How to Amend an EHR

In the days of paper records, medical professionals were warned to never add information to a handwritten entry after the date of the original entry. One of the primary reasons for this advice is that such changes could be construed as records alterations and could be detected through a forensic evaluation of the ink used to make the change. Now that most offices utilize EHR, medical professionals should follow the same advice: never delete or add information to an EHR entry after you electronically sign and close an entry. Instead, create procedures for attaching an amendment to the patient's record. Following are some details about how to amend an EHR entry.

It is important to understand that much like the old system of dating pen ink, changes to EHR entries can be detected by evaluating the EHR's metadata. Metadata is the underlying technical data that indicates when a patient record was accessed, who accessed it and what parts of the record were modified or viewed. If you attempt to retrospectively change the notes you initially made, the metadata could reveal the date and time you made the change and what the original text showed. Altering a medical record after the entry has been completed can compromise your credibility if the record must be used to defend a malpractice claim. Additionally, altering a medical record could affect (and possibly void) your policy and leave you exposed in a claim.

Making changes to a medical record may be necessary for several reasons: 1) You realize after you complete and sign an EHR entry that you made an error in documentation or omitted pertinent information; 2) Test results or diagnostic information entered in the EHR record needs to be revised due to a report received from a laboratory, radiologist, or consultant; and 3) A patient reviews their record and requests that you amend it.

HIPAA addresses changes to medical records only in the context of patient requests for amendments. HIPAA outlines the process through which a patient may request an amendment and the various ways a medical office may respond. If you receive a patient request to amend a record and you agree to the patient's request, the amendment should be made following the applicable guidelines outlined below. If you choose *not* to make an amendment, inform the patient of your decision, and let the patient know that

he or she may submit the additional information and request it be attached to their record.[1]

EHR systems will differ in the ways in which amendments can be made. Typically, you will be able to create an amendment as a separate entry and electronically connect it to the original entry. There will also likely be a way to flag the original entry to indicate that a change was made and to point to the amended information.

Your office should create and document procedures for making changes to EHR entries. Following are some of the elements you may want to include in your EHR amendment policies:

- Prohibition against deleting or altering information entered in an EHR after the date and time of the original entry.
- Description of the steps a provider should follow to correctly incorporate an addendum or correction into a patient's EHR.
- How a provider should flag the original entry to indicate that an addendum or correction has been made.
- The scope of information that should be included in an addendum or correction. For example, an addendum might reference the date of the original entry, the reason for the addendum, the new information about the patient and the name of the person making the change.
- A process for notifying the original author of an entry when someone else in the office creates an addendum.
- How patient requests for amendments will be evaluated. This includes describing how denials of patient requests will be handled and how agreed upon patient requests for amendments will be made. There could also be a policy describing how patients will be notified of these decisions.

[1]HHS.gov. *Your Medical Records*. Accessed April 16, 2018.https://www.hhs.gov/hipaa/for-individuals/medical-records/index.html

- A process for conducting periodic audits of corrections, addendums and late entries. If certain providers in your office routinely make such entries, perhaps they would benefit from additional education on documentation.

  A schedule for holding periodic reminder sessions about making amendments for staff members who have access to the EHR. The session could use a recent addendum as an example; reinforcing the importance of never deleting or changing an EHR entry and describing the correct way to create an amendment. You may also want to educate staff about the existence of metadata and the detailed information it includes about every EHR entry that is made.

If you have received a records request from an attorney or suspect that a patient may be considering legal action, contact us prior to amending a patient record. Making amendments after records have been requested may be construed as an attempt to "cover" an error.

The EHR can be the best defense tool in the event of a claim. But if changes are made in an inappropriate manner, the EHR can be used by plaintiff attorneys to cast doubt on your veracity. Using your EHR wisely will allow us to use it to support the defense of a claim.