Codify
BY AAPC

Health Information Compliance Alert

Reader Question: Link Revisions to the EMR or EHR Appropriately

Question: When we see that documentation doesn't match a code choice, we usually go back to the physician with questions, and sometimes they'll acquiesce, agreeing that a lower-level code should be submitted on the claim. But other times the doctor will want to add additional documentation so the chart matches the code he wants to bill. Is this okay?

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Answer: "Yes, a physician can go back and add an addendum to the record to correct/add additional information," says **Jennifer Lame, MPH, RHIT**, a medical coding instructor with **Southwest Wisconsin Technical College**. Of course, you must stay within the regulations of your payer, state laws, hospital rules, and your own compliance program to do this. In addition, you must ensure that the physician isn't amending the record just to get the claim paid.

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.

Therefore, your first question to the physician should be "Why are you amending it?" 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.

Sign and date: When adding information to the medical record, the physician should initial or sign the addendum, and include the date and time that she made the revision.

Remember, the caregiver who performed the service should personally make the change to the record. The signature and date can't be added by a representative or the coder. But as long as the doctor actually remembers the information, or reads notes or other written information that triggers his memory of the additional information, he can add information at any time.

EHR tip: If the physician is making entries on an electronic medical record (EMR) or electronic health record (EHR), this approach may not be possible depending upon the software being utilized. Nevertheless, every effort possible should be made to link the revision to the incorrect entry.

Follow these five steps to make sure your corrections will pass a review:

1. If you are correcting an incorrect statement in the record, you should draw a line through the statement and put the word "error" next to it. Then sign or initial it (depending on your policy) and put the date. The original information must still be readable and included in the record. Use just a single line to cross it out.

2. Never try to make a late entry appear like it was there all along. Be sure to clearly mark the correction or supplementation as a late entry with a title, such as "Addendum to the medical record made on August 12, 2019, by Steve Smith, MD."

3. Any late entry should include its date. Plus, corrections or additions to documentation should ideally be made by the documentation's original author. That person should sign the correction as well as date it.

4. It's a good idea to jot down the purpose of the entry. It's also helpful to indicate the source of the additional information, such as "based on notes jotted during the visit" or "addended note after listening to dictated report."

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5. If you make a correction in the EHR and there was also a hard copy printed from the electronic record, the hard copy must also be corrected.

Tip: Always review your payers' rules on addendum, especially federal health programs like Medicare and Medicaid.

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