Coding Policy **Policy and Procedure**		
SUBJECT: Coding Policy 60.0 Documentation Guidelines for Amended Medical Records	DEPARTMENT: **Coding Compliance**	
ORIGINAL EFFECTIVE DATE: 03/2004	DATE(S) REVIEWED/REVISED: 1/05, 1/06, 1/07, 1/08, 01/09, 01/10, 01/11, 01/12, 08/12, 01/13, 01/14, 01/15, 01/16, 01/17, 01/18, 01/19, 01/20, 01/21	
APPROVED BY: Coding Policy Review Committee	NUMBER: **MC 60.0**	PAGE: **1 of 2**

SCOPE:
Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:
Health Plan Providers
All Lines of Business

POLICY:
Late entries, addendums, or corrections to a medical record are legitimate occurrences in documentation of clinical services. A late entry, an addendum, or a correction to the medical record bears the current date of that entry and is signed by the person making the addition or change.

PROCEDURE:
A **late entry** supplies additional information that was omitted from the original entry. The late entry bears the current date, is added as soon as possible, and is written only if the person documenting has total recall of the omitted information.

Example: A late entry following treatment of multiple traumatic injuries might add: *"The left foot was noted to be abraded laterally."*

An **addendum** is used to provide information that was not available at the time of the original entry. The addendum should also be timely and bear the current date and reason for the addition or clarification of information being added to the medical record.

Example: An addendum could note*: "The chest x-ray report was reviewed and showed an enlarged cardiac silhouette."*

When making a **correction** to the medical record, never write over or otherwise obliterate the passage being corrected. Draw a single line through the erroneous information, keeping the original entry legible. Sign and date the deletion, stating the reason for correction above or in the margin. Document the correct information on the next line or space with the current date and time, making reference back to the original entry.

Correction of electronic records should follow the same principles of tracking both the original entry and the correction with the current date, time and reason for the change. When a hard copy is generated from an electronic record, both records must be corrected. Any corrected record submitted must make clear the specific change made, the date of the change, and the identity of the person making that entry.

Author of Note No Longer With Provider Group
If the author of a medical note is no longer with the provider group and has left the group without signing a note, the following steps should be taken:

- The provider group will make every attempt to contact the original author of the record to review and obtain an attestation statement as described above bearing the current date, noting clearly that the signature was added late and why.
- If the provider is unable to provide an attestation statement, the bill will be removed and/or, if necessary, refunded.

The burden of proof is placed on the provider to substantiate services and/or supplies billed to Company.

During the audit process, if documentation is needed, the provider or supplier must send the beneficiary's medical record by the deadlines given in the written request.

Falsified Documentation
Providers are reminded that deliberate falsification of medical records is a felony offense and is viewed seriously when encountered. Examples of falsifying records include:

- Creation of new records when records are requested
- Back-dating entries
- Post-dating entries
- Pre-dating entries
- Writing over
- Adding to existing documentation (except as described in late entries, addendums and corrections)

Corrections to the medical record legally amended prior to claims submission and/or medical review and/or coding audit will be considered in determining the validity of services billed. If these changes appear in the record following payment determination based on medical review and/or coding audit, only the original record will be reviewed in determining payment of services billed to Company.

Appeal of claims denied on the basis of an incomplete record may result in a reversal of the original denial if the information supplied includes pages or components that were part of the original medical record but were not submitted on the initial review.

REFERENCE:
CMS/Medicare Rules and Regulations
Providence Health Plan Coding Edits