AAPC local chapter meetings. She has developed coding tools to help train physicians in E/M documentation and coding. Hall trains new coders and is an accomplished trainer for ICD-10. She is a member of the Canton, Ohio, local chapter.

OIG to begin MEANINGFUL USE AUDITS

The Office of Inspector General (OIG) of the Department of Health and Human Services is initiating an audit program of the Medicare EHR incentive (meaningful use) Program that was included in its Work Plan for FY 2015. A random sample of eligible professionals (EPs) who received incentive payments from Jan. 1, 2011 to June 30, 2014 will be selected for auditing. The agency stated that it will review some, but not all, meaningful use measures to determine whether EPs received any incentive payments in error. OIG will determine whether EPs have adequately protected electronic health information created or maintained by the EHR. As part of the auditing process, the agency will send audit notice letters to EPs requesting specific information and documents, including documentation of compliance with the particular meaningful use measures under review.

EPs are strongly encouraged to review their documentation for each measure and for every year an incentive payment was received. This documentation could include measure calculation reports supplied by the EHR, the practice's security risk analysis and dated screen shots that establish successfully meeting a particular measure. Members should note that these OIG audits are being conducted in addition to the current meaningful use audits by Figliozzi & Company, the audit contractor for the Centers for Medicare & Medicaid Services. For more information, visit CMS' meaningful use audits webpage and access MGMA's Meaningful Use Resource Center.

problems surface with reporting of MEANINGFUL USE PUBLIC HEALTH DATA

The Centers for Medicare & Medicaid Services (CMS) announced a problem with the EHR Incentive (meaningful use) Program's Stage 1 public health menu measures. The CMS Meaningful Use Registration and Attestation System may prompt a Medicare eligible professional (EP) to report on additional measures even after he or she has already claimed an exclusion for that measure. This is because, starting in 2014, exclusion criteria no longer counts toward reporting a meaningful use objective from the menu set. CMS has since posted an FAQ that provides EPs with a walk-through of the attesting process. For additional information, contact the CMS EHR Information Center at 888.734.6433.

in the SPOTLIGHT

NAME: Jamie Carney

POSITION: Revenue Recovery Associate

YEARS WITH PMB: 1 year, 4 months

PETS: I have a 3-year-old Corgi named Barry. He's trouble.

FAVORITE SONG: "Meant to Live" by Switchfoot has always been my go-to song.

FAVORITE QUOTE: "Happy are those who dare courageously to defend what they love." —Ovid

BET YOU DIDN'T KNOW: People tend to think of me as a serious person, but I'm really funny. I'm kind of a comedian.

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TEXAS ASSOCIATION FOR HOME CARE & HOSPICE ANNUAL MEETING
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September 15-16 | Columbus, Ohio
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