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# Part B Insider (Multispecialty) Coding Alert

## DOCUMENTATION: Documentation Addendums Are Acceptable--Most of the Time

**Ensure that the physician isn't amending the record just to get the claim paid**

**Imagine this:** Your physician documents a visit with a patient but leaves out critical information about the services that the doctor provided. Now you-re unable to report the appropriate code for the visit.

**How can you remedy this?** In many cases, the doctor can simply write an addendum to the medical record--but be sure that your addendum meets the requirements.

**Ensure clarity:** -The critical issue when amending a patient's medical record is that the physician needs to ensure that any subsequent treating provider reviewing the patient's medical record can determine precisely what the amendment is and when it was made,- says **Mark**. **C. Rogers, Esq.,** with **The Rogers Law Firm** in Boston.

**Make sure you-re amending for the right reasons:** -My first question to the physician is, -Why are you addending it?-- says **Margaret T. Atkinson, BS, CPC, RMC**, business manager at **Centennial Surgery Center** in Vorhees, N.J. -You should never consider whether the patient has coverage when making your decision on how to treat the patient, and you can't change the record to reflect information that will help get the claim paid if it's not true to what the doctor performed,- she says.

**Example:** A gastroenterologist sees a patient and orders a colono-scopy screening. He notes the chief complaint as, -Patient's over 50 and presents for colonoscopy screening.-

The coder reviews the chart and knows that Medicare will deny coverage because the patient has already had a screening colonoscopy within the last two years, so she alerts the physician to this.

The physician tells the coder that the patient had rectal bleeding, and that he-d like to amend the chart to include that as the chief complaint.

**Solution:** -In this case, I would ask the physician what the timing and duration was of the rectal bleeding,- Atkinson says.

-If the rectal bleeding is resolved by the time of the visit, then that would be categorized as past, family and social history, so you couldn't amend the record to make it the chief complaint,- Atkinson says. -But if it is a current condition, you can amend the record to reflect that.-

**Make sure the addendum is signed, dated:** When you add information to the medical record, the physician should initial or sign the addendum, and include the date and time that he made the revision, Rogers says.

**Keep in mind:** The caregiver who performed the service should personally make the change to the record, Atkinson says. -The signature and date can't be performed by a representative or the coder,- she says.

**EMR tip:** -If  the physician is making entries on an electronic medical record, this approach may not be possible depending upon the software that is being utilized,- Rogers says. -Nevertheless, every effort possible should be made to link the revision to the incorrect entry.-

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**Potential pitfall:** -I am aware of certain electronic medical record software that -lock- entries and do not allow a direct amendment to the entry,- Rogers says.

-The physician is required to revise the entry through an addendum; the addendum, however, is not available for review on future patient visits,- Rogers advises. -Such a process absolutely creates a potential liability exposure to the physician and the institution in which he/she
is practicing.-

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