

Falsified Medical Records

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Introduction

In 2009, the United States government implemented the transition to electronic health record (EHR) technology. While EHR tools offer many invaluable benefits, certain features may compromise the integrity of the medical documentation if not used appropriately. Workforce Safety & Insurance (WSI) considers any record containing non-authentic documentation a falsified medical record. The purpose of this document is to outline WSI's policy on falsified medical records.

Definitions

Cloning – The practice of using previously documented information to document a current patient encounter, e.g., carry-forward, copy/paste.

Over-Documentation – The practice of inserting false or irrelevant documentation into a medical record to support a higher-level of service than was performed. Each entry must have identifiable and appropriate updates authentic to the individual encounter.

Non-Authentic Documentation – The result of using cloning or over-documentation in the medical record. Features like auto-fill and auto-prompts can result in cloned or over-documented medical records. This can occur in documentation between visits for a specific patient or in documentation from patient to patient.

Policy

WSI considers any record containing non-authentic documentation a falsified medical record. Each entry in the record must have identifiable and appropriate updates specific to the individual encounter. WSI will audit all medical documentation for medical appropriateness, necessity, and authenticity. It is the expectation all documentation in the medical record must:

- Be specific to the patient
- Be specific to the encounter
- Accurately reflect the services performed
- Support the necessity for the services
- Clearly identify who performed the services and assessments documented
- Clearly identify the author of each note or entry
- Clearly identify the date and time of the entry

In the event a medical audit reveals falsified information, WSI will only reimburse the level of service supported by authentic documentation.

Falsified Medical Records (Continued)

References

American Health Information Management Association. (2013, August). Integrity of the Healthcare Record: Best Practices for EHR Documentation. Retrieved November 2, 2020, from http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_050286

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