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# Note Bloat Consequences and Solutions

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One of the primary goals of the 2021 evaluation and management (E/M) guidelines was to reduce administrative burden on clinicians and their practices. The American Medical Association (AMA) has an initiative beyond the 2021 guidelines to reduce clinical documentation by 75 percent by 2025.

Many practices have noticed an increase in note bloat in recent years. Note bloat is a euphemism for when a healthcare provider's encounter note contains far too much irrelevant information. The use of templates, default text, drop-down lists, and copy-forward features make it too easy to add extraneous information into an encounter note.

The consequences of note bloat are serious, potentially impacting revenue and patient care.

**Consequences of Note Bloat**

In a recent litigation case, an urgent care group paid $2 million to resolve allegations of false billings for inflated and upcoded E/M services. The claim stated the practice required clinical staff to increase documentation even when it was not medically necessary. The clinicians used an EHR template that utilized defaulted text not filled out by them. The Department of Justice (DOJ) stated medical record documentation should be medically necessary to the patient's complaint. Performing a full review of the patient's history and a comprehensive examination may not be clinically relevant nor medically necessary, the DOJ contended.

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Many studies show clinical staff spend anywhere from 30 to 50 percent of their day reviewing, documenting, and entering orders into an EHR. This often results in patient appointments getting backed up or clinicians documenting on their own time.

Note bloat can also weaken the interprofessional communication between physicians within or outside of the organization. For example, when another clinician must pore over lots of pages within a medical record, clinical nuances could be missed, which can hinder the development of a patient's narrative.

**Identifying Note Bloat**

There are many areas in the medical record where we see note bloat, including the problem list. EHR systems make it easy to drop a problem list into the assessment for the encounter. The issue with these lists is that they are rarely accurate, often including outdated, unrelated, and/or unaddressed problems.

Note Bloat occurs due to clinicians pulling forward previous notes or portions of previous notes. In outpatient and inpatient visits alike, elements such as history of present illness, a complete review of system, and a comprehensive medical, family, and social history may not be clinically pertinent to the reason the patient was last seen if the clinician does not update the information.

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Clogging documentation in the medical record with labs and other diagnostic tests from several years past can also result in inaccurate coding. The documentation may not clearly indicate which tests were reviewed at the visit and clinically relevant for inclusion into E/M leveling.

**Eliminating Note Bloat**

Training coders on the basics of medical record documentation requirements is essential to eliminating note bloat. The goal of medical record documentation is to paint a picture of what occurred with the clinician and patient, so that those who were not present during the visit can understand what was done. The more succinct the medical record, the more communications with other healthcare providers will improve, and the less likely an external auditor will question the medical necessity of services.

The general principles of medical record documentation did not change with the implementation of the 2021 E/M guidelines; however, E/M services vary in several ways, such as the type of visit, the amount of physician work required, and procedures and other tests performed and/or reviewed. Also, there are minimum elements that must be documented on every visit. Per the Centers for Medicare & Medicaid Services' (CMS') E/M guidelines, these include:

⇒ reason for the encounter,

⇒ relevant history,

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⇒ physical examination findings,

⇒ prior diagnostic test results that are relevant to the visit and the physician's clinical decision making,

⇒ assessment (which is not just the ICD-10-CM codes/descriptions but the overall clinical impression), and

⇒ medical plan of care.

These general principals do not require section headers for specific elements or need to be in a specific order in the record, contrary to the 1995 and 1997 E/M guidelines. The CMS E/M guidelines state, "If the rationale for ordering a diagnostic and other ancillary service is not documented, it should be easily inferred. Past and present diagnoses should be accessible to the treating and/or consulting physician." Inference is accepted in this limited instance, and the problem list does not need to be in every note.

**Team Documentation**

Another approach to eliminating note bloat is utilizing team documentation. This process can improve overall patient care because the clinician is less focused on EHR documentation and more focused on the patient during the visit. It can also be an important cost-saving tool for organizations.

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Team documentation, or multiple contributor documentation, is a process where nonphysician team members assist with documenting visit notes, entering orders and referrals, reconciling medications, and preparing prescriptions during a patient visit. Clinical team members, such as medical assistants and nurses, and nonclinical team members, such as scribes, can all support team documentation.

The degree to which you can task share varies by state and local scope of practice regulations, however, so be mindful and do your homework before implementing this system.

**Putting an End to Note Bloat**

Eliminating unnecessary documentation (note bloat) will not only improve your practice's clinical documentation, it will also improve communication between clinicians, give clinicians more time to see patients, and help decrease burnout. Reducing note bloat will also lead to improved efficiency and accuracy of coders and auditors, reduce denials due to poor medical documentation, and, as a result, increase your practice's bottom line.

**References: AMA, AAPC**