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Internal Medicine Coding Alert

Documentation: Protect Yourself From Audits with These Documentation Tips

Records corrections need to be done wisely.

A long list of government entities pour over your patient records, but that doesn't mean you have to be a helpless target. Follow these tips about documenting corrections and additions to your physician's notes to help avoid red flags.

Yes, You Can Correct On Behalf of Others

Staff sometimes question whether they are allowed to make corrections to a medical record if someone else (i.e., a supervisor) asks them to do so.

The answer: It is perfectly OK for a clinician to make changes to the record at another person's request, says consultant **Judy Adams** in Chapel Hill, N.C. Be sure the physician actually remembers the information, or reads notes or other written information that triggers their memory of the additional information, adds Washington, D.C.-based attorney **Elizabeth Hogue**.

Judge Whether Clarifications Are Too Late

Whether your correction or late entry is helpful or harmful may depend on its timing. "The later after the fact that documentation is added or changed, the less credible it becomes," Adams points out. "The most accurate documentation occurs when it is written at the time of the event."

Changes "should not be common, particularly if time has elapsed," says consultant **Rebecca Friedman Zuber** in Chicago, Ill. Physicians "that make a lot of corrections in their clinical records will raise questions, should their records be reviewed. It will look like they are writing what they want to have there, not documenting what actually occurred during the delivery of care."

Modifications at almost the same time as the original documentation, however, are usually more acceptable -- especially if your group is making a big push to improve its charting.

"If you're working to improve staff documentation, you should be working concurrently with those staff members, so any documentation changes that result should be pretty contemporaneous with the original entry," Zuber says.

Follow 5 Steps to Successful Changes

Appropriate late entries will only help when you follow the rules. Follow these five steps to make sure your corrections pass muster during review:

- Cross out, don't black out. If you are correcting an incorrect statement in the record, draw a line through the statement and put the word "error" next to it, Zuber says. Then sign or initial it (depending on your group's policy) and put the date. Be sure the original information is still readable and is included in the record.
- Don't forget the title. The cardinal sin of making corrections is failing to note the late entry. Clearly mark the correction or supplementation as a late entry.
- Include a date and signature. If someone other than the physician makes the correction, the record should document who made the entry and coordination of that person's input with the original writer.
- Don't be stingy. Jot down the purpose of the entry, such as "clarification." "It's also helpful to indicate ... the source of the additional information, such as 'based on notes jotted during the visit'," Adams says.

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- Consider these issues for computer records. When you correct an electronic record, remember that the original information must remain in the record, advises the University of Michigan Health System in its medical documentation policy. And "in situations where there is a hard copy printed from the electronic record, the hard copy must also be corrected."

Don't Be Scared Away From Corrections

Don't let the caution you must exercise with corrections or additions scare you away from using them altogether.

"We all find times ... when someone else reads what we have written, or we re-read" and it's not as clear as we originally thought, Adams says. "Or we left some key information out of the documentation. Whenever this occurs, additions or corrections to our documentation can occur."

In fact, "sometimes, it is the questions of others that trigger us to improve our documentation," Adams adds. "We suddenly realize that 'what I meant as I was writing did not communicate what I thought it did.'"

Bonus: And making such changes can spur clinicians to produce better documentation in the future, experts add.

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