Case Closed: Tracking Test Results

Missed or delayed diagnosis is a top claim received by SVMIC. A well-established tracking system for lab and diagnostic test results is essential in avoiding these scenarios. A patient may fall through the cracks if an abnormal test result fails to return, or is scanned into the EHR without provider review and follow-up.

Tracking procedures should be simple and organized, and staff should be trained and accountable for accurately maintaining the system. The most common systems used include EHR task systems, logbooks, tickler files, and scheduling of follow-up appointments. **Tracking by scheduling follow-up appointments will only work if staff is diligent in tracking all no shows and cancellations.** In addition, a manual tracking system will be necessary for results from labs or facilities that do not interface with the EHR.

Consider the following closed SVMIC claims:

CASE 1

A 37 year old male, being treated by his primary care provider for hypertension, was diagnosed with elevated BUN and creatinine levels. A renal ultrasound and MRA of kidneys were ordered and scheduled by office staff. The physician documented his plan to refer the patient to a nephrologist once test results were returned. The ultrasound results were read as normal. The MRA results did not return, as the patient never went to the scheduled appointment. There was no further follow-up by the office staff. The patient was diagnosed with end stage renal failure by another provider five months later and was placed on a transplant list. A lawsuit followed in which SVMIC paid a substantial loss. **The failure to have a "safety net" tracking system, to alert the physician that results had not returned, made the lawsuit indefensible.**

CASE 2

A 68-year-old male was being treated for hypertension. During one of the office visits, his provider detected a carotid bruit and ordered a Carotid Doppler study. The Doppler study revealed 80% stenosis. Upon receipt of the Doppler study, staff scanned it into the medical record without forwarding it to the physician for his review. The results revealed 80% carotid stenosis and the patient was not notified. One year later, the patient suffered a stroke. In deposition, the patient stated he asked about the results during a follow-up office visit and was told that all test results were normal. The patient understood this to mean that the Doppler results were normal. **The failure to review and follow-up on abnormal test results made the lawsuit indefensible.**

CASE 3

A 57 year old male patient underwent a hip arthroplasty complicated by early dislocation and the need for further surgery (closed reduction and revision arthroplasty). During physical therapy, wound drainage was noted and a culture was ordered. The results were positive, and the surgeon reviewed the results, however, decided to order additional testing before treating the patient. The patient was never informed of the test results, and the surgeon never documented his rationale for not instituting antibiotic therapy. The patient experienced post-op pain for five months before a diagnosis of infection was made and the infected implant was removed. Despite a successful second hip implant, the patient demanded restitution for medical expenses, pain and suffering. **The failure to follow-up on abnormal test results made the lawsuit indefensible.**

Once the provider orders a lab or diagnostic test, he/she has a duty to follow-up on the results appropriately. If a single tracking system is consistently used for all providers, the risk of losing important tests or follow-ups is significantly reduced.

There should be a consistent method for notifying patients of ALL test results and instructing them to call the office if they have not received the results within the expected time frame. These instructions should be documented in the medical record. Although instructing the patient to call for test results does not absolve the doctor of the duty to inform the patient, it does act as a safety net to ensure that important test results are not overlooked and is a legitimate means of vesting the patient in his/her own healthcare. The provider, rather than a staff member, should give abnormal results with potentially serious or unanticipated consequences to the patient. Take the time to document all calls in which clinical information is exchanged, including who you spoke with and what information/ instructions were given.

Surgeons and other physicians performing invasive procedures are responsible for the review of pre-operative lab work, diagnostic tests and medical clearance consults, regardless of who orders them. Keep in mind, providers are also responsible for tests they order in a hospital setting, including intraoperative pathology. Offices should have a tracking system in place to ensure hospital pathology reports are received and reviewed by the provider. It is **NOT** safe for the staff to assume the provider has already seen hospital test results.

For more information about tracking systems, contact Risk Evaluation Services at 1-800-342-2239.