Codify
BY AAPC

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Medical Review: Stave Off Common Late Entry Mistakes With These Tips

When does a clarification hurt instead of help?

Documentation corrections and additions can be a lifesaver as audits, reviews, and other scrutiny is on the rise (see Eli's Hospice Insider, Vol. 9, No. 10). But 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 health care attorney **Elizabeth Hogue**. "Whether or not it is appropriate to supplement documentation must be decided on a case-by-case basis."

"Agencies 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: "Agencies that make a lot of corrections in their clinical records will raise questions should their 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** with **Adams Home Care Consulting** 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 your organization is making a big push to improve its charting. "Agencies 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.

Another example: "I have worked closely with agencies during periods when they were under threat of decertification from Medicare due to survey findings of conditions of participation out of compliance," Zuber tells **Eli**. But again, the key is that the corrected entries "are contemporaneous with the service delivery and original documentation."

Remember, "changes ... should be made just to clarify existing entries or to deal with contradictory information in the record," Zuber adds.

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.