

## Notes – Addendum Documentation Guidelines

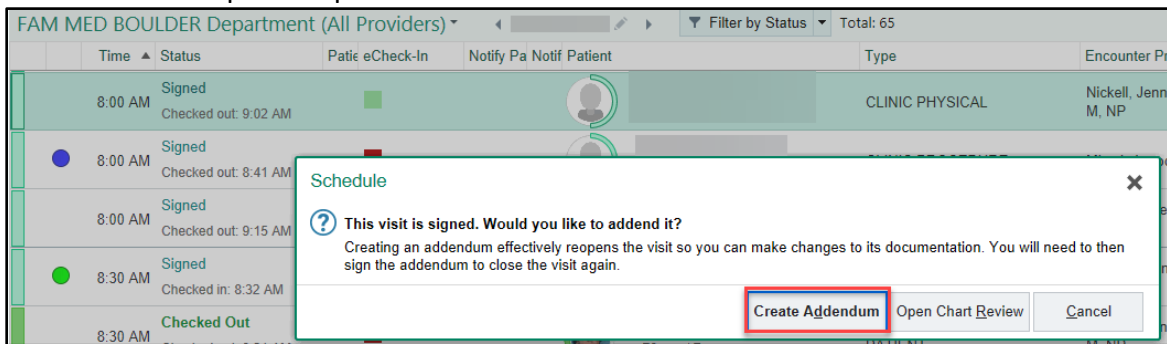
Clinical notes can be added after signing for various reasons like to add information originally omitted or unavailable at the time of the visit or to correct erroneous documentation. Follow the steps below when an addendum to clinical documentation is needed and refer to the Nordinian guidelines for specific requirements (*Nordinian Documentation Guidelines for Amended Medical Records*, Oct. 2018)

### Important information

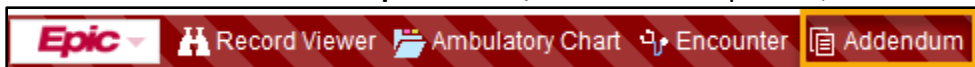
- Late entries, addendums, or corrections to a medical record are legitimate occurrences in documentation of clinical services. A late entry, an addendum or a correction to the medical record, bears the current date of that entry and is signed by the person making the addition or change.
  - Late entry: Supplies additional information to the medical record that was missed or not written timely from original entry. Should only be written if the individual documenting has complete recollection of the omitted information. Identify the new entry as “late entry” if the entry is added after the date of service.
  - Addendum: Used to provide information that was not available at the time of the original entry. Should be timely and include reason for the addition or clarification of information being added to the medical record. Write "addendum" and state the reason for the addendum referring back to the original entry.
  - Correction: Written to avoid incorrect information that had been previously documented. Document the correct information on the next line or space with the current date and time, making reference back to the original entry.
  
- Deliberate falsification of medical records is a felony offense and is viewed seriously when encountered. Examples of falsifying records include:
  - Creation of new records when records are requested
  - Back-dating entries
  - Post-dating entries
  - Pre-dating entries
  - Writing over
  - Adding to existing documentation (except as described in late entries, addendums and corrections)
  
- Example: Patients sometimes call providers and ask them to change their medical coding (CPT or diagnosis coding) in order to better obtain insurance reimbursement or payment if the claim has been denied. Is this okay?
  - Coding changes are appropriate only if the changes are legitimate corrections, and the medical care provided and documentation supports the requested code change. A provider should not go back and make a late entry, addendum, or correction only for the purposes of obtaining reimbursement.
  
- Please review the full guidelines as necessary  
[Documentation Guidelines for Amended Records - JF Part B - Nordinian \(nordinianmedicare.com\)](https://www.noridianmedicare.com/Documentation-Guidelines-for-Amended-Records-JF-Part-B-Noridian)

## Try It Out

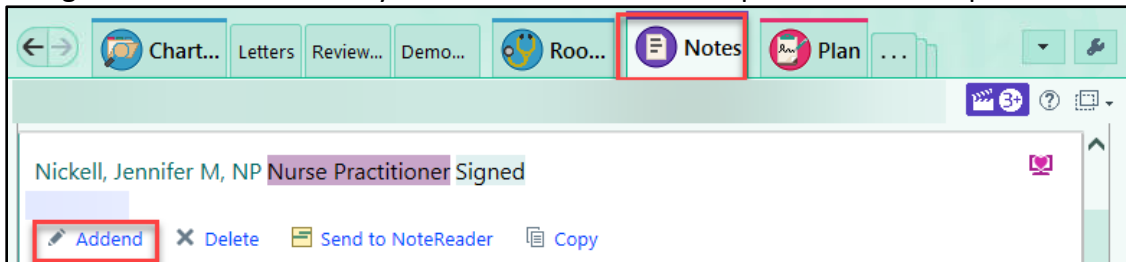
1. Create an addendum.
  - a. **Double-click** to open the patient from the **Multi Provider Schedule** and click **Create Addendum**.



- b. Select **Addendum** from the **Epic toolbar**, search for the patient, and select the correct encounter.



2. Navigate to the **Notes** activity and click **Addend** at the top of the note to update.



3. When finished documenting, click **Accept** at the bottom of the note.



4. Click **Sign Addendum** on the **Visit Taskbar**.



5. Route the addendum if necessary from the **Sidebar** and click the **Looks Good for Signing** icon.

