RECORDS - CORRECTION OF INFORMATION

THE LAW

"A subject **individual**, or the parent, guardian or person in the place of a parent of a minor, or the guardian of an individual adjudicated incompetent may, after having gained access to treatment records, challenge the **accuracy, completeness, timeliness, or relevance of factual information** in his or her treatment records and **request in writing** that the facility maintaining the record **correct the challenged information**. The request shall be **granted or denied within 30 days** by the director of the treatment facility, the director of the county department under s. 51.42 or 51.437, or the secretary depending upon which person has custody of the record. Reasons for denial of the requested changes shall be given by the responsible officer and the individual shall be informed of any applicable grievance procedure or court review procedure. If the request is denied, the individual, parent, guardian or person in the place of a parent shall be allowed to **insert into the record a statement correcting or amending the information at issue**. The statement shall become a part of the record and shall be released whenever the information at issue is released." § 51.30(4)(f), Wis. Stats. [Emphasis added.]

"(a) Correction of factual information in treatment records **may be requested by** persons authorized under s. 51.30(4)(f), Stats., or by an attorney representing any of those persons. Any requests, corrections or denial of corrections shall be in accordance with s. 51.30(4)(f), Stats., and this section.

(b) A written request shall **specify the information to be corrected and the reason for correction** and shall be entered as part of the treatment record until the requested correction is made or until the requester asks that the request be removed from the record.

(c) **During the period that the request is being reviewed**, any release of the challenged information shall include a copy of the information change request.

(d) If the request is **granted**, the treatment record shall be **immediately corrected** in accordance with the request. Challenged information that is determined to be completely **false**, **irrelevant or untimely** shall be **marked through and specified as incorrect**.

(e) If the request is **granted**, **notice of the correction** shall be sent to the person who made the request and, upon his or her request, to any specified past recipient of the incorrect information.

(f) If investigation **casts doubt** upon the accuracy, timeliness or relevance of the challenged information, but a **clear determination cannot be made**, the responsible officer shall set forth **in writing** his or her doubts and both the challenge and the expression of doubt shall **become part of the record** and shall be included whenever the questionable information is released.

(g) If the request is **denied**, the denial shall be made **in writing** and shall include **notice to the person** that he or she has a right to **insert a statement in the record** disputing the accuracy or completeness of the challenged information included in the record.

(h) Statements in a treatment record which render a diagnosis are deemed to be **judgments based on professional expertise** and are **not open to challenge**."

DHS 92.05(5), Wis. Admin. Code [Emphasis added.]

[NOTE: The federal **Health Information Portability and Accountability Act of 1996** (**HIPAA**) went into effect April 14, 2003. That act contains provisions concerning correction of records that affect or may supercede state law. Level III and IV grievance decisions issued concerning issues that arose prior to that date do not take into account HIPAA standards. The HIPAA standards are:

"(1)... An individual has the right to have a [service provider] **amend** protected health information or a **record** about the individual in a designated record set for as long as the protected health information is maintained in the designated record set.

(2) ...A [facility] **may deny** an individual's **request for amendment**, if it determines that the protected health information or record that is the subject of the request:

(i) Was **not created** by the [service provider], unless the individual provides a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment;

(ii) **Is not** part of the designated **record** set;

(iii) Would **not be available** for **inspection** under [other provisions]; or

(iv) Is **accurate** and **complete**."

45 CFR 164.526(a) [Emphasis added.]

DECISIONS

1. A client **objected to an entry** in her chart which raised the possibility that the client was **stalking her therapist**. She was informed of her **right to enter a correction** of information into the treatment record per § 51.30(4)(f), Stats. She did enter an addendum in the record and it is now attached to the reference about possible stalking concerns and will be released whenever the related record is released. This was the **appropriate remedy** for her objection. (Level III Grievance Decision in Case No. 04-SGE-07, affirmed at Level IV on 8/15/05)

2. An outpatient client **disagreed with** her therapist assigning her an Axis II Borderline Personality Disorder **diagnosis**. A diagnosis is ultimately a professional opinion and given “due deference”. However, the professional opinion of the therapist did not take into account the physiological factors that the client later became aware of, post-

therapy. It was **recommended** that she **submit a clarification** of her treatment record that included her experiences and the m**edical information** from her **physician**. (Level III Grievance Decision in Case No. 05-SGE-12 on 5/16/06)

3. A discharged patient complained about the **accuracy of his treatment records**. An **addendum was added** to his records by the same doctor who saw him originally. **He was not satisfied** with the addendum and grieved the matter. In the response to his appeal to Level IV, the **provider recommended that he submit a "Statement of Disagreement" setting forth his own version for the treatment records**. Copies of that statement would be disclosed simultaneously with any subsequent release of his records. **That is the appropriate remedy** for a disagreement about the contents of treatment records and is consistent with Sec. 51.30(4)(f), Wis. Stats., DHS 92.05(5), Admin. Code, and federal HIPAA rules. (Level IV decision in Case No. 09-SGE-01 on 8/19/09)

4. A client **complained about the evaluation** she received at a clinic. She **wanted the results of the evaluation removed** from records because of the state of mind she was in at the time of the evaluation. She argued that the result of the assessment were harmful to her in the past and continued to harm her relationship with her current physician. **The remedy available to challenge record inaccuracies was set by the Legislatur**e in ss. 51(30)(4)(f), Stats. The accompanying **right to insert ones own version of the facts** into one's records offers **an appropriate solution** for those who disagree with their records. That process is legally adequate to remedy any perceived errors in the records. (Level IV decision in Case No. 10-SGE-02 on 10/19/10)

5. **Documents will not be removed from records under any circumstances**, **even if flawed.** The appropriate **remedy**, if one was necessary, **would be for the client to include a clarifying document in the records** referring to the original document and stating what the client felt was wrong with it. The **client's version of the facts will be released** along with the client's records to anyone who has the client's consent to obtain copies of those records or to anyone who is exempt under the consent provisions under law. (Level IV decision in Case No. 10-SGE-02 on 10/19/10)

6. If a client feels that there are inaccuracies in her treatment record, she **can prepare a narrative** and have that **placed in her records**. It will be released along with any future releases of records that occur. However, **she cannot undo her diagnosis.** (Level III decision in Case No. 09-SGE-05 on 3/04/11)

7. An ex-patient **felt that her records inaccurately reflected her behavior.** A **rights violation could not be found without a showing of inaccuracies that affected her current treatment.** She **had the right to add any information to her treatment file** that she felt was necessary to accurately depict her status. Her right to inspect, copy or challenge her confidential medical records was not violated. (Level III decision in Case No. 11-SGE-01 on 6/28/11)

8. A patient challenged her medical record. The provider **initiated a medical record amendment process**. Her doctor found her records to be accurate and complete. **Two addenda were added** to her record with clarifications. These addenda show that the provider did allow her to challenge the accuracy of her record and properly considered each of her challenges. Therefore, **her right to challenge her records was respected.** (Level III decision in Case No. Case No. 11-SGE-07 on 06/22/12)

9. Doctors have **discretion to speculate** as to the reasons for a patient's symptoms **without having to match them to the patient's own speculations**. (Level III decision in Case No. Case No. 11-SGE-07 on 06/22/12)

10. A patient had several complaints that stemmed from her alleged misdiagnosis by one of the provider's doctors. The patient was diagnosed with bi-polar II, which allegedly caused severe problems in her life. The patient alleged that her medical record had not been adequately changed to reflect the correct diagnosis. It was held that removing items from records would leave blank gaps and corrupt the record. **The word "amend" in the context of a patient's treatment record means "add" not "change."** The accepted method is to add to records, not delete from them. **The provider added second opinions that differed from the bipolar diagnosis to the patient's treatment record. There was no violation of the patient's right to challenge her treatment record. (**Level III decision in 12-SGE-0006 decided on 11/14/2012)

11. A patient claimed that her former therapist **lied in her progress notes**. The provider denied her challenge and offered to **add the grievant's desired amendments to the record as a means of resolving her concerns and did so, even though the grievant indicated that inclusion of her amendments would not assuage her concerns**. No violation of the patient's right to challenge the accuracy of her records was found. **(**Level III decision in Case No. 16-SGE-03 on 11/3/2016)

12. A patient claimed that a provider lied in her treatment record to avoid potential liability. Evidence showed that the **patient did not submit a written request to challenge her treatment records**. Further, she was allowed to two addendums to the record to challenge items that she considered inaccurate or deceptive. **Disputed items in treatment records are not rights violations even if the record does in fact contain an error. The violation would occur if the client were not allowed the opportunity to challenge something in her treatment record.** Although intentionally falsifying a treatment record may be a violation of the client's rights, any claim that the provider included lies in her record to avoid liability would have to be supported by more than statements made by the grievant. Since the patient was provided the opportunity to challenge her treatment record and since she could not provide any evidence that the record was intentionally falsified there was no violation of the client's rights. (Level III decision in Case No. 16-SGE-04 on 4/20/2017)

13. A patient challenged the accuracy of her treatment records. Provider refused to change the records to accommodate patient's desires, however facility offered patient the opportunity to add and addendum to the record. Since there is **no requirement to change treatment records to suit a patient's view of events** there was no violation of the patient's right to challenge the accuracy of the records under these facts. (Level III decision in Case No. 16-SGE-08 on 5/26/2017)

14. A patient complained that the facility violated his client rights when he was provided with treatment which he and previously refused; was diagnosed and treated incorrectly; and was lied to by the provider. The Level III Decision concluded that **the grievant's right to challenge his record was violated because the provider did not adequately explain the process of how to challenge one's treatment record. The provider explained that he could amend his record, but did not explain or allow him to challenge his record.** The Level IV Decision concluded that the Level III Decision was reasonably based in fact and law and was upheld. (Level III and IV Decision, Case No. 17-SGE-04)

15. A patient's guardian had an appointment with a Behavioral Health Consultant to discuss strategies for communicating to the patient their family dynamics. A progress note from the consultation was created, and the guardian **requested to correct the progress note as she did not think it accurately reflected what was discussed during the appointment. The provider accepted the changes, however, the guardian then wanted the progress note to be removed altogether. Because the appointment did occur, the note is unable to be removed entirely, as the provider is required to document all services provided**. There was no violation of the patient's right. (Level III grievance decision in Case No. 21-SGE-01)

16. A patient claimed that information in the **discharge summary was inaccurate**. The statement was taken from an assessment summary which was written by a Licensed Clinical Social Worker that had been working with the patient for many months. The **grievant also signed the assessment summary after it was written.** There was no violation of the patient's right to complete and accurate information. (Level III decision in Case No. 21-SGE-04)

17. The grievant **alleged that staff at the provider had falsified and/or tampered with her records. The allegations were unable to be substantiated.** The grievant was reminded that if she continues to dispute the content of her records, there is a process to request a correction of her records with the provider, as described in Wisconsin DHS Administrative Code 92.05. The grievant was further reminded that if the facility denied her request for correction, she has the right to request that they insert a statement from her in the record disputing the accuracy or completeness of the challenged information included in the record. (Level III Grievance Decision in Case Number 24-SGE-00273).

[See: “Introduction to Digest-Date Last Updated” page]