



Medical Record Documentation & Coding Compliance

Corrections, Regulatory Compliance, Discharge Status & DRGs

CODING DECODED

This guide covers how to properly correct health record documentation, the regulatory bodies that oversee compliance, and how fraud and abuse are defined and enforced in medical coding.

1. Correcting Health Record Documentation

There are two accepted ways to correct or supplement a medical record after the original entry has been made: an addendum and an amendment. Both preserve the original documentation — neither permits deleting or overwriting it.

Addendum

An addendum is used to add information that was missing from the original entry. The original documentation is never altered or deleted — the addendum is a separate, dated entry that supplements it.

Key Features of an Addendum

- Adds information that was missing from the original entry.
- Cannot alter or delete existing documentation.
- Must include the date, time, and signature of the person making the addendum.
- Must follow facility and legal compliance rules (e.g., HIPAA, Medicare guidelines).

Example of an Addendum

Situation: A doctor forgot to mention a medication given to the patient.

Original Entry (April 5, 2025, 2:00 PM): "Patient seen for headache. Advised rest and hydration."

Addendum (April 5, 2025, 9:00 PM): "Addendum to the 2:00 PM entry: Patient was also given Tylenol 500 mg (Paracetamol). Forgot to document it earlier. — Dr. Lee, April 5, 2025, 4:00 PM."

Key takeaway: The original note remains unchanged.

Amendment

An amendment is a correction to an existing medical record when incorrect information needs to be updated. Amendments are permitted for factual errors, but the original entry must not be deleted or overwritten.

Key Features of an Amendment

- Used to correct errors (e.g., incorrect date, wrong diagnosis entry).
- The original entry remains visible, with the amendment attached.
- Must include the reason for the correction, along with date, time, and author signature.
- Cannot be used for fraudulent alterations or misrepresentation.

Example of an Amendment

Situation: A nurse mistakenly documents the wrong dosage of a medication and needs to correct it.

Original Entry (March 12, 2025, 10:00 AM): "Administered 50 mg of Lisinopril to patient."

Amendment (March 12, 2025, 11:30 AM): "Correction to 10:00 AM entry: The correct dosage administered was 10 mg, not 50 mg. The initial note contained a documentation error. — Nurse Kelly, March 12, 2025, 11:30 AM."

Key takeaway: The nurse corrected the error without deleting the original note, and the reason for the correction is clearly stated.

2. Regulatory Compliance

Coders and health information staff are responsible for ensuring documentation practices meet the following regulatory standards:

- Ensure integrity of health records
- Apply payer-specific guidelines

- Recognize patient safety indicators (PSIs) and hospital-acquired conditions (HACs) based on documentation
- Ensure compliance with HIPAA guidelines
- Ensure adherence to AHIMA's Standards of Ethical Coding
- Apply the Uniform Hospital Discharge Data Set (UHDDS)

3. Oversight & Enforcement Bodies

HIPAA

Governs transactions and code set changes.

OIG — Office of Inspector General

- Has been granted increased oversight of CMS activities.
- Focuses on high-dollar fraud and abuse complaints and investigations.

DOJ — Department of Justice

- Can enforce civil/criminal proceedings.

4. Fraud and Abuse

Term	Definition
Fraud	The intentional deception or misrepresentation that an individual knows to be false, or does not believe to be true, and makes, knowing that the deception could result in an unauthorized benefit to himself/herself or some other person.
Abuse	Billing Medicare for services that are not covered or not correctly coded.

Government Auditors

- Medicare Administrative Contractors (MACs)
- Medicaid Integrity Contractors (MICs)
- Recovery Auditors (RAC)
- Zone Program Integrity Contractors (ZPICs)