Documentation Guidelines for Amended Medical Records

Elements of a Complete Medical Record

When records are requested, it is important that you send all associated documentation that supports the services billed within the timeframe designated in the written request. Sometimes that information may come from a visit or test performed earlier than the claim in question. Elements of a complete medical record may include:

- Physician orders and/or certifications of medical necessity
- Patient questionnaires associated with physician services
- Progress notes of another provider that are referenced in your own note
- Treatment logs
- Related professional consultation reports
- Procedure, lab, x-ray and diagnostic reports
- Billing provider notes for billed date of service

Amended Medical Records

Late entries, addendums, or corrections to a medical record are legitimate occurrences in documentation of clinical services. A late entry, an addendum or a correction to the medical record, bears the current date of that entry and is signed by the person making the addition or change.

Late Entry: A late entry supplies additional information that was omitted from the original entry. The late entry bears the current date, is added as soon as possible, is written only if the person documenting has total recall of the omitted information and signs the late entry.

Example: A late entry following treatment of multiple trauma might add: *"The left foot was noted to be abraded laterally. John Doe MD (Medical Doctor or Maryland) 06/15/09"*

Addendum: An addendum is used to provide information that was not available at the time of the original entry. The addendum should also be timely and bear the current date and reason for the addition or clarification of information being added to the medical record and be signed by the person making the addendum.

Example: An addendum could note*: "The chest x-ray report was reviewed and showed an enlarged cardiac silhouette. John Doe MD (Medical Doctor or Maryland) 06/15/09"*

Correction: When making a correction to the medical record, never write over, or otherwise obliterate the passage when an entry to a medical record is made in error. Draw a single line through the erroneous information, keeping the original entry legible. Sign or initial and date the deletion, stating the reason for correction above or in the margin. Document the correct information on the next line or space with the current date and time, making reference back to the original entry.

Correction of electronic records should follow the same principles of tracking both the original entry and the correction with the current date, time, reason for the change and initials of person making the correction. When a hard copy is generated from an electronic record, both records must show the correction. Any corrected record submitted must make clear the specific change made, the date of the change, and the identity of the person making that entry.

Falsified Documentation

Providers are reminded that deliberate falsification of medical records is a felony offense and is viewed seriously when encountered. Examples of falsifying records include:

- Creation of new records when records are requested
- Back-dating entries
- Post-dating entries
- Pre-dating entries
- Writing over, or
- Adding to existing documentation (except as described in late entries, addendums and corrections)

Corrections to the medical record legally amended prior to claims submission and/or medical review will be considered in determining the validity of services billed. If these changes appear in the record following payment determination based on medical review, only the original record will be reviewed in determining payment of services billed to Medicare.

Appeal of claims denied on the basis of an incomplete record may result in a reversal of the original denial if the information supplied includes pages or components that were part of the original medical record, but were not submitted on the initial review.

Resources

- Section 1833(e) Title XVIII of the Social Security Act (No Documentation)
- Section 1842(a)(1)(c) of the Social Security Act (Carrier Audits)
- Section 1862(a)(1)(A) of Title XVIII of the Social Security Act (Medical Necessity)
- Schott, Sharon. "How Poor Documentation Does Damage in the Court Room." Journal of AHIMA (American Health Information Management Association) 74, no. 4 (April 2003): 20-24
- Dougherty, Michelle. "Maintaining a Legally Sound Health Record." Journal of AHIMA (American Health Information Management Association) 73, no. 8 (April 2003): 64A-G

Last Updated Aug 14 , 2018