Amending/Correcting Records

written by Richard Leslie | February 1, 2024

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***Note**: This article was first published on the CPH Insurance website in March 2015. It is republished here with minor changes. Mental health practitioners know the importance of keeping patient treatment records, whether it is to meet the requirements of insurance companies who may review records for reimbursement purposes, or whether it is for the practitioner's self-protection. This article addresses circumstances that may arise where the practitioner, for one reason or another, desires to change or correct the records. Careful thought must be given to such circumstances, and hopefully, this article will help practitioners examine and navigate through these situations.*

Amending/Correcting Records

A reader asked me to comment on how corrections should be made in a patient's treatment records when a mistake or error has been discovered, such as writing the wrong date, CPT code, or accidentally writing the wrong word in the content of the note. This article will discuss various aspects of this question. It is a fundamental, well-accepted principle that patient treatment records should be accurate, for several reasons. Most importantly, records should be accurate because subsequent treatment providers may use them in their treatment of the patient, which could lead to better quality care and help to avoid errors. Additionally, should there be litigation, a mistake or error could prove costly to the patient's case, and sometimes, to the treating practitioner. In short, accurate recordkeeping is necessary to provide for accountability to the patient and the legal system.

It is important to recognize that there is a difference between *correcting* records and *altering* records.

With respect to altering records, I have previously consulted with practitioners who altered records either on their own, sometimes after the receipt of a subpoena, or at the request of a patient's attorney in anticipation of the production of the records in a legal proceeding and the practitioner's sworn testimony at a pre-trial deposition or at trial. Perhaps the attorney saw something in the records that could have presented a problem for the plaintiff/patient and asked the therapist "to reconsider" or "clarify" what had been written and to alter/change the entry in a particular manner. The changes that were made were alterations because the practitioners made the changes for reasons that ultimately turned out to not be supported by the facts or the practitioners' true clinical beliefs. In each case, the alterations were made without properly indicating the changes in the records. This could have been done in a variety of ways – from erasing, rewriting, or adding to the existing record at a later date without indicating that the entry was made later …or other "creative" ways.

Altering records after receipt of a subpoena is particularly problematic, unwise, and likely unethical or unlawful. If and when such alteration is discovered by the opposing side in a lawsuit, it will not only hurt the case, but it might result in a disciplinary action by the licensing board against the practitioner who altered the records. The bottom line is – do not alter records because an attorney or the patient believes that the content is not helpful. The facts are the facts, and your honest opinion should not be compromised. The attorney will have to find ways to overcome any hurdle. Perhaps the practitioner might be able to truthfully explain or bring context to the entry in their testimony.

Changes to patient records are sometimes initiated as a result of patients reviewing their treatment records. In most states, and under HIPAA regulations (for "covered providers"), patients have broad rights to inspect and obtain a copy of their records. As a result, patients may request a change to their records. Additionally, and in cases where the practitioner believes it is appropriate to not make a change to the records, patients will usually have the right to provide the practitioner with an addendum to the records, which typically must become a part of the records. Under HIPAA regulations, there is a process spelled out on how requests for changes are to be handled. Of course, if the practitioner agrees with the change requested by the patient, there is no problem with making the change – assuming that the change is executed in an appropriate manner. Generally, the manner of making a change is likely not specified in law or regulation, nor is there much guidance in codes of ethics of professional associations.

It is commonly understood that entries into the record are generally made contemporaneously with the treatment being rendered, or shortly thereafter. This allows the record to be introduced as evidence in a legal proceeding and lends to its credibility. Generally, erasures, white-outs, or removal are all considered to be inappropriate, arguably constituting an alteration – or at least raising the issue. Such conduct may indicate an attempt to fool or mislead. It is also generally accepted that a strike through should be made to the language to be changed, such that the material struck through is readable. Then, the correction can be made. It is important to indicate the date and time of the change. Any corrections should be initialed by the practitioner, sometimes signed (the identity of the person making the change, wherever employed, should be ascertainable). The reason for making the change should also be indicated, unless the change is self-explanatory. Some say that the word "error" should be entered into the record next to the item being corrected. If the practitioner works within a hospital or other health facility, or is employed by an entity other than the practitioner's private practice, the entity may have written guidelines that employees or independent contractors are expected to follow.

When the reader asks about changing a date or changing a CPT code, or for that matter, writing the wrong word in the notes, I think about insurance reimbursement situations. More particularly, I recall cases where a therapist may have billed an insurance company for a session that was not held on the date indicated in the billing, or may have billed the insurer for individual psychotherapy when a family session or couples session occurred. I think of therapists who may have changed their diagnosis for the purposes of reimbursement and perhaps not for sound clinical reasons. Under such circumstances, a therapist might later desire to change the records in some manner or to some degree. This can be a dangerous road to travel. Each case is of course different, and changes to the records with respect to

date, CPT code, or writing a wrong word may be proper and justifiable.

Why are you making the change? Is it the result of a legitimate patient request or discovery on your part? Or has an attorney made the request prior to a deposition or trial, or after the time you are served with a subpoena by opposing counsel? Is the correction you intend to make simply called for because of an innocent error, or is the change being made to hide or mislead? These are some of the questions that practitioners must think about before making changes to treatment records. Errors can be corrected. Leave the alterations to tailors!