Dermatology Coding Alert

Reader Question: Correct EHR Entries As You Would Paper

Question: We are aware of how to correct a mistake on a paper medical record, but how do we do this with an EHR?

Codify Subscriber

Answer: Errors in the medical record no matter what the format should be legibly corrected so the reviewer can draw an inference to its origin. If your provider makes a correction, he should include the date and (preferably) the time of the amendment. Then, the person making the change should also sign or initial the entry within the EHR. Never remove the original information from the record simply mark it as inaccurate or corrected so that any auditor can clearly read both the original entry and the addendum.

Example: Your provider accidently copies and pastes a sentence from one patient's record into another patient's record. Someone in your practice catches the error later on.

Even if you realize that you put it on the wrong patient's record or that that comment is totally inappropriate for that particular patient, then it should not be taken out of the record, but instead should be corrected using an appropriate method such as lining through it and initialing above it to say that was an error, along with the date and time of the correction.

Be clear: Delayed written additions/explanations 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 example, if your practice did an audit and found that one of your providers was billing based on time but never included the total time spent with the patient in the chart notes, you cannot go back later on and add the time to support the billing.