

"Painting Pictures" of Patients

As the fight against “fraud, abuse and waste” continues, responding to audits has become an ongoing burden for many providers. Providers have repeatedly been urged to “paint a picture” of patients in clinical documentation in order to help achieve positive results. “Painting a picture” of the patient, however, may have become more difficult as the use of electronic health records (EHRs) has increased. That is, it’s difficult to adequately describe patients’ conditions when there are so many boxes to check and blanks to fill in.

In addition, when it comes to narrative descriptions of patients’ conditions, it is extremely tempting to “copy and paste,” “cut and paste” and/or “copy forward” previous documentation in the EHR. The copy and paste feature allows users to use the content of another entry and to select information from an original or previous source to reproduce in another location. The copy forward capability replicates all or some information from a previous note to a current note, while the cut and paste feature removes documentation from the original location and places it in another location. In addition to the obvious potential problems for quality of care related to the use of these functions, auditors are understandably skeptical of documentation that repeats itself throughout patients’ medical records.

Auditors are especially likely to deny claims that include documentation that was obviously copied using the above functions, when the information copied “sticks out like a sore thumb.” If hospice staff document, for example, that “the patient eats a lot of Mexican food” over and over in clinicians’ visit notes, auditors are understandably skeptical about whether services were necessary for a hospice patient who seems to have a continuous robust appetite or whether services were, in fact, rendered.

What does it mean to “paint a picture?” If a home health patient needs wound care or injections of medications, for example, the “picture” must account for

why patients or their caregivers are not performing these activities themselves. Clinicians need to describe the following in a “picture” of the patient:

- Does the patient live alone or have caregivers?
- Why can't patients do wound care or self-inject medications
- Why can't caregivers perform these activities?
- What attempts did clinicians make to assist patients and caregivers to provide wound care and injections?
- Why were these attempts unsuccessful?
- What attempts were made to find other caregivers - either paid or voluntary - who might provide these types of care?
- What were the results of these attempts to find other caregivers?
- Despite the initial inability of patients and caregivers to render this care themselves, what efforts did clinicians make to help ensure that they became able to do so?

You get the picture. It's difficult, if not impossible, to paint the above picture using only the boxes and blanks of forms in EHRs. More is needed if providers are serious about positive audit results.

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