900 42nd Street South
Fargo, ND 58103

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ELECTRONIC HEALTH RECORDS AND ADDENDA

Dear Clinician,

Recent DME MAC claim review experience has highlighted an issue with electronic health records (EHR) and documentation of additional clinical information that occurs following the initial beneficiary visit. The Centers for Medicare & Medicaid Services (CMS) refers to this additional information as amendments; however, similar principles as discussed below apply to corrections and delayed entries.

Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) often request your patient's medical record in support of their claim to Medicare. When providing records, particularly those that have been amended or corrected, it is critical that you provide both the original note and any subsequent amendments or corrections to the original note.

For reference, the Medicare Program Integrity Manual (Internet-only Manual 100-08), Chapter 3, Section 3.3.2.5 provides the following guidance on amendments, corrections and delayed entries:

Regardless of whether a documentation submission originates from a paper record or an electronic health record, documents submitted to MACs, CERT, Recovery Auditors, and ZPICs 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. *Not delete but instead clearly identify all original content.*

The above record keeping principles apply to all medical records, whether electronic or handwritten; however, the Program Integrity Manual also specifically addresses amendments, corrections and delayed entries in EHRs with the following instructions:

Medical record keeping within an EHR deserves special considerations; however, the principles above remain fundamental and necessary for document submission to MACs, CERT, Recovery Auditors, and ZPICs. Records sourced from electronic systems containing amendments, corrections or delayed entries must:

a. *Distinctly identify any amendment, correction or delayed entry; and,*
b. *Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record.*

The manner in which an EHR system notates amendments and corrections can differ by software vendor. Many electronic health records can be configured to deliver documentation which meets these requirements. If you are uncertain about the reports which are generated by your EHR, you are encouraged to consult with your organization's EHR project team to ensure that these reports are being produced properly. In addition, you and your staff are encouraged to be careful when preparing your response to a record request. Often in reviewing claim documentation, the Medical Review staff receive only the amended record with no indication of what was amended or corrected, when the change occurred or by whom the change was made. Failure to provide a complete medical note or a record

with changes inconsistent with the CMS manual instructions may result in a claim denial and the inability for your DMEPOS supplier to provide the necessary equipment to accomplish your treatment goals.

Sincerely,

Wilfred Mamuya, MD, PhD
Medical Director, DME MAC, Jurisdiction A
Noridian Healthcare Solutions

Stacey V. Brennan, MD, FAAFP
Medical Director, DME MAC, Jurisdiction B
CGS Administrators, LLC

Robert D. Hoover, Jr., MD, MPH, FACP
Medical Director, DME MAC, Jurisdiction C
CGS Administrators, LLC

Peter J. Gurk, MD, CPE, CHCQM
Medical Director, DME MAC, Jurisdiction D
Noridian Healthcare Solutions