Documentation Addendums for Billing Guideline

FROM: **CU Medicine Finance/Audit Committee**
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Approved by CU Medicine Finance & Audit Committee on May 29, 2012

Purpose

- The purpose is to implement a guideline to clarify when documentation addendums are valid for billing.
- This guideline is not applicable for addendums to the medical record that is recorded for medical/legal purposes.
- This guideline is not applicable for addendums to the medical record that is recorded to update the daily status of a patient, or to document an updated change in the plan of care of a patient.

General Guidelines

- Co-signature only (without a tie-in statement to the resident note or a physical presence statement) on an E&M or procedural/surgical encounter will be allowed for 30 days from the date of completion of the encounter.
    - It is assumed an attending physician, and the resident if needed, can clearly recall and validate attending physician and involvement in a resident encounter.
- Alteration of the documented time spent with a visit, for time based E&M codes will be allowed for 30 days from the date of completion of the E&M documentation.
    - It is assumed the documentation in either the attending physician or resident note supports the time spent by the attending physician.
- Addendums should only be necessary on rare occasions and should not be used in a common practice of documenting services performed. **Amending medical records to meet payment policy guidelines is inappropriate.**
    - Providers who have a pattern of amending medical records for the above purposes will be notified by CU Medicine to assess for additional education.

E&M Guidelines

- Documentation addendums to E&M services **will not** be allowed for billing after 24 hours from the date of completion of the E&M note.
    - Documentation that influences a level of service in history, exam, or medical decision making components considered clinically irrelevant and added solely to meet regulatory requirements
    - Documentation added >24 hours to validate a CPT code that was initially down coded due to lack of supporting documentation.
- Communication from Fee Coordination and Quality Coding, Audit & Education is for educational purposes and given in a supportive manner and should not be considered as opportunities for providers to make addendums to E&M documentation for billing purposes.

Procedural/Diagnostic Guidelines

- Communication from Fee Coordination and/or Quality Coding, Audit & Education to a provider submitting a procedural code/diagnostic code, where objective evidence exists that the service in question was provided, **can be used** by the provider to create a documentation addendum in the medical record, to insure accuracy of the CPT code(s) or the service provided.