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In this Issue

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CMS RECORD AMENDMENT GUIDE

All services provided to members are expected to be documented in the medical record at the time they are rendered. Occasionally, certain entries related to services provided are not properly documented. In this event, the documentation will need to be amended to show a correction or to add an addendum.

RECORD KEEPING PRINCIPLES

Regardless of whether a documentation submission originates from a paper record or an electronic health record, amended documents submitted containing corrections or addenda must:

1. *CLEARLY AND PERMANENTLY IDENTIFY ANY CORRECTION OR ADDENDUM AS SUCH.*
2. *CLEARLY INDICATE THE DATE AND AUTHOR OF ANY CORRECTION OR ADDENDUM.*
3. *CLEARLY IDENTIFY ALL ORIGINAL CONTENT, WITHOUT DELETION.*

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MEDICAL RECORD AMENDMENT DEFINITIONS

A ***correction*** is done when there was an error in the original entry that has been identified and it needs to be amended. The original entry should never be erased but amended to show the correction.

- For example: Patient's second B/P reading was 120/100 80, John Doe MD 06/15/16

An ***addendum*** is used when there is a need to add additional pertinent information to the record that wasn't available at the time of the original entry.

- For example: "The chest x-ray report was reviewed and showed an enlarged cardiac silhouette. John Doe MD 06/15/16"

In both instances, it should have the name and the date of the person adding the information, see below for more information.

PAPER MEDICAL RECORDS:

When correcting or adding an addendum to a paper medical record, these principles are generally accomplished by:

1. **Using a single line strike through so the original content is still readable**
2. **If adding an Addendum, clearly state what information is now available**
3. **Amendments or corrections to paper records must be clearly and permanently identified as such and must be signed and dated upon entry into the record by the person making the amendment.**

ELECTRONIC MEDICAL RECORDS:

Medical record keeping within an EHR deserves special considerations; however, the principles specified above remain fundamental and necessary for document submission. Records sourced from electronic systems containing corrections or addendums must:

1. **Distinctly identify any correction or addendum**
2. **Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record**

FALSIFIED DOCUMENTATION:

PROVIDERS ARE REMINDED THAT DELIBERATE FALSIFICATION OF MEDICAL RECORDS IS A FELONY OFFENSE AND IS VIEWED SERIOUSLY WHEN ENCOUNTERED.

EXAMPLES OF SUCH INCLUDE BUT ARE NOT LIMITED TO:

- **CREATION OF NEW RECORDS WHEN RECORDS ARE REQUESTED**
- **BACK-DATING ENTRIES**
- **POST-DATING ENTRIES**
- **PRE-DATING ENTRIES**
- **WRITING OVER OR ADDING TO EXISTING DOCUMENTATION, EXCEPT AS DESCRIBED IN THE ABOVE PROCESS FOR CORRECTIONS AND ADDENDUMS**

References: cms.gov (official website) https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R732PI.pdf
https://med.noridianmedicare.com/web/jeb/cert-reviews/mr/documentation-guidelines-for-amended-records