Part B Insider (Multispecialty) Coding Alert

Documentation Red Flags: Know When A Clarification Hurts Instead of Helps

If you correct or add to every medical record that gets reviewed, you may come to regret it.

"With regard to supplementing documentation in preparation for ... audits, providers certainly need to proceed with care," advises Washington, D.C.-based attorney **Elizabeth Hogue.** "Whether or not it is appropriate to supplement documentation must be decided on a case-by-case basis."

You should not be routinely making revisions to clinical records prior to sending them off in response to an advance development request (ADR), counsels regulatory consultant **Rebecca Friedman Zuber** in Chicago, Ill.

Red flag: If you make a lot of corrections in your clinical records, that will raise questions should your records be reviewed, Zuber warns. "It will look like they are writing what they want to have there, not documenting what actually occurred during the delivery of care."

When correcting or adding to the medical record, "the greatest error of all is to write information just because someone told you to do so, but you have no memory of the information," stresses consultant Judy Adams in Chapel Hill, N.C. "With all of the patients seen and visits made, sometimes a clinician just cannot remember additional information or actually forgot to do something on a visit."

Bottom line: "Making up information that actually never happened is fraudulent documentation and can never be justified," Adams maintains.

How Late Is Your Late Entry?

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," Zuber agrees.

Modifications at almost the same time as the original documentation, however, are usually more acceptable -- especially if you are making a big push to improve charting. Practices that are working to improve staff documentation should be working concurrently with those staff members, so any documentation changes that result should be pretty contemporaneous with the original entry, Zuber says.

Don't Get Scared Off Of 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 ob-serves. "Or we left some key information out of the documentation," she adds. "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 relates. "We suddenly realize that 'what I meant as I was writing did not communicate what I thought it did.'"

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

Codify
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