Audits and Documentation Update 2026

LA County Podiatric Medical Association
Present Treasure Hunt Conference

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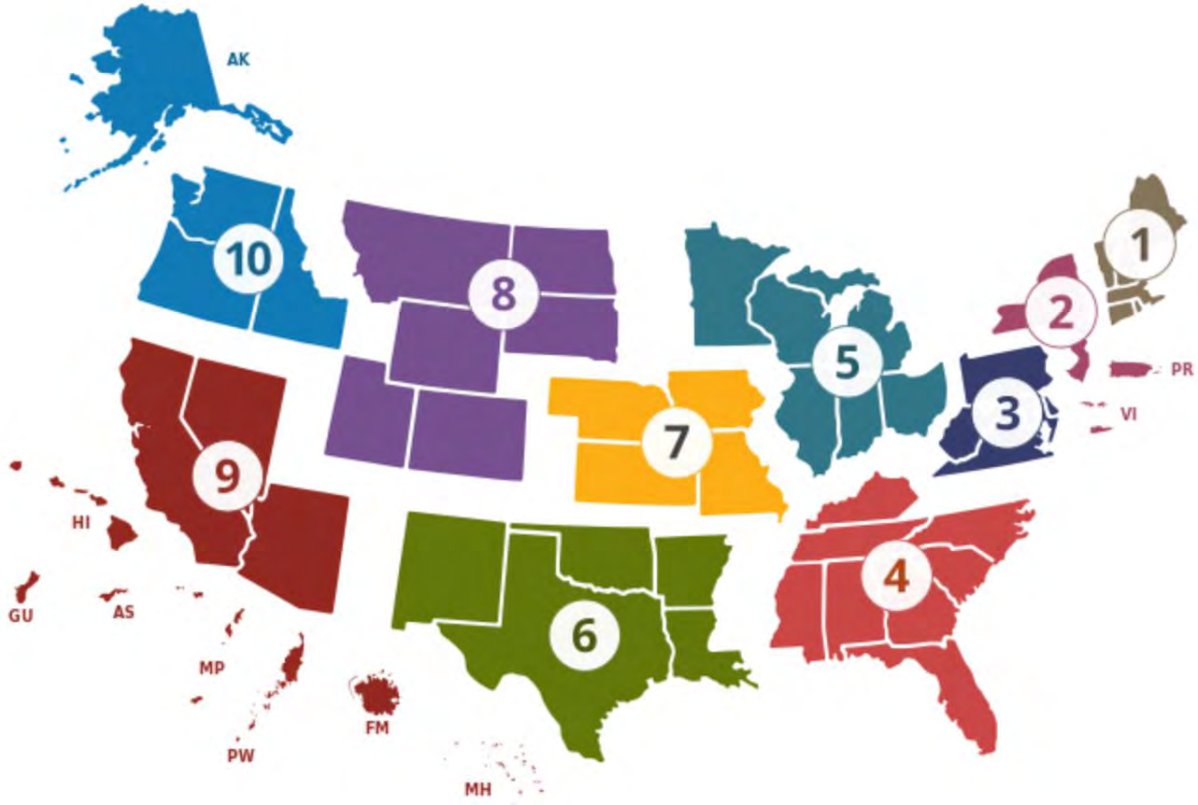
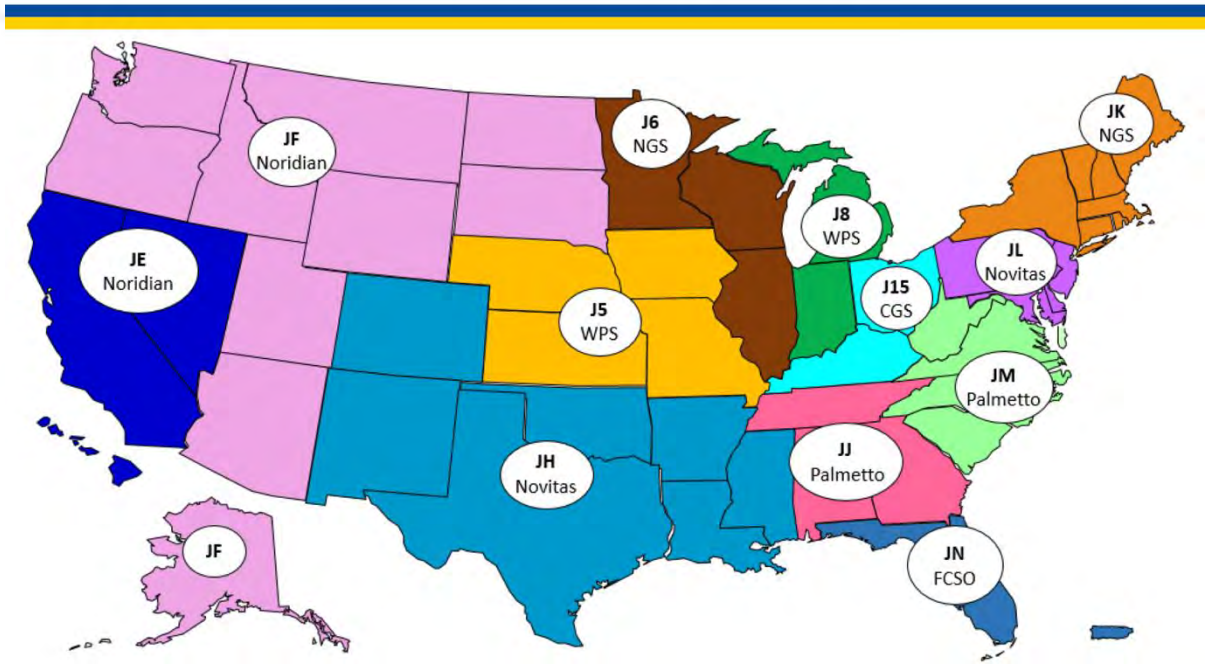
Know Your Audit Region and MAC

Regional Map



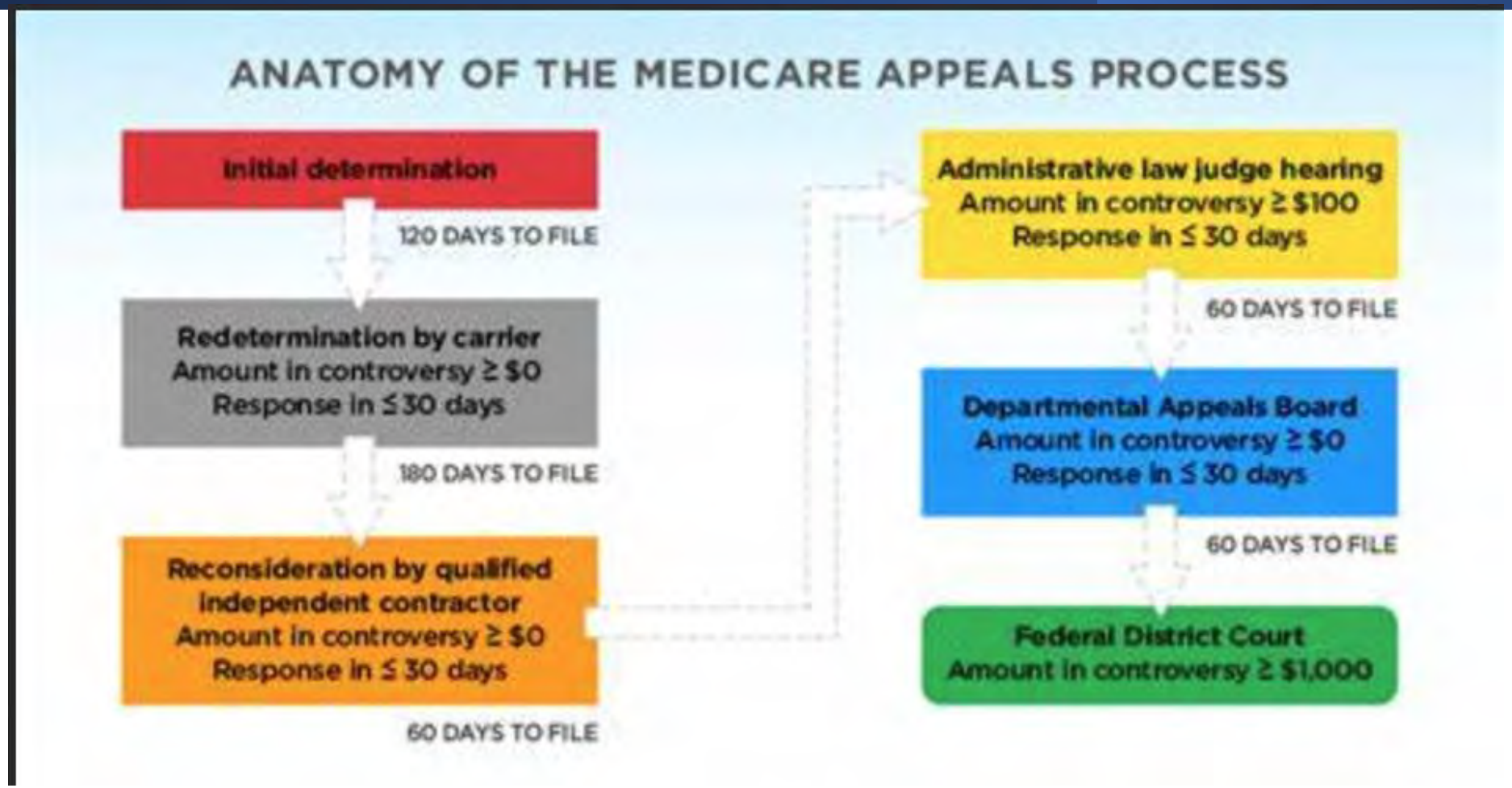
A/B MAC Jurisdictions



Types of Audits

- Noridian Pre-payment or Post-payment
- TPE
- SMRC - Noridian National Contract
- RAC
- CERT
- UPIC – Qlarant, among others

Anatomy of an Audit



Medicare Advantage Appeal Process

Medicare Advantage

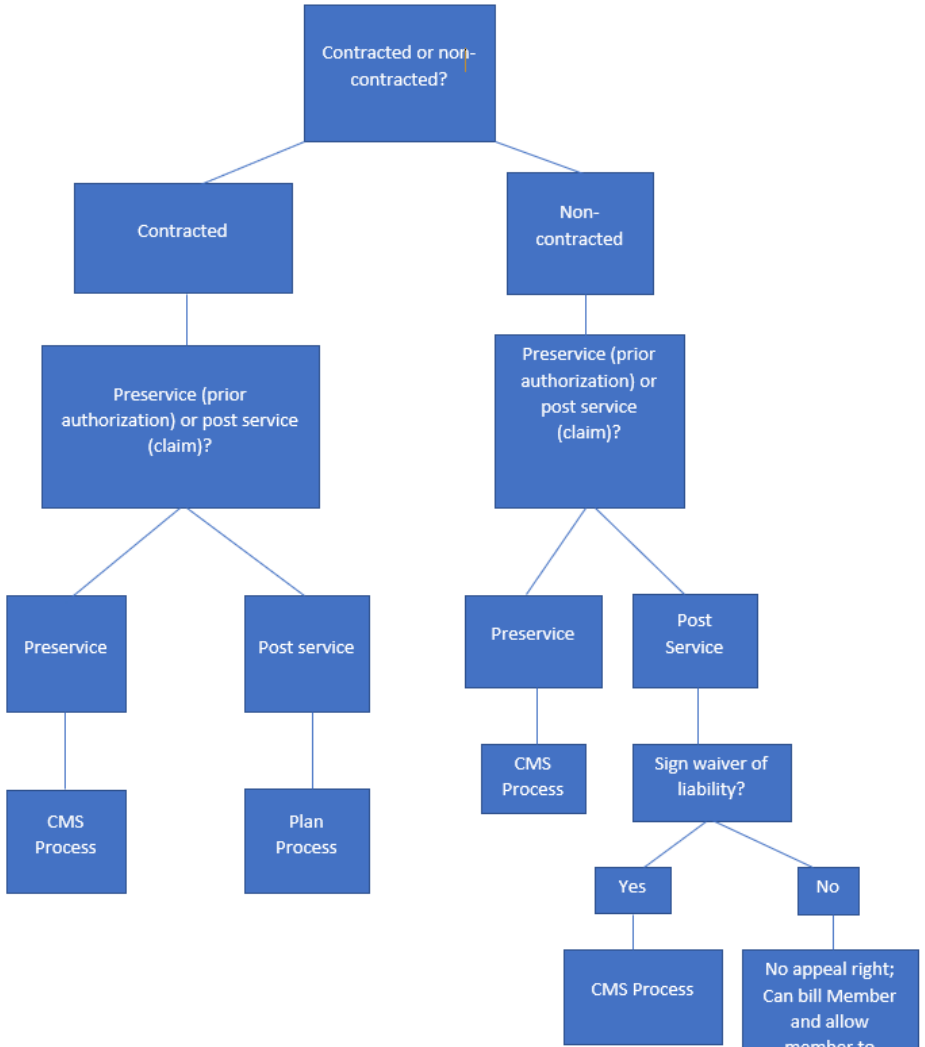
Determinations and Appeals

Part C Services

Regulatory Process[1]	**Plan Process**
Initial Decisions Claims payment determination – clean claims submitted by enrollees or non-contract providers must be paid in 30 days. All other claims submitted by non-contract providers must paid in 60 days. [42 CFR 422.520(a)] Pre-service organization determinations – Standard decisions must generally be made in 14 days.[2] [42 CFR 422.568] Expedited preservice organization determinations – Decisions must be made within 72 hours. An MAO must expedite a determination if the physician indicates that applying the standard timeframe for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum. [42 CFR 422.572] Appeals[3] (1) Reconsideration – a reconsideration must be requested within 60 days of an adverse organization determination unless good cause is shown. [42 CFR 422.582(b) and (c)] Standard Reconsideration Decisions -- The plan must make a standard pre-service	Initial Decisions Claims payment determination – claim must be paid within the prompt payment timeframe set forth in agreement between the plan and provider. [42 CFR 422.520(b)] (Note that state prompt payment laws are preempted.) Appeals No process is prescribed by regulation. The plan process is determined by the relevant plan or by the parties through contract negotiations. Note that in reviewing Medicare Advantage plan policies, some of the largest plans (United, Humana and Anthem) offer two levels of internal appeals and no external appeals.

[1] Note that different (shorter) timeframes apply with regard to Part B drugs, but the process is the same. This chart does not address Part D drugs

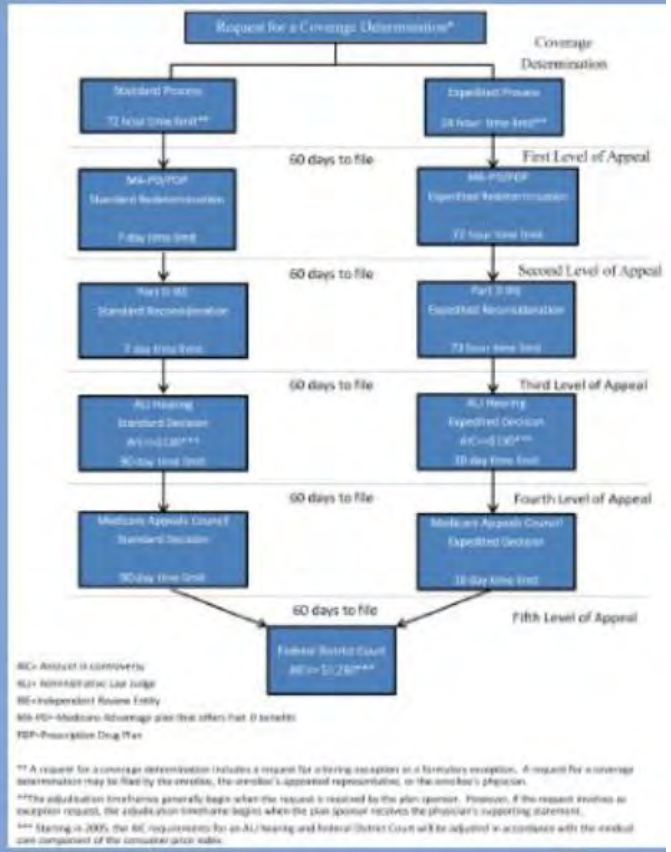
Medicare Advantage Appeal Process



Medicare Part D Appeal Process

Medicare Part D Appeals Process

- Redetermination with the Part D plan (sponsor)
- Reconsideration with the independent review entity (IRE)
- Hearing with an administrative law judge (ALJ)
- Review by the Medicare Appeals Council (MAC)
- Review by a federal district court



Medicare Appeals Process

- Level 1 – Redetermination
  - 120 days from the demand to file the appeal
  - Appeal is to your Medicare Administrative Contractor (MAC)
  - MAC has 60 days to review and respond

- Level 2 – Reconsideration
  - 180 days from MAC's determination
  - Appeal is to a Qualified Independent Contractor (QIC)
  - QIC has 60 days to review and respond

Medicare Appeals Process

- Level 3 – Administrative Law Judge (ALJ)
  - 60 days from the QIC determination to file appeal to ALJ
  - Amount in controversy?
  - Any new evidence?
  - ALJ has 90 days to review and respond
- Level 4 – Departmental Appeals Board (DAB) / Medicare Appeals Council
  - 60 days from ALJ determination
  - DAB has 90 days to review/respond

If all else fails…

- Level 5 – Judicial Review in US District Court
  - 60 days from the DAB determination
  - Need legal representation
  - Contested claim amount > $1,300

$$$$$$$$$$$$$$$$$$$$$$$$$$$$$$$$$$$$

Medical Review Process

Other types of appeals and review contractors

Other Review Contractors

Comprehensive Error Rate Testing (CERT) - View program background, request and response timeline, communication used between Noridian and providers, Provider Corrective Actions, responding to a CERT request, contact details, and resources

Office of Inspector General (OIG) - View OIG information and access the OIG website.

Quality Improvement Organization (QIO) - View QIO functions and access state QIOs.

Recovery Auditor - View RA program details, contact information, types of reviews and the options available when receiving an RA decision.

Supplemental Medical Review Contractor (SMRC) - Access current and completed projects, the discussion/education period, documentation requests and hot SMRC topics.

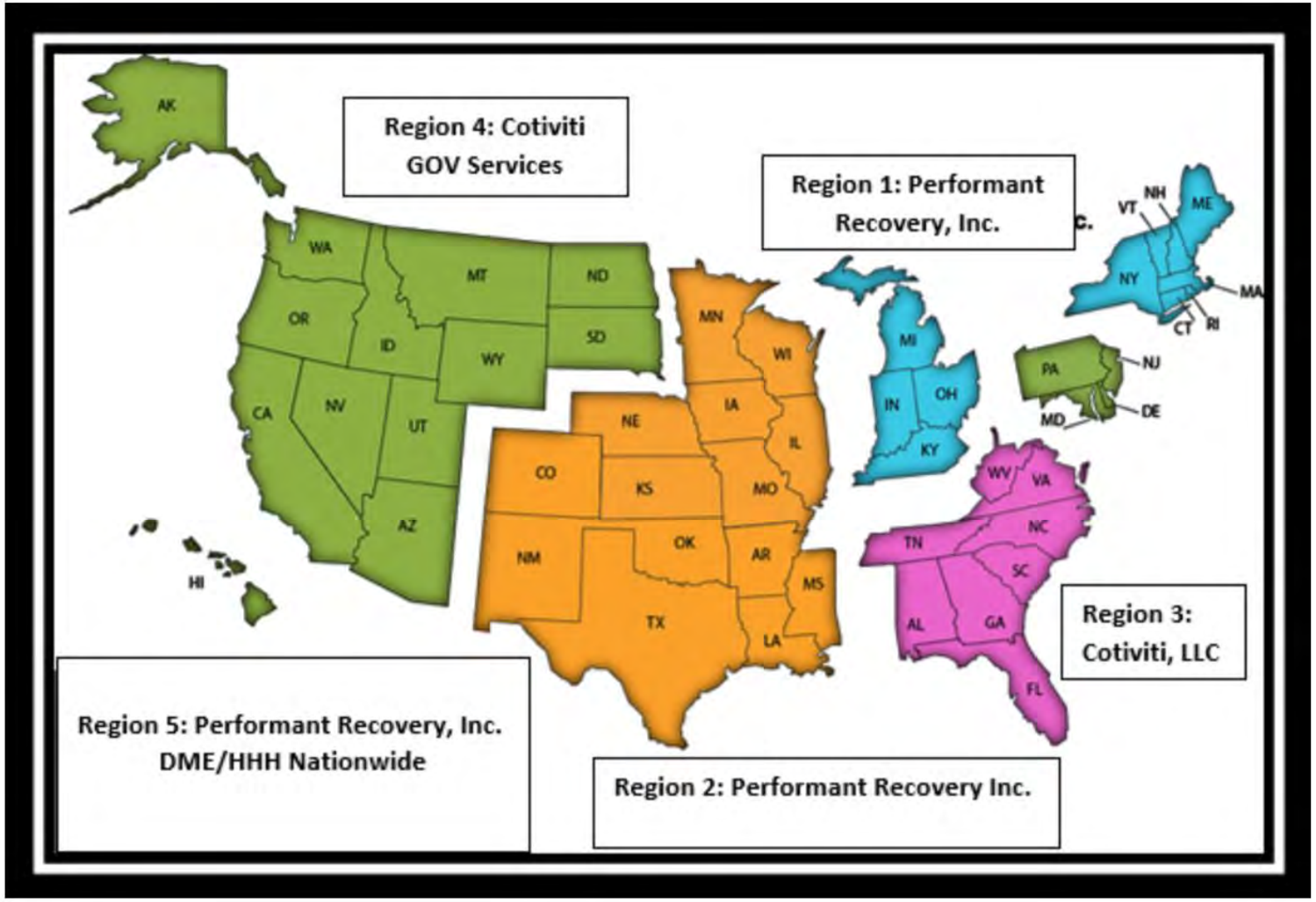
Unified Program Integrity Contractor (UPIC) - View UPIC information, access the Midwest and Western UPIC websites and view UPIC functions and non-functions.

Recovery Audit Contractor (RAC)

Region 3 Cotiviti LLC	AL, FL, GA, NC, SC, TN, VA, WV, Puerto Rico and U.S. Virgin Islands	https://www.Cotiviti.com/RAC	racinfo@cotiviti.com	1-866-360-2507
Region 4 Cotiviti GOV Services (formerly HMS)	AK, AZ, CA, DC, DE, HI, ID, MD, MT, ND, NJ, NV, OR, PA, SD, UT, WA, WY, Guam, American Samoa and Northern Marianas	https://rac4info.cotiviti.com	rac4info@cotiviti.com	**Part A:** 1-87[illegible] 350-7992 **Part B:** 1-877-350-7993
Region 5 DME/HHE/Performant Recovery, Inc.	Nationwide for DMEPOS/HHA/Hospice	https://performantrac.com/PROVIDERPORTAL.aspx	info@Performantrac.com	1-866-201-0580

Feedback

RAC Audit


Region 4: Cotiviti GOV Services
Region 1: Performant Recovery, Inc.
Region 3: Cotiviti, LLC
Region 5: Performant Recovery, Inc. DME/HHH Nationwide
Region 2: Performant Recovery Inc.
AK
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WV
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MA
CT
RI
NJ
DE
MD

Three Types of RAC Reviews

- Automated (NO medical records needed)
- Semi-automated (Providers are given the option to submit medical records, but they are not required)
- Complex (Medical records REQUIRED)

Automated RAC Review

- Auditors may perform automated reviews which occurs when they make a claim determination at the system level without review of medical records (determined by embedded algorithms and other scrubbing software)
  - *Duplicate payment*
  - *Charges for date of services after date of death*
  - *Payment errors*

RAC Reviews

- RAC may perform semi-automated and complex reviews and will send providers an Additional Development Request (ADR) for documentation.
  - Providers have 45 days to respond to ensure proper review of documentation.
  - Documentation must be ***sent directly to the Recovery Auditor,*** not to Noridian

- RAC will **not** review a claim that has been reviewed by another entity.

RAC Reviews

- RAC analyzes the claim data using their proprietary software and identify claims that clearly contain improper payments.
  - If an improper payment is identified, a demand letter will be issued.

- Providers can identify claims that have been recouped by the RAC by checking the remittance advice for the remark message code **N432**

Quality Improvment Organization (QIO)

- The mission of the QIO Program, by law, is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries.
- Based on this statutory charge, and CMS' Program experience, CMS identifies the core functions of the QIO Program as:
  - Improving quality of care for beneficiaries
  - Protecting the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable and necessary and that are provided in the most appropriate setting
  - Protecting beneficiaries by expeditiously addressing individual complaints, such as beneficiary complaints; provider-based notice appeals; violations of the Emergency Medical Treatment and Labor Act (EMTALA); and other related responsibilities as articulated in QIO-related law.

QIO

- QIOs are private, mostly not-for-profit organizations, which are staffed by professionals, mostly doctors and other health care professionals, who are trained to review medical care and help beneficiaries with complaints about the quality of care and to implement improvements in the quality of care available throughout the spectrum of care.
  - California: HSAG
  - Hawaii, American Samoa, Guam, the Northern Mariana Islands: Mountain-Pacific Quality Health
  - Nevada: Health Insight
- QIO contracts are three years in length, with each three-year cycle referenced as an ordinal Statement of Work (SOW)

Targeted Probe and Education (TPE)

- Notice of Review – Targeted Probe and Education

Dear Medicare Provider:

In order to fulfill our contractual obligation with the Centers for Medicare & Medicaid Services (CMS), Noridian Healthcare Solutions, LLC, your Jurisdiction E Medicare Administrative Contractor (MAC), performs reviews in accordance with the CMS instruction. CMS has authorized Jurisdiction E to conduct the Targeted Probe and Educate (TPE) review process. The TPE review process includes three rounds of a prepayment probe review with education. If there are continued high denials after three rounds, Noridian will refer the provider to CMS for additional action, which may include 100% prepay review, extrapolation, referral to a Recovery Auditor, etc. Note, discontinuation of review may occur at any time if appropriate improvement is achieved during the review process.

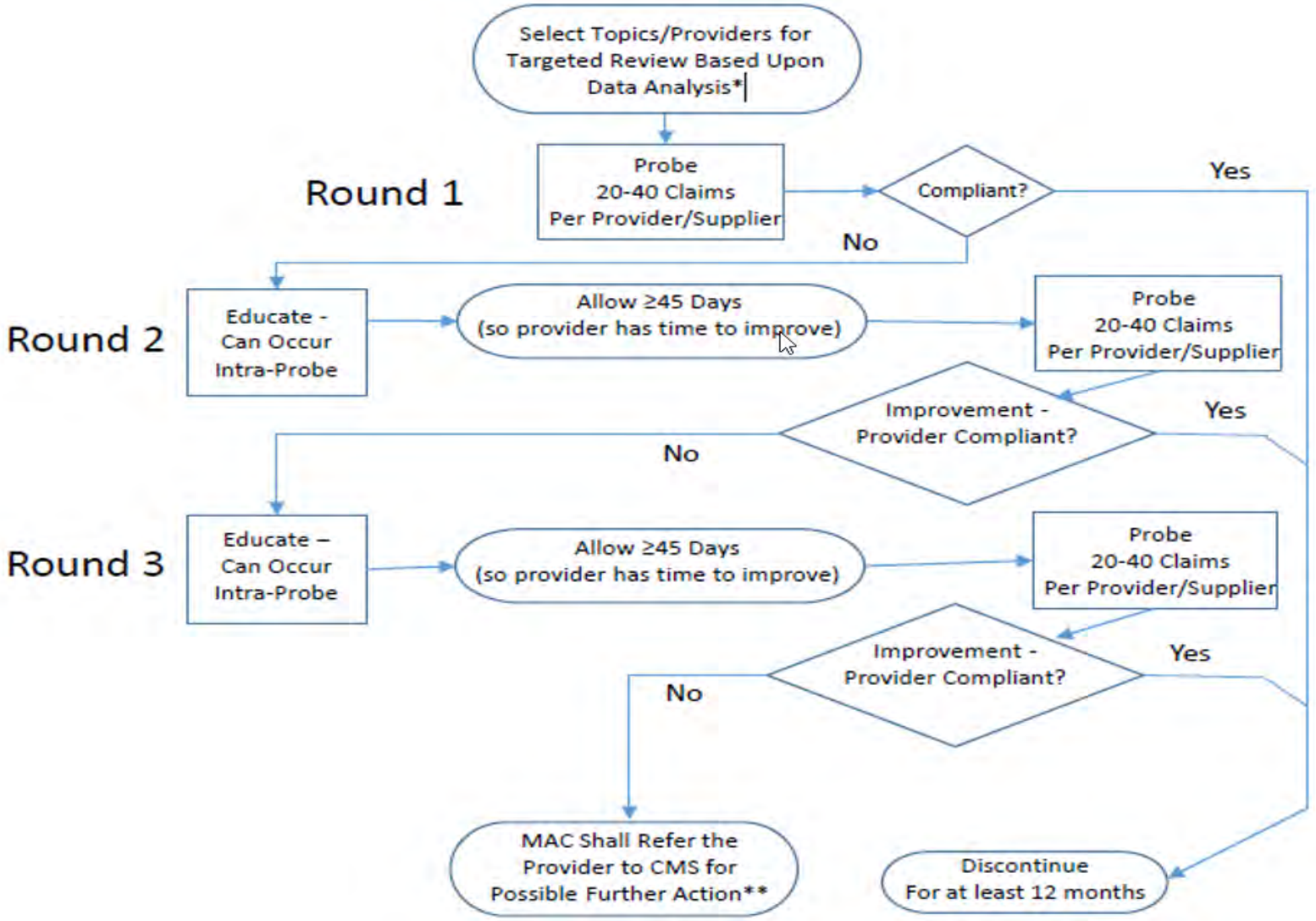
This letter serves as notification of the TPE process and to notify you of the initiation of the review. The purpose of the claim review is to ensure documentation supports the reasonable and necessary criteria of the services billed and follows Medicare rules and regulations.

Reason for Review

A prepayment review has been initiated to probe a sample of your claims billed with the following code(s):

Healthcare Common Procedure Coding System (HCPCS) code G0277

TPE


Select Topics/Providers for Targeted Review Based Upon Data Analysis*
Round 1
Probe 20-40 Claims Per Provider/Supplier
Compliant?
Yes
No
Round 2
Educate - Can Occur Intra-Probe
Allow ≥45 Days (so provider has time to improve)
Probe 20-40 Claims Per Provider/Supplier
Improvement - Provider Compliant?
Yes
No
Round 3
Educate – Can Occur Intra-Probe
Allow ≥45 Days (so provider has time to improve)
Probe 20-40 Claims Per Provider/Supplier
Improvement - Provider Compliant?
Yes
No
MAC Shall Refer the Provider to CMS for Possible Further Action**
Discontinue For at least 12 months

TPE

- What comes next?
  - Receive an e-mail asking for specific pt, code(s), and DOS
    - Usually every 3rd-4th claim for the pt
  - How are you and the code(s) selected an outlier compared to your peers (same locality, state, regions)
  - How does your previous self compare to your current self?

TPE

- Codes being reviewed heavily:
  - 11042-11047 – Excisional wound debridement
  - 11102, 11106 – Tangential/incisional biopsy
  - 11721 – Debridement of 6 nails or more
  - 11760 – Repair of nail bed
  - 15271-15278 – Skin substitute application
  - 17000-17004 – Destruction of pre-malignant lesions (actinic keratosis)
  - 29581 – Application of multi-layer compression system
  - 64455 – Injection of anesthetic/steroid; plantar common digital nerve

TPE

- Codes being reviewed heavily:
  - 77014 – CT scan for surgical planning
  - 93925 – BLE arterial duplex
  - 93970 – BLE venous duplex
  - 95913 – Nerve conduction studies
  - 99183/G0277 – Hyperbaric oxygen
  - 99487-99490 – Chronic care management
  - SNF claims
  - KX-modifiers
  - **ALL A-code and Q-code biologics**

TPE

RE: Notice of File Closure - Targeted Probe and Educate

Dear Medicare Provider,

This letter is to inform you of the round 1 findings for the review initiated on January 4, 2022 for Current Procedural Terminology (CPT®) code 96374. This file is now closed.

An e-visit is not required given the low error rate for the round 1 file, however if you determine that one to one education would be beneficial, Noridian encourages your facility to contact me to set up an e-visit.

Claim Review Summary

Your facility had 20 claims selected for pre-payment review from January 4, 2022 through June 3, 2022 with an overall payment error rate of 2.8% and a claim error rate of 5%. The results are based on the documentation requests submitted by your facility. This review does not guarantee coverage and payment as the claims identified may be subject to other claim processing issues or reviews by other CMS contractors.

The formula to calculate the error rate, which is based on pre-payment decisions only, is the dollar amount of charges billed in error (minus any confirmed under-billed charges) divided by the total amount of charges for services medically reviewed. Individual claim correction is not required as the claims were reviewed on a pre-payment basis and processed per medical review determinations.

A summary of the claim determinations is as follows:

- 19 claims were accepted
- 0 claims required correct coding:
  - Documentation Supporting Infusion Units Billed
  - Therapeutic Administration Billing
  - Therapeutic Administration Billing Integral to a Procedure

Refer to the Claim Review Summary at the end of this letter for more detailed information on your individual claim determinations.

Education

This section provides education on errors found in the claims reviewed from your facility; it does not educate on all of CMS's guidelines required for this service. Furthermore, practitioner orders were not part of Noridian's scope of review and not incorporated in the error rate; however, orders are still required per Medicare

TPE

“No mistakes or few mistakes and you need have no fear…

Our requests for extra charts will stop and disappear…

We won’t bother you for this code set for at least a year!”

Supplemental Medical Review Contractor (SMRC)

- Noridian was selected by CMS to conduct nationwide medical reviews as directed by CMS.
- Conducts nationwide medical reviews **(Part A, Part B, and DME)** in accordance with all applicable statutes, laws, regulations, NCDs, LCDs, and coding guidance
  - Determines whether Medicare claims have been billed in compliance with coverage, coding, payment, and billing practices.

SMRC

- Reviews are assigned through CMS formal notifications and focus on analysis of national claims data issues identified by Federal agencies:
  - HHS-OIG
  - Government Accountability Office (GAO)
  - CMS internal data analysis
  - Comprehensive Error Rate Testing (CERT) program
  - Professional organizations, and/or analysis reports such as First-Look Analysis Tool for Hospital Outlier Monitoring (FATHOM) report, and Program for Evaluating Payment Patterns Electronic Report (PEPPER).

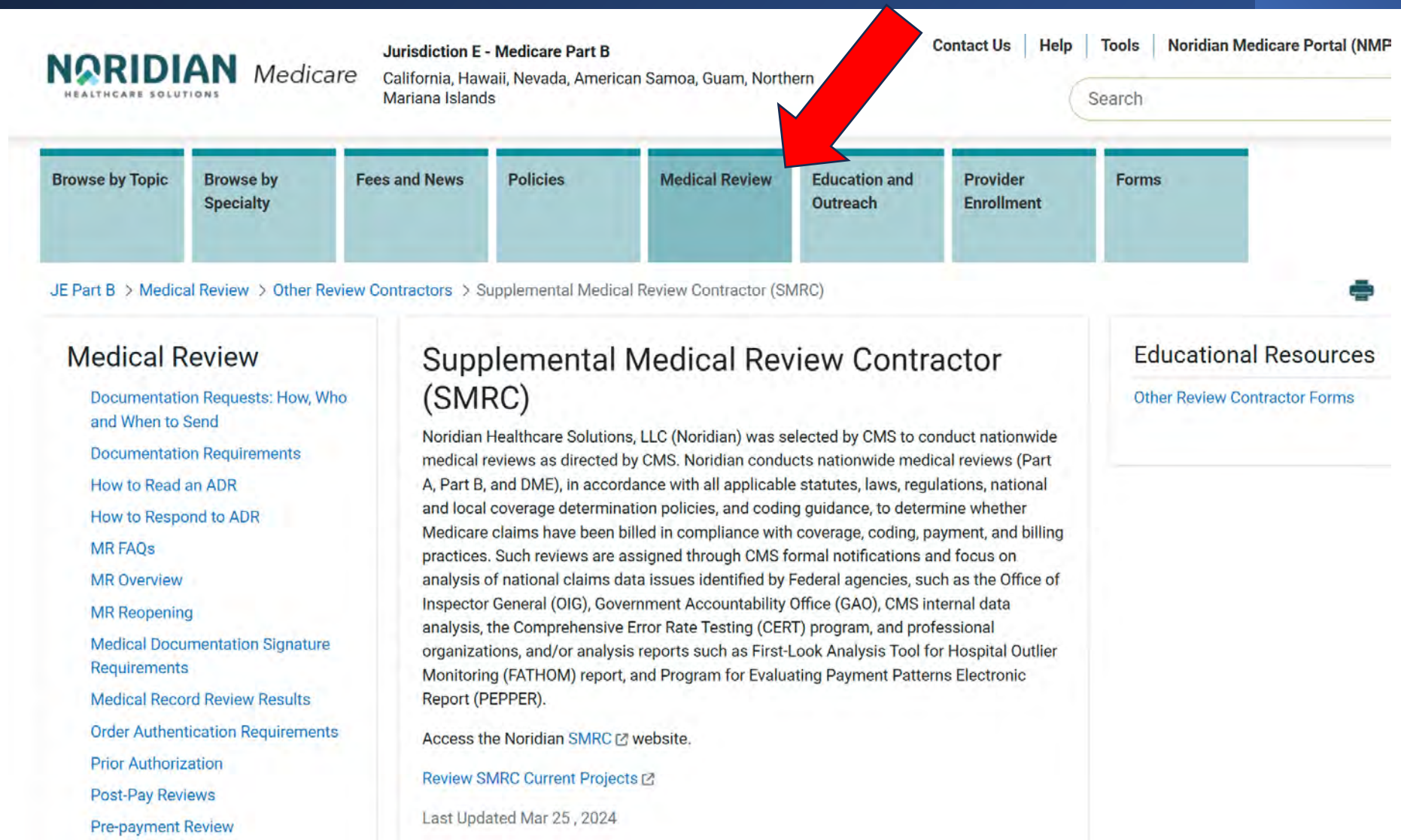
SMRC

- When a claim is denied for no receipt of documentation requested by the SMRC, the next step is to submit the documentation to the MAC that issued the demand letter for the overpayment.
  - This must occur within 120 calendar days of the demand letter.
- This situation is considered a reopening and the MAC will send the submitted documentation to the SMRC for a re-review decision.
- SMRC has up to 60 calendar days to make this decision.
- SMRC will then mail a letter to the supplier with their findings, either to pay the claim or they will outline the reasons for denial.
- SMRC will next notify the MAC of the payment or denial decision.

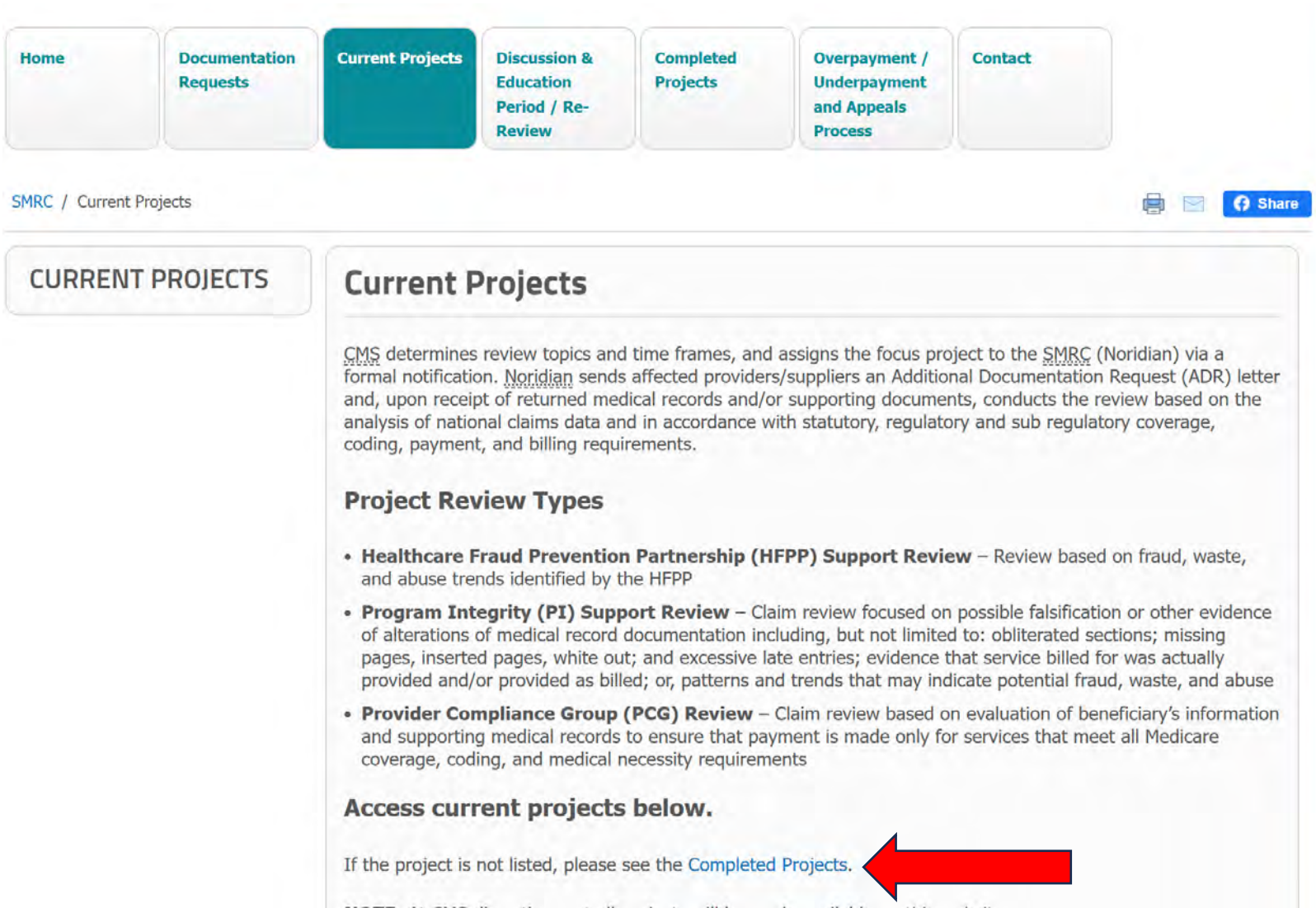
SMRC

- MAC will adjust the claim and a remittance advice with the adjustment results will be generated.
- The provider has the right to appeal the SMRC decision, if the claim remains denied.
- Based on the timeframes and steps listed above, please call the MAC about the status of the SMRC re-review only after at least 140 calendar days have passed from when documentation was sent.

SMRC


NORIDIAN Medicare
HEALTHCARE SOLUTIONS
Jurisdiction E - Medicare Part B
California, Hawaii, Nevada, American Samoa, Guam, Northern Mariana Islands
Contact Us | Help | Tools | Noridian Medicare Portal (NMP
Search
Browse by Topic
Browse by Specialty
Fees and News
Policies
Medical Review
Education and Outreach
Provider Enrollment
Forms
JE Part B > Medical Review > Other Review Contractors > Supplemental Medical Review Contractor (SMRC)
Medical Review
Documentation Requests: How, Who and When to Send
Documentation Requirements
How to Read an ADR
How to Respond to ADR
MR FAQs
MR Overview
MR Reopening
Medical Documentation Signature Requirements
Medical Record Review Results
Order Authentication Requirements
Prior Authorization
Post-Pay Reviews
Pre-payment Review
Supplemental Medical Review Contractor (SMRC)
Noridian Healthcare Solutions, LLC (Noridian) was selected by CMS to conduct nationwide medical reviews as directed by CMS. Noridian conducts nationwide medical reviews (Part A, Part B, and DME), in accordance with all applicable statutes, laws, regulations, national and local coverage determination policies, and coding guidance, to determine whether Medicare claims have been billed in compliance with coverage, coding, payment, and billing practices. Such reviews are assigned through CMS formal notifications and focus on analysis of national claims data issues identified by Federal agencies, such as the Office of Inspector General (OIG), Government Accountability Office (GAO), CMS internal data analysis, the Comprehensive Error Rate Testing (CERT) program, and professional organizations, and/or analysis reports such as First-Look Analysis Tool for Hospital Outlier Monitoring (FATHOM) report, and Program for Evaluating Payment Patterns Electronic Report (PEPPER).
Access the Noridian SMRC website.
Review SMRC Current Projects
Last Updated Mar 25 , 2024
Educational Resources
Other Review Contractor Forms

SMRC


Home
Documentation Requests
Current Projects
Discussion & Education Period / Re-Review
Completed Projects
Overpayment / Underpayment and Appeals Process
Contact
SMRC / Current Projects
Share
CURRENT PROJECTS
Current Projects
CMS determines review topics and time frames, and assigns the focus project to the SMRC (Noridian) via a formal notification. Noridian sends affected providers/suppliers an Additional Documentation Request (ADR) letter and, upon receipt of returned medical records and/or supporting documents, conducts the review based on the analysis of national claims data and in accordance with statutory, regulatory and sub regulatory coverage, coding, payment, and billing requirements.
Project Review Types
• Healthcare Fraud Prevention Partnership (HFPP) Support Review – Review based on fraud, waste, and abuse trends identified by the HFPP
• Program Integrity (PI) Support Review – Claim review focused on possible falsification or other evidence of alterations of medical record documentation including, but not limited to: obliterated sections; missing pages, inserted pages, white out; and excessive late entries; evidence that service billed for was actually provided and/or provided as billed; or, patterns and trends that may indicate potential fraud, waste, and abuse
• Provider Compliance Group (PCG) Review – Claim review based on evaluation of beneficiary's information and supporting medical records to ensure that payment is made only for services that meet all Medicare coverage, coding, and medical necessity requirements
Access current projects below.
If the project is not listed, please see the Completed Projects.

SMRC

01-020	Outpatient Hyperbaric Oxygen (HBO)	38%
01-028	Therapeutic Shoes for Diabetics	70%
01-050	Podiatry	45%
01-069	Treatment of Chronic Venous Insufficiency	61%
01-083	HBO for LE Diabetic Wounds	92%
01-121	Nail Avulsions	44%
01-136	Surgical Dressings	72%
01-303	Surgical Dressings	91%
01-307	Orthopedic Footwear	69%

Recently completed projects

(also Home Health and SNF)

SMRC

- Only podiatry-relevant current project:

01-144	Hyperbaric Oxygen (HBO) for Lower Extremities (LE) Diabetic Wounds Part 2

SMRC

Option for Response – Appeal May be Available

Unless an overpayment demand letter has been sent to the provider/supplier from their respective MAC, an appeal request cannot be submitted.

Since SMRC does not handle appeal requests, requestors must address any overpayment recovery process or appeal rights with their MAC.

Last Updated Dec 6, 2024

HHS-OIG – Office of Inspector General

- Office of Inspector General of the U.S. Department of Health & Human Services (HHS). Establised in 1976.
  - At the forefront of the effort to fight waste, fraud, and abuse in Medicare, Medicaid and more than 300 other HHS programs.
- OIG develops and distributes resources to assist the health care industry in its efforts to comply with the Nation's fraud and abuse laws and to educate the public about fraudulent schemes so they can protect themselves and report suspicious activities.
- Works closely with DOJ and FBI

Unified Program Integrity Contractor (UPIC)

- UPICs were created to perform program integrity functions for Medicare Parts A, B, DMEPOS, HH&H, and Medicare-Medicaid data matching
  - Medicare Part C and D handled separately by MEDIC (Medicare Drug Integrity Contractor)

- UPICs and the MEDIC work under the direction of the Center for Program Integrity (CPI) in CMS.

UPIC

UPIC Region	Contractor	Covered States/Territories
Western	Qlarant	Am. Samoa, Guam, N. Mariana Is., AK, AZ, CA, HI, ID, MT, NV, ND, OR, SD, UT, WA, and WY

UPIC

- UPICs primary goal is to investigate suspected fraud, waste, and abuse in Medicare and Medicaid claims.
- UPIC develop investigations early, timely, and take immediate action to ensure Medicare Trust Fund monies are not inappropriately paid.
- UPIC may also identify any improper payments that are to be recouped by the MAC

UPIC

- Actions the UPICs take to detect and deter fraud, waste, and abuse in the Medicare program include:
  - Investigate potential fraud and abuse for CMS administrative action or referral to law enforcement
    - **Only auditor that can refer to take away your Medicare billing privileges**
  - Conduct investigations in accordance with the priorities established by CPI's Fraud Prevention System
  - Perform data analysis in coordination with CPI's Fraud Prevention System, IDR and OnePI
  - Perform medical reviews, as appropriate
  - Identify the need for administrative actions such as payment suspensions, prepayment or auto-denial edits, revocations, post-payment overpayment determination
  - Share information (e.g. leads, vulnerabilities, concepts, approaches) with other UPICs to promote the goals of the program and the efficiency of operations at other contracts
  - **Refer cases to law enforcement to consider civil or criminal prosecution**

When conducting investigations, UPIC may…

- Request medical records and documentation
- Conduct interviews with beneficiaries, complainants, or providers
- Conduct site verification
- Conduct an onsite visit
- Identify the need for a prepayment or auto-denial edit
- Institute a provider payment suspension
- Refer cases to law enforcement.

When conducting investigations, UPIC may…

- UPICs also support victims of Medicare identity theft.
- A provider or supplier who believes he/she may have had their provider information stolen and used to submit Medicare claims for which payment was made can request their UPIC to investigate the case.
- The UPIC will then work with CMS to determine the appropriate remedial action to assist the provider. See the CMS Victimized Provider Project for guidance on how to avoid and report Medicare identity theft and information on current scams.

UPIC Documentation Request

- Name and telephone number of the contact person for facility.
- Complete account statement of all charges, payments, or adjustments for the claims identified in the review period:
  - Billing Forms (example: CMS-1500 or UB92).
  - Remittance Advice (evidence relating to payments and adjustments).
- List of all personnel billing services under your National Provider Identifier (NPI) and their credentialing, training, licensure, etc., during the review period.
- A list of all abbreviations and/or acronyms used, including definitions.
- Any documentation of prior audit, investigation, or review, and repayment or refund back to Medicaid/Medicare.

UPIC Documentation Request

- List of staff, including licensing, certifications, qualifications, and background checks during the review period (if applicable).
- Organization chart
- Policies and procedures for operations including personnel, billing, coding, etc.
- Signature attestation of all personnel providing services (if applicable)
- Prior Authorization form (if applicable)
- Waiver of non-covered services (if applicable)
- Any additional documentation that demonstrates the medical necessity of the services provided, if applicable.
- Beneficiary identification, date of service and provider of service shall be clearly identified on each page of the submitted documentation.
- Photos (if necessary)

UPIC Documentation Request

- Consult notes
- Progress notes, including H&Ps (from others as well) and other progress notes
- Notes from other places of service
- Plan of care / treatment plan
- Procedure notes
- Operative reports
- Provider's orders
- Photos (if necessary)
- Nurses notes
- Lab, radiology, and pathology reports
- SNF notes
- Patient log showing dates, time, and length of appointments
- **NOTE:** Beneficiary ID information, DOS, and Provider of service ***MUST*** be clearly identified on each page of the submitted documentation

Documentation Tips

- Lab and Imaging Tests
  - Signed and dated order exists in the chart (hospital, SNF, office, etc.)
  - Chart shows doctor ordered tests and MDM for the tests.
- Total time and what occurred during office visit (E&M)
- MDM of office visit
  - What's your thought process
  - Are you ruling out anything
  - Treatment plan

Document Reasonable and Necessary

- Only the actual provider who is treating the pt knows wat is reasonable and necessary for that pt being evaluated and treated at that visit.
- The only way a reviewer can determine if something was reasonable and necessary on a claim is to review the complete documentation submitted

“Send in all the documents you wrote

so all the reviewers can read your note!”

National/Local Coverage Determination (NCD/LCD)

- NCD
  - Made by CMS, must be followed as written
  - Areas not spefically mentioned may or may not be covered by the MAC (LCD)
  - NCDs **CANNOT** be changed by MAC, QIC, or ALJ.
- LCD
  - Made by one MAC or collaboration of MACs
  - Can be asked for policy reconsiderations with legitimate reasoning and medical literature
  - Can be asked for individual consideration for a patient with an unusual or off-label use, with medical literature support

- NCDs and LCDs are posted in the CMS Coverage Database

What if no NCD/LCD?

- Product Literature
- Accepted medical literature (RCTs given more weight)
- Accepted standard of care

How to handle documentation requests

- Have a set office process for dealing with record requests for any insurance or agency
- Have ONE individual responsible for sending all records as part of the set office process
  - Experienced office manager or equivalent
- Know how and where to get offsite records
- Have a check-off sheet to include:
  - All documentation and signature(s) are legible
  - Pt name, DOB, and DOS on every page submitted
  - Name, DOS, and signature of provider
  - Signature sheet, or attestation if needed
  - Correct address for records to be sent
  - Timeliness
  - Send by a trackable mail service (USPS certified w/return receipt or FedEx/UPS)

What about amending records?

- Late entries and addendums in a medical record are legitimate occurrences
- It should have the **current date** of that entry and **signed** by the person making the correction

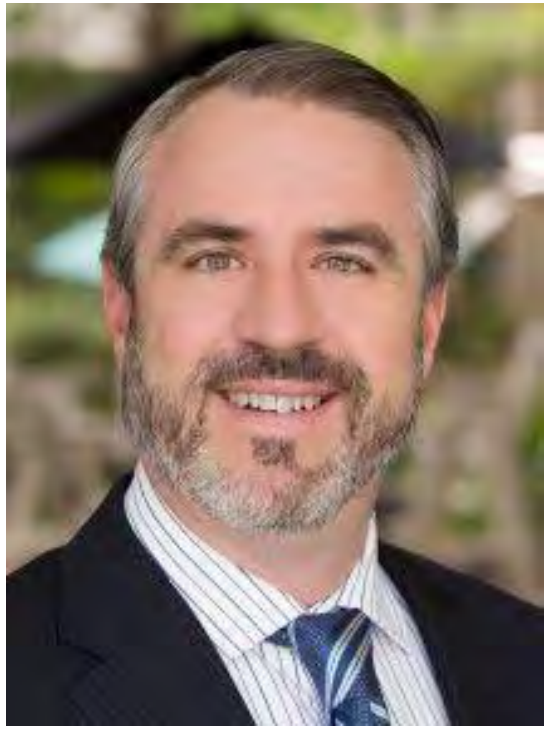
- Late Entry
  - Supplies additional information that was omitted from original documentation. It should be added ASAP
  - Only written if the person documenting has total recall of the omitted information

- Addendum
  - Provides information that was not available at the time of the original entry
  - Should be timely
  - Explains the reason for the addition or clarification of information being added to the medical record

How to make the correction

- NEVER write over or obliterate the previous information
- Draw a single line through the erroneous information, keeping the original entry legible
- Date and sign/initial the deletion, stating the reason for the correction in the next line or in the margin
- Document correct information on the next line or space, along with the current date and time

Thank you!



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