Internal Medicine Coding Alert

Documentation: New CMS Guidelines To Be Followed To Keep Record Amendments Updated

Heads up: Single-line corrections are fine.

No practice or physician is immune to documentation that needs to be updated. Maybe the physician left out an important piece of information, such as the amount of time spent counseling the patient, or the patient's diagnosis. When records need to be amended, be sure your practice follows the latest CMS rules, which were revised on Dec. 7, 2012, in Transmittal 442.

In the transmittal, CMS encourages providers to "enter all relevant documents and entries" into the record at the time of service. However, CMS also acknowledges that "occasionally, upon review a provider may discover that certain entries, related to actions that were actually performed at the time of service but not properly documented, need to be amended, corrected, or entered after rendering the service."

Do this: When adding, correcting, or entering information after the date of service, you should identify it as an amendment, and the physician should sign and date it. Never delete the original entry—instead, ensure that all original content is identifiable. You can do this on a paper record by using a single strike line through the original content. For electronic records, you must "provide a reliable means to clearly identify the original content, the modified content, and the date of authorship of each modification of the record," CMS says in the transmittal.

If an auditor ever reviews your files, CMS directs them to consider your amended entries—but only if you follow the rules. Auditors "shall not consider undated or unsigned entries handwritten in the margin of the document," for instance, the Transmittal advises.

CMS advises MACs and auditors that see potential fraud in the documentation to refer those cases to the ZPIC auditors. To read the complete transmittal, visit www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R442PI.pdf.