Molina Healthcare
Coding Education
Amending the Medical Record

According to the Centers for Medicare & Medicaid Services (CMS), patient encounters should be documented at the time of service or ***shortly*** thereafter. Delayed entries may be reasonable for up to 48 hours. However, waiting any longer may result in the record being considered invalid.

The CMS Medicare Program Integrity Manual offers guidelines for amending a progress not, although a clear cut-off point is not included. Descriptions like "timely" and "within a few days" are used. Even more complicated, various institutions and organizations have their own internal rules and timelines.

This same CMS manual states that an auditor can give "less weight" to entries over 30 days old, and can report a pattern of delayed entry (Medicare Program Integrity Manual, Pub. 100-08, chapter 3, section 3.3.2.5). The best policy is to document as quickly and completely as possible.

Documentation Examples:

Initial Diagnosis

Assessment: 68 year old female with hypertension

BP 155/92, no edema, angina, or DOE

ICD-10 Code: 10Essential (primary) hypertension

Plan: Start metoprolol, provide BP monitor, check BP log at follow up in 1 week

Correction: I11.9 is not essential hypertension; it is hypertensive heart disease without heart failure. The correction to I10 should be made as soon as the error is noted, following the guidelines specified by the Medicare Program Integrity Manual and your organization's regulations.

Established Diagnosis

Assessment: 80 year old male with paroxysmal atrial fibrillation

- Asymptomatic, no palpitations, considering ablation

ICD-10 Code: I48.0 Paroxysmal atrial fibrillation

Plan: Referral to electrophysiology, 30-day event monitor placed

Correction: Event monitor showed persistent atrial fibrillation (I48.1). This correction would best be made with a follow up visit in clinic. If this is not possible, then the correction could be made with an addendum if within 30 days of the original appointment.

Have Questions?
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