Cloning and Chart Similarity

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Practice Points

- Medical record documentation for evaluation and management services includes information relevant to the patient encounter. Providing identical documentation for different patients may under certain circumstances be considered cloning and hence inappropriate.
- Following best practices can minimize the risk for being flagged for cloning.

Health care providers select *Current Procedural Terminology* codes based on the service provided and then document to support the level of service reported.[1] According to the Office of Inspector General (OIG) for the US Department of Health and Human Services, "Medicare contractors have noted an increased frequency of medical records with identical documentation across services," which may under certain circumstances be considered inappropriate.[2] Regarding this practice, the OIG work plan for the 2014 fiscal year stated:

> We will determine the extent to which selected payments for evaluation and management (E/M) services were inappropriate. We will also review multiple E/M services associated with the same providers and beneficiaries to determine the extent to which electronic or paper medical records had documentation vulnerabilities.[2]

The OIG's annual work plan reflects areas of concern that will be investigated in the coming years. These investigations may result in audits of specific Medicare and Medicaid providers, including physicians.

Concerns about physicians providing identical documentation across services has evinced an ongoing focus on the so-called cloning of medical records. Cloning is not well defined but generally refers to inappropriate use of the same exact documentation, perhaps via cutting and pasting, in different patient encounters. This type of cloning could occur in office visits with the same patient or different patients. The advent of electronic health records has made such duplication easier, and the concern is that duplicated notes in a medical record for a particular encounter may not accurately reflect the services that were provided in another encounter; in some cases, services may be overdocumented, with this creating a risk that that they may also be overcoded.

How can dermatologists minimize the risk for being flagged for cloning records? If you use templates for procedures, you may consider reviewing the completed template before filing the record to ensure that the details are consistent with the procedure that was performed. If you use abbreviations or other unique documentation that may not be easily understandable to an outside authority, you may want to keep a manual somewhere in your office that defines or describes such abbreviations and notations. Also, be aware that scribing is different than cloning, and scribing is not under scrutiny by OIG.

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This article provides general information. Physicians should consult *Current Procedural Terminology (CPT)* guidelines, state regulations, and payer rules for coding and billing guidance relevant to specific cases. The opinions represented here are those of the author and have not been reviewed, endorsed, or approved by the American Medical Association, the American Academy of Dermatology, or any other coding or billing authority.
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A scribe writes word for word as a physician dictates and cannot act independently to alter or embellish the notes; once scribing is complete, both the scribe and the physician should sign the notes.

The American Academy of Dermatology has been concerned that an imprecise definition of so-called cloning can unfairly marginalize appropriate coding practices. In particular, when similar procedures or E/M services are performed by the same physician, the documentation may be very similar, even identical, while still being accurate and appropriately descriptive of the services provided. To help explain when similar notes are an acceptable practice in dermatology and when notes should be different, the American Academy of Dermatology has developed a guidance document that has been approved by its board of directors.[3]

Current Procedural Terminology coding guidelines clearly indicate that documentation cannot drive the level of coding and that excessive documentation cannot be used to justify a higher-level code, such as a higher-level E/M code. Instead, the level of service delivered should be appropriate for the patient's condition and should be documented accordingly.[4]

It is important for dermatologists to document patient encounters as accurately and completely as is necessary for good patient care. Documentation will often vary substantially from patient to patient and encounter to encounter, but sometimes routine procedures or E/M visits may be coded similarly. For instance, a shave biopsy on the cheek to rule out nonmelanoma skin cancer may be performed by a particular practitioner with a standard instrument and after standard preparation and infiltration of local anesthetic; postoperative care may also be the same. To minimize regulatory scrutiny when similar descriptions are used, review the documentation for accuracy and to confirm that important specific information has not been inadvertently omitted or that wrong information has not been appended.

Unfortunately, there are dermatologists who have been audited for cloning during the last year. As with any audit, it is important to be vigilant regarding deadlines and to file appeals in a timely manner. Keep all the notifications you receive safely and explain to your staff that any communications should be promptly forwarded to you. If you are audited for suspected cloning, you may wish to contact the coding staff of professional dermatology societies for general guidance.

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