Correcting Lab Results in an EHR

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By Lou Ann Wiedemann, MS, RHIA, FAHIMA, CPEHR

The laboratory system within an EHR automates the historical process in which technicians documented results on lab shingles and pasted them on pages in the health record. In the paper environment, shingles were numerous and often taped one on top of the other to condense the record.

In the EHR the results are automatically integrated into the system so that they can be viewed by clinical care providers, sometimes without printing a single sheet of paper. In either system, the process for correcting lab results is often labor intensive and time sensitive.

HIM, IT, and laboratory professionals in acute care facilities or integrated health delivery systems in particular should collaborate regarding how to correct lab results in the EHR to prevent incorrect lab results from negatively affecting patient treatment.

Functionality Concerns

In the case of electronic laboratory results, as with any correction in the EHR, the concern is that new information will override or potentially eliminate information that a clinical care provider relied upon to determine an appropriate course of treatment.

In the paper world the original documentation would most likely be corrected with a single line through the notation and initialed by the person changing the information. Both the original and revised documentation would remain a permanent part of the health record.

In an EHR the actual repository for the data would be the laboratory system, which is interfaced or integrated with the EHR. The benefit of an electronic laboratory system is the speed with which lab results are relayed to clinical care providers so that treatment can begin within a matter of hours. That same benefit can turn into a quality of care concern if the information used is later found to be inaccurate.

System functionality is crucial due to the high speed of data exchange and the volume of orders received. Correct laboratory data must reside in the data repository, which can be an independent lab system. However, few EHR systems have the ability to push the corrected lab results to the EHR without overriding the original document and notify clinical care providers without human intervention.

Some systems allow for both preliminary and final laboratory results to be maintained within the data repository, and end users are responsible for reviewing the correct lab result. End users can identify preliminary from final results because they are separately and clearly identified within the repository. Organizations should clearly define in policy and procedure how versioning will be stored and maintained.

In the case of corrected laboratory orders, organizations should maintain both the original and corrected documents within the laboratory database. The laboratory system may issue an override alert if the end user attempts to save a report with the same file name as another report in the database. Appropriate staff should review the alert and change the file name to include “edit” or “new version” so that both documents reside within the EHR. The organization then needs to define how notification of the revised version will be sent to the clinical care providers.

The system may be able to alert the clinician of updated results with a notification such as “view updated lab results” or “new lab results available,” but the clinician still must access the system to view the results. These types of custom rules take time to build and test. In addition, depending on system functionality, the physician may only receive notification when a laboratory result is listed as final.

CLIA Regulations

In addition to individual system functionality, organizations must be aware of the Clinical Laboratory Improvement Amendments. Congress enacted CLIA in 1988 to ensure the accuracy and reliability of all laboratory testing. The regulatory standards apply to all laboratory testing, regardless of healthcare setting.

On March 3, 2010, the Centers for Medicare and Medicaid Services clarified that CLIA does permit laboratories to electronically exchange test data. This clarification is an essential feature to health IT adoption and health information exchange.

CLIA regulations hold laboratories accountable for the way an EHR displays laboratory results to clinical care providers. Under CLIA, laboratories are required to ensure that the right lab tests and results are sent to the correct provider. CLIA further requires laboratories verify that the EHR configures the lab results in the correct format. Before an organization decides to change a laboratory value format, view, or display, it should verify with the vendor that the customization is compliant with CLIA.

Maintaining the integrity of the health record is a fundamental HIM principle in records management. As custodians of the health record, HIM professionals should be aware of the laboratory system functionality for corrections and revisions.

If corrected lab values are placed within the health record, the documentation should substantiate the need for any change in the treatment plan. Correcting the lab results within the laboratory database and EHR is one piece of the puzzle.

Clinical care providers should clearly document within the progress notes the care of the patient. If a care decision has been based on a lab result that is later found to be inaccurate, clinical care providers should clearly document within their progress notes what portion of the patient's care was based on an inaccurate or incorrect lab value and further state changes to the treatment plan when the corrected value was made available.

Sample Corrections Policy

Policies and procedures for correcting laboratory reports will likely be located within the laboratory standard operating procedures. Due to CLIA regulations and system limitations, HIM professionals should confer with laboratory personnel and IT prior to developing a policy of this nature.

The policy and procedure below is not intended as a substitute for a customized internal organizational policy and procedure. It is not inclusive of specific state or organizational requirements and should not be used without editing that adapts it to the organization's specific situation.

Purpose: The integrity of the health record is paramount to providing high quality patient care. It is essential that incorrect information that has been presented to clinical care providers is identified and corrected in a manner that does not compromise patient care.

Policy: Immediately upon notification of an erroneous laboratory report clinical care providers will be notified of the error.

Procedure:

- Upon discovering an error, [NAME OF STAFF RESPONSIBLE] should report the occurrence to the appropriate manager.
- [STAFF RESPONSIBLE] should immediately note in the system that a report contains incorrect information. (This will depend on system functionality.)
- [STAFF RESPONSIBLE] will notify the physician and any other clinical care provider, as appropriate.
- A corrected report shall be placed in the electronic health record.
- The physician should document any clinical care decisions made as the result of the incorrect value within the progress note section.
- [NAME OF ORGANIZATION] should retain the incorrect laboratory value in the electronic health record. As a part of the legal health record, the information should remain a part of the health record along with all corrected

information.

Resources

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Lou Ann Wiedemann (lou-ann.wiedemann@ahima.org) is a director of practice resources at AHIMA.

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