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Retrospective Documentation Changes Tip Sheet

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General Principles

Services are expected to be documented at the time they are rendered. Documentation should support the services billed and be complete by the time the claim is submitted. Payers recognize that occasionally services are not properly documented and require corrections or amendments. However, the frequent or routine use of retrospective updates as a means of "documentation" ***after*** a claim has been subsequently denied should be avoided. See *"Section A. Inappropriate Changes"* for changes that are inappropriate. Some modifications may be appropriate in the course of carrying out revenue cycle activities as outlined in *"Section C. Types of Amendments Which May Be Appropriate"*.

A. Inappropriate Changes

The below retrospective modifications to Orders and Documentation following order placement or claims processing are ***not appropriate*** and should be avoided.

Orders The original order should not be altered after the service has been performed and billed. CMS does not permit retrospective orders. When an order has a missing or flawed element, information that was already documented elsewhere in the record may support payment.	
Action to Avoid	***Example***
Retrospectively changing an order after the service has already been performed	*Physician orders a diagnostic test due to patient's recent complaints of symptoms. Physician is requested to change the diagnosis on the order to a screening dx so the patient avoids cost sharing.*
Submitting a new or "corrected order" after a denial	*An insurance company tells the patient a lab denial is due to the provider submitting the "wrong" diagnosis. An APN is requested to submit a new order with a diagnosis that will get the claim paid.*
Documentation Original documentation should not be altered retrospectively with a "covered" condition the patient does not have, or was not addressed during the encounter.	
Action to Avoid	***Example***
Altering documentation retrospectively after billing to add information that was not originally present	*A claim is denied because it does not meet medical necessity policy. A coding review finds there are no additional conditions documented by the physician that meet medical necessity. An administrator requests the physician add a "supporting" diagnosis from the LCD policy which was clearly not originally present.*
Claim coding changes that are unsupported by the original documentation present just to get the "claim paid"	*A claim fails a billhold because the diagnosis does not meet medical necessity per the Local Coverage Determination policy for the service. To bypass the hold, the coder adds a diagnosis to the claim that has passed billhold edits for other claims. However, the diagnosis is not supported in the documentation.*

B. Documentation Risk Area: Falsification of Records

Knowingly altering medical records or claim forms to receive a higher payment, or a payment that one is not entitled to, is an offense under the federal False Claims Act.

Adding to existing documentation for this purpose is considered falsifying records. Below are examples of alterations of the medical record which would be fraudulent:

- Creation of new records when records are requested
- Back-dating, post-dating or pre-dating entries
- Writing over existing documentation
- Adding to existing documentation (except for late entries, corrections, and some addendums – see Section C1.)
- Documenting services which were not provided for the purpose of payment
- Documenting conditions the patient did not have for the purpose of payment

C. Types of Amendments Which May Be Appropriate

The below scenarios may represent compliant reasons for updating a record in the course of carrying out revenue cycle activities. This list is not exhaustive; scenarios that are not listed should be considered on a case-by-case basis.

- Addendums to correct an error or omission, or to add a late entry which follow UCM policy
- Addendums to include clinical/patient information not available at the original time of entry
- Addendums that are needed to clarify information or add more specification (e.g. laterality)
- Addendums made prior to billing in response to coding, CDI or other provider queries
- Addendums related to a request for information from a payer (e.g. payer requests failed treatment history prior to prescription of a drug, and info is incomplete or not present)

Resources:

- UCM Policy: PC 128 Documentation of Patient Care
- NGS: Signatures for Amendments, Corrections, and Delayed Entries
- Ingalls UCM False Claims Act Training
- CMS Laboratory Services Documentation Requirements
- CMS Retrospective Orders
- Noridian: Falsified documentation, amendments, corrections and late entries
- Code of Federal Regulations Documentation and recordkeeping requirements
- CMS Missing/Flawed Order Supported Elsewhere
- NGS: Reopening Not Appropriate to Change Diagnosis on Paid Claims