



Medical Coding and Reimbursement Solutions LLC

Documentation Drives Medical Necessity

donnine@mcrsconsulting.com

Preventing Cloning in Electronic Health Records

Use Diagnosis Status and Plan to keep every encounter current

By Donnine Day, BS, CPC, CPMA, CRC, CVBC, CEMC, CENTC, CGSC

Published and reviewed October 20, 2026 | Physicians, APPs, and coding teams

Copy-forward can save time. It can also carry yesterday's findings into today's record. Every note should accurately describe the care delivered. Thoughtful documentation helps explain medical necessity and support appropriate reimbursement. Use Diagnosis, Status, and Plan (DSP) to connect each condition addressed with its current clinical impact and management.

What makes a note “cloned”?

In this resource, cloning means reusing prior documentation without checking that it accurately represents the current encounter. A repeated statement may be correct; the concern is unverified, outdated, or misleading content. Copy-and-paste is not automatically improper, and repetition alone does not establish fraud. [1,2]

Why it matters

- **Patient care:** An old medication list, symptom description, or examination finding can mislead the next clinician.
- **Claim support:** A note that does not reflect the work performed may fail to explain the service or its medical necessity.
- **Record integrity:** Conflicting dates, findings, or authorship make the clinical story harder to trust. Inaccurate documentation can contribute to improper payments and compliance concerns. [1,2]

Use DSP to keep the encounter specific

Use Diagnosis, Status, and Plan (DSP) for each condition addressed. This practical framework links the problem to its current clinical impact and the actions taken today.

- **D — Diagnosis:** Identify the condition evaluated, treated, or otherwise addressed today. A carried-forward problem list alone does not show that a condition was managed.
- **S — Status:** Describe the current severity, control, symptoms, relevant findings, or response to treatment. State what changed or what remains stable, supported by today's assessment.
- **P — Plan:** Connect the condition and status to the actual management decisions, such as treatment, testing, referrals, coordination, monitoring, or follow-up. Explain the rationale when relevant.

Stable conditions may have an unchanged plan. Document the current assessment and reason for continuing it. Review copied text before signing; changing the date alone does not verify the note.

Before signing the note

- Confirm the correct patient, encounter date, and author or source of imported information.
- Review copied history and reconcile medications, allergies, and the problem list as appropriate.
- Remove obsolete text and correct contradictions between the history, examination, assessment, and plan.
- Ensure examination findings and services documented actually occurred at this encounter.
- Check DSP for each condition addressed: Is the diagnosis clear, the status current, and the plan linked to today's assessment?
- Review template defaults and auto-populated fields. Authenticate the note under practice policy. [1]

Apply DSP to a carried forward note

Illustrative scenario: A note still says an ankle is swollen and an MRI is pending. Today, the swelling has resolved and the MRI has been reviewed. Update the record to reflect the current encounter.

- **Diagnosis:** Identify the ankle condition actually evaluated today, including the side when known.
- **Status:** Record the resolved swelling, current symptoms and function, and relevant MRI findings reviewed.
- **Plan:** Explain how today's findings informed treatment, monitoring, or follow-up. Record the decisions actually made.

Use the same approach when symptoms are unchanged: describe the current status and why the existing plan remains appropriate. The example is a documentation prompt; use only supported clinical facts.

DSP helps make clinical reasoning visible. When selecting an E/M level, apply the MDM or time rules for the service family. Explain relevant data reviewed and how it informed decisions. DSP alone does not establish an E/M level or guarantee payment. [4]

Build a repeatable practice workflow

Set clear rules for copying and attribution, teach staff how EHR defaults behave, and review a small sample for stale text, contradictions, and missing Diagnosis, Status, or Plan details. Use findings for targeted education and follow-up. [1,2]

A 2013 HHS-OIG hospital study identified gaps in copy-and-paste safeguards and recommended stronger oversight. The report offers historical context for practice attention to EHR controls, documentation policies, and education. [3]

MCRS can review documentation patterns and provide practical education to help your notes tell the full clinical story.

References

1. [CMS. Ensuring Proper Use of Electronic Health Record Features and Capabilities: Decision Table \(2016\).](#)
2. [CMS. Program Integrity Issues in Electronic Health Records: An Overview \(2016\).](#)
3. [HHS-OIG. Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology \(2013\).](#)
4. [CMS. Evaluation and Management Services. Documentation, medical necessity, and service-level selection.](#)

Sources accessed October 20, 2026. Educational guidance on documentation integrity. Apply current organizational, payer, and record-amendment policies.