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Documentation Guidelines for Amended Records – Revised

Note: This article from "Medicare B News," Issue 236 dated April 17, 2007 is being updated and reprinted to ensure that the NAS provider and supplier community has access to recent publications that contain the most current, accurate and effective information available.

Medical Review Payment Decisions

Incomplete or illegible records can result in denial of payment for services billed to Medicare. Claim payment decisions that result from a medical review of your records are not a reflection on your competence as a health care professional or the quality of care you provide to your patients. Specifically, the results are based on review of the documentation that Medicare received.

In order for a claim for Medicare benefits to be valid, there must be sufficient documentation in the provider's or hospital's records to verify the services were performed, were "reasonable and necessary" and required the level of care that was delivered.

Please understand that Medicare is aware that some patients do require professional services at greater frequency and duration than others, including more extensive diagnostic procedures. When this is the case, documentation substantiating the medical necessity for such treatment must be in the medical record. The documentation of all services rendered is absolutely necessary in order for a claim to be properly evaluated.

If there is no documentation, then there is no justification for the services or level of care billed. Additionally, if there is insufficient documentation on the claims that have already been adjudicated by Medicare, reimbursement may be considered an overpayment and the funds can be partially or fully recovered.

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. 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

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 or initials 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 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 or initialed 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 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 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 be corrected. 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.

Sources: 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 74, No. 4 (April 2003): 20-24; Dougherty, Michelle, "Maintaining a Legally Sound Health Record." Journal of AHIMA 73, no. 8 (April 2003): 64A-G

Medicare Program Integrity Manual
Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

Table of Contents

(Rev. 512, 04-18-14)

Transmittals for Chapter 3

"Medicare requires that medical record entries for services provided/ordered be authenticated by the author. The method used shall be a handwritten or electronic signature. Stamp signatures are not acceptable. Beneficiary identification, date of service, and provider of the service should be clearly identified on the submitted documentation.

The documentation you submit in response to this request should comply with these requirements. This may require you to contact the hospital or other facility where you provided the service and obtain your signed progress notes, plan of care, discharge summary, etc.

If you question the legibility of your signature, you may submit an attestation statement in your ADR response.

If the signature requirements are not met, the reviewer will conduct the review without considering the documentation with the missing or illegible signature. This could lead the reviewer to determine that the medical necessity for the service billed has not been substantiated."

J. Potential Fraud Referrals

At any time, suspected fraud shall result in a referral to the ZPIC for development. If MAC, Recovery Auditor or CERT reviewers identify a pattern of missing/illegible signatures, the reviewer shall refer to the appropriate ZPIC for further development.

3.3.2.5 - Amendments, Corrections and Delayed Entries in Medical Documentation

(Rev. 442, Issued: 12-07-12, Effective: 01-08-13, Implementation: 01-08-13)

This section applies to MACs, CERT, Recovery Auditors, and ZPICs, as indicated.

A. Amendments, Corrections and Delayed Entries in Medical Documentation

Providers are encouraged to enter all relevant documents and entries into the medical record at the time they are rendering the service. Occasionally, upon review a provider may discover that certain entries, related to actions that were actually performed at the time of service but not properly documented, need to be amended, corrected, or entered after rendering the service. When making review determinations the MACs, CERT, Recovery Auditors, and ZPICs shall consider all submitted entries that comply with the widely accepted Recordkeeping Principles described in section B below. The MACs, CERT, Recovery Auditors, and ZPICs shall NOT consider any entries that do not comply with the principles listed in section B below, even if such exclusion would lead to a claim denial. For example, they shall not consider undated or unsigned entries handwritten in the margin of a document. Instead, they shall exclude these entries from consideration.

B. Recordkeeping Principles

Regardless of whether a documentation submission originates from a paper record or an electronic health record, documents submitted to MACs, CERT, Recovery Auditors, and ZPICs containing amendments, corrections or addenda must:

1. Clearly and permanently identify any amendment, correction or delayed entry as such, and

2. Clearly indicate the date and author of any amendment, correction or delayed entry, and

3. Not delete but instead clearly identify all original content

Paper Medical Records: When correcting a paper medical record, these principles are generally accomplished by using a single line strike through so that the original content is still readable. Further, the author of the alteration must sign and date the revision. Similarly, amendments or delayed entries to paper records must be clearly signed and dated upon entry into the record.

Electronic Health Records (EHR): Medical record keeping within an EHR deserves special considerations; however, the principles wed above remain fundamental and necessary for document submission to MACs, CERT, Recovery Auditors, and ZPICs. Records sourced from electronic systems containing amendments, corrections or delayed entries must:

a. Distinctly identify any amendment, correction or delayed entry, and

b. Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record.

C. If the MACs, CERT or Recovery Auditors identify medical documentation with potentially fraudulent entries, the reviewers shall refer the cases to the ZPIC and may consider referring to the RO and State Agency.

3.3.2.6 - Psychotherapy Notes

(Rev. 377, Issued: 05-27-11, Effective: 06-28-11, Implementation: 06-28-11)

This section applies to MACs, CERT, Recovery Auditors or ZPICs, as indicated.

Psychotherapy notes are defined in 45 CFR§164.501 as "notes recorded by a mental health professional which document or analyze the contents of a counseling session and that are separated from the rest of a medical record." The definition of psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of administered treatment, results of clinical tests, and any summary of diagnosis, functional status, treatment plan, symptoms prognosis, ongoing progress and progress to date. This class of information does not qualify as psychotherapy note material. Physically integrating information excluded from the definition of psychotherapy notes and protected information into one document or record does not transform the non-protected information into protected psychotherapy notes.

Medical Record Entries: What Is Timely and Reasonable?

September 1st, 2013

Coding Compass

Because so many factors weigh into the answer, it depends.

By Robert A. Pelaia, Esq., CPC, CPCO

Every year at AAPC's national conference, several members of AAPC's Legal Advisory Board present an open forum session to respond to a wide variety of questions from attendees. For the past few years, without fail, audience members have asked for guidance on medical record entry timeliness and reasonable record keeping. This is not an easy topic and there is no one answer that will apply to the many scenarios coders encounter.

In 2006, however, useful and practical guidance regarding medical record documentation was released by the medical director of First Coast Service Options, Inc. (FCSO). The current Medicare administrative contractor for Puerto Rico, the U.S. Virgin Islands, and Florida also has recently issued helpful information regarding this. In addition to several other issues, FCSO's medical director touched upon the overall timeliness of documentation, medical record addenda, legibility, and "cloning." Here are selected excerpts in regards to timeliness from the FCSO memo (see pages 3-6), followed by practical compliance tips that apply to each issue raised.

Medicare Comment No. 1

"Medicare expects the documentation to be generated at the time of service or shortly thereafter. Delayed entries within a reasonable time frame (24 to 48 hours) are acceptable for purposes of clarification, error correction, the addition of information not initially available, and if certain unusual circumstances prevented the generation of the note at the time of service."

Compliance Tips: Medicare has clearly stated that "reasonable" means 24 to 48 hours. Understand that anything beyond 48 hours could be considered unreasonable. Providers should comply with this requirement and complete documentation in a timely manner. Those responsible for coding and/or entering charges need to be cognizant of the timeliness of medical record completion. It's unreasonable to expect a provider to recall the specifics of a service two weeks after the service was rendered. Nor should an entry be made in advance.

Medicare Comment No. 2

"The medical record cannot be altered. Errors must be legibly corrected so that the reviewer can draw an inference as to their origin. These corrections or additions must be dated, preferably timed, and legibly signed or initialed."

Compliance Tips: To properly execute a medical record addendum, the provider must, at a minimum, write the following details in the medical record:

- The date the record is being amended
- The details of the amended information
- A statement that the entry is an addendum to the medical record (An addendum should not be added to the medical record without identifying it as such.)
- The date of the service being amended
- The signature of the provider writing the addendum

The medical record should be amended within a reasonable time that would allow the service provider to recall the specific details of the patient encounter. Medical record addenda should be an exception, rather than a routine or recurring part of medical record documentation. Medical record addenda must be properly identified and reference must be made to the original note being amended. Failure to properly amend the medical record may give the appearance of "falsifying documentation," which is considered fraudulent.

Medicare Comment No. 3

"Every note must stand alone, i.e., the performed services must be documented at the outset. Delayed written explanations will be considered. They serve for clarification only and cannot be used to add and authenticate services billed and not documented at the time of service or to retrospectively substantiate medical necessity. For that, the medical record must stand on its own with the original entry corroborating that the service was rendered and was medically necessary."

Compliance Tips: Again, addenda to the medical record should not be a normal practice—these should be the exception and not the rule. Coders responsible for reviewing documentation should be cognizant of providers who demonstrate patterns of insufficient documentation that necessitate addenda. It's also important to remember that medical record addenda need to be made to the original medical record, not just to the billing copy.

Medicare Comment No. 4

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"All entries must be legible to another reader to a degree that a meaningful review may be conducted. All notes should be dated, preferably timed, and signed by the author."

Compliance Tips: Legibility of medical record documentation is not just a billing issue; it's a patient care issue. Illegible documentation may result in medication errors and incorrect diagnoses being assigned to the patient. The medical record must be legible to an individual who is not familiar with the provider's handwriting. Notes should be timed and dated appropriately, as well. The timing of a medical record note is especially important in inpatient charts, emergency department settings, trauma settings, and critical care units. It's especially critical for the service provider's identity to be legible. Signatures also should include the provider's credentials.

Medicare Comment No. 5

"Documentation is considered cloned when each entry in the medical record for a patient is worded exactly alike or similar to the previous entries. Cloning also occurs when medical documentation is exactly the same from patient to patient. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment."

"Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information. All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter. Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made."

Compliance Tips: Templates certainly are useful tools, but providers must use caution when applying "templated" language. Specifically, (although it may seem obvious) providers must ensure that what is being represented in the medical record actually took place and isn't something the provider normally does, but may not have done for that particular patient.

Robert A. Pelaia, Esq., CPC, CPCO, is senior university counsel for health affairs at the University of Florida College of Medicine in Jacksonville, Fla. He is certified as a Health Care Law Specialist by the Florida Bar Board of Legal Specialization and Education, serves on AAPC's Legal Advisory Board, and was a 2011-2013 AAPC National Advisory Board member. Pelaia is a member of the Jacksonville River City, Fla., local chapter.

Tags: Compliance, Medical Record, pelaia, reasonable, templates, timeliness

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September 1st, 2007

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Every year at the AAPC national conference, several members of AAPC's Legal Advisory Board present an open forum session to respond to a wide variety of questions from attendees. For the past few years, without fail, numerous audience members have asked for guidance on the timeliness of entries to the medical record. This is not an easy topic and there is no way to give one answer that will apply to the many scenarios that coders may encounter.

The medical director of First Coast Service Options, Inc. (FCSO), the Medicare Part B carrier for Florida and Connecticut, recently issued some useful and practical guidance regarding medical record documentation. In addition to several other issues, the medical director touched upon the overall timeliness of documentation, medical record addenda, the legibility of medical records and medical record "cloning."

The following are some selected excerpts from the memo, followed by some practical compliance tips that apply to each issue raised.

Medicare Comment #1: Medicare expects the documentation to be generated at the time of service or shortly thereafter. Delayed entries within a reasonable time frame (24 to 48 hours) are acceptable for purposes of clarification, error correction, the addition of information not initially available, and if certain unusual circumstances prevented the generation of the note at the time of service.

Compliance Tips on Comment #1: Medicare has clearly stated that "reasonable" means 24 to 48 hours. As such, it is important to understand that anything beyond 48 hours could be considered unreasonable. Providers should comply with this requirement and complete documentation in a timely manner. Those responsible for coding and/or entering charges need to be cognizant of the timeliness of medical record completion. It is not reasonable to expect that a provider would normally recall the specifics of a service two weeks after the service was rendered. An entry should never be made in advance.

Medicare Comment #2: The medical record cannot be altered. Errors must be legibly corrected so that the reviewer can draw an inference as to their origin. These corrections or additions must be dated, preferably timed, and legibly signed or initialed.

Compliance Tips on Comment #2: To properly execute a medical record addendum, the provider must, at a minimum, write the following details in the medical record:

- The date the record is being amended.
- The details of the amended information.
- A statement that the entry is an addendum to the medical record (it is not appropriate to add an addendum to the medical record without identifying it as such).
- The date of service of the service being amended.
- The signature of the provider writing the addendum.

The medical record should be amended within a reasonable period of time that would allow the provider of service to recall the specific details of the patient encounter. Medical record addendums should be an exception rather than a routine or recurring part of medical record documentation. Medical record addenda must be properly identified and reference must be made to the original note being amended. Failure to properly amend the medical record may give the appearance of "falsifying documentation," which is considered fraudulent.

Medicare Comment #3: Every note must stand alone, i.e., the performed services must be documented at the outset. Delayed written explanations will be considered. They serve for clarification only and cannot be used to add and authenticate services billed and not documented at the time of service or to retrospectively substantiate medical necessity. For that, the medical record must stand on its own with the original entry corroborating that the service was rendered and was medically necessary.

Compliance Tips on Comment #3: Addenda to the medical record should not be a normal practice — these should be the exception and not the rule. Coders responsible for reviewing documentation should be cognizant of providers who demonstrate patterns of insufficient documentation that necessitate addenda. It is important to remember that medical record addenda need to be made to the original medical record, not just to the billing copy.

Medicare Comment#4: All entries must be legible to another reader to a degree that a meaningful review may be conducted. All notes should be dated, preferably timed, and signed by the author.

Compliance Tips on Comment #4: Legibility of medical record documentation is not just a billing issue; it is a patient care issue. Illegible documentation may result in medication errors and incorrect diagnoses being assigned to the patient. The medical record must be legible to an individual who is not familiar with the provider's handwriting. In addition, notes should be timed and dated appropriately. The timing of a medical record note is

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especially important in an inpatient chart, emergency department settings, trauma settings, and critical care [illegible] especially critical that the identity of the provider of service be legible. Signatures should also include the provider's credentials.

Medicare Comment #5: Documentation is considered cloned when each entry in the medical record for a patient is worded exactly alike or similar to the previous entries. Cloning also occurs when medical documentation is exactly the same from patient to patient. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment. Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information. All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter. Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

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Tags: cloning, Compliance, documentation, fraud, medical necessity, Medical Record, Medicare, overpayment, pelvis, signature, template, timeliness

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