Documentation Integrity in the Electronic Record—
Common EHR Audit Findings and Recommended Parameters

Area	Issue	Concern	Recommendation
Chief Complaint		Should be individualized	▪ Require "Subjective" notation
HPI	Must be performed by the billing physician	Ancillary staff may not collect this information and enter into the record with the physician only signing or acknowledging they read the notation	▪ Do not allow classes other than the physician (or APC) to enter into this field
Review of Systems	Automatic generation of negative findings	May result in a higher level of service delivered because in documenting a "negative" finding, it implies the provider did the assessment to reach that conclusion	▪ The ROS should be in drop-down box format ▪ The default should be blank with "negative" one of the options; prohibit "negative" as the default ▪ Must be completed at least annually
Using a Previously Recorded ROS	Automatic statements and macros stating generically that a prior ROS was reviewed	Generic ROS reviewed statements give the appearance of copy/paste/carry forward type documentation or use of a macro without actual review of a prior ROS Audit logs will show whether the physician in fact reviewed the prior ROS OIG has taken issue with ROS that never change	▪ There may be a statement that a prior ROS was reviewed ▪ There must be a blank that the physician must enter the date of the ROS that was reviewed ▪ There must be a drop-down box indicating "no changes since that date" or "the patient now reports" with a free text to indicate what has changed OR the drop down boxes used in a new ROS so that section can be updated ▪ A new ROS should be completed annually
PFSH	Carry forward with no variation	PFSH without variation across visits over time gives the appearance of copy/paste/carry forward type documentation or use of a macro without actual review of a prior PFSH	▪ There may be a statement that a prior PFSH was reviewed ▪ There must be a blank that the physician must enter the date of the PFSH that was reviewed ▪ There must be a drop-down box indicating "no changes since that date" or "the patient now reports" with a free text to indicate what has changed

		Audit logs will show whether the physician in fact reviewed the prior PFSH	
Examination	Automatic negative findings as default in template	Automatic negative findings in a template may encourage over-documentation to meet reimbursement requirements even when that portion of the exam was not performed Lack of individualization of the record	▪ The examination should be in the form of drop-down boxes by system ▪ Negative should not be the default but should be an option
	Templated exams	Exams that are templated could raise the level of exam if template is filled out completely every visit	▪ Allow what the physician does as a result of the patient's presenting issue guide his/her exam and let the coding fall based on what was done
Medical Decision-Making	Medical decision-making relates to the complexity of establishing a diagnosis and/or selecting a management option	Auditors routinely find fault with the documentation of medical decision-making, especially with respect to patients who are being seen for stable problems	▪ For each encounter, require inclusion of assessment, clinical impression or diagnosis; this could be a drop down by specialty and/or free text ▪ For a presenting problem with an established diagnosis, require drop-down boxes indicating whether the problem is (a) improved, (b) well controlled, (c) resolving, or (d) or resolved; or (e) inadequately controlled, (f) worsening, or (g) failing to change as expected ▪ Initiation of/ or changes in treatment should be documented; this may include nursing instructions, patient instructions, therapies or medications ▪ If referrals are made or consultations requested, the record should indicate to whom the referral or consult was made. Can be a drop down and/or free text ▪ If a test is reviewed, note date of the test reviewed and any initiation or change in treatment ▪ If medications are reviewed, there should be a note that says "On XX/XX/XXX the current medication list was reviewed and [drop down – there have been no changes in

			medication since the last visit OR there have been changes made in the patient's medication regime as described in the attached medication section"
	Plan	Medical necessity should be substantiated	▪ If additional testing is ordered, there should be free text indicating why it was ordered
Template: General	Templates Designed to Meet Reimbursement Levels	May encourage over-documentation to meet reimbursement requirements even when services are not medically necessary or are never delivered May make the record appear fabricated in order to increase reimbursement	▪ Require templates to be clinically oriented (i.e., abdominal pain) versus "level 4 visit" ▪ Allow what the physician does as a result of the patient's presenting issue guide his/her exam and decision-making and let the coding fall based upon what was done ▪ Educate providers on E&M requirements and provide tools
	Blanket Statements in Templates; use of Macros "If the patient is a smoker, smoking cessation counseling was performed" "If the patient is a diabetic, an A1C was performed" "The ROS was reviewed and unchanged unless noted below" "If diabetic, it is being managed by primary care provider or endocrinologist. Importance of appropriate diabetic control in the management of cardiovascular disease	Blanket cause the record to appear un-individualized/fabricated and may cause false information to be entered in a record Are they a smoker or not? Are they diabetic? Who is actually managing the diabetes?	▪ Prohibit use of blanket statements in templates

	stressed to patient – prognostic significance of last Hb1Ac explained (Last Hb1Ac where available has been noted)" "Study dates and results are detailed above" "Complex Medical Decision Making" noted in an assessment		Any attribution to data reviewed or notes by others should include the date/time/location/author of the note Medical decision-making must be substantiated by the record; blanket statements should be removed/prohibited
Accuracy of Record	Cloning Copy/Paste Carry Forward	Automatic insertion of previous or outdated information using EHR tools may raise significant quality of care and compliance concerns when not modified to be patient-specific and pertinent to the current visit	▪ Turn on copy/paste/carry forward Epic tool to highlight use of this functionality ▪ Routine audit of these alerts ▪ [Any functionality to require copy/pasted/carry forwarded documentation to be attributed to original entry and edited?] ▪ Prohibit pulling forward information from previous visits as a basis for increasing the E&M level
	Borrowed Documentation	May increase the level of service billed if it appears the physician performed the exam/service in the borrowed documentation; may create a quality of care/patient safety issue due to reliance on no longer relevant information	▪ Require borrowed documentation to be attributed to the original author, original date/time and original source (or prohibit it) ▪ Free-text changes must be noted by current physician