Correcting Dates of Service in the EHR

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Data errors are inevitable, and they happen every day. Various types of errors can occur in electronic health records (EHRs), including errors in dates of service (DOS). DOS errors happen for a number of reasons, such as a user choosing the wrong encounter or entering the wrong date.

Incorrect dates of service compromise subsequent uses of the record downstream. In an outpatient setting, for example, if the DOS and the billing date are different, the entire bill and reimbursement will be affected. A report filed incorrectly due to wrong DOS will make finding the information difficult (dependent upon the type of system). It is important that DOS errors be caught and corrected as soon as possible.

HIM professionals are responsible for managing these errors as they occur to reduce the risk to the organization and strive for optimal outcomes.

Monitoring and Tracking DOS Errors

Identifying and monitoring DOS errors is the first step to effectively managing corrections. Every facility 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 should be a point person or system responsible 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.

Organizations must also determine who will track all corrections. This could fall within the HIM, process improvement, risk management, quality, or other relevant department.

Environmental Scan

Managing DOS errors also requires a thorough understanding of the organization's systems environment, system capabilities, and the organization's policies on its legal record, including:

- The definition of the legal health record
- What system is considered the official EHR
- What other systems are interfaced with the EHR
- System capabilities

At a minimum, the EHR should be able to distinguish between the original and new versions of the document.

Organizations must also understand the system's tracking abilities, including audit trails and the tools used to make corrections. There are some systems in which changing DOS can be permission-controlled and some in which it cannot and anyone can change the DOS. Every organization must understand its system capabilities and outline its policies and processes accordingly.

Elements of a Corrections Policy and Procedure

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

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

- The point personnel who should receive error reports for logging and tracking purposes.
- Which staff are permitted to make corrections in the EHR. Is this limited to two or three people, a certain department, or position type?
- The appropriate steps that must be taken to make a correction.
- Which systems permit corrections. Should corrections be made within the EHR, or is there a specific module, tool, or system used for corrections?
- Potential time limitations, although with DOS errors there most likely is no time limitation, especially if it affects billing and reimbursement. After 24 hours, can only an addendum be applied to make the change?
- When to make a correction to the DOS. If the DOS error affects the billing or reimbursement of the claim or clinical relevance and patient care, then the correction must be made. On the other hand, if the DOS error is the date of vital signs taken in a nurse note, organizations must determine if the correction is necessary.
- Elements of a correction. Each correction should be accompanied by the same verbiage, such as "In Error," for easy identification, followed by at a minimum the date, time, purpose for change, and who made the change.

Deleting DOS Errors: A Last Resort

Deleting a document should be a last resort reserved for extreme cases only. For DOS errors identified before being electronically signed or locked, organizations must determine whether deleting the entry with the incorrect DOS and replacing it with the correct DOS is warranted. It should be remembered that deleting is not actually eliminating the entry from the system, but rather "hiding" it from the user.

The incorrect DOS should still always be available to be found and viewed if needed. It is another way of tracking errors.

Training and Ensuring Accountability

Once the policy and procedure is established and approved, the final critical step is training and educating staff. Staff require resources and training in order to meet the expectations set for them.

Organizations should make sure that key personnel (e.g., HIM and help desk) know the available resources and where they can be located. Those key personnel should also understand the details of the policies and procedures in order to help those with questions.

Retraining is also important for those who repeatedly choose the wrong DOS. It is also a recommended practice to keep users well trained and abreast of any changes.

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.

HIM professionals are the gatekeepers of health information within an organization and are charged with reconciling health records (e.g., date, time) as well as certifying them as accurate and complete. As such, proper management of corrections made within the health record is imperative to maintaining the best quality and integrity of information possible.

For guidance on the overall management and best practices of amendments, corrections, and deletions for all types of information, please refer to AHIMA's toolkit "Amendments, Corrections, and Deletions in the Electronic Health Record," available online at www.ahima.org.

Reference

AHIMA. "Amendments, Corrections, and Deletions in the Electronic Health Record: An American Health Information Management Association Toolkit." 2009. Available online in the AHIMA Body of Knowledge at www.ahima.org.

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Article citation:
Dinh, Angela K.. "Correcting Dates of Service in the EHR" *Journal of AHIMA* 81, no.6 (June 2010): 54-55.