American Health Information Management Association

Amendments in the Electronic Health Record

TOOLKIT

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Amendments in the Electronic Health Record Toolkit

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Foreword

The electronic health record (EHR) has not changed the fundamental principles of health information management (HIM). Integrity and accuracy continue to be key components to HIM. Although not new concepts, the process for handling amendments corrections and deletions does change when working with an EHR.

Traditional practices within the paper record support a single-line strike-through of the original documentation. However, these practices will not necessarily transfer to an electronic environment, and new practices should be evaluated against organizational policy and specific system limitations.

This toolkit is designed to provide guidance to HIM professionals when addressing the amendment functionality in an EHR. For the purpose of this toolkit the authors have made the assumption that electronic signatures are used in the EHR. This toolkit defines the term *amendments* to include addendums, corrections, and deletions.

Introduction

Healthcare organizations must have a health record that is created and developed to meet the requirements of a legal business record. An official record of care is required by regulation, has specified content, and follows accepted practices for maintaining integrity.

Though both the ASTM International and Health Level Seven (HL7) provide guidelines for technical requirements, neither is mandated. Therefore, EHR vendors do not have to follow these recommendations. In the absence of these requirements the accuracy of the health record is at risk. However, HIM professionals should review guidelines that outline best practices that help provide direction when creating and managing this functionality. Further guidance can be sought from state, federal, and accrediting body requirements. HIM professionals can make recommendations for how the amendment functionality will be applied in the organization's medical staff rules, regulations, and bylaws. HIM professionals must have a fundamental understanding of how the amendment functionality operates in the EHR systems in order to appropriately guide their organizations in managing this function.

Organizations must have established policies and procedures to guide the provider when changes need to be made and how to make these changes within the health record. HIM professionals should ensure that these policies and procedures support and maintain the integrity of the record.

Organizational processes defined in this toolkit may be different depending on whether there are transcribed reports, direct data entry documentation, draft documentation, final signed documents, or scanned documentation. It is an important distinction for organizations to develop policies and procedures regarding these different processes in order to ensure the integrity of the health record.

Issues Today

EHRs may not provide an easy distinction between original and edited text when changes are made to the draft or after the record has been finalized. The edited text can often occur with little or no versioning or track-changes functionality. These changes often occur without the knowledge of the HIM professional or other care providers.

As providers become more comfortable with electronic documentation and editing capabilities, changes may be made to health record documentation on a regular basis without HIM oversight. System functionality regarding changes may be developed within an application of the EHR (such as a progress note). It is not necessarily a product of poor application architecture, but rather a design feature to allow providers to edit health information as incorrect or incomplete documentation is identified. The ability to ensure this functionality is used appropriately is imperative in order to ensure patient safety and the integrity of the health record.

HIM professionals must understand the functionality of their EHR systems and make guidance and best practices for amending health records available to providers. The amendment processes will most likely vary from vendor to vendor. Not all will handle this functionality in the same way, even with ASTM and HL7 guidelines and EHR certifications. However, there are some essential elements that should be present in vendor systems to accommodate these functionalities.

Medicare Compliance Rules

The Medicare Program Integrity (MPI) Manual by the Centers for Medicare and Medicaid (CMS) directs the program safeguard contractors (PSCs) [soon to transition to zone program integrity contractor (ZPICs)] and the Medicare administrator contractors (MACs) to identify cases of suspected fraud. In Benefit Integrity/Medical Review Determinations section of the MPI, there is language directly aimed at inappropriate alterations of health information.

When the PSC are reviewing health records, their focus is not solely on coding compliance, but rather reviewing for possible falsification of health information. The manual specifically spells out that:

> "The PSC shall evaluate the medical record for evidence of alterations including, but not limited to: obliterated sections, missing pages, inserted pages, white out, and excessive late entries." [1]

While the guideline appears to be paper-based, it also applies to EHRs. The manual defines fraud to include altering medical documentation.

Key Terms

Although the terms *amendments, corrections,* and *deletions* are often used interchangeably, they do not refer to the same actions. The intent of this toolkit is to provide some clarity regarding these terms and guidelines for managing this functionality within the EHR.

Amendments

An amendment is an alteration of the health information by modification, correction, addition, or deletion. There are many terms used that ultimately amend the health record. For the purpose of this toolkit, the term "amendment" is the overarching term indicating that documentation has been altered. There are many ways that a health record may be altered; these terms may include corrections, addendums, retractions, deletions, late entries, re-sequencing, and reassignment. An amendment is made after the original documentation has been completed and signed by the provider. It should be noted that unsigned documentation will have changes and then be signed, the changes made prior to the initial signature need to be tracked as well. All amendments should be timely and bear the current date and time of documentation.

Addendum

Entries added to a health record to provide *additional* information in conjunction with a previous entry. The addendum should be timely, bear the current date, time, and reason for the additional information being added to the health record, and be electronically signed.

Correction

A correction is a *change* in the information meant to clarify inaccuracies after the original electronic document has been signed or rendered complete. Corrections may also involve removing information from one record and posting it to another within the electronic document management system.

Retraction

A retraction is the action of *correcting information that was incorrect, invalid, or made in error,* and preventing its display or hiding the entry or documentation from further general views. However, the original information is available in the previous version. An annotation should be viewable to the clinical staff so that the retracted document can be consulted if needed.

Deletion

A deletion is the action of permanently *eliminating information* that is not tracked in a previous version. Most EHRs do not allow permanent deletion.

[1] Medicare Program Integrity Manual, Chapter 4—Benefit Integrity (Rev. 389, 09-30-11) www.cms.gov/manuals/downloads/pim83c04.pdf

Late Entry
An addition to the health record when a pertinent entry was missed or was not written in a timely manner.[1] The late entry should be timely, bear the current date, time, and reason for the additional information being added to the health record and be electronically signed.

Re-sequencing
The process of moving a document from one location in the EHR to another within the same episode of care, such as a progress note that was linked to the wrong date. No annotation of this action is necessary.

Reassignment
The process of moving one or more documents from one episode of care to another episode of care within the same patient record, for example, the history and physical posted to the incorrect episode. An annotation should be viewable to the clinical staff so that the reassigned document can be consulted if needed.

Guiding Principles
On the occasion that the health record must be amended, policies and procedures must be in place to ensure integrity of the health information contained in the record for patient safety, the business record and the legal record of the organization. Policies must outline who, when, and how records may be amended.

Processes for receiving the patient amendment request, identifying the PHI affected by the request, determining whether it should be accepted or denied based on the type of request, and notifying the patient of the outcome must be developed. Organizations may have different processes set up for billing requests versus clinical requests. In most organizations, providers are responsible for determining whether an amendment is needed to clinical information in the health record. Amendments can be made by direct entry or through dictation.

The system should have the functional capabilities to lock a record from any further editing once the final signature has been applied. In addition, the organization should clearly define who can "unlock" a document once it has been signed. Only one individual or department should have the ability to unlock a report, and the functionality should be carefully monitored and audited. An HIM professional should be assigned the unlock function within the EHR; however, the choice will depend on the organization and their EHR system.

Each organization should develop guidelines regarding dual signatures, such as residents and attending physicians. In these cases, organizational policy will dictate when the report and visit note is locked. If the system has already been implemented, HIM professionals should be proactive in addressing a system issue that does not lock the record after final signature and request modifications from the vendor.

Organizations should define when to lock down records, for example, 48 hours after an outpatient visit or 30 days after an inpatient encounter. However, when there is an amendment request, the organization must have designated staff who can unlock the health record processes in place to ensure the unlocked record is amended and signed, then locked again.

Each organization may develop specific guidelines that outline what the HIM staff may amend versus what must be sent back to the provider to correct. HIM staff may be allowed to change demographic data such as a date of birth upon verification, whereas all clinical amendment requests must be sent back to the provider for updates. Regardless of the type of change, any amendments the content of the health record must be approved by the provider.

Another key practice would be ensuring the corrected information does not permanently erase the incorrect information. The new information should stand out from the original. The system may show the new information in bold, underlined, italics, or in a different color so that it is easily identifiable. The system should also provide tracking functionality to indicate when the change was made and by whom.

Organizational policies and procedures should ensure that only documents defined in the organization's legal health record and designated record set are kept in the EHR, are used for clinical care, and are used for other secondary reasons. Source systems, such as the transcription system, are not consistently updated and may not have the most current information.

The organization should have processes in place to forward the amendments to any other place where the information has been sent to ensure providers have the most up to date information.

See Appendix A for a sample Amendment policy.

Addendums Practice Guidelines
Organizations should clearly define for providers that once a document has a final sign-off, the only way to correct or revise documentation is to provide an addendum. The organization should have a specific policy and procedure addressing how addendums are made in the health record.

[1] AHIMA Pocket Glossary of Health Information Management and Technology

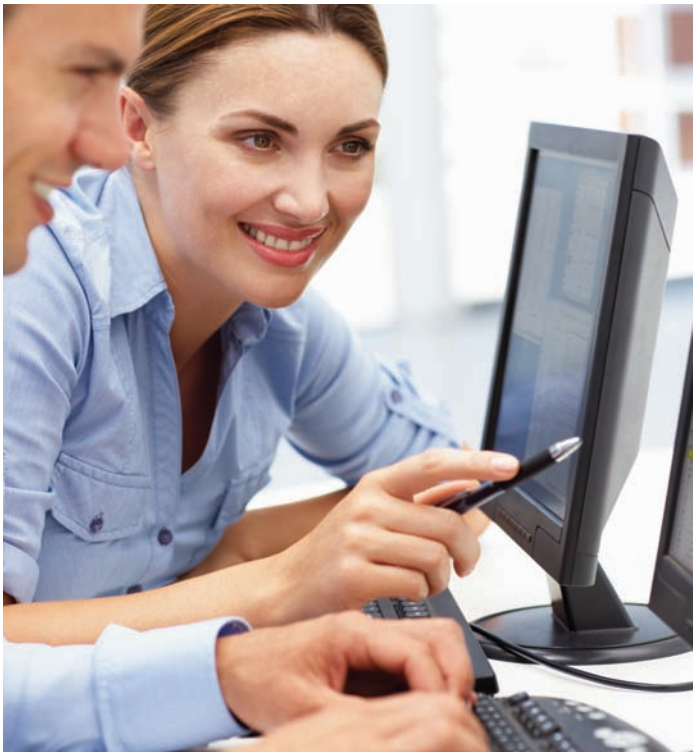
The policy and procedure includes information regarding where the additional information is located within the body of the original report and the requirement that the addendum include a separate signature, date, and timed entry. The procedure indicates who is responsible for entering addendums into the EHR. If the addendum is generated through a transcription system, the interface is monitored to ensure the addendum is correctly merged with the original report. HIM professionals have the ability to track and trend addendums within the EHR and provide appropriate follow-up as needed.

In addition, the organization should clearly define what type of information is considered an addendum. Organizations may also choose to define how extensive an addendum can be. If the provider is correcting entire paragraphs of documentation and editing extensive information, the organization may choose to have the first report retracted from the EHR and ask the provider to re-dictate or re-document a new report. In either case, the original version should remain a part of the EHR.

Addendums should be made in the source system or where the documentation was originally created, as well as in any long-term medical record or data repository system.

Corrections Practice Guidelines

The organization should have a clear policy and procedure covering its system's abilities regarding corrections. The policy and procedure outlines the organization's definitions of corrections made to a signed document as well as corrections made before the document is signed. The processes need not be the same; they should, however, indicate who is responsible for making the corrections in both scenarios. If applicable, corrections should be made in the source system or where the documentation was originally created as well as in any long-term medical record or data repository system.



Note: *Organizations require policies for an instance in which the wrong patient's name is in the report but the information is for the correct patient. The document should be retracted, and a correct copy without the wrong patient's name should be placed in the record. Just crossing out an incorrect patient name and adding the correct name is not enough. Every time the record is released, a HIPAA privacy violation would occur.*

Late Entries Practice Guidelines

Any provider documenting within the health record may need to enter a late entry. The organization should clearly define how this process occurs within its system, including the time frame that late entries may be made. Tracking and trending within the electronic record will be dependent on the system; the organization should clearly understand this process. In addition, specific policies and procedures should guide clinical care providers on how to correctly make a late entry within the health record. The author should document within the entry that it is a late entry.

Typically, late entries apply to direct documentation only; for example, physician orders, progress notes, or nursing assessments. Dictated reports such as history and physicals, although dictated outside of organizational time frames, would not be considered a late entry.

Note: *Some systems may not have late entry functionality. The late entry is shown as an addendum.*

Retractions Practice Guidelines

Depending on the organization's electronic system, locked reports may require specific interventions to retract information; for example, only the HIM department personnel can unlock a report, thus creating a user audit trail of instances where information was altered. In addition, the organization should develop guidelines for making these types of entries. Retractions should be made in the source system or where the documentation was originally created, as well as in any long term medical record or data repository system.

This information should still be available in the background, but will not display in the regular record view or be released upon request for the record. It is important to consider that

while this information may be in the "background" of the EHR, it should not be reproduced on any printed versions of the record. If the record is requested for litigation or patient care purposes, the system should keep the retracted information from printing as a part of the legal health record.

If the provider selects the wrong patient chart in EHR, documents visit information, and then realizes he or she is in the wrong chart, before signing the visit the provider will need to delete all information entered into this patient chart and select the correct patient chart and begin his or her documentation over again in the correct patient chart. The provider can copy and paste information into the correct patient chart rather than type all of the information over again.

If the provider has already signed the visit before he or she realized they are in the wrong patient chart, then the provider will be asked to alert HIM and place an addendum in the record stating that entry was in error. The provider can copy and paste the information keyed into the wrong patient chart and copy it back into the correct patient chart if a policy is in place to do so.

Retractions are different from corrections in that they change the main point of the original documentation. A correction will leave the original documentation intact along with the revision.

Deletion Practice Guidelines

It is recommended that system functionality never allow for total elimination of information. If the organization allows information to be deleted, it requires clear policies and procedures to ensure the integrity of the health record, and it should monitor and audit this functionality. Organizations that allow this functionality should carefully review clinical actions taken based on initial documentation. Many EHRs do not allow for a total deletion of information, but rather use the retraction method, where the information is hidden from the general view.

When the deletion functionality is not used appropriately, there must be an immediate follow-up and education. In addition, organizations need to realize that audit trails are part of the metadata and therefore discoverable for use in litigation. Without context, the audit trail will have little value for the organization.

Note: *The ability to delete and retract information within the EHR is dependent on the system. HIM professionals must always ask the vendor if the system will allow for total deletion of the record. Organizations should carefully review both functionalities within their system and apply appropriate policies and procedures.*

Re-sequencing or Reassignment

Identifying and monitoring date of service errors is crucial to effectively manage corrections in the EHR. Organizations should have a process for reporting errors found within the EHR. Whether the error is found in billing, on the floor, or in the HIM department, there must be a point person or process for receiving the report in order for the appropriate correction process to take place.

All corrections made within the EHR should be documented and tracked. The same correction elements noted in the corrections policy below should be logged within the system, which should also include the ability to be audited as necessary. See Appendix B for a Sample Deletion and Retraction Policy.

Record Completion Processes

Policies and procedures should identify how and by whom corrections are made. Facilities should develop guidelines for changes made to signed and unsigned documents. Some type of annotation may be made in the EDMS system so that clinical staff will know who to contact if they feel they may need to see the original document. HIM should designate staff to view or print the previous version of the amended document.

Organizations should have clearly defined policies on when and how a record and its individual components (for example, dictated reports, progress notes, orders, and such)

are considered complete. System functionality should be evaluated to determine whether or not the end-user functionality to add information or make corrections can be removed at a certain point in time (such as 24 hours after discharge). Any changes that need to be made after this point in time should be handled on a case-by-case basis and the documentation functionality temporarily reactivated for that specific record. Once that has been established further policies and procedures surrounding how alterations within the record are made should be established.

Making amendments in the EHR systems should follow the same basic principles as correcting paper copies. HIM professionals must consider how the information will display electronically, on paper, and through interfaces and HIEs. For example if color is used in the EHR, how will this display when printed or sent through an interface? Does the document show who updated the information and when it was updated? HIM professionals should develop a practice policy to ensure their organization corrects and reports errors in a consistent and timely manner.

See Appendix E, Sample Questions for the EHR Vendor, and Appendix F, Sample Questions for the Information Technology Department.

Implementation of Amendment Processes

Establishing and executing the policy and procedure is vital to accurate, timely, and appropriate management of amendments. Some considerations for an organization's implementation include:

» Approval and endorsement of the policy and procedure by senior management, medical staff, and HIM

» Identifying staff who should receive error reports for logging and tracking purposes

» Coinsidering which staff are permitted to make corrections in the EHR. Is this limited to certain staff within a department, position type, or provider?

» Identifying the appropriate steps that must be taken to make an amendment

» Identifying which systems permit amendments. Should amendments be made within the EHR, or is there a specific module, tool, or system used for amendments?

» Assessing potential time limitations with expectations for

- Patient requests for amendments in the designated record set
- Date of service errors especially if it affects billing and reimbursement

» Noting that each correction should be accompanied using verbiage such as "Entered in Error" for easy identification, followed by, at a minimum, the date, time, purpose for change, and who made the change

Record Maintenance and Legality

All health records must be maintained in accordance with state and federal guidelines as well as accreditation agencies. HIM professionals should review their state guidelines for potential amendment and deletion requirements as well as other appropriate federal or accrediting body rules or regulations.

HIM professionals must be aware that the term *deletion*, found within state or federal record-keeping guidelines, can refer to the act of destroying a health record once it has met the statute of limitations for record retention. HIM professionals must ascertain the definition of deletion when reviewing their state guidelines and applying those to policies and procedures.

The Occupation Safety and Health Act of 1970 allows for certain deletions. In these instances, the custodian is allowed to delete specific information related to a family member, personal friend, or others who have provided confidential information regarding an employee's health status.

In addition to the rules cited above, the HIPAA privacy rule provides the individual the opportunity to request an amendment to their health records. In these instances, the covered entity has the right to review, investigate, and potentially refuse the patient's request.

HIPAA Requests for Amendment

The Health Insurance Portability and Accountability Act (HIPAA) also requires the covered entity to append information in the health record, not delete it. If accepted, a covered entity must then inform the individual that the amendment was made and make reasonable efforts to notify others with whom the amendment needs to be shared.

In addition to written patient requests, requests for amendments are now requested through EHR portals. The use of patient portals are on the rise and are open to patients to allow them to access their information in a secure and private manner. Many requests identify information that needs to be corrected; however, there are a noticeable number of requests that appear to be frivolous. Regardless, of the nature of the request, the following steps must be followed to ensure all requests are responded to in a timely manner.

Request to Amend PHI

Patients have the right to request an amendment of the protected health information (PHI) in their designated record set (DRS) for as long as the DRS is maintained. Therefore is it crucial for organizations to clearly define what is in the DRS in order to process amendment requests. In addition, organizations may deny a patient's request to amend PHI.

Organizations may develop policies and procedures that require patient requests for amendments to be submitted in writing and to provide a reason to support a requested amendment. The covered entity must act on the individual's request for an amendment no later than 60 days after receipt of such a request. This means that if the request is granted, the amendment must be made and the patient informed within 60 days of the receipt. Covered entities should provide an alert or the amended PHI to other individuals and organizations with whom the PHI was shared. See Appendix G for the Sample Patient Request to Amend the Health Record.

If the request is denied, a written denial must be sent to the patient within 60 days. If the request cannot be completed within 60 days, the organization may have a single 30-day extension, so long as the patient is sent a written statement stating the reason for the delay and date by which the request will be completed.

Accepted Amendments

If the request is granted, the following will occur:

» The amendment, or a link to the amendment, will be added at the site of the original information in question

» The patient requesting the amendment will be informed that the amendment request is accepted

» The patient will be asked to provide the names of any relevant persons with whom the amendment must be shared

» Any persons, including business associates that the organization knows have the amended PHI and may have or could foreseeably rely on such information when treating the patient

» The amended information will also be provided with all subsequent disclosures of the PHI to which the amendment relates

Denial

Requests may be denied for the following reasons:

» PHI was not created by this organization (or its business associates).

» PHI was not part of the patient's designated record set.

» Federal law prohibits making the PHI in question available to the patient for inspection (psychotherapy notes).

» PHI is accurate or complete.

Written Denials

If the request for amendment is denied, the following will occur:

» Amendment denials will be made in writing to the patient who requested the amendment and must meet the 60 day timeframe.

» The written denial will describe

- The basis for the denial
- The process for the patient to submit a written statement of disagreement with the denial
- The process of requesting the organization to provide the patient's request and the denial with any future disclosures of the affected PHI, if a letter of disagreement is not submitted
- How the patient can complain to the organization and the Secretary of the Department of Health and Human Services regarding the denial
- The name or title and telephone number of the designated contact person who handles these types of complaints for the organization

Letters of Disagreement

The patient may submit a letter of disagreement to the organization disagreeing with the denial of all or part of a requested amendment and the basis of such disagreement. The organization may prepare a written rebuttal. If this is done, the following must occur:

» The organization will identify the PHI that is subject to the disputed amendment and append or otherwise link the patient's request for an amendment, the denial, the statement of disagreement and the rebuttal.

» The organization will include the letter of disagreement and the rebuttal with subsequent disclosures of the PHI to which the disagreement relates.

See Appendix H for a Sample Patient Statement of Disagreement.

See Appendix C for a sample policy on Patient Right to Amend Protected Health Information (PHI).

Notices of Amendments

Organizations that receive notices of amendments from another covered entity must have procedures in place to update the PHI in the DRS in the EHR. Notices of

amendments should be forwarded to the HIM department for processing. The following actions should include, but not be limited to:

» Ensuring the amendment, or a link to the amendment, will be added at the site of the original information in question

» Processing the request immediately to ensure patient safety

» Notifying the providers on active patients for continuing care

See Appendix D for a sample policy on Notices of Amendments.

Clinical Trustworthiness

A major underlying concern is the clinical trustworthiness and integrity of the health record. From a clinical point of view, adding information that is not current, accurate, or applicable into the record may have a direct impact on patient care. If there are not processes in place when amendments are added to the health record to share the updated information, other providers may become confused by the inconsistent documentation.

Education and Training

The implementation of policies and procedures combined with readily available resources enforces accountability and expectations of all staff. **Users must be held accountable for every entry made, especially errors and corrections.** When accountability is enforced, errors are reduced, ultimately reducing the risk to the organization and improving overall quality of care.

After policies have been implemented, the final critical step is training and educating staff. Organizations should define key personnel to receive training, such as nursing, physician, billing, and HIM staff.

Organizations should make sure that key personnel (such as HIM and help desk) know the available resources for the amendment functionality and where the information can be located. Those key personnel should also understand the details of the policies and procedures in order to help those with questions.

Even if the organization implements a policy that states the complete obliteration of information will not occur, appropriate training of personnel is required to educate on the importance of accurate, timely clinical documentation as well as the ramifications of errors in documentation. End users who have privileges to document within the EHR must be held accountable for every entry made, including errors.

Retraining is also important for those who use the amendment functionality incorrectly such as deleting information. If a user repeatedly uses the amendment function incorrectly, advance corrective action may be required. It is also a recommended practice to keep users well trained and abreast of any changes.

HIM professionals are the stewards of health information within an organization and are charged with reconciling health records (such as date and time) as well as certifying them as accurate and complete. Management of amendments made within the health record is imperative to maintain the best quality and integrity of information possible.

Audit Trails

Organizations must determine who will track and trend all amendments. This could fall within HIM, process improvement, risk management, quality, or other relevant departments. EHR systems should allow amendments and have the ability to track corrections, and identify that an original entry has been changed. The original entry should be viewable, along with a date and time stamp, person making the change, and reasons for the change.

The audit trail must capture what is amended (to include deletions) within the health record itself and provide auditors

with a starting point for compliance audits. Audit trails should include the name of the user, the application triggering the audit, the workstation, the specific document, a description of the event (for example, deletion), and the date and time.

It is important for organizations to utilize the audit trail function of the EHR system in order to identify and trend the utilization of these functionalities. Reports should be generated by provider and type in order to provide education to individuals who may be utilizing it incorrectly. Each organization should determine the time frame to review reports (for example, quarterly) and results should be reported to the compliance or HIM committee.

Case Scenarios

Addendum:

Case Scenario: A patient was referred from his primary care physician for a long-term cough. He presents to the outpatient department for a chest x-ray and sputum culture. The resident physician provides the initial interpretation of the x-ray film and states pneumonia and signs the report. Seven days later the sputum culture indicates a streptococcal infection. The radiologist returns to the original note and completes an addendum to indicate the infection.

Concern: The new information actually changes information within the EHR. The new information may affect the current treatment of the patient. The infection may require a change in antibiotics or treatment. Then new information may also change the code assignment, which may impact billing.

Questions to Ask

» Are there processes in place to notify the primary care physician of the change in diagnosis? Does the radiologist have to notify the HIM department of the change?

» Does the system allow for the report to be sent automatically when it has been updated and signed again?

» Does the system notify the coding department? Coders will need to see if the case has been coded and, if so, if the amendment changes the code assignment.

Corrections:

Case Scenario: A patient presents to the emergency department (ED) and states that she fell down the stairs, fracturing her arm. The ED physician completes his documentation as such in the ED note. After further discussion and follow up the patient admits that her spouse pushed her down the stairs. The ED physician creates an amendment to the original ED note clarifying the nature of the accident.

Concern: In this case the additional information may require additional reporting to protective services or law enforcement.

Questions to Ask

» When corrections are made, is the HIM department notified?

» Who will ensure the report is made to protective services or law enforcement?

Late Entry:

Case Scenario: A nurse on the general medical/surgical floor completes an intake assessment for a new patient to the unit. She is called away to care for an emergency with another patient and forgets to document the assessment within the electronic record at the end of her shift. The next day, she reports for her shift and enters the information at that time.

Concern: Visit documentation was not completed in a timely manner, requiring the clinical provider to document information about the visit as a late entry or after the visit is locked. In order to place the documentation in the proper place in the EHR the visit may have to be unlocked. In addition, the late entry may not be readily identifiable. It may or may not appear in the correct chronological order. Late entries should be entered the on date they are made with a note indicating the date the note should have been recorded. Adding the note in correct order may give the illusion that information was available for patient care.

Questions to Ask

» Did the nurse indicate that the note was a late entry by identifying the date and time the note should have been made?

» Did the nurse clearly document that this note was late?

Retraction:

Case Scenario: A physician is seeing patient John S. Doe in the ED. The patient has a birth date of 12/12/89. However, when the physician pulls up the patient record, he inadvertently selects John S. Doe with a birth date of 12/29/87 and documents his findings. He signs the report before realizing that he has documented on the wrong patient. The document is now locked from editing. The physician calls the HIM department to have the entry retracted from the incorrect entry and placed in the correct chart.

Concern: There are two concerns; the first is patient safety and the second is HIPAA privacy. In order to accomplish the correction, the information must be stricken from the incorrect record and should not be seen on the final record, or

any printed versions of the record. The wrong information must be removed from the incorrect health record to ensure patient safety. The information must also be retracted to ensure HIPAA privacy. However, since the report has been signed and is considered locked from editing, the physician no longer has access to remove the information within the electronic system.

Note: *The information from the incorrect health record must be added to the correct patient health record.*

Questions to Ask

» Does the EHR system have versioning so the incorrect record is still maintained behind the scenes?

» How do you handle notifications to all who received information on the wrong patient?

» How do you handle retractions for the records that were interfaced to other systems or via an HIE?

Deletions:

Case Scenario: A patient is admitted to a behavioral health facility. As a part of her counseling process the therapist meets with the patient, enters the counseling note in the EHR, and final signs the note. The note includes a sentence that the patient is suicidal. Upon review, the therapist realizes that this sentence was intended for a different patient. The rest of the documentation within the note was accurate. System functionality does not allow for the elimination of one sentence; instead it shows a strike-through line, which is inappropriate in this case. The entire document needs to be retracted and a corrected copy created without the incorrect sentence.

Concern: In the scenario above the provider is requesting the removal of information from a signed document within the health record. In order to accomplish this, the information must be stricken from the record and should not be seen on the final report. However, since the report has been signed and is considered locked from editing, there is no way to remove the information within the electronic system.

Questions to Ask:

» Does the EHR system record the deletion for tracking purposes?

» How do you handle notifications to all who received information on the wrong patient?

» How do you handle retractions for the records that were interfaced to other systems or through an HIE?

Re-sequencing:

Case Scenario: A physician dictated his progress note on his ICU patient on the same day he saw the patient. Transcription attached the progress note to the previous day. The physician signs the note then realizes it has been placed on the wrong date within the patient's current encounter and notifies the HIM department. The HIM department moves the progress note to the correct date.

Questions to Ask:

» Does the audit trail show how the note initially came into the system?

» Does the audit trail show who moved the note?

Reassignment:

Case Scenario: A patient presents to the hospital for a planned surgery. The patient has been given a pre-admission account for all pre-operative blood work and radiology. On the day of surgery the physician dictates the history and physical with the date of pre-operative blood work as the admission date and encounter number, and applies a final signature. The report does not connect to the admission in the EHR due to the incorrect admission date and the HIM department must correct the admission date and encounter number in order for the report to cross the interface and connect appropriately in the EHR.

Concern: The concern is that the report has received a final sign-off, thus locking the report and keeping the report from crossing the interface. If the operating room nurses are searching for a history and physical in the EHR there would not be anything to view, possibly affecting the start of the surgical procedure. There should be a way for the appropriate organizational staff to correct the date and encounter in order for the report to cross the interface.

Questions to Ask:

» When moving documents from one date of service to another, does this information transfer across the interfaces?

See Appendix E for Sample Questions for the EHR Vendor and Appendix F for Sample Questions for the Information Technology Department.

Glossary

Additional terms factor into the guidance provided within this toolkit. The definitions of these terms are important to understanding the context. For the purpose of this toolkit, the following definitions apply.

Augmentation: Providing additional information regarding the healthcare data. HL7 uses this term instead of *amendment*.

Completion: The process of ***completing an entry*** in the health record by applying the provider's signature, either electronic or manual. Once the signature is applied, the entry is considered complete and the only opportunity to make changes is through an amendment or addendum to that entry. Organizational policy should define documentation points required for completing an entry and how long documents are available in an incomplete status.

Designated Record Set (DRS): A group of records maintained by or for a covered entity that may include patient medical and billing records; the enrollment, payment, claims adjudication, and cases or medical management record systems maintained by or for a health plan; or information used, in whole or in part, to make patient care-related decisions[1]

Direct documentation: ***Text entries*** made into the health record; for example, progress notes, nursing notes, physician orders

Electronic Signature: A generic, technology-neutral term for the various ways an electronic record can be signed, such as a digitized image of a signature, a name typed at the end of an e-mail message by the sender, a biometric identifier, a secret code or PIN, or a digital signature[2]

Electronic signatures frequently also have the added benefit of ensuring the integrity of the signed document to signify that (1) the document has not been changed since it was signed and (2) the signer cannot "repudiate" or claim that they did not sign the document. Electronic signatures encompass a broad gamut of technologies and methodologies, ranging from an "I agree" button in a click-through agreement to an electronic tablet which accepts a handwritten signature to a *digital signature* cryptographically tied to a digital ID or certificate.

Final Signature: The process of applying the responsible provider's electronic signature to documentation. Once applied, the documentation is considered complete.[3] See **Completion**

Information: Data that have been deliberately selected, processed, and organized to be useful[4]

Locked: The process by which health record entry is complete and any changes to the entry must be made through an amendment[5]

Protected Health Information (PHI): Individually identifiable health information, transmitted electronically or maintained in any other form, that is created or received by a healthcare provider or any other entity subject to HIPAA requirements[6]

Provider: Physician, clinic, hospital, nursing home, or other healthcare entity (second party) that delivers healthcare

Reports: Refers to transcribed reports; for example, history and physical or operative note, not generated within the electronic health record

[1–6] AHIMA Pocket Glossary of Health Information Management and Technology

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Sample Amendments in the Electronic Health Record (EHR) Policy

Subject:	Sample Amendments in the Electronic Health Record (EHR) Policy
Purpose:	The health record provides a basis for patient care and for the continuity of such care. Each record should provide documentary evidence of the patient's medical evaluation, treatment, and change in condition as appropriate. The purpose of this policy is to provide guidance on the instances in which an amendment is necessary to support the integrity of the health record.
Policy:	Providers documenting within the EHR must avoid indiscriminate use of amendments as a means of documentation. All attempts to correctly identify patients and their medical conditions should be made prior to documenting within the record.
	Designated Record Set: A group of records maintained by or for *[insert name of organization]* that includes the medical records and billing records about patients that is used in whole or part by or for *[insert name of organization]* to make decisions about patients. The term record is defined as any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for *[insert name of organization]*. **Protected Health Information (PHI):** The demographic and health information collected from an individual that: 1. Is created or received by a healthcare provider 2. Relates to past, present, or future physical or mental conditions of an individual, the provision of care to an individual, or payment related to the provision of care to an individual 3. Identifies the individual or provides for a reasonable basis to believe the information can be used to identify the individual 4. Is transmitted or maintained in any form (for example, electronic, paper, oral) **Treatment Information:** Any PHI related to the provision, coordination, or management of health care and related services. **Patient:** For the purposes of this policy, "patient" refers to the patient or authorized representative of the patient requesting information. **Amendment**: An amendment is an alteration of the health information by modification, correction, addition, or deletion. There are many terms used that ultimately amend the health record. Amendment is the overarching term indicating that documentation has been altered. There are many ways that a health record may be altered; these terms may include corrections, addendums, retractions, deletions, late entries, re-sequencing and reassignment. An amendment is made after the original documentation has been completed by the provider. All amendments should be timely and bear the current date and time of documentation and be electronically signed. **Addendum:** Entries added to a health record to provide *additional* information in conjunction with a previous entry. The addendum should be timely, bear the current date, time and reason for the additional information being added to the health record and be electronically signed. **Correction:** A correction is a *change* in the information meant to clarify inaccuracies after the original electronic document has been signed or rendered complete. Corrections may also involve removing information from one record and posting it to another within the electronic document management system. **Retraction:** A retraction is the action of *correcting information that was incorrect, invalid, or made in error* and preventing its display or hiding the entry or documentation from further general views.

Sample Amendments in the Electronic Health Record (EHR) Policy (cont.)

Subject:	Sample Amendments in the Electronic Health Record (EHR) Policy
	However, the original information is available in the previous version. An annotation should be viewable to the clinical staff so that the retracted document can be consulted if needed. **Deletion:** A deletion is the action of permanently *eliminating information* that is not tracked in a previous version. Refer to the **Deletion and Retraction Policy.** **Late Entry:** An addition to the health record when a pertinent entry was missed or was not written in a timely manner. The late entry should be timely and should bear the current date, time, and reason for the additional information being added to the health record and be electronically signed. **Re-sequencing:** The process of moving a document from one location in the EHR to another within the same episode of care, such as a process note that was dated incorrectly. No annotation of this action is necessary. **Reassignment:** The process of moving one or more documents from one episode of care to another episode of care within the same patient record, such as the history and physical posted to the incorrect episode. An annotation should be viewable to the clinical staff so that the reassigned document can be consulted if needed.
	Provider: 1. If the provider determines that additional information is appropriate, the provider is responsible for ensuring the total content of the documentation. 2. The provider must identify the correct patient and encounter prior to documenting within the health record, which includes the following information: a. Patient name b. Date of service c. Account number d. Health record number e. Original report that the addendum is to be attached to 3. Ensure that the proper format is utilized (for example, dictated report or direct data entry) 4. Edit document as appropriate 5. Ensure documentation is complete and accurate 6. Apply electronic signature *[Insert name of department]:* 1. Review each amendment for appropriateness prior to attaching it to the original report 2. Attach to original report 3. Ensure the addendum has a separate date, time, and signature line 4. Through reporting, track amended records a. Send out updated information as appropriate b. Ensure updates were transmitted across systems c. Track and trend amendments and report potential violations to *[insert name of appropriate committee or department]* *See also:* Patient Rights to Amend Protected Health Information (PHI) Policy Deletions and Retractions Policy Notice of Amendment for PHI Policy

Sample Deletion and Retraction Policy

Subject:	Sample Deletion and Retraction Policy
Purpose:	The health record provides a basis for patient care and for the continuity of such care. Each record should provide documentary evidence of the patient's medical evaluation, treatment, and change in condition as appropriate. The purpose of this policy is to provide guidance on the instances in which a deletion or retraction is necessary to support the integrity of the health record.
Policy:	Providers documenting within the EHR must avoid indiscriminate use of a deletion or retraction functionality as a means of documentation. All attempts to correctly identify patients and their medical conditions should be made prior to documenting within the record.
Definitions:	**Designated Record Set:** A group of records maintained by or for *[insert name of organization]* that includes the medical records and billing records about patients that is used in whole or part by or for *[insert name of organization]* to make decisions about patients. The term "record" is defined as any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for *[insert name of organization]*. **Protected Health Information (PHI):** The demographic and health information collected from an individual that: 1. Is created or received by a healthcare provider 2. Relates to past, present, or future physical or mental conditions of an individual; the provision of care to an individual; or payment related to the provision of care to an individual 3. Identifies the individual or provides for a reasonable basis to believe the information can be used to identify the individual 4. Is transmitted or maintained in any form (such as electronic, paper, oral) **Treatment Information:** Any PHI related to the provision, coordination, or management of health care and related services. **Patient:** For the purposes of this policy, "patient" refers to the patient or authorized representative of the patient requesting information. **Amendment:** An amendment is an alteration of the health information by modification, correction, addition, or deletion. There are many terms used that ultimately amend the health record. Amendment is the overarching term indicating that documentation has been altered. There are many ways that a health record may be altered; these terms may include corrections, addendums, retractions, deletions, late entries, re-sequencing and reassignment. An amendment is made after the original documentation has been completed by the provider. All amendments should be timely and bear the current date and time of documentation and be electronically signed. **Retraction:** A retraction is the action of *correcting information that was incorrect, invalid or made in error*, and preventing its display or hiding the entry or documentation from further general views. However, the original information is available in the previous version. An annotation should be viewable to the clinical staff so that the retracted document can be consulted if needed. **Deletion:** A deletion is the action of permanently *eliminating information* that is not tracked in a previous version.

Sample Deletion and Retraction Policy (cont.)

Subject:	Sample Deletion and Retraction Policy
Procedure:	*Deletion of information should never occur if the record is a part of any ongoing litigation.* (ADD IF APPROPRIATE FOR THE ORGANIZATION: The total elimination of information or documentation after final signature should never occur. For instances in which the deletion function is utilized to this end, prior approval, or notification must be obtained.) **Provider** 1. If the provider determines that additional information is appropriate, the provider is responsible for ensuring the total content of the documentation. (If the record is locked, HIM department will unlock the record for the provider to immediately amend following the process below and then lock again after signed.) 2. The provider must identify correct patient and encounter prior to documenting within the health record which includes the following information: a. Patient name b. Date of service c. Account number d. Health record number e. Original report that the addendum is to be attached to 3. Ensure that the proper format is utilized (for example, dictated report or direct data entry) 4. Edit document as appropriate 5. Ensure documentation is complete and accurate 6. Apply signature **Department** *[Insert department name]* 1. Review each amendment for appropriateness prior to attaching it to the original report 2. Attach to original report 3. Ensure the addendum has a separate date, time, and signature line 4. Through reporting, track amended records a. Send out updated information as appropriate b. Ensure updates were transmitted across systems c. Track and trend amendments and report potential violations to *[insert appropriate committee or department name]* *See also:* Patient Right to Amend Protected Health Information (PHI) Policy Amendments in the Electronic Health Record Policy Notice of Amendment for PHI Policy

Sample Patient Right to Amend Protected Health Information (PHI) Policy

Subject:	Sample Patient Right to Amend Protected Health Information (PHI) Policy
Purpose:	To ensure that all *[insert name of organization]* employees are aware of and comply with all laws, statutes, rules, and regulations involving a patient's rights to amend his or her protected health information.
Policy:	*[Insert name of organization]* employees shall comply with all federal and state laws, statutes, rules and regulations regarding a patient's rights in relation to their protected health information. All patient requests shall be handled in a timely manner and as set forth in this policy.
	Designated Record Set: A group of records maintained by or for *[insert name of organization]* that includes the medical records and billing records about patients that is used in whole or part by or for *[insert name of organization]* to make decisions about patients. The term *record* is defined as any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for *[insert name of organization]*. **Protected Health Information (PHI):** The demographic and health information collected from an individual that 1. Is created or received by a healthcare provider 2. Relates to past, present, or future physical or mental conditions of an individual, the provision of care to an individual, or payment related to the provision of care to an individual 3. Identifies the individual or provides for a reasonable basis to believe the information can be used to identify the individual 4. Is transmitted or maintained in any form (such as electronic, paper, oral) **Treatment Information:** Any PHI related to the provision, coordination, or management of healthcare and related services **Patient:** For the purposes of this policy, *patient* refers to the patient or authorized representative of the patient requesting information **Amendment:** An amendment is an alteration of the health information by modification, correction, addition, or deletion. There are many terms used that ultimately amend the health record. Amendment is the overarching term indicating that documentation has been altered. There are many ways that a health record may be altered; these terms may include corrections, addendums, retractions, deletions, late entries, re-sequencing, and reassignment. An amendment is made after the original documentation has been completed by the provider. All amendments should be timely and bear the current date and time of documentation and be electronically signed. **Addendum:** Entries added to a health record to provide *additional* information in conjunction with a previous entry. The addendum should be timely and should bear the current date, time, and reason for the additional information being added to the health record and be electronically signed. **Correction:** A correction is a *change* in the information meant to clarify inaccuracies after the original electronic document has been signed or rendered complete. Corrections may also involve removing information from one record, and posting it to another within the electronic document management system. **Retraction:** A retraction is the action of *correcting information that was incorrect, invalid, or made in error,* and preventing its display or hiding the entry or documentation from further general views. However, the original information is available in the previous version. An annotation should be viewable to the clinical staff so that the retracted document can be consulted if needed.

Sample Patient Right to Amend Protected Health Information (PHI) Policy (cont.)

Subject:	Sample Patient Right to Amend Protected Health Information (PHI) Policy
	Deletion: A deletion is the action of *permanently eliminating information* that is not tracked in a previous version; refer to the **Deletion and Retraction Policy**. Late Entry: An addition to the health record when a pertinent entry was missed or was not written in a timely manner. The late entry should be timely and should bear the current date, time, and reason for the additional information being added to the health record and be electronically signed. Re-sequencing: The process of moving a document from one location in the EHR to another within the same episode of care, such as a process note that was dated incorrectly. No annotation of this action is necessary. Reassignment: The process of moving one or more documents from one episode of care to another episode of care within the same patient record, such as the history and physical posted to the incorrect episode. An annotation should be viewable to the clinical staff so that the reassigned document can be consulted if needed.
Procedure:	I. Request to Amend PHI A. **Patient's Right:** Patients have the right to request an amendment of the protected health information in their designated record set. However, *[insert name of organization]* may deny a patient's request to amend PHI when permitted by law. B. **Request:** Patient requests for amendments to treatment information must be in writing and submitted to the health information management (HIM) department for review and handling. Patient requests for amendments to billing or payment information may be made in writing, in person, or by phone to the billing department for review and handling. C. **Identification of Requesting Party:** Every reasonable effort shall be made to verify the identity of the party requesting the information (for example, picture ID, signature verification, requests for identifying personal information, and such) and validate their legal right to the request. D. **Timeliness:** The request for an amendment must have a completed action within sixty (60) days of the receipt of the request. This means that if the request is granted, the amendment must be made and the patient informed within 60 days of the receipt. If the request is denied, a written denial must be sent to the patient within 60 days. If the request cannot be completed within 60 days, *[insert name of organization]* may have a single 30-day extension, so long as the patient is sent a written statement stating the reason for the delay and date by which the request will be completed. E. **General Process:** HIM or the Billing Department will determine the PHI affected by the request, log the request, and determine whether it should be denied based on the type of request or whether it should be forwarded to the health care provider whose documentation is in question (see F) below for a determination of whether to accept or deny the request. F. **Accepted Amendments:** If the request is granted, the following will occur: 1. The amendment request will be sent to the Quality Review Department to locate any similar information in the patient's record to assure all information is updated. 2. The amendment, or a link to the amendment, will be added at the site of the original information in question and be dated, time stamped, and electronically signed.

Sample Patient Right to Amend Protected Health Information (PHI) Policy (cont.)

Subject:	Sample Patient Right to Amend Protected Health Information (PHI) Policy

3. The patient requesting the amendment will be informed that the amendment request is accepted
   a. In writing for a treatment request
   b. In writing, in person, or by phone for a billing or payment request.
4. The patient will be asked to provide the names of any relevant persons with whom the amendment must be shared.

G. HIM or the Billing Department will provide the amended information to persons identified by the patient, and those that [insert name of organization] knows have the PHI that is the subject of the amendment and that may have relied on or could foreseeably rely on the information to the detriment of the patient. The amended information will also be provided with all subsequent disclosures of the PHI to which the disagreement relates.

H. **Denials:** Requests may be denied for the following reasons
1. PHI was not created by this organization (or its business associates).
2. PHI was not part of the patient's designated record set.
3. Federal law prohibits making the PHI in question available to the patient for inspection (psychotherapy notes).
4. PHI is accurate or complete.

I. **Written Denials:** If the request for amendment is denied, the following will occur:

1. Amendment denials will be made in writing to the patient who requested the amendment and must meet the timeliness standard listed in this policy.
2. The written denial will describe
   - The basis for the denial
   - How the patient can submit a written statement of disagreement with the denial
   - How, if a letter of disagreement is not submitted, the patient may request that [insert name of organization] provide the patient's request for amendment and the denial with any future disclosures of PHI
   - How the patient can complain to *[insert name of organization]* and the Secretary of the Department of Health and Human Services regarding the denial
   - The name or title, and telephone number of the designated contact person who handles these types of complaints for [*insert name of organization]*
3. *[Insert name of organization]* will include the patient's request for amendment and its denial, or an accurate summary of such information, with any subsequent disclosure of PHI to which the disagreement relates if the patient requests such action

J. **Letters of Disagreement:** The patient may submit a letter of disagreement to which [insert name of organization] may prepare a written rebuttal. If this is done, the following must occur:

1. HIM or the billing department will route the letter of disagreement to the healthcare provider responsible for the documentation in dispute. The healthcare provider will determine whether to write a letter of rebuttal. If done, HIM or the billing department sends a copy of the rebuttal to the patient.
2. *[Insert name of organization]* will identify the PHI that is subject to the disputed amendment and append or otherwise link the patient's request for an amendment, the denial, the statement of disagreement, and the rebuttal.

Sample Patient Right to Amend Protected Health Information (PHI) Policy (cont.)

Subject:	Sample Patient Right to Amend Protected Health Information (PHI) Policy
	3. *[Insert name of organization]* will include the letter of disagreement and the rebuttal with subsequent disclosures of the PHI to which the disagreement relates. *See also:* Deletion and Retraction Policy Amendments in the Electronic Health Record Policy Notice of Amendment for PHI Policy

Sample Notice of Amendment for PHI Policy

Subject:	Sample Notice of Amendment for PHI Policy
Purpose:	To ensure that all *[insert name of organization]* employees are aware of and comply with all laws, statutes, rules, and regulations involving a patient's rights to amend his or her protected health information.
Policy:	*[Insert name of organization]* employees shall comply with all federal and state laws, statutes, rules, and regulations regarding a patient's rights in relation to his or her protected health information. All amendment notices shall be handled in a timely manner and as set forth in this policy.
Definitions:	**Designated Record Set:** A group of records maintained by or for *[insert name of organization]* that includes the medical records and billing records about patients that is used in whole or in part by or for *[insert name of organization]* to make decisions about patients. The term *record* is defined as any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for *[insert name of organization]*. **Protected Health Information (PHI):** The demographic and health information collected from an individual that: 1. Is created or received by a healthcare provider 2. Relates to past, present, or future physical or mental conditions of an individual; the provision of care to an individual; or payment related to the provision of care to an individual 3. Identifies the individual or provides for a reasonable basis to believe the information can be used to identify the individual 4. Is transmitted or maintained in any form (such as electronic, paper, oral) **Treatment Information:** Any PHI related to the provision, coordination, or management of healthcare and related services **Patient:** For the purposes of this policy, *patient* refers to the patient or authorized representative of the patient requesting information. **Amendments:** An amendment is an alteration of the health information by modification, correction, addition, or deletion. There are many terms used that ultimately amend the health record. Amendment is the overarching term indicating that documentation has been altered. There are many ways that a health record may be altered; these terms may include corrections, addendums, retractions, deletions, late entries, re-sequencing, and reassignment. An amendment is made after the original documentation has been completed by the provider. All amendments should be timely and bear the current date and time of documentation and be electronically signed. **Addendum:** Entries added to a health record to provide *additional* information in conjunction with a previous entry. The addendum should be timely and should bear the current date, time, and reason for the additional information being added to the health record and be electronically signed. **Corrections:** A correction is a *change* in the information meant to clarify inaccuracies after the original electronic document has been signed or rendered complete. Corrections may also involve removing information from one record, and posting it to another within the electronic document management system. **Retractions:** A retraction is the action of *correcting information that was incorrect, invalid, or made in error,* and preventing its display or hiding the entry or documentation from further general views. However, the original information is available in the previous version. An annotation should be viewable to the clinical staff so the retracted document can be consulted if needed.

Sample Notice of Amendment for PHI Policy (cont.)

Subject:	Sample Notice of Amendment for PHI Policy
	Deletions: A deletion is the action of *permanently eliminating information* that is not tracked in a previous version; refer to the **Deletion and Retraction Policy**. **Late Entries:** An addition to the health record when a pertinent entry was missed or was not written in a timely manner. The late entry should be timely, and should bear the current date, time, and reason for the additional information being added to the health record and be electronically signed. **Re-sequencing:** The process of moving a document from one location in the EHR to another within the same episode of care, such as a process note that was dated incorrectly. No annotation of this action is necessary. **Reassignment:** The process of moving one or more documents from one episode of care to another episode of care within the same patient record, such as the history and physical posted to the incorrect episode. An annotation should be viewable to the clinical staff so that the reassigned document can be consulted if needed.
Procedure:	**I. Notice of Amendment for PHI** A. **Amendment Notification:** When *[insert name of organization]* is informed that an amendment has been made by another covered entity, [insert name of organization] must amend the protected health information in the designated record set. B. **General Process:** Amendment notification will be forwarded to the HIM Department. HIMs will determine the PHI affected by the notice. The amendment, or a link to the amendment, will be added at the site of the original information in question. C. **Timelines:** The request will be processed immediately to ensure patient safety. D. **Notifications:** If the patient is still an active patient, the following will occur 1. Providers actively caring for the patient will be notified of the amendment *See also:* Deletion/Retraction Policy Amendments in the Electronic Health Record Policy Patient Right to Amend Protected Health Information (PHI) Policy

Appendix E

Sample Questions for the EHR Vendor

The following is an initial set of questions the HIM professional should use when assessing the amendment functionality with an EHR. These questions also pertain to interfaces as many EHRs are connected to other electronic systems.

Vendor Questions	Response to Draft	Response for Final	Response for Locked
Does the EHR vendor have an established process and confirm that system allows for amendments?			
Does the EHR keep the original version when changes are made?			
When amendments are made to an entry, are the original entry, current date and time, name of the person making the change, and the reason viewable?			
Does the location of the error point to a correction (the correction may be in a different location from the error if there is narrative data entered), and is there a mechanism to reflect the correction?			
Can the EHR system notify the HIM department every time an amendment is made?			
Can the user determine what changes were made in a document without doing a side-by-side review of the two versions?			
If changes can be seen, what does the user see? • Different color text • Different font • Strikethrough • Record of who changed, date, and time?			

Sample Questions for the EHR Vendor (cont.)

Vendor Questions	Response to Draft	Response for Final	Response for Locked
Does the printed record look different? • Different color text • Different font • Strikethrough • Record of who changed, date, and time?			
Does the record that is copied onto another form of media (for example, USB drive, CD) look different? • Different color text • Different font • Strikethrough • Record of who changed, date and time?			
Does the record that is electronically transmitted (such as interfaces, HIE) transmit the headers to show the changes?			
When amended information is entered into the EHR, will providers caring for the patient be notified?			
Does the system track and run reports for tracking changes to the record and identify what changes were made, who made the changes, and when the changes were made?			

Appendix F

Sample Questions for the Information Technology Department

In addition to the EHR Vendor questions, IT must ensure that when health records are amended in the EHR system, the information is transmitted to all locations to which the original document was sent.

IT Questions	Response to Draft	Response for Final	Response for Locked
Does the interface send updated documents?			
Will the updated information be sent through the HIE?			
Will the updated information be automatically sent to all referring providers who received the original document?			
How will updated documents received from the HIE be handled in the EHR?			

Sample Patient Request to Amend the Health Record

Patient Name:_____ Date of Birth:_____

Address: _____

City:_____ State:_____ Zip Code: _____

Home Phone: (_____)_____ Work Phone: (_____)_____

I have reviewed my health record; I do not feel the information in the record made by

_____ is correct.
(Name of provider)

This date(s) of service _____should be updated with the following information:

_____

_____

_____

This form may be returned to your clinic or mailed directly to: *[insert name of organization and address/fax number]*

Signature: _____ _____Date: _____

Provider Response

❑ An amendment will be made to your permanent health record.

❑ This request for an amendment has been made a part of your permanent record; however, your request to amend your health record directly has been denied for the following reasons:

_____

_____

_____

Provider Signature:_____ Date: _____

If you disagree with the provider, you may submit a written statement of disagreement.

(Attach copy of Statement of Disagreement for patient)

Sample Patient Statement of Disagreement

Patient Name:_____ Date of Birth:_____

Address: _____

City:_____ State:_____ Zip Code: _____

Home Phone: (_____)_____ Work Phone: (_____)_____

Statement of Disagreement:

_____

_____

_____

_____

You may request that *[insert name of organization]* provides your request for amendment and the denial with any future request for information.

If you want more information about our privacy practices, have questions or concerns, or believe that we may have violated your privacy rights, please contact:

[Insert name, address and phone number of organization]

You also may submit a written complaint to the US Department of Health and Human Services. We will provide you with the address upon request. We support your right to protect the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint.