# Clinical Documentation Excellence

CAPSTONE PERFORMANCE SYSTEMS®

*A Tabula Rasa Company*

Realizing True Potential

Premier Edition
Vol. I Issue 1

## Capstone Provider Education Initiative

*At the urging of our clients, we kick off 2017 — and the first issue of our CDE Bulletin— with the first in a series of topics relevant to Primary Care Providers and their efforts to improve clinical documentation. Each month, we will focus on a topic that is timely or requested by our clients. The information will typically include clinical background, diagnosis tips, documentation requirements and ICD-10 coding guidance. From time to time, we'll digress to make sure that providers are in the know regarding issues that impact* ***compliance****. The format is intended to be a quick read for busy providers, with emphasis on key words and bottom-line actions or conclusions.*

*With that, we address our first topic, a frequent issue that is often the source of misunderstanding and presents a high level of risk: how to change the documentation in the medical record.*

## Changing Documentation in the Medical Record

When documenting in the medical record, providers should take care to capture their thoughts and findings as completely as possible. Best practice is to document the patient encounter at the time, or shortly afterwards. Inevitably, situations require some changes in the medical record, of which four types are recognized.

**Addendum**. Addenda add omitted information to an existing document without altering the original document. Addenda should bear the current date and reason for the additional information being added to the record. Both the original and addendum should be signed by the same provider. For the additional information to have meaning, it should be connected to the original report.

*Example*: Foot pain was not mentioned in original note. Addendum to original document notes "patient complained of pain in left foot, rating pain as 4 out of 10 and bruising was noted. Patient indicated contusion followed dropping a box on the foot while moving. No clinical evidence of fracture and no treatment required."

**Amendment**. Amendments are used to clarify information presented in the original document without altering the original document, after the original documentation has been completed by the provider. Amendments should bear the current date of documentation.

*Example*: Amended documentation clarifies that the reference to "foot" means patient's left foot.

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### Capstone Performance Systems

Richard Schamp, MD
*CEO*

Our company is a market leader in provider education and a premier documentation and coding consultancy, serving over fifty organizations with an expert staff of physicians, nurses and coders.

Besides training providers and organizations, we provide auditing and coding services, including concurrent coding, retrospective reviews and our exclusive prospective reviews.

### Upcoming Topics

- Morbid Obesity
- Malnutrition
- Depression
- Heart Failure
- Vascular Disease
- Diabetes & Complications
- Complicated Dementias
- Hematological Disorders
- Parkinson's Disease

Capstone gladly accepts suggestions for topics to address in this bulletin. Please contact us at info@cpstn.com

*Did you know...*

- D69.2 is used to code Senile Purpura and it maps to HCC 48.
- At this time, telehealth encounters are NOT considered face-to-face.
- Some ICD-10 codes may not map to a CMS HCC for a Part C premium, but will map to a RxHCC, which helps Part D payments, for example, Hypertension.
- "Hepatitis C" (B19.2) does NOT map to an HCC, but "Chronic Hepatitis C (B18.2) maps to HCC 29.
- CMS is moving away from paying for non-specific codes. For example, Major Depression, single episode, unspecified (F32.9) will not trigger an HCC payment. However, Major Depression, single episode, mild (F32.0) maps to HCC 58 as it is more specific.

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**Correction**. Corrections change the information in the document to amend inaccuracies after the original document has been signed or rendered complete.

*Example*: Original document noted that the patient complained of pain in the right foot. Corrected information clarifies that pain was in the left foot.

**Deletion**. Deletions eliminate incorrect information from a closed/finalized document without substituting new information.

*Example:* A note was placed in the wrong patient's chart, so it is removed from the incorrect chart.

When **any** changes (addenda, amendments, corrections, deletions) or delayed entries in medical documentation are needed, the Medicare Program Integrity Manual (chapter 3, section 3.3.2.5) stipulates the following guidelines to comply with widely-accepted Recordkeeping Principles:

> Regardless of whether a documentation submission originates from a paper record or an electronic health record, **documents** … containing amendments, corrections or addenda must:
> 1. Clearly and permanently identify any amendment, correction or delayed entry as such, and
> 2. Clearly indicate the date and author of any amendment, correction or delayed entry, and
> 3. Clearly identify all original content, without deletion.
>
> When correcting a **paper medical record**, these principles are generally accomplished by:
> 1. Use a single line strike through so the original content is still readable, and
> 2. The author of the alteration must sign and date the revision.
>
> Changes to paper records must be clearly signed and dated upon entry into the record.
>
> Medical recordkeeping within an **electronic health record** also requires the principles specified above as fundamental and necessary. Records in electronic systems containing addenda, amendments, corrections or delayed entries must:
> 1. Distinctly identify any changed entry, and
> 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.

Note that the Manual does not specify a timeframe during which amendments, corrections, or delayed entries may occur. However, common sense suggests that entries made weeks or months after the encounter may be viewed as suspect.

**We strongly recommend providers and organizations protect themselves with clearly defined policies** on when and how a record is considered complete. System functionality should include limiting the end-user ability to add information or make corrections after a certain point in time (e.g., 24 hours after encounter). Changes that need to be made after this point in time should be on a case-by-case basis. Further policies and procedures surrounding how alterations within the record are made should be established.

Finally, we urge organizations to **utilize the audit trail function of their EHR** system to identify and trend the utilization of these functionalities. Reports should be generated in such a way to identify opportunities to provide education to individuals using it incorrectly. If you need assistance in establishing policies and procedures or have questions about your current practices regarding changing your medical records, please contact us at info@cpstn.com.



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