AHIMA Distance Education
Career-building Resources

Amending Closed Health Records

Audio Seminar/Webinar

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Practical Tools for Seminar Learning

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Faculty

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April Robertson directs the Corporate Compliance Office for ChartOne Incorporated. ChartOne is a national company with corporate offices in Burlington, Massachusetts. ChartOne's on-demand solutions combine innovative Web-based technology with premier chart management services to provide an affordable answer to electronic medical record. April spearheads internal and external HIPAA training, regulatory compliance and education efforts. April also advises on HIM software product development requirements. Before joining ChartOne, April has been HIM director for a number of California healthcare organizations, including the Golden Gate Service Area of Kaiser Permanente, and Vice President of Ambulatory Services for the QuadraMed Corporation. April holds RHIA, RHIT and CHP credentials, and is a Fellow of AHIMA, in addition to a Master's degree in Public Administration and Health Services Administration. Ms. Robertson speaks nationally on the HIPAA Privacy and Security Rules, Best Practices for Regulatory Compliance, AHIMA's E-HIM® Vision and the Legal Electronic Health Record, and other topics as required.

April is past president and director of the California Health Information Association, national chair of the vendor task force working on strategic initiatives for the 14th Congress of the International Federation of Health Records Organizations (IFHRO) which will be held in Seoul, Korea in May 2007. Ms. Robertson is currently a 2nd year AHIMA Director serving a 3-year term.

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Ms. Servais is VP, Compliance and Privacy Officer at Precyse Solutions. She has more than 20 years of experience in Health Information Management. At Precyce, Servais' responsibilities include planning, designing, implementing and maintaining corporate-wide compliance programs, policies and procedures, and updating them to accommodate changes in federal and other regulations; overseeing training and development programs related to ethics, compliance and patient privacy; developing and chairing compliance and privacy advisory committees at the Executive and Board levels; and taking an active role in professional organizations.

Ms. Servais has proven expertise in a wide range of HIM-related areas, including product development and marketing strategies, system analysis and installation, operations improvement and re-engineering, electronic medical record project management, DRG and data quality analysis and education, compliance strategies, and clinical database management. Servais most recently established HIM Consulting Services, which provided a variety of services to various HIM consulting companies and was also associated with Atlanta-based eWebCoding/InterTech as a consultant and Domain Expert. Prior to that Servais held increasingly responsible positions with Tenet Healthcare, ultimately serving as the company's manager of Health Information Services. She also established a successful HIM consulting business, Servais Holloway & Associates, and served as one of its principals. Other past experience includes medical records ***(cont'd)***

management at three California hospitals and research at UCLA's School of Public Health.

Ms. Servais holds a B.S. in Health Records, and an M.P.H. in Health Information Systems from UCLA. Her many professional accomplishments include authoring several published columns, manuals and papers, and developing and teaching courses for both colleges and professional associations.

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Closed Record Definition

- Providers need to determine if there will be a definition of a "closed" record. Consider:
  - Record never closed
  - Closed when all deficiencies complete
  - Closed x days after discharge (e.g., 30)
  - Other

1

Definition – Closed Health Record

- In an acute care setting, a "closed health record":
  - Pertains to the health record of a discharged patient where all regulatory, licensing and accreditation requirements have been met, along with specific requirements stated in the facilities' bylaws and rules and regulations

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Polling Question #1

Do you have a definition for a closed record?

- **1 Yes**
- **2 No**

3

Closed Record Definition

- **Document is "closed" once it is made final or is authenticated**
  - **Cannot "unsign" document to make changes**
  - **Closed documents must have amendments or second versions in order to add or correct information**

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Definition – Amendment

- What is an Amendment?
  - Merriam-Webster Dictionary:
    - A correction of faults
  - aqua - alteration
  - Thomson & Gale Law Encyclopedia
    - The modification of materials by the addition of supplemental information; the deletion of unnecessary, undesirable, or outdated information; or the correction of errors existing in the text

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Definition – Addendum/Appendment

- An addendum – additional information to be added to an existing entry in the patient's record
- Appendment — information that an individual has requested and the organization has accepted from the individual to be appended to the organization's system of health information

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Joint Commission

- **Silent on medical record amendment or correction**

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HL7 Legal EHR Functional Profile – Proposed

- **1. The system SHALL time stamp initial entry, modification, or exchange of data, and identify the actor/principal taking the action as required by users' scope of practice, organizational policy, or jurisdictional law (IN.1.5)**

- **The system SHALL provide the ability to associate any attestable content added or changed to an EHR with the content's author (for example by conforming to function IN.2.2 (Auditable Records) (IN.1.8)**

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HL7 Legal EHR Functional Profile – Proposed

- **Audit functionality includes the ability to generate audit reports and to interactively view change history for individual health records or for an EHR-S**
- **The system SHALL provide the ability to view change history for a particular record or data set in accordance with users' scope of practice, organizational policy, or jurisdictional law (IN.2.2)**

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HL7 Legal EHR Functional Profile – Proposed

- **Statement:** Updates to health record information made after finalization (or the signature event) will be handled as an amendment, correction or augmentation.
- **Description/Legal Rationale:** Clinicians need the ability to correct, amend or augment notes or documents once they have been completed. When an amendment, correction or augmentation has been made, principles for documentation practices require that the original documentation must be accessible, readable, and unobliterated. A user must have a clear indication that modifications have been made to the entry. IN.2.5.3.2.

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HL7 Legal EHR Functional Profile – Proposed

1. The system SHALL provide the author or a designee the ability to enter an amendment, correction or augmentation to a note or document.
2. The system SHALL allow the author to indicate whether the change was an amendment (additional information), a correction of erroneous information and the reason, or an augmentation to supplement content.

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HL7 Legal EHR Functional Profile – Proposed

3. The system SHALL record and display with the amendment, correction or augmentation the date,time and user.
4. The system SHALL display an indicator or flag that an amendment or correction has been made to a note or document when it is viewed or printed.
5. The system SHALL retain the prior version(s) of a note or document before the amendment, correction or augmentation.
6. The system SHALL provide a link or clear direction for accessing the original version of the note or document.

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HL7 Legal EHR Functional Profile – Proposed

- **Statement:** A system shall retain previous versions of a document in accordance with the organization's business rules and manage document succession.
- **Description/Legal Rationale:** The organization must have the ability to establish business rules for identifying and handling of versions of documents and managing document succession. Succession management is based on a document's status change over time.

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HL7 Legal EHR Functional Profile – Proposed

A version of a document is:

1. A completed document
2. A document completed and modified one or more times
3. A document that has been viewed for clinical decision-making purposes by an individual other than the author
4. A document that has been captured in an incomplete state per organization business rules and updated over time (e.g., a preliminary lab test)
5. A document that electively, according to the author, must be preserved in the current state at a given point in time (e.g., History and Physical)

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HL7 Legal EHR Functional Profile – Proposed

- **Certain types of records are typically handled in versions, for example:**
  - **Lab results (preliminary and final)**
  - **Dictated reports**
  - **Work-ups (over course of days)**

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HL7 Legal EHR Functional Profile – Proposed

1. **The system SHALL provide the ability to establish business rules identifying the types of documents and notes that will be handled as a version when the record state changes (e.g., augmented, amended, corrected, etc.)**
2. **The system SHALL provide the author or a designee the ability to revise a document or note and save it as a new version**
3. **The system SHALL record and display the original date, time and user and the new date, time and user for the updated version**

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HL7 Legal EHR Functional Profile – Proposed

4. **The system SHALL manage the succession of documents by applying sequentially numbered versions**
5. **The system SHALL retain the prior version(s) of a note or document before the changes was made**
6. **The system SHALL display an indicator or flag that there is a prior version(s) when it is viewed**
7. **The system SHALL provide a link or clear direction for accessing the original version of the note or document**
8. **The system SHALL provide the ability to designate which version will be the final version for disclosure purposes**

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HL7 Legal EHR Functional Profile – Proposed

- **Statement**: Remove a document from view if it is deemed erroneous and cite the reason.
- **Description/Legal Rationale**: Record retraction is used to reverse changes that have been made to an existing record/report.

  Once a record has been retracted, it is no longer visible in standard queries, though it remains accessible in EHR audit records should evidence ever be required for legal or other exceptional circumstances.

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HL7 Legal EHR Functional Profile – Proposed

There are times that a record is entered in an EHR and completed then found to be erroneous, e.g., the record may belong to another individual. In these cases, it is necessary to remove that record from view (storing it in case it may be needed for litigation or investigation purposes, etc.). After retracting an erroneous record, a user has the ability to resubmit a corrected record with no visible indication that there was ever a previous version.

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HL7 Legal EHR Functional Profile – Proposed

1. The system SHALL provide the ability to retract a document from view so that it is no longer visible in standard queries.
2. The system SHALL retain the retracted document and keep it accessible through EHR audit records to designated staff for legal purposes should the document be needed for litigation or internal investigation/quality assurance.
3. The system SHALL provide the ability to submit a corrected record in the place of one removed from view when applicable.

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HL7 Legal EHR Functional Profile – Proposed

4. **The system MAY provide the ability to identify the users who viewed the record prior to its removal and present them the new/corrected record that has been resubmitted**
5. **The system SHOULD provide the ability to identify the reason why the record was retracted**

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HL7 Legal EHR Functional Profile – Proposed

- **Statement**: Remove from view (redact) for disclosure or reporting purposes portions of an EHR (at either the data or record level) and cite the authority for doing so
- **Description/Legal Rationale**: Redaction is used to assure that information considered private or protected is not disclosed inappropriately. Systems must provide the ability to redact information at the data level or at the record level, provide a mechanism to capture the reason for redaction and retain a copy of the redacted records that were disclosed. Redaction may be used for a variety of purposes such as protecting certain types of confidential or privileged information from being disclosed

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HL7 Legal EHR Functional Profile – Proposed

1. The system SHALL provide the ability to redact (block from view) data elements or portions of a document
2. The system SHOULD provide the ability to cite the reasons for redaction
3. The system SHALL store a copy of the redacted record

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HIPAA

- Requires providers to allow patients to amend documentation

"Standards for Privacy of Individually Identifiable Health Information; Final Rule."45 CFR Parts 160 and 164. Section 164.526 (a). Federal Register 65, no.250(2000)

Available online at www.hhs.gov/ocr/hipaa/finalreg.html

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Individual's Request for Amendment

- The covered entity (CE) must permit an individual to request that the CE amend the PHI maintained in the Designated Record Set (DRS)
- The CE may require individuals to make requests for amendment in writing and provide a reason to support a requested amendment, provided that it informs individuals in advance of the requirement

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Reasons to Request an Amendment

- Patient feels:
  - The personal health information (PHI) is erroneous
  - The PHI is incorrect
  - The PHI is misleading
  - That PHI has been omitted

26

Making the Amendment

- The CE must make the appropriate amendment to the PHI or record that is the subject of the request for amendment
- Identify records in DRS affected by the amendment/appending
- Provide link to location of the amendment

27

Informing Patient and Others

- Inform patient in a timely manner that the amendment is accepted
- Secure patient's permission to notify relevant persons with which the amendment needs to be shared
- Ensure notification to others is made within a time period

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Who Needs to Be Informed?

- **Persons identified by the patient as having received PHI**
- **Business associates**
- **Others who could possibly rely on information which if not corrected could prove to be detrimental to the individual**

29

Denial of Amendment

- **The CE must provide (in plain language) the individual with a written denial**
- **Include – reason for denial**
- **Individual has a right to disagree and file a statement**
- **Individual may request the statement be included with any further requests for PHI (that is the subject of the amendment)**

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Procedure – Patient Amendment

- Request for Amendment to be in writing
- Received from Patient or Legal Representative
- Suggest the CE has a "Request for Amendment Form" available in Health Information Management (HIM) department

(Continued)

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Polling Question #2

Do you us a specific form created by your facility which the patient must complete when requesting an Amendment to their PHI?

*1 Yes

*2 No

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Procedure – Patient Amendment

(Continued)

- **Allow HIM staff to verify and correct demographic information such as:**
  - **Encounter date**
  - **Date of birth**
  - **Full name**
  - **Spelling, etc.**

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Procedures for Corrections, Late Entries, and Amendments

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Paper or Electronic?

- **Is amendment to be made on a paper document?**
- **Is amendment to be made electronically?**

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Key Principles for Correction

- **Be able to:**
  - **Track corrections or changes to documentation**
  - **Identify the author of the original entry and the change(s)**
  - **Identify the date and time of the original entry and the change(s)**

(Continued)

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Key Principles for Correction
(Continued)

- **Retrieve and view the original incorrect documentation as well as the corrected version**
- **Make the correction on both the on-line document and the printed version**

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Procedure – Paper Corrections

- **Line through incorrect information**
  - **Do not white out**
  - **Do not obliterate/cross out**
- **Print "error" by the incorrect information and state reason for error**
- **Sign name, credentials/title and date**
- **Enter correct information as a notation**

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Procedure – Electronic Information

- Most likely – paper process won't work with electronically generated information in exactly the same way
- Have several other alternatives

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EHR Correction Process

- Original entry must have date and time stamp and identify the author
- When a correction occurs, the original document must have a symbol to indicate additional or corrected information exists
- Must not change or delete original information
- The notation with the additional or corrected information must have its own date and time stamp and author identification

40

Imaged Record Correction Process

- Document on wrong patient record (retraction)
  - Remove the incorrect document from standard view – though it will still be available if needed for any legal or audit purposes
  - Note the date and time and circumstances under which the document was removed
  - Post the document to the correct record

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Imaged Record Correction Process

- Document posted to wrong episode of care for patient (reassignment)
  - Remove the document from the incorrect episode of care
  - Post the document in the correct episode of care
  - Note the date and time and circumstances of the change in the original episode of care record

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Notes/Comments/Questions

Imaged Record Correction Process

- Document posted to wrong document type or in wrong location within record (resequencing)
  - Re-index the document to the correct document type or move the document to the correct location within the same episode of care
  - No notation needed

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Late Entries

- A late entry provides information about a patient event when the pertinent entry was not made in a timely fashion
  - Begin with the words "late entry"
  - Enter the current date and time
  - Refer to the date and time of the event
  - Identify the source of the information
  - Sign the entry

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Amendments

- **Used to provide additional information for a prior entry. May be used for corrections**
  - **Begin with the words "addendum"**
  - **Enter current date and time**
  - **Note the reason for the addendum and refer back to the original entry**
  - **Sign the entry**

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Amendments

- **Note – in an electronic system – create a link back to the original entry or a symbol by the original entry to indicate the existence of an amendment**
- **ASTM and HL7 have standards related to amendments**

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Versioning – Definition

- **Version – Record Version**
- **A particular form or variation of an earlier or original record**
- **For electronic records the variations may include changes to file format, metadata or content**

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Version Management

- **Once information has been made available for viewing for patient care, it must be retained and managed regardless of whether the document was authenticated.**

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Version Management

- **Versions are used for:**
  - **Draft and final reports**
  - **Preliminary and final results**
  - **Original and corrected documents**

49

Version Management

- **Providers must decide:**
  - **If all versions will be available for viewing or only the latest version**
  - **Who will have access to various versions**
  - **How the versions will be identified**

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Version Management

- OK to have a draft transcribed document that is changed before authentication
- Define how long the document can remain in draft form (24–72 hours)

51

Version Management

- Final and/or authenticated versions may only be changed according to the procedures for corrections or amendments
- Maintain both the original and corrected/amended version of the document

52

Polling Question # 3

Does your software allow you to keep all versions of a changed document?

***1 Yes**

***2 No**

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Resource/Reference List

Clark, Jean S. Documentation for Acute Care AHIMA, 2004. page 228

Johns, Merida L. Health Information Technology An applied approach. AHIMA. 2007. page 92

The Sedona Conference, 2005
Visit: www.thesedonaconference.org

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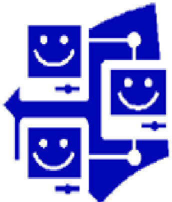
Audience Questions

Audio Seminar Discussion



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Appendix

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CE Certificate Instructions 38

Sample correction of documentation in EHR policy

Title: Correction of documentation in EHR		**Number:**	**Pages:**
Owner:	**Effective date:**	**Approved by:**	
Date(s) reviewed:	**Date(s) revised:**	**Distribution:**	

Scope

This policy addresses the need for accuracy in data entry into the EHR, the correction of an error in the EHR, and the identification of an error state in the EHR.

Related policies

The following policies relate to this policy:

- Correction of electronic documents
- Electronic authentication
- Management of personal health record content

Definition of terms

- Documentation—the content of the EHR that has been captured as discrete or narrative data other than that which is contained in a digital image (e.g., scanned document, image from a Picture Archiving and Communication Systems [PACS], e-mail, e-fax).
- Document—a digital image retained in the EHR. (See the policy on correction of electronic documents.)
- Error—wrong information recorded in an individual's EHR.

- Addendum—additional information to be added to an existing entry in an individual's EHR.
- Amendment—a change or an addition from an individual to existing content in the designated record set requested by an individual and approved by the organization. (See the policy on managing individuals' rights to request an amendment to the designated record set.)
- Appendment—information that an individual has requested and the organization has accepted from the individual to be appended to the organization's system of health information. (See the policy on management of the personal health record.)
- System of health information—all individually identifiable health information that may reside in any temporary system, component of an EHR, or part of the designated record set.
- Designated record set—a group of medical and billing records about individuals maintained by or for a HIPAA-covered healthcare provider and maintained and used, in whole or in part, by or for the covered entity to make decisions about individuals (HIPAA CFR §164.501).
- Legal health record—as defined by the American Health Information Management Association, "it is a subset of the entire patient database . . . and of the designated record set. It is generated as the healthcare organization's business record and is the record that will be disclosed upon request. It does not affect the discoverability of other health information by the organization. It contains individually identifiable data, stored on any medium, and collected and directly used in document healthcare or health status. It must meet accepted standards as defined by Centers for Medicare & Medicaid Conditions of Participation, federal regulations, state laws, standards of accrediting agencies, as well as the policies of the healthcare provider."
- Electronic authentication—verification that the person requesting access/making an entry into an electronic system is as he or she

claims. Verification may occur by entering a password or other form of authentication, such as a token or form of biometrics. Note: an authentication process is generally required to accompany a login, but may be additionally required to accept an entry.

- Login—the entry of a unique user identification (such as a name/number) that specifies the access privileges of the person accessing the electronic system. Note: a login is generally accompanied by an authentication process.

Policy statements

The manner in which an erroneous entry may be corrected or an addendum made to an existing entry in an EHR should reflect the principles of medical record documentation requirements; that is, an error should not be obliterated but marked as an error, with date/time and identification of the person noting the error, and with an indication of where the corrected information is located and that such information is a correction to a previous entry. Because error correction in an EHR system may be difficult to perform and may not be clearly visible to other users, it is critical to follow error correction procedures carefully:

- Prior to implementing or accepting any upgrade or interface to any information system that will capture, maintain, or transmit individually identifiable health information, the process of correcting errors and making an addendum in documentation shall be tested by purposefully creating an error state and an addendum and ensuring the appropriate correction and addendum.
- Prior to authenticating and accepting as final any entry into the EHR system that serves as the designated record set, verify the identity of the individual's record and accuracy and completeness of the data entry. All persons authorized to enter data into the EHR system will be

held accountable for data entries made using their login/authentication process.

- When an error state in documentation has been identified, immediately invoke the process for correcting an error, which shall result in:
  - the erroneous data being suppressed from normal viewing.
  - a flag indicating that an error state exists and has been corrected, with a pointer to where the correction is located.
  - a flag where the corrected entry exists, indicating the entry is a correction of a previous error. This entry should not only capture the date and time of the correction or entry, and the identity of the person making the correction, but should capture the date and time of the intended entry for any time- sensitive data or data that may be plotted in a series or graphical display to enable the entry to appear in proper sequence.
- Where an addendum is required, such as for a cosignature or review of and comment on a student data entry, the addendum process must be followed carefully. In the latter case, the content added must not be suppressed from viewing.
- It is the responsibility of any clinician entering data into the EHR to observe if any error state exists and retrieve the error from suppressed view if it is clinically relevant to do so.
- Our policy on data quality management will be followed to verify that clinicians are performing correction/addendum properly and to look for common error situations that could perhaps be modified to reduce the risk of subsequent errors.

Sample correction of electronic documents policy

Title: Correction of electronic documents		**Number:**	**Pages:**
Owner:	**Effective date:**	**Approved by:**	
Date(s) reviewed:	**Date(s) revised:**	**Distribution:**	

Scope

This policy addresses the need for the proper adding of an addendum, correction, and cancellation of documents, which may be maintained as part of the EHR system.

Related policies

The following policies relate to this policy:

- Correction of documentation in the EHR
- Electronic authentication
- Management of personal health record content

Definition of terms

- Documentation—the content of the EHR that has been captured as discrete or narrative data but not content that is contained in a digital image (e.g., scanned document, image from a Picture Archiving and Communication Systems [PACS] e-mail, e-fax).
- Document—a digital image retained in the EHR. (See the policy on the correction of electronic documents.)
- Error—wrong information recorded in a given individual's EHR.

- Addendum—additional information that must be added to an existing entry in an individual's EHR.
- Amendment—placement of an individual's request with the organization's approval of additional information to existing content in the designated record set. (See the policy on managing an individual's right to request an amendment to the designated record set.)

Policy statement

The HL7 document change standard, sections 9.4.5 through 9.4.11, will be followed to ensure the ability to

- create an addendum
- correct errors discovered in a document that has not been made available for patient care
- correct errors discovered in the original document, which has been made available for patient care
- notify appropriate staff when a document is cancelled

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