Codify
BY AAPC

Dermatology Coding Alert

Reader Question: Amend Documentation With Care

Question: One of our dermatologists wants to amend documentation of a procedure, but we don't know the correct way to do this without running into compliance issues. Can you recommend any resources?

North Carolina Subscriber

Answer: You can find CMS instruction for amending documentation in the Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.5 at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf. This section is titled "Amendments, Corrections and Delayed Entries in Medical Documentation."

CMS encourages providers to "enter all relevant documents and entries into the medical record at the time" of service. But CMS also recognizes that "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."

Audit survival: CMS directs reviewing parties (MACs, CERT, RACs, and ZPICs) to consider amended entries only if the amendments follow specific rules. To quote the manual, documentation must:

- Clearly and permanently identify any amendment, correction, or delayed entry as such, and
- Clearly indicate the date and author of any amendment, correction, or delayed entry, and
- Not delete but instead clearly identify all original content.

Keep in mind: If your practice uses an electronic health record (EHR), Medicare advises paying particular attention to ensuring documentation clearly identifies which information is original and which information has been added. Additionally, "the date and authorship of each modification of the record" must be identifiable, so work with providers to create a system for meeting these requirements.