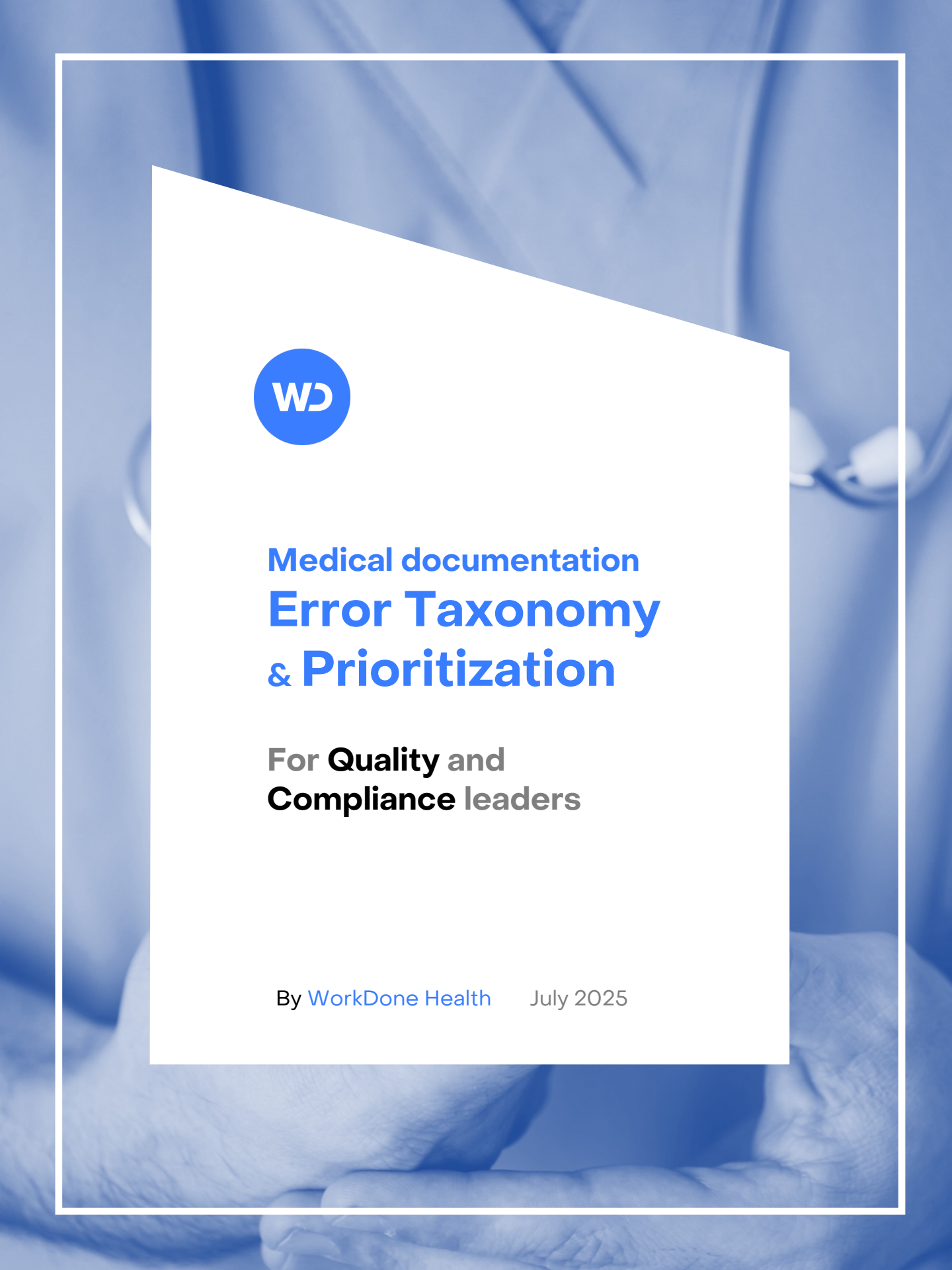


Medical documentation

Error Taxonomy & Prioritization

For **Quality** and **Compliance** leaders

By WorkDone Health

July 2025

Medical documentation error taxonomy &
Clinical Documentation Integrity query prioritization

for Medical, Quality and Compliance Officers

Executive summary

Updated July 2025

Poor clinical documentation remains one of the most persistent—and expensive—sources of preventable harm in U.S. healthcare. In FY 2024 alone, the Office of Inspector General (OIG) projected **$7.13 billion** in recoveries tied to documentation-related investigations and settlements, while CMS estimated that **79 % of Medicaid improper payments** stemmed from "insufficient documentation". At the same time, the Joint Commission's 2024 Sentinel-Event review lists incomplete or incorrect documentation as a major contributing factor in wrong-site surgery, medication management failures, and fatal patient falls.

This paper gives Medical, Quality and Compliance leaders and their teams a pragmatic framework to:

1. **Classify documentation** mistakes by combined weighted patient-safety risk and financial impact**.**

2. **Prioritize remediation initiatives** (CDI queries, EHR design changes, CDS rules, training, auditing, AI tools) on the highest-yield error classes.

The taxonomy presented in this paper empowers healthcare leaders to act decisively—, auditing 100% of records with automation and targeting the 20% of errors that cause 80% of harm and cost. Use this as your north star for documentation risk management and leverage AI to capture accelerated value for your hospitals and systems.

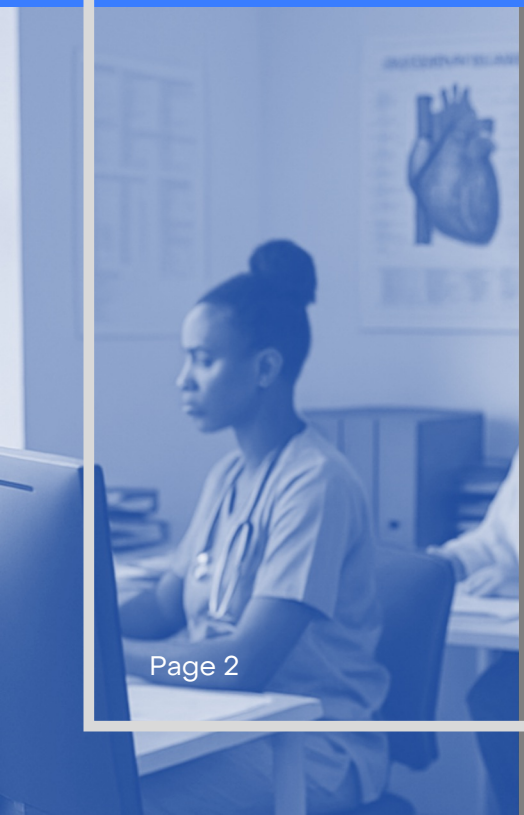
Best,
Dmitry Karpov, MS, MBA
CEO,
WorkDone Health

Practical Methodology

For Scoring and Grouping of errors in medical records

1. Dimensions and composite

Dimension	Definition	Typical weight in composite priority (choose your own)
Patient-Safety Risk (PSR)	Likelihood and magnitude of patient harm (temporary, permanent, or fatal).	**60-80 %**
Financial Impact (FI)	Direct reimbursement loss, regulatory penalties, lawsuits, and cost of rework.	**30-50 %**



2. Scoring

Scores (1 – 100) were derived from: sentinel-event prevalence, malpractice verdicts, OIG/CMS penalty data, and expert consensus panels (HIM professionals, clinicians, revenue-cycle leaders). Thresholds:

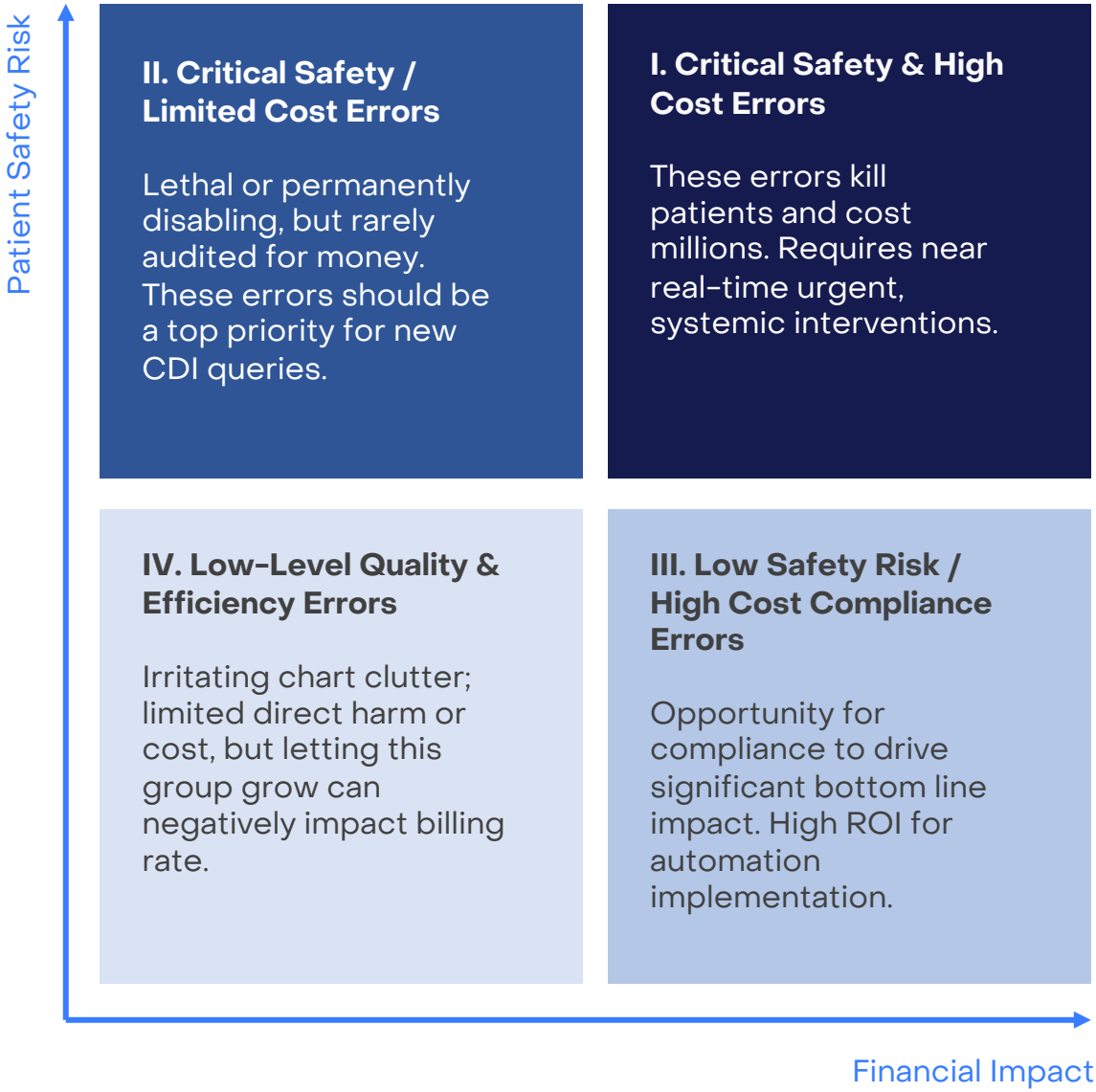
High ≥ **80**

Moderate 50 – 79

Low < 50

Severity Groups

Each group demands a tailored strategy to detect, remediate, and proactively prevent future medical errors.



Errors Group I – Critical Safety & High Cost

Type 1A – Medication Documentation Errors	PSR	FI
Insulin order written in **units but entered in mL** in the MAR	98	85
High-alert infusion rate default (Heparin) left at 50 mL/h instead of 5 mL/h	97	90
Omitted last-dose time for nephrotoxic antibiotic, causing double-dosing	94	80
Wrong **weight unit (lbs vs kg)** used to calculate paediatric chemo	99	95
Discontinued opioid **not signed/communicated**, auto-dispensed overnight	93	83

Type 1B – Allergy Documentation Errors	PSR	FI
Penicillin anaphylaxis recorded in paper intake but **not copied to EHR**	97	88
Allergy field auto-populates “NKDA,” overwriting true **iodine contrast allergy**	95	85
EHR allergy list lacks **reaction description**, CDS fails to fire	90	78
Duplicate “morphine allergy” entry with **inactive flag**, alert suppressed	88	75
Bulk copy-paste from prior admission excludes new latex allergy	89	70

Type 1C – Critical Diagnostic Result Documentation Errors	PSR	FI
Positive **blood culture** final result **never routed to attending**	96	87
Critical potassium = 2.1 mmol/L posted to inbox after discharge, no action	94	82
Radiologist’s note “probable aortic dissection” filed under wrong patient	98	92
Post-op pathology “malignant” scanned but not indexed, referral delayed	93	85
STAT **CT head bleed** alert buried under routine labs in EHR queue	97	88

Group II – Critical Safety / Limited Cost

Type 2A – DNR / Advance-Directive Misdocumentation	PSR	FI
DNR order absent; patient receives full code against wishes	95	35
DNR rescinded, **EHR banner not cleared**, staff withhold resuscitation	96	40
Conflicting "POLST" vs chart orders, **erroneous intubation**	92	38
Advance directive scanned but **labelled wrong encounter**, unseen	88	30
Out-of-state DNR entered without verification, causing delay	86	28

Type 2B – Fall-Risk Assessment Omissions	PSR	FI
No Morse score documented; **anticoagulated patient** left unassisted	90	25
Automatic import of prior "low-risk" status overrides new **mobility limits**	88	22
Missed **bed-alarm order** entry after night shift	85	24
PT eval delayed due to missing referral order in note	80	20
Duplicate fall-risk tools yielding conflicting scores	78	18

Type 2C – Infection-Control Documentation Errors	PSR	FI
Central-line insertion checklist left blank; CLABSI ensues	93	45
MRSA isolation discontinued in chart but **room signage left**	88	38
Antibiotic start time omitted, therapy >1 h post-sepsis onset	92	42
Negative pressure room status mis-documented for TB patient	90	40
Incomplete **surgical scrub timeout note**	87	30

Group III – Low Safety Risk / High Cost Compliance Errors

Type 3A – DRG / Coding Specificity Errors	PSR	FI
MI coded as **NSTEMI** instead of STEMI; **CMS downcodes $12 k**	30	92
Major CC **respiratory failure not linked** to COPD exacerbation	25	88
Missing **laterality modifier** on orthopedic procedure	20	85
Sepsis ruled out but coded, triggering RAC audit	40	90
COVID-19 diagnosis carried over after negative PCR	15	80

Type 3B – Charge-Capture Omissions	PSR	FI
Neural-block procedure note lacks **CPT 64447**, $1.2 k lost	10	86
OR nurse forgets to document **implantable device serial**, no revenue match	12	83
Missing **prolonged service time** documentation for critical care	20	90
Infusion stop times absent, denying 2nd-hour charges	18	87
Self-administered drug not flagged, payer rejects	10	82

Type 3C – Pre-Authorization / Medical-Necessity Documentation Errors	PSR	FI
MRI of spine scheduled without documented failed PT; denied	12	89
Cosmetic vs reconstructive **breast surgery rationale** omitted	18	88
Inpatient admission order lacks "expect ≥ 2 midnights."	25	90
Skilled-nursing certification signature late, 100 % payment claw-back	20	86
Home-health OASIS note missing functional score documentation	10	84

Group VI – Low-Level Quality & Efficiency Errors

Type 4A – Copy/Paste & Note-Cloning	PSR	FI
Resident duplicates **9-day-old vitals**, hiding new fever	50	40
Anticoagulation plan pasted even after drug stopped	45	32
15 pages of cloned HPI obscure critical radiology result	48	35
Wrong gender pronouns throughout note	20	15
Repeated “alert and oriented” after patient intubated	55	30

Type 4B – Template Default Values Not Updated	PSR	FI
Discharge template lists **“follow-up in 2 weeks”** for hospice patient	38	28
Auto-checked **“no drains”** though JP drain placed	42	25
Admission power-plan defaults to outdated VTE prophylaxis	35	30
Nil per os status auto-expires; diet order not revised	30	22
BMI auto-calc error due to missing height	20	18

Type 4C – Spelling / Grammar & Note Bloat	PSR	FI
“Allergic to sulfa” typed as “sulfur” (ambiguous)	25	15
12-page discharge summary includes **four duplicate med lists**	22	18
Mis-typed decimal in creatinine (“0.8” vs “.08”) flagged later	28	25
SOAP note contains jargon acronyms unreadable to patient	15	10
Excess verbiage delays cross-cover review	18	12

Translating the taxonomy into action plans

1 Prioritize Groups I &II

EHR-embedded forced functions (weight-based dose calculators, allergy import validation).

Near-real-time **AI monitoring** of EHR/EMR data and **automated prioritization** of CDI Queries

High-reliability hand-off protocols (IPASS, read-backs).

Monthly “no-blame” chart audits tied to safety huddles.

2 Address Group III concurrently

AI-Assisted Coding (AIC) with daily CDI query workflow.

Automate **charge-capture reconciliation** (clock-in/clock-out infusion, device serial import).

Maintain a **living library of payer medical-necessity rules** surfaced at order entry.

3 Sustain Group II and IV with education & housekeeping

Embed **decision aids** (fall-risk calculators, isolation dashboards).

Tighten note templates, throttle copy/paste, and expose note-length metrics to providers.

Leverage **Speech-to-Text with intent tagging** to replace free-text sprawl.

Implementation Roadmap

Blueprint for documentation compliance initiatives

Step 1: Baseline Audit

Conduct a comprehensive review of current documentation and workflows to identify existing error types, frequency, and root causes. This establishes a quantitative and qualitative baseline against which future improvements will be measured.

Step 2: Prioritize Top-Scoring Error Types

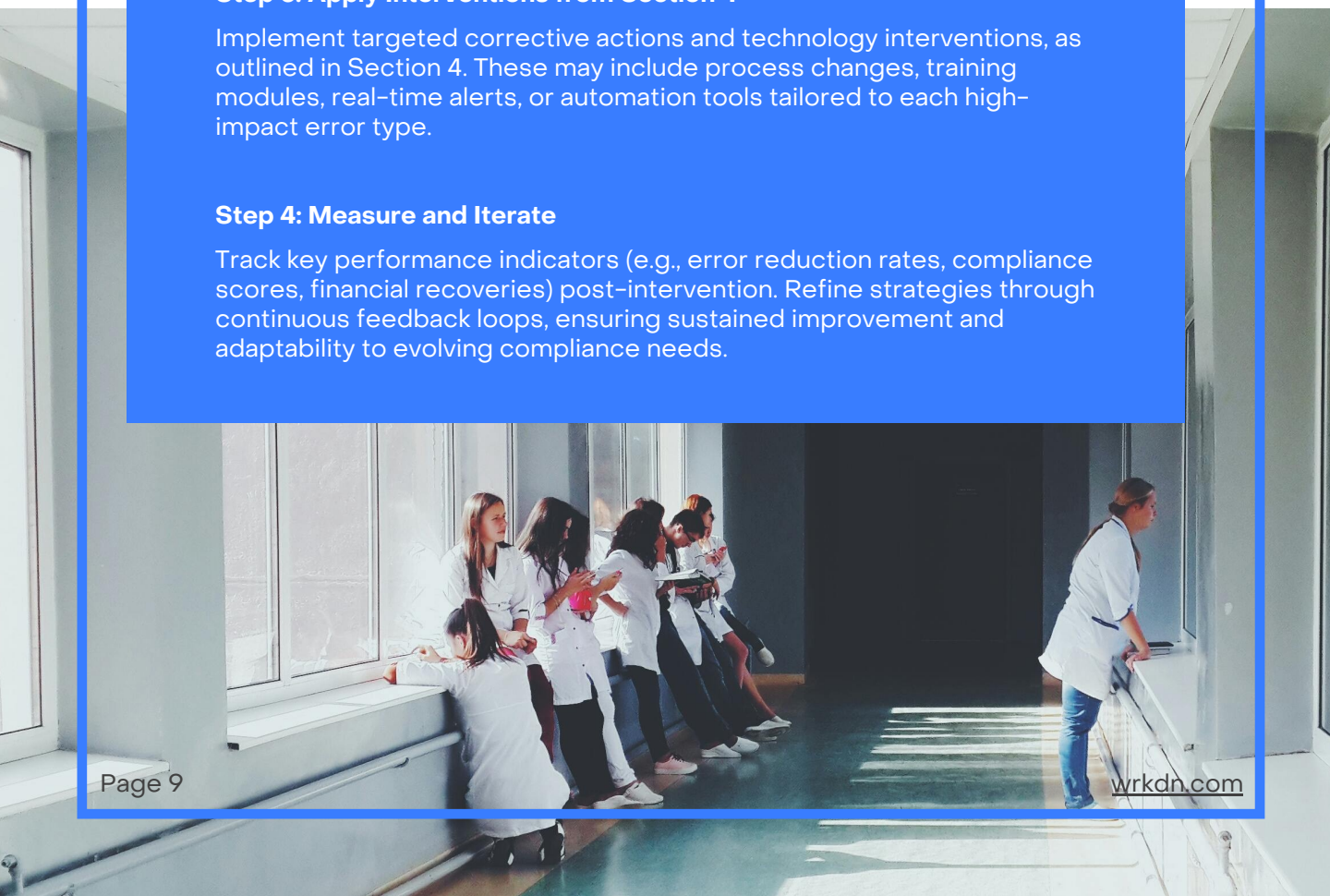
Use audit findings to rank error categories by severity—based on patient safety risk and financial impact. Focus initial efforts on the highest-priority issues to maximize ROI and clinical outcomes.

Step 3: Apply Interventions from Section 4

Implement targeted corrective actions and technology interventions, as outlined in Section 4. These may include process changes, training modules, real-time alerts, or automation tools tailored to each high-impact error type.

Step 4: Measure and Iterate

Track key performance indicators (e.g., error reduction rates, compliance scores, financial recoveries) post-intervention. Refine strategies through continuous feedback loops, ensuring sustained improvement and adaptability to evolving compliance needs.



The first 90 days - pilot initiative

90 days pilot initiative

Begin with a focused, high-impact pilot. Identify one high-risk documentation error from **Groups I & II** and one high-dollar compliance issue from **Group III**. Implement targeted interventions in a single clinical unit, leveraging existing CDI, QI, or EHR support infrastructure.

Within 60-90 days, health systems can usually demonstrate:

- Reduced documentation-related patient safety risks
- Improved charge capture and audit defensibility
- Staff engagement around measurable, fixable problems

These early results can serve as a platform for broader institutional buy-in, resourcing, and scale.

Baseline audit & AI automation PoC – no EHR integration required

A basic proof of concept with a simple PoC metric – errors in **Groups I-III** uncovered with AI automation vs existing CDI workflows (or CDI automation focused on coding/diagnosis only):

1. Prepare sample of 200-500 charts that have been reviewed manually/with existing workflow.

3. Categorize previously identified CDI issues into groups, evaluating them on both PSI and FI scales.

2. Test the sample with a secure HIPPA-complaint AI software without integrating it into your IT infrastructure (sandbox test).

3. Establish the baseline and differential, evaluate ROI from potential automaton.

WORK DONE Introduction

WorkDone Health is San-Francisco based technology company that provides real-time AI compliance solutions for medical documentation in hospitals, clinics, billing providers and vendors. The platform proactively monitors Electronic Health Records (EHR) and billing documents to catch, fix and prevent clinical and billing-related errors.

Key Capabilities:

Proactive compliance monitoring
Uses a secure, high-accuracy, proprietary HIPAA-compliant large language model (LLM) to continuously audit documentation and find issues in real time.

Automated correction and coding
Suggests one-click corrections, identifies missing notes and diagnoses, and assigns accurate codes.

Always up to date compliance rules and controls
WorkDone maintains up-to-date compliance database for medical documentation based on the following sources:

- **CMS**
- **The Joint Commission**
- **AMA, OIG, AHIMA, AAPC**
- **Payor guidelines** (UHC, Anthem, Aetna, Cigna, Humana, BCBS, Association, Molina, Centene, Highmark)

WorkDone also ingest hospital-specific custom policies and learns from clinician feedback to continuously improve accuracy and usability.

Competitive differentiators:

Real Time Analysis & Notifications

Intelligent Scoring & Prioritization

Automated drafts of fixes

Own LLM for Privacy & Security

Epic athenahealth Cerner MEDITECH Kipu

Ready for the Next Step?

Choose one or more

- ❑ Improved patient care quality
- ❑ Lower readmission rate
- ❑ Fewer claims denials
- ❑ Faster billing and reimbursement
- ❑ Reduced regulatory and legal risks
- ❑ TJC Readiness

Book a demo with
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