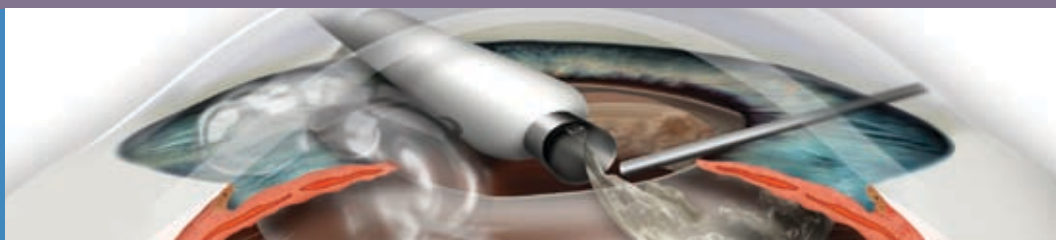

Medical Record Corrections and Alterations

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The medical record serves many purposes: it promotes patient safety and continuity of care by providing a comprehensive account of the patient's diagnosis and treatment, provides evidence that can be used to defend—or possibly assail—the ophthalmologist's care during the course of a claim or lawsuit, serves as the basis for coding and billing decisions, and supports medical research. Entries in the medical record should be objective, signed (or initialed), and dated; subjective comments, speculation, blame, and references to incident reports, legal actions, attorneys, or risk management activities should not, therefore, be included.

Policyholders often learn of the importance of the medical record when they are notified of a claim. Faced with a potential lawsuit, a few are so worried that they are tempted to alter or add to their documentation. While it is never proper to alter records deceptively or fraudulently, there are times when you may need to make a correction or addition to a medical record. OMIC's policy differentiates between these two circumstances to protect you when you make a legitimate change, but also to protect the rest of the policyholders and the company if you make an improper alteration. This article will elaborate on these differences.

Policy Terms

As with all of the terms and conditions of the policy, coverage is contingent upon insureds complying with Section VIII.9.e of the policy, which states that: "The **Insured** must not create, alter, modify, or destroy medical records with the intent to defraud or deceive or otherwise misrepresent or conceal facts pertinent to any **professional services incident** or **Claim**." In other words, records alterations that are not mere corrections are prohibited. Section VIII.9.e continues, however: "This does not preclude coverage where a proper correction or addendum to a medical record has been made, the original entry remains legible, and the correction or addendum is dated and initialed by the Insured."

Corrections to the Medical Record

It is common when documenting care to make "data entry errors." Correcting these errors as soon as possible when they are discovered improves the accuracy of the medical record and promotes safe care. For example, after noting a new medication order he received over the telephone from the ophthalmologist, the technician realized he had written the wrong dosage in the chart. He crossed out the incorrect number once, making sure it was still legible. Over it, he noted the correct one and added his initials and the date.

Similarly, dictated reports such as operative notes and consultation letters should be reviewed and corrected as needed before being placed in the medical record or sent to referring physicians. Such corrections should always be related to ongoing care and made with the intention of contributing to that care. The former entry should always remain in the record; as a general rule, information should never be deleted. Corrections removed in time from the event, made after learning of poor outcomes or after receiving notice of a claim, are always subject to scrutiny and viewed as self-serving if not fraudulent, and should be avoided.

Addenda to the Medical Record

An addendum should be created when additional information not available at the time of documentation but necessary for ongoing care is received. For example, a surgeon dictated her operative report, noting the absence of complications during the cataract procedure. Minutes after completing the dictation, the nurse clearing out the instruments informed the surgeon that one of the sterility indicators had not changed, alerting the ophthalmologist that the instruments may not have been properly sterilized. After instructing the nurse to sequester the instruments, the physician met with the patient, explained the situation and the possible increased risk of endophthalmitis if the instruments weren't sterile, advised the patient of symptoms to watch for and report, and later dictated an addendum to the operative report, in which she accurately noted the time sequence of events.

Addenda should begin with an explanation of why one is necessary. Designed to ensure that accurate and timely information is available to properly care for the patient, they should not be used to justify former decisions or actions. Just as with corrections, the timing and motivation behind the addendum will be carefully evaluated in the event of a claim.

When in doubt, contact our **Risk Management Hotline** for advice before correcting or adding to a record.