Amendments, Corrections, and Deletions in Transcribed Reports Toolkit

American Health Information Management Association
2009

Table of Contents

Foreword

A key component of health information management is the handling of amendments, corrections, and deletions in transcribed reports. When a clinical provider determines that documentation within a report is inaccurate or incomplete, organizations must have established policies and procedures to guide the provider in making corrections within the body of the record. HIM professionals should ensure that these policies and procedures support and maintain the integrity of the record.

Traditional practices within the paper record support a single error line through the original documentation. However, these practices will not necessarily transfer to a transcribed report, and new practices should be evaluated against organizational policy. This toolkit is designed to provide guidance to HIM professionals when addressing amendment, correction, and deletions within a transcribed report.

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Introduction

Healthcare organizations must create and develop health records that meet the requirements of a legal business record. As such, health records must be maintained in a manner that is consistent with state and federal requirements. Guidance can be sought from state, federal, and accrediting body requirements as well as individual organizational requirements found within organizational medical staff rules and regulations or bylaws. HIM professionals should have a fundamental understanding of all of these documentation requirements in order to appropriately guide their organization in managing this documentation practice.

Organizational processes defined in this toolkit may be different depending on reports and individual transcription system capabilities as well as draft versus final documents. It is important for organizations to develop policies and procedures regarding these different processes in order to ensure the integrity of the health record.

Terms

For the purpose of this toolkit the following definitions apply:

Addendum: a supplement to a signed report that provides *additional* health information within the health record.

Amendment: a *clarification* made to the health information after the original documentation has been final signed by the provider.

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 who is responsible for "unlocking" the visit and when that function is applicable. An organization must determine the time period the locked visit function is allowed in order to change information within the record before and when the document or report is considered complete.

Correction: a *change* in the information that is meant to clarify inaccuracies after the original electronic document has been signed and completed.

Deletion: the action of *eliminating information* from a signed document without substituting new information.

Direct documentation: *text entries* made into the health record (e.g., progress notes, nursing notes, physician orders).

Distribution: the act of providing copies (either by fax or direct mailing) of transcribed reports to providers, consultants, or other healthcare professionals as indicated by the dictating physician.

Draft: an initial version of a transcribed report that has not been signed by the provider. Depending on organizational policy, this document may or may not be viewable within the electronic health record. In addition, provider edits could be allowed by the organization because a draft is not considered completed until the final signature is applied.

Electronic signature: a legally recognized *electronic duplication of a clinical provider's name* that indicates his or her agreement with the accompanying documentation. These entries may be authenticated after

the information has been entered by someone else, and they require review and authentication by the author. Electronic signatures should follow the appropriate organizational policies regarding authentication. Electronic documents may be signed by more than one party.

Final signature: for the purpose of this toolkit the term *final signature* or *final sign* refers to the act of applying an electronic signature to the documentation by the provider. Once the electronic signature is applied the document is considered complete, and the only way to correct or change information is to enter an addendum.

Information: any entry, including amendments, addendums, or corrections, within a health record that is either direct documentation or transcribed reports (e.g., a deletion can be made to either a progress note (direct documentation) or a dictated operative note (report)).

Locked: a point in time that the report is completed and editing is barred. This usually occurs when the report is signed by the physician. Once the electronic signature is applied to the report, no further edits of any kind can be made. The only way to make changes to a locked report is to add an addendum to the record. Policy should define who within the organization can unlock a visit.

Provider: for the purpose of this toolkit, provider includes clinical and allied health practitioners (e.g., physicians, advanced nurse practitioners, respiratory therapists) who have the appropriate organizational role-based privileges to document within the EHR.

Report: for the purpose of this toolkit, report refers to transcribed reports (e.g., history and physical or operative note).

Retraction: the action of *hiding or removing (in the background) information that was incorrect, invalid, or made in error*.

Version: the specific *form or variation* to a report. Report versions would include draft documents and editing or reviewing actions that occur prior to the final signature. The final version is the document with the final signature on it. Previous versions or forms would be saved in the background depending on system functionality.

Guiding Principles

Although the terms *amendments, corrections*, and *deletions* are often used interchangeably, they do not refer to the same thing. Organizations should have clearly defined policies, procedures, and practices to ensure that the integrity of the health information remains intact, regardless of how and when information is clarified. Organizations must ensure that clarifications or changes to health information are consistent with state and federal rules and regulations, medical staff bylaws, and accrediting body requirements. *Once the signature has been placed the document should be considered locked from any editing.* The intent of this toolkit is to provide further clarity for organizations and providers regarding the key terms listed above and practice guidelines below.

Signed Reports

Once a report has been signed by the dictating provider no further edits should be allowed. Any additions, corrections, or deletions should be applied through an addendum. The addendum should be included within the original report and identified as such. The addendum should include a new signature line that the provider must sign in addition to the signature that has already been placed at the end of the original document. Each organization should develop policies and procedures regarding this practice. Organizations should also address issues such as dual signatures (e.g. resident and attending physicians). In these cases, organizational policy will dictate when the report and visit note are locked from editing.

The organization may choose to lock the record from provider editing, but in some cases allow this documentation privilege to specific staff within the organization. In cases where the correction is limited to a change in the patient's age or sex, asking the provider to complete an addendum may seem inappropriate. The organization instead may allow HIM professionals to unlock the report, add the correct age into the document, and then lock the report. In this case, the provider should still be required to resign the new report. Another key practice would be to ensure that the correct age does not erase the incorrect information. The new information should stand out from the original. The system functionality may show the new information in bold, underlined, italics, or in a different color so that it is easily identified. The system should also

provide tracking functionality to indicate when the change was made and by whom.

Organizational policies and procedures should ensure that documents created in the source system (e.g., the transcription system) are not utilized for release of information.

Key Recommendations:
- Require addendums to any document that has been final signed.
- Ensure that addendum information is added to each report in the same manner (e.g., at the top of every report).
- Require a new signature for the addendum by the provider.
- Develop policies and procedures to address minor corrections.

Unsigned Reports

Once a report has been dictated, it is usually either printed or electronically sent to the electronic health record (EHR). If it is printed for a manual signature, the report should be considered draft until it is manually signed. If the report is sent to the EHR, it should automatically populate in the provider's electronic signature queue. Unsigned reports, by nature are considered draft documents; in other words, the documentation has not been validated or confirmed by the provider. In these cases, providers may consider the documents to be available for editing. It is up to each organization to define the extent of editing that can occur on an unsigned report and who should perform the editing function. In the paper world, it may be the transcriptionist who edits based on the physician's handwritten corrections. In the electronic environment, it is recommended that providers edit their own transcribed reports within the EHR system.

The distribution of unsigned transcribed reports should not be considered a best practice. Distribution methods can include e-mail or faxing the paper copy, as well as viewing the unsigned report within the EHR. However, in order to facilitate continuityof care it is recognized that the distribution of unsigned documents is necessary to coordinate clinical care. Organizations should clearly define how this process is handled in their policies and procedures. All unsigned reports should be clearly

marked as draft. Immediately upon application of the provider signature the report should convert to a final status.

> ### Key Recommendations:
> - Organizations should define unsigned reports as draft documents.
> - If utilizing electronic signature capabilities in the EHR, draft documents should automatically populate in the provider's queue.
> - Once signed a report should immediately convert to a final status.
> - Providers should be responsible for making their own edits to draft documents.

Distribution

Distribution of reports is inherent to the continuity of care. In the paper world, reams of paper are printed, followed by a mailing of the document to the dictating provider as well as any copy providers on the report. This process can create volumes of workload for the clerical staff. As organizations move toward an EHR some pieces of the process can be automated, thus saving clerical time. However, organizations still need to define how the distribution of reports will be handled. For the purposes of this toolkit, distribution of reports is the process of making the reports viewable to providers. That process may be viewing a draft document within the EHR, or some organizations may choose to still mail or autofax transcribed documents.

Organizations must first define when the distribution of reports will occur, either prior to signature, after final signature, or a combination of both. An organization that chooses to distribute an unsigned report should have certain safeguards in place to redistribute reports that have been edited prior to final signature. The transcription system or module may have the capabilities to autofax or print to network printers. The transcriptionist would choose the applicable method of distribution once the report has been transcribed, thus distributing an unsigned report. The report should clearly indicate it is a draft document. System capabilities should be in place to flag any report that is edited prior to final signature. The system should allow the physician to edit and append the final signature to the report, and it should also then prompt the appropriate

HIM personnel (e.g., transcription supervisor) that an edit has been made and prompt the personnel to resend the report to the provider(s).

Some organizations may choose to discontinue printing or autofaxing reports once the EHR has been implemented, choosing instead to have providers view the information within the EHR itself and eliminating the paper processes associated with distribution. In these cases, draft documents should be clearly identified within the EHR so that all clinical providers (e.g., physicians, nurses, or consultants) understand that the report has not been validated. The organization should ensure that edits clearly stand out within the document (e.g., different font, color of text).

Key Recommendations:
- Organizations must define when distribution occurs.
- If unsigned reports are distributed, safeguards should be put in place to notify providers of changes made to draft documents.
- Organizations may choose to discontinue paper distribution after EHR implementation.

Record Completion Guidelines

Organizations should have clearly defined policies on when and how a record and its individual components (e.g., dictated reports, etc.) are considered complete. Health records may be incomplete for a variety of reasons (e.g., lack of dictated report or lack of signature on a verbal order). Upon discharge, the record is reviewed by clerical staff to ensure that all required reports and signatures are on the record before marking the record as complete.

As organizations implement EHRs, it does not necessarily mean that the providers will comply with record completion activities. If a provider has difficulty completing his or her records in a paper environment, the implementation of an EHR alone will not correct the issue. In the area of transcribed reports, providers must still apply the final signature. Applying an electronic signature still requires a provider to log into the system, enter his or her unique PIN number, and apply the final signature. It should never be an automatic process. Record completion should be consistent with all state, federal, and accrediting body rules and regulations.

Organizations should clearly define when individual reports are considered complete. Upon application of the final signature a report should be considered complete, and any revisions or corrections considered addendums. However, when viewing the entire health record, the organization should consider it complete when all defined components of the record are included within the body of the record and final signature applied.

Key Recommendations:

- Organizational policy should clearly define when an entire record is considered complete in accordance with all state, federal, and accrediting body rules and regulations.
- Organizational policy should clearly define that a report within the entire record is complete upon application of the final signature.
- Dictated reports within the EHR should automatically populate in a provider's electronic signature queue.
- Applying electronic signatures should never be an automatic process within the EHR.

Case Scenarios

Case Scenario #1

A transcriptionist assigns the incorrect attending physician to a discharge summary. As a result the incorrect physician's name populates on the transcribed report. The mistake is not noted at the time of transcription. The incorrect physician logs into the EHR and is notified of pending electronic signature needed. The patient is not validated prior to electronic signature and the incorrect physician signs the report. The analysis clerk realizes that the discharge summary has the incorrect physician signature and notifies the transcription manager.

Action: The corrected report is placed within the EHR as a draft document for the correct physician to sign. The incorrect report is maintained in an audit trail in accordance with organizational policy.

Case Scenario #2

A transcriptionist assigns incorrect physician to a discharge summary. As a result the incorrect physician's name populates the transcribed report.

The mistake is noted by the analysis clerk after the report has populated the EHR, prior to the application of the electronic signature. The analysis clerk notifies the transcription manager.

Action: The report is corrected per organizational policy and placed within the EHR as a draft document for the correct physician to sign. The initial report is removed from the incorrect physician's electronic signature queue.

Note: The key difference in case scenarios 1 and 2 is the application of the final signature.

Case Scenario #3

A physician dictates a history and physical on a patient admitted for pneumonia via the emergency department. Under the past medical history the physician dictates that the patient had a hip replacement in 2004. The report is transcribed and imported into the EHR. The physician receives the report via the system electronic signature queue and signs the report. On day three the physician realizes that the patient never had a hip replacement and that the information is incorrect. The physician then calls the HIM department to correct the report.

Action: The physician dictates an addendum to the original history and physical indicating the patient's corrected information. The transcriptionist identifies the addendum and original report. Per organizational policy the addendum is transcribed into the original report, in the correction location of the original report and clearly identified as an addendum. The new report is then imported into the EHR. The physician receives the report via the electronic signature queue and re-signs the report.

Note: Organization policy and system capabilities will dictate where and how the addendum is processed. The addendum may be at the beginning of the report, the end of the report, or in a separate document all together. Organizational policies and procedures should be consistently followed in all cases.

Case Scenario #4

An emergency department report is dictated on a 67-year-old female who cut herself while peeling potatoes. The dictating physician does not indicate an account number. In order for the report to be attached to the patient's EHR an account number must be placed in the document. The transcriptionist searches the master patient index (MPI) and selects an account number. The report is completed, sent to the EHR, and electronically signed by the physician. The analysis clerk realizes that the wrong account number has been selected. The transcription manager is notified.

Action: The transcription manager administratively "unsigns" the report per organizational policy. The account number is corrected. The report is sent back to the EHR to be electronically signed by the physician.

Case Scenario #5

Jane Smith is admitted to an acute care facility directly from her primary care physician's (PCP) office for pneumonia. She is admitted to the medical unit and actively treated for pneumonia via intravenous antibiotics and fluids. She is discharged on day three of her hospital stay. When dictating the discharge summary the PCP incorrectly dictates her name as Mary Smith. The transcriptionist does not identify the incorrect name and completes the discharge summary as dictated. The PCP recognizes the error and simply lines through the incorrect name in the EHR and retypes the correct name. Both names appear on the final report, and the physician applies his final signature. The HIM department receives a request for release of information from the insurance company and releases the report. The insurance company notifies the organization that an incorrect name is on the report. The release of information clerk notifies the privacy officer.

Action: The privacy officer identifies the HIPAA privacy violation that occurred when the incorrect names was released. The privacy officer works with the transcription manager to administratively "unsign" the report per organizational policy, correct the report so that only the correct patient name appears, and updates the report. The report is then forwarded back to the provider for electronic signature. The privacy officer follows organization policy in reporting the HIPAA violation.

Case Scenario #6

General Hospital has an electronic health record and currently outsources its transcribed reports to Anytime Transcription. Anytime Transcription completes the dictation and sends the report via a secure network back to the hospital. The hospital staff manually places the report within the EHR utilizing copy and paste technology, copying the report from the transcription system and pasting it into the EHR. The HIM staff then assigns an electronic signature deficiency for the provider utilizing the EHR deficiency module of the EHR.

Action: The HIM staff will need to verify the correct patient and date of visit within the EHR in order to place the report in the appropriate record and then assign the electronic signature deficiency. Corrections that need to be made by the provider should be made within the EHR report. If the provider signs the report without verifying the accuracy of the report and then determines that there is an error within the report, an addendum should be dictated and attached to the original report.

Note: Some systems have an electronic feed from the transcription system to their EHR, thus automating the copy/paste issue in this scenario. In those cases, HIM staff should have appropriate processes in place to ensure that all reports connect to the correct patient and visit and that the electronic signature deficiency is assigned. Corrections should still be made through an addendum.

Resources
AHIMA. "Legal Health Record: AHIMA Leadership Model." Available online at www.ahima.org.

AHIMA. "Amendments, Corrections, and Deletions in an Electronic Record Toolkit." 2009. Available online in the FORE Library: HIM Body of Knowledge at www.ahima.org.

AHIMA. "HIM and Health IT: Discovering Common Ground in an Electronic Healthcare Environment." *Journal of AHIMA* 79, no. 11 (Nov.–Dec. 2008): 69–74.

AHIMA. "Quality Data and Documentation for EHRs in Physician Practice." *Journal of AHIMA* 79, no. 8 (Aug. 2008): 43–48.

AHIMA EHR Practice Council. "Developing a Legal Health Record Policy." *Journal of AHIMA* 78, no. 9 (Oct. 2007): 93–97.

AHIMA e-HIM Task Force. "The Strategic Importance of Electronic Health Records Management." *Journal of AHIMA* 75, no. 9 (Oct. 2004): 80A–B.

AHIMA e-HIM Work Group: Guidelines for EHR Documentation Practice. "Guidelines for EHR Documentation to Prevent Fraud." *Journal of AHIMA* 78, no. 1 (Jan. 2007): 65–68.

AHIMA e-HIM Work Group on Maintaining the Legal EHR. "Update: Maintaining a Legally Sound Health Record—Paper and Electronic." *Journal of AHIMA* 76, no. 10 (Nov.-Dec. 2005): 64A–L.

ASTM International. "ASTM E2017 - 99(2005) Standard Guide for Amendments to Health Information." Available online atwww.astm.org/Standards/E2017.htm.

Certification Commission for Healthcare Information Technology. Available online at www.cchit.org.

e-HIM Work Group on Implementing Electronic Signatures. "Implementing Electronic Signatures." Updated October 2003. Available online in the FORE Library: HIM Body of Knowledge at www.ahima.org.

Health Level Seven. HL7 Electronic Health Record (EHR) Work Group's Home Page Available online at www.hl7.org/ehr.

Nunn, Sandra. "Applying Legal Holds to Electronic Records." *Journal of AHIMA* 79, no. 10 (Oct. 2008): 72–73, 80.

Rinehart-Thompson, Laurie A. "Raising Awareness of Medical Identity Theft: For Consumers, Prevention Starts with Guarding, Monitoring Health Information." *Journal of AHIMA* 79, no. 10 (Oct. 2008): 74–75, 81.

Vigoda, Michael. "e-Record, e-Liability: Addressing Medico-Legal Issues in Electronic Records." *Journal of AHIMA* 79, no. 10 (Oct. 2008): 48–52.