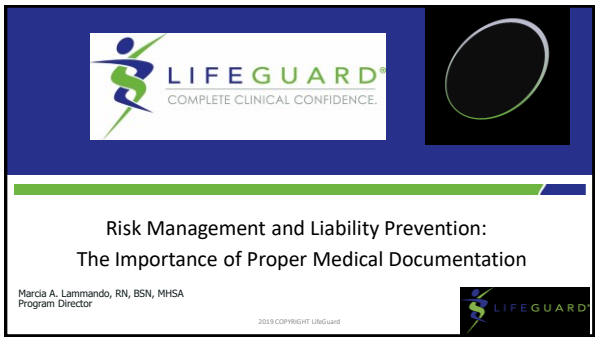
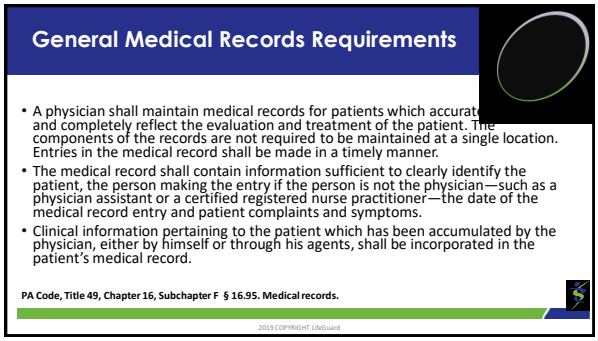
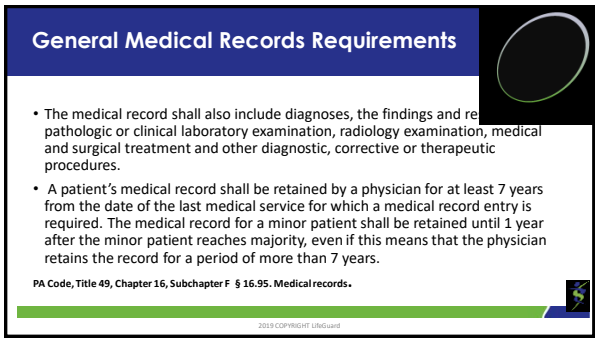

LIFEGUARD
COMPLETE CLINICAL CONFIDENCE.
Risk Management and Liability Prevention:
The Importance of Proper Medical Documentation
Marcia A. Lammando, RN, BSN, MHSA
Program Director
2019 COPYRIGHT LifeGuard
LIFEGUARD

1


General Medical Records Requirements
• A physician shall maintain medical records for patients which accurately and completely reflect the evaluation and treatment of the patient. The components of the records are not required to be maintained at a single location. Entries in the medical record shall be made in a timely manner.
• The medical record shall contain information sufficient to clearly identify the patient, the person making the entry if the person is not the physician—such as a physician assistant or a certified registered nurse practitioner—the date of the medical record entry and patient complaints and symptoms.
• Clinical information pertaining to the patient which has been accumulated by the physician, either by himself or through his agents, shall be incorporated in the patient's medical record.
PA Code, Title 49, Chapter 16, Subchapter F § 16.95. Medical records.
2019 COPYRIGHT LifeGuard

2


General Medical Records Requirements
• The medical record shall also include diagnoses, the findings and results of pathologic or clinical laboratory examination, radiology examination, medical and surgical treatment and other diagnostic, corrective or therapeutic procedures.
• A patient's medical record shall be retained by a physician for at least 7 years from the date of the last medical service for which a medical record entry is required. The medical record for a minor patient shall be retained until 1 year after the minor patient reaches majority, even if this means that the physician retains the record for a period of more than 7 years.
PA Code, Title 49, Chapter 16, Subchapter F § 16.95. Medical records.
2019 COPYRIGHT LifeGuard

3

Specific Medical Records Requirements

Medical records. Accurate and complete medical records must the evaluation and care received by patients.

(i) On the initial occasion when a drug is prescribed, administered or dispensed to a patient, the medical record must include the following:

(A) A specification of the symptoms observed by the licensed health care provider and reported by the patient.
(B) The diagnosis of the condition for which the drug is being given.
(C) The directions given to the patient for the use of the drug.
(D) The name, strength and quantity of the drug and the date on which the drug was prescribed, administered or dispensed

PA Code, Title 49, Chapter 16, Subchapter F § 16.92.(4)(I, A-D) Prescribing, Administration and Dispensing

4

What is a "Medical Record"

- Records pertinent facts, enables planning and evaluatio treatment
- Enhances communication between professionals:
  - ✓assuring continuity of care
  - ✓decrease medical error
  - ✓Increasing patient safety
- Assists communication with third parties (legal, regulatory, research)

5

Patient's Medical Record

- Like a police report in an auto accident case, your patie will be the center of attention in a medical liability case. Well kept records will act as an effective **SHIELD** to liability. They will protect you and show you met the standard of care.
- However, poorly kept records are likely to be used as a **SWORD** or weapon against you as evidence of your failure to comply with the minimum standard of care.

6

Medical Record as a "SHIELD"

- Well maintained medical records will shield you from liability and provide key evidence that you met the applicable standard of medical care
- Hopefully, your patient's chart will be "Exhibit A" used by your defense attorney to keep you out of trouble

EXAMPLES

1. Allergic reaction — a detailed patient history with documentation of known allergies and reactions will shield you from allegation you gave a drug to which the patient had an allergy
2. Failure to order diagnostic test — documentation of diagnostic testing recommended to the patient by you will protect you from allegations that you failed to order same. (If you feel an MRI is needed and patient is unwilling, document that fact.)

7

Other "SHIELDS"

- Written policies and procedures
- Documented protocols
- Self-assessment/audit and internal monitoring
- Staff and provider education related to medical record documentation

8

Medical Record as a "SWORD"

- Poorly kept records can be used as a weapon against y in a medical liability claim
- The last thing you want to see is your own records listed by the Plaintiff's attorney as "Exhibit A" in their case against you

EXAMPLES

1. Failure to diagnose breast cancer case—issue of whether breast exam was done (not charted = not done)
2. Failure to notify patient of lab results—issue of whether patient was made aware of significant lab results (not charted=not done)

9

Other "SWORDS"

- No policies/procedures/protocols
- Documentation that lacks an assessment or an incomplete assessment
- Incomplete notes
- Unrelated treatment ordered/prescribed
- Utilizing the same list of diagnoses for every patient

10

2 Types of "Medical Records"

11

Designated Record Set

HIPAA Privacy Rule defined the Designated Record Set (DR
group of records maintained by or for a covered entity that is:

- ✓The Medical Records & Billing Records of a patient/individuals for a covered entity
- ✓Enrollment, payment, claims adjudication, and case or medical management records systems maintained by a Health Plan
- ✓Used by the covered entity to make decisions about patients/individuals, in whole or in part

CFR 164.501

12

Legal Health Record

- The legal health record serves to:
  - ✓Support the decisions made in a patient's care
  - ✓Support the revenue sought from third-party payers
  - ✓Document the services provided as legal testimony regarding the patient's illness or injury, response to treatment, and caregiver decisions
  - ✓Serve as the organization's business and legal record
- The legal health record is typically used when responding to formal requests for information for evidentiary purposes. It does not affect the discoverability of other information held by the organization.

13

How to Avoid Red Flags (BE ABLE TO DEMONSTRATE ON DEMAND)

Clinical	Administrative	Regulatory
Minimum content	Medical Record Organization	Coordination of Care
Strong Provider Involvement	Ease of Retrieving Records	Handling of Confidential Information

14

Minimum Documentation

EACH PATIENT ENCOUNTER should include

- The reason for the encounter
- Office Visit
  - Relevant history – include med REVIEW and appropriate health risk factors
  - Physical exam findings (BMI?)
  - Prior diagnostic test results
  - Assessment / clinical impressions/diagnosis
  - Plan for care
  - Date/Time/ legible identity of observer
- Hospital visit
  - Patient's progress, response to and changes in treatment (revised diagnosis?)
  - CPT and ICD9-CM codes on health insurance claim form should be supported by this documentation

15

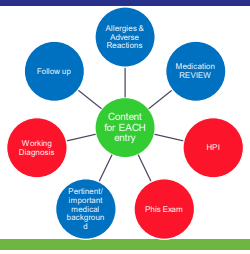
Documentation Standards

- Additional Standards for Primary Care Physicians
  - Vital Signs at every encounter, including BMI
  - Problem list
  - Complete medical information/medication reconciliation
  - Ongoing tracking (of condition, of meds, etc.)
  - Consultation review
  - Immunization
  - Preventive Health

16

Documentation Standards

- RED = must be done by provider



17

Procedural Reports

- Full note written immediately after….or
- Dictated immediately after procedure with a short handwritten note immediately
  - Names of procedural provider & any assistant
  - Name of the procedure(s) performed
  - Description of the procedures (steps)
    - The only element not required on the short note
  - Findings at surgery
  - Estimated blood loss
  - Specimens removed (and disposition)
  - Post procedure diagnosis & patient condition

18

How to Avoid Red Flags (BE ABLE TO DEMONSTRATE ON DEMAND)

Clinical	Administrative	Regulatory
Minimum content	Medical Record Organization	Coordination of Care
Required Provider Involvement	Ease of Retrieving Records	Handling of Confidential Information

19

Documentation Standards

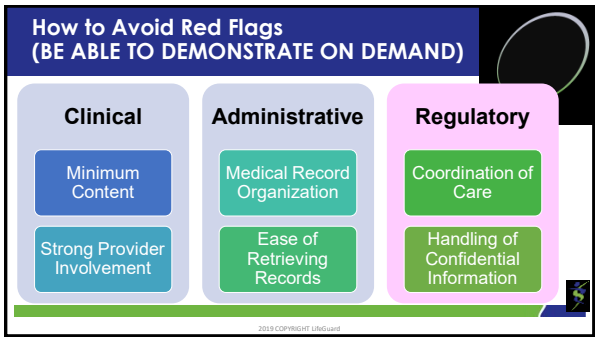
- Medical Record Organization
  - Patient identification
  - Separate records for each patient (NOT FAMILIES)
  - Dated/timed
  - Clear identification for every treating practitioner (legible signature) on every entry
  - Data Integrity
  - Legibility

20

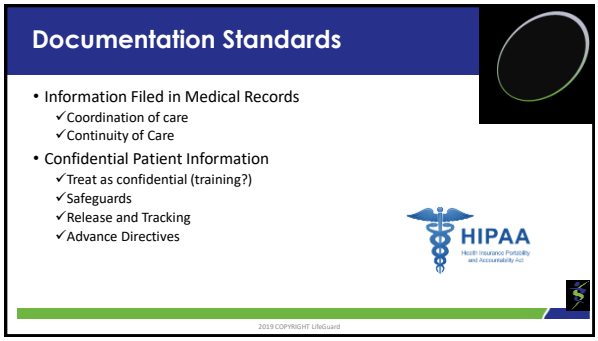
Documentation Standards

- Ease of Retrieving Medical Records
  - Identification
    - ✓retrieved in a timely manner
  - Systematic Storage
    - ✓NOT IN CAR TRUNK

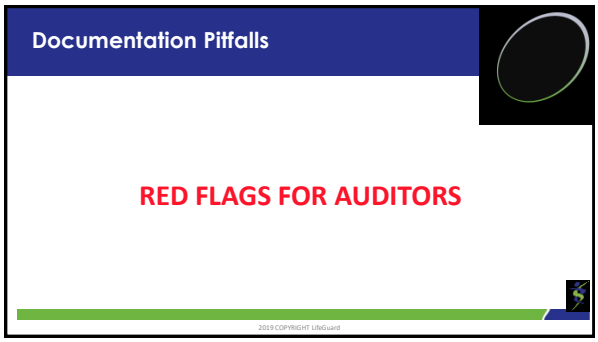
21


How to Avoid Red Flags
(BE ABLE TO DEMONSTRATE ON DEMAND)
Clinical
Minimum Content
Strong Provider Involvement
Administrative
Medical Record Organization
Ease of Retrieving Records
Regulatory
Coordination of Care
Handling of Confidential Information
2019 COPYRIGHT LifeGuard

22


Documentation Standards
• Information Filed in Medical Records
✓Coordination of care
✓Continuity of Care
• Confidential Patient Information
✓Treat as confidential (training?)
✓Safeguards
✓Release and Tracking
✓Advance Directives
HIPAA
Health Insurance Portability and Accountability Act
2019 COPYRIGHT LifeGuard

23


Documentation Pitfalls
RED FLAGS FOR AUDITORS
2019 COPYRIGHT LifeGuard

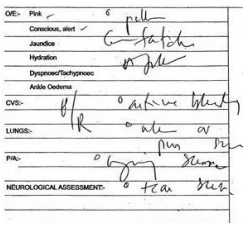
24

Red Flags for Auditors

- Not legible
- Late entries
  - Date and time it as the current date, not the date for which it is being corrected
- Different handwriting in the same entry (scribe or other staff) without authentication
- **NO CHART** for patients to whom you've prescribed medications – especially controlled substances
- Abbreviations that are not readily acceptable or understood

25

Legible????



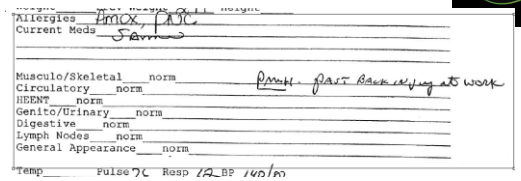
26

Red Flags for Auditors

- Documentation does not comply with guidelines, regulations or
- Lack of specificity or clarity
- Pre-printed forms and check boxes
  - ✓Still must add patient specific information
- Dictation Templates
  - ✓Be cautious if always using the default
- Inaccurate gender use
- Non-professional tone

27

Clear and Understandable???


Allergies Amox, PCN
Current Meds James

Musculo/Skeletal ___norm___ PMH: Past Back injury at work
Circulatory ___norm___
HEENT ___norm___
Genito/Urinary ___norm___
Digestive ___norm___
Lymph Nodes ___norm___
General Appearance ___norm___

Temp ___ Pulse 72 Resp 12 BP 140/80

28

E.M.R.
Red Flags for Auditors

- Copy and paste
  - Leaves electronic tag, implies no patient specificity
- E.M.R. macro's
  - Patient specific information
- "Tailgating"
- Lack of training/lack of updated education
- Delay in documentation

29

E.H.R.
Red Flags for Auditors

- Incorrect selection of templates (i.e., selection of "New Patient" template for an established patient or vice-versa)
- Selection of a "follow-up" exam without specifically indicating the true "chief complaint"
- Contradictory documentation between areas such as: HPI, ROS, exam components
- Typographical or "nonsensical" documentation

30

EHR Copy and Pasting (CLONING)

The potential risks associated include:

- Incorrect information may impact patient care
- Documentation of services provided when in fact they were not - upcoding
- Discrepancies in information leading to confusion
- Patient's condition not updated
- Decline in accuracy if careful review and update of information is not performed
- Incorrect information/treatment protocols could result in injury to the patient (even death)
- Pertinent aspect of patient safety

31

Documentation Opportunities

RISK REDUCTION

32

Risk Reduction Practices

- Organize charts
- Avoid sticky notes
- Use a running problem list – update it / review it / resolution
- Do not use "dictated but not read" stamp; Don't use STAMPS at all
- Initial or sign outside documents as evidence of your review
  - ✓not part of your legal record unless you review
- Provide detailed management/treatment plan

33

Risk Reduction Practices

- Fill in or void spaces on forms
- Avoid cross outs, write-overs
- Corrections
  - ✓ draw a single line, write "error" above the entry with date and initial
  - ✓Do not obliterate entry / scratch out/ white out
- Dispense education materials and document, especially drug education
- Provide the REASON for the test, med, etc.....
- Avoid risk management comments

34

Risk Reduction Practices

- Late Entry
  - ✓ written as 'addendum" and reflect date and time the entry was made, not when it was supposed to be made, (explain why it was late)
- Use a medication reconciliation process
  - ✓All prescriptions and dates of refills/discontinued medications
  - ✓Even list drugs that you are not prescribing
  - ✓Avoid global statements like "renew meds"
- Resolve medical problems reported on prior visits, keep a running list with dates and initials of who reviewed the problem on that date
  - ✓To be able to bill for it, the provider must review it

35

Risk Reduction Practices

- Supplement narrative text with line drawings, diagrams
- Document informed refusal discussion as well as informed consent discussions
- Document patient non-compliance in progress record
- Include positive and negatives from patient's H&P
- Document return visit advice and did not keep appointments
- Avoid criticism of other professionals in chart notes

36

Risk Reduction Practices

- Use a medication control record
  - All prescriptions and dates of refills
  - Even list drugs that you are not prescribing
  - Avoid global statements like "renew meds"
- Resolve medical problems reported on prior visits, keep a running list with dates and initials of who reviewed the problem on that date
  - To be able to bill for it, the provider must review it

37

Risk Reduction Practices

SCRIBES

- Physician must be physically with them, must be clinically appropriate to use scribe
- Their entry should include notation that:

"<name of scribe> is working for, and in the presence of <physician name> " with the scribe's signature date and time

- Physician should sign each entry with:

"I, <physician name> personally performed the services describe in this documentation as scribed by <name of scribe>, and it is both accurate and complete" with physician signature, date and time

38

Risk Reduction Practices

POLICIES AND PROCEDURES

- Ensure that all policies and procedures are consistent with your practice
- Review annual and update as needed
- Document updates and archive old policies
- Maintain old policies electronically for legal purposes

39

Risk Reduction Practices

GUIDELINES, STANDARDS, LAWS AND STATUTES

- Be informed of all information pertaining to medical records documentation
  - ✓Ignorance is not a defense
- Educate other providers and staff related documentation obligations and requirements
  - ✓Document the education as well – may be a life-saver at some point

40

Who is Watching You?

41

Audit Risks- Who is Watching!

- Federal (CMS) – conditions of participation
  - MACs, RACs , ZPICs
- State (WC, Medicaid)
- Third party – e.g. Highmark, BC – med necessity
  - ASK FOR THEIR BILLING MANUAL
- Accrediting agencies
- Organizational Bylaws
  - Rules about how soon a medical record must be completed , what constitutes a post op note

42

Others Who are watching

- Office of Inspector General
  - ✓improves HHS programs and protects them against fraud, waste, and a
- Licensing boards
- State Attorney Generals
- Health Departments
- Med Mal carriers
- Payers

43

Conclusions

If it is **NOT** documented, → then it did **NOT** happen

If it **CANNOT** be understood, → then it did **NOT** happen

If it **CANNOT** be read, → then it did **NOT** happen

44

Questions and Answers

Thank you!

www.LifeGuardProgram.com

mlammando@lifeguardprogram.com
(717) 909-2590
(717) 558-7864

LIFEGUARD
COMPLETE CLINICAL CONFIDENCE

45

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Medical Documentation Issues in Administrative Proceedings

Maria Battista, J.D., Ed.D.
September 14, 2019

46

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Regulations - Medical Documentation

Pennsylvania Board of Medicine — **49 Pa. Code § 16.95. Medical records**

Pennsylvania Board of Osteopathic Medicine — **49 Pa. Code § 25.213. Medical records**

47

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Medical Board

A physician shall maintain medical records for patients which accurately, legibly and completely reflect the evaluation and treatment of the patient. The components of the records are not required to be maintained at a single location. Entries in the medical record shall be made in a timely manner.
49 Pa. Code § 16.95(a).

Osteopathic Medical Board

A medical record shall be maintained for each patient, identifying the patient, the person making the entry, the date of each contact, pertinent clinical information, diagnoses, findings, laboratory results and other diagnostic, corrective or therapeutic procedures, including prescription drug orders, arising out of the licensee's care of the patient.
49 Pa. Code § 25.213(a).

48

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Medical Board

(b) The medical record shall contain information sufficient to clearly identify the patient, the person making the entry if the person is not the physician—such as a physician assistant or a certified registered nurse practitioner—the date of the medical record entry and patient complaints and symptoms.

(c) Clinical information pertaining to the patient which has been accumulated by the physician, either by himself or through his agents, shall be incorporated in the patient's medical record.

(d) The medical record shall also include diagnoses, the findings and results of pathologic or clinical laboratory examination, radiology examination, medical and surgical treatment and other diagnostic, corrective or therapeutic procedures.

49 Pa. Code § 16.95(b), (c), and (d).

49

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Medical Board

Regulation: **49 Pa. Code § 16.92. Prescribing, administering and dispensing.**

***

(b) When prescribing, administering or dispensing drugs regulated under this section, a person licensed to practice medicine and surgery in this Commonwealth or otherwise licensed or regulated by the Board **shall carry out, or cause to be carried out, the following minimum standards**:

(1) Initial medical history and physical examination. An initial medical history shall be taken and an initial physical examination shall be conducted unless emergency circumstances justify otherwise…

50

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Medical Board

(2) Reevaluations. Reevaluations of the patient's condition and efficacy of the drug therapy shall be made consistent with the condition diagnosed, the drug or drugs involved, expected results and possible side effects.

***

(4) Medical records. Accurate and complete medical records must document the evaluation and care received by patients.

(i) On the initial occasion when a drug is prescribed, administered or dispensed to a patient, the medical record must include the following:

(A) A specification of the symptoms observed by the licensed health care provider and reported by the patient.

(B) The diagnosis of the condition for which the drug is being given.

(C) The directions given to the patient for the use of the drug.

(D) The name, strength and quantity of the drug and the date on which the drug was prescribed, administered or dispensed.

(ii) After the initial occasion when a drug is prescribed, administered or dispensed, the medical record must include the information required in subsection (b)(4)(i)(D) and changes or additions to the information recorded under subsection (b)(4)(i)(A)—(C).

49 Pa. Code § 16.92(b)(2), (4).

51

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Standard of Care

Pennsylvania Board of Medicine → **63 P.S. § 422.41(8)**

Pennsylvania Board of Osteopathic Medicine → **63 P.S. § 271.15(a)(8)**

52

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Medical Board

(8) Being guilty of immoral or ***unprofessional conduct***. Unprofessional conduct shall include departure from or failing to conform to an ethical or ***quality standard*** of the profession. In proceedings based on this paragraph, actual injury to a patient need not be established.

63 P.S. § 422.41(8).

Osteopathic Medical Board

(8) Being guilty of immoral or ***unprofessional conduct***. Unprofessional conduct shall include ***any*** departure from, or the failure to conform to, the ***standards*** of acceptable and prevailing osteopathic medical practice. Actual injury to a patient need not be established.

63 P.S. § 271.15(a)(8).

53

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Medical Board

Section 41(8)(ii) – Further defines deviating from quality standard

A practitioner departs from, or fails to conform to, a **quality standard** of the profession when the practitioner provides a ***medical service at a level beneath the accepted standard of care***. The board may promulgate regulations which define the accepted standard of care. In the event the board has not promulgated an applicable regulation, the accepted standard of care for a practitioner is that which would be normally exercised by the average professional of the same kind in this Commonwealth under the circumstances, including locality and whether the practitioner is or purports to be a specialist in the area.

63 P.S. § 422.41(8)(ii).

54

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Board of Medicine

Violating a lawful regulation

Medical Record regulation or other

unprofessional conduct

departure from or failing to conform to

quality standard of the profession

aph,

63 P.S. § 422.41(6), (8).

55

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Board of Osteopathic Medicine

Violating a regulation

Medical Record regulation

unprofessional conduct

any departure from, or the failure to conform to, the *standards* of acceptable and prevailing osteopathic medical practice

63 P.S. § 271.15(a)(6), (8).

56

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Department of State/Prosecutor

1. **Professional Compliance Office receives a tip, complaint or other.**
2. **Investigation by BEI investigator.**
3. **Prosecutor obtains medical records at issue.**
4. **Prosecutor sends medical records to an expert for review.**
5. **Prosecutor prepares Order to Show Cause, if warranted OR prepares Consent Agreement OR both.**

57

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Physician

1. Receives Order to Show Cause in mail*
2. Possibly panics, confused, upset or not sure what to do.
3. Possibly calls an attorney.
4. Decides how to respond.

*In some cases, physician or attorney for physician would receive a Consent Agreement to try to settle before OTSC issued.

58

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Order to Show Cause

1. Charging document.
2. Provides Notice to physician.
3. Outlines factual allegations.
4. Outlines alleged violations.
5. Advises of possible penalties.
6. Outlines procedures.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BEFORE THE STATE BOARD OF MEDICINE

Commonwealth of Pennsylvania
Bureau of Professional and
Occupational Affairs
vs.
M.D.,
Respondent

File No.: 16-49
Standard of Care

Docket No: -49-18

NOTICE

Formal disciplinary action has been filed against you. You may lose your license, certificate, registration or permit to practice your profession or occupation. You may be subject to civil penalties of up to $10,000 for each violation, and the imposition of costs of investigation.

If you wish to defend against the charges in the attached order to show cause or to present any matters in mitigation of penalty that may be imposed, the procedures for doing so are explained in the Order to Show Cause.

You have the right to retain an attorney. Although you may represent yourself without an attorney, you are advised to seek the help of an attorney. You also have the right to have an interpreter provided should you request one.

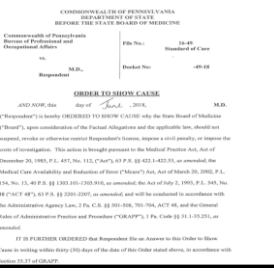
All proceedings are conducted under the Administrative Agency Law and the General Rules of Administrative Practice and Procedure.

You are directed to respond to the charges by filing a written answer within thirty (30) days of the date on the Order to Show Cause. IF YOU DO NOT FILE AN ANSWER, DISCIPLINARY ACTION MAY BE TAKEN AGAINST YOU WITHOUT A HEARING. To file your answer, you must bring or send an original and three (3) copies of your answer and any pleadings or

59

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Order to Show Cause



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BEFORE THE STATE BOARD OF MEDICINE

Commonwealth of Pennsylvania
Bureau of Professional and
Occupational Affairs
vs.
M.D.,
Respondent

File No.: 16-49
Standard of Care

Docket No: -49-18

ORDER TO SHOW CAUSE

AND NOW, this day of June, 2018, M.D. ("Respondent") is hereby ORDERED TO SHOW CAUSE why the State Board of Medicine ("Board"), upon consideration of the Factual Allegations and the applicable law, should not suspend, revoke or otherwise restrict Respondent's license, impose a civil penalty, or impose the costs of investigation. This action is brought pursuant to the Medical Practice Act, Act of December 20, 1985, P.L. 457, No. 112, ("Act"), 63 P.S. §§ 422.1-422.55, *as amended*; the Medical Care Availability and Reduction of Error ("Mcare") Act, Act of March 20, 2002, P.L. 154, No. 13, 40 P.S. §§ 1303.101-1303.910, *as amended*; the Act of July 2, 1993, P.L. 345, No. 48 ("ACT 48"), 63 P.S. §§ 2301-2397, *as amended*; and will be conducted in accordance with the Administrative Agency Law, 2 Pa. C.S. §§ 501-508, 701-704, ACT 48, and the General Rules of Administrative Practice and Procedure ("GRAPP"), 1 Pa. Code §§ 31.1-35.251, *as amended*.

IT IS FURTHER ORDERED that Respondent file an Answer to this Order to Show Cause in writing within forty (30) days of the date of this Order stated above, in accordance with Section 35.37 of GRAPP

60

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Order to Show Cause:

Factua

[redacted]

FACTUAL ALLEGATIONS

1. Respondent holds the following license to practice as a medical physicians and surgeon in the Commonwealth of Pennsylvania: license no.:

COUNT ONE

5. Paragraphs 1 through 4 are incorporated by reference.
6. Respondent practices medicine in the specialty of
7. On or about patient presented to the Respondent for an initial appointment.
8. Patient was a male patient.
9. Patient date of birth was

61

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Respondent did not document any pill counts in the medical record for patient ZZ.

Respondent never took a drug screen of patient ZZ until after the patient was arrested for selling pills.

Respondent's medical record prepared for patient ZZ did not document why Respondent added or changed medications for the patient.

Respondent did not document any urine drug screens in the medical record for patient ZZ.

Order to Show Cause
Factual Allegation Examples

Respondent did not document that he diagnosed Substance Use Disorder as a medical diagnosis for patient ZZ.

Respondent prescribed large dosages of opiate pills to patient ZZ without identifying the source of pain for patient ZZ.

Physical examinations and interim history noted by Respondent in the treatment record for patient ZZ were repeatedly scant in terms of questioning the patient on the level of pain.

1. Patient ZZ presented to Respondent early for opioid medication renewal on a regular basis.
2. Patient ZZ sometimes presented to Respondent weeks early for opiate medical renewal.
3. Respondent never noted in the treatment record for patient ZZ that he had questioned the patient regarding the actions referenced in paragraphs 1 and 2.

62

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Although no documented in the ED records for the treatment/services Patient received on May 25, 2012, Respondent avers that he questioned Patient two separate times while Patient was in the ED regarding his statements that he was having suicidal thoughts and/homicidal thoughts towards his wife. Specifically, Respondent avers the he asked Patient twice if he was still having suicidal or homicidal thoughts, and Patient stated "no" on each occasion.

Order to Show Cause
Factual Allegation Examples

The ED records for the treatment/services Patient received on May 25, 2012 do not identify that Respondent: performed any psychiatric examination on Patient, requested a psychiatric consult of Patient, referred Patient a for a psychiatric evaluation, and/or instructed him to seek counseling after his discharge.

Respondent's treatment of Patient departed from and/or failed to conform to a quality standard of the profession by providing a medical service at a level beneath the accepted standard of care and/or was performed in a negligent manner in that:

(1) Respondent failed to ensure that Patient's medical chart was accurate and complete;
(2) Respondent failed to appropriately evaluate Patient regarding his suicidal and homicidal statements, request a psychiatric consult of Patient, refer Patient for a psychiatric evaluation by another health professional, and/or instructed Patient to seek counseling after his discharge.

63

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Order to Show Cause
Factual Allegation Examples

21. At 0740, there was a change in LTV, now with decreased LTV; the contraction pattern represents a high frequency low amplitude pattern.

22. At 0835, the baseline changed to 150 BPM, with continued decreased LTV.

23. At 0908, a spontaneous deceleration was noted.

24. At 0950, a baseline change was noted, now at 160 BPM, with continued decreased LTV and the contraction pattern continued to be irregular.

64

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Medical Board

Order to Show Cause
Factual Allegation Examples

43. Respondent did not adhere to minimum standards for taking an initial medical history and physical examination when prescribing controlled substances to a patient, as outlined in Board regulations at 49 Pa. Code §16.92(b)(1).

44. Respondent did not adhere to minimum standards for reevaluations of efficacy of drug therapy when prescribing controlled substances to a patient, as outlined in Board regulations at 49 Pa. Code §16.92(b)(2).

45. Respondent did not adhere to minimum standards for preparing accurate and complete medical records with reference to evaluation and care when prescribing controlled substances to a patient, as outlined in Board regulations at 49 Pa. Code §16.92(b)(4).

65

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Medical Board

Order to Show Cause
Alleged Violation Example

46. Based upon the foregoing Factual Allegations, the Board is authorized to suspend or revoke, or otherwise restrict Respondent's license under Sections 41 and 42 of the Act, 63 P.S. §§ 422.41 & 422.42; or impose a civil penalty under Sections 39 through 42 of the Act, 63 P.S. §§ 422.39-422.42 and/or Section 5(b)(4) of ACT 48, 63 P.S. §2205(b)(4); and/or impose the costs of investigation under Section 5(b)(5) of ACT 48, 63 P.S. § 2205(b)(5), because Respondent violated Section 41(6) of the Act, 63 P.S. §422.41(6), in that Respondent was in violation of Board regulations at 49 Pa. Code §16.92 with regard to prescribing controlled substances to a patient.

66

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Medical Board

Order to Show Cause
Alleged Violation Example

41. Based upon the foregoing Factual Allegations, the Board is authorized to suspend or revoke, or otherwise restrict Respondent's license under Sections 41 and 42 of the Act, 63 P.S. §§ 422.41 & 422.42; or impose a civil penalty under Sections 39 through 42 of the Act, 63 P.S. §§ 422.39-422.42 and/or Section 5(b)(4) of ACT 48, 63 P.S. §2205(b)(4); and/or impose the costs of investigation under Section 5(b)(5) of ACT 48, 63 P.S. § 2205(b)(5), because Respondent violated Section 41(8) of the Act, 63 P.S. §422.41(8), in that Respondent departed from, or failed to conform to, a quality standard of the profession in which actual injury to a patient need not be established.

67

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Osteopathic Medical Board

Order to Show Cause
Alleged Violation Example

122. Based upon the foregoing Factual Allegations, the Board is authorized to suspend or revoke, or otherwise restrict Respondent's license, or impose a civil penalty under 63 P.S. §271.15(a)(6) and/or impose the costs of investigation under Section 5(b)(5) of Act 48, 63 P.S. §2205(b)(5), in that Respondent violated Board regulations regarding medical records at 49 Pa. Code §25.213(a) by failing to annotate pertinent clinical information in a patient's medical record.

68

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Osteopathic Medical Board

Order to Show Cause
Alleged Violation Example

149. Based upon the foregoing Factual Allegations, the Board is authorized to suspend or revoke, or otherwise restrict Respondent's license, or impose a civil penalty under 63 P.S. §271.15(a)(8) and/or impose the costs of investigation under Section 5(b)(5) of Act 48, 63 P.S. §2205(b)(5), in that Respondent departed from, or failed to conform to, standards of acceptable and prevailing osteopathic medical practice in regard to the prescribing of controlled substances by a family physician to a patient.

69

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Osteopathic Medical Board

Order to Show Cause
Alleged Violation Example

64. Based upon the foregoing Factual Allegations, the Board is authorized to suspend or revoke, or otherwise restrict Respondent's license, or impose a civil penalty under 63 P.S. §271.15(a)(6) and/or impose the costs of investigation under Section 5(b)(5) of Act 48, 63 P.S. §2205(b)(5), in that Respondent violated Board regulations regarding medical records at 49 Pa. Code §25.213(a) by failing to annotate pertinent clinical information in a patient's medical record.

70

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Osteopathic Medical Board

Order to Show Cause
Alleged Violation Example

61. Based upon the foregoing Factual Allegations, the Board is authorized to suspend or revoke, or otherwise restrict Respondent's license, or impose a civil penalty under 63 P.S. §271.15(a)(8) and/or impose the costs of investigation under Section 5(b)(5) of Act 48, 63 P.S. §2205(b)(5), in that Respondent departed from, or failed to conform to, standards of acceptable and prevailing osteopathic medical practice in regard to medical treatment provided by an OB/GYN to a obstetric patient.

71

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Penalties / Corrective Action

Medical Board

1. Public Reprimand
2. Probation of License
3. Suspension of License
4. Revocation of License
5. Civil Penalty up to $10,000 per violation
6. Submit to care, counseling or treatment of physician or psychologist
7. Refresher education courses
8. Cost of investigation
9. Voluntary surrender (not in statute)

63 P.S. § 422.39(b); 63 P.S. § 422.42(a); 63 P.S. § 2205(b)(4), (5) (ACT 48)

Osteopathic Medical Board

1. Public or Private Reprimand
2. Probation of License
3. Suspension of License
4. Revocation of License
5. Civil Penalty up to $10,000 per violation
6. Submit to care, counseling or treatment of physician
7. Continuing education courses
8. Cost of investigation
9. Voluntary surrender (not in statute)

63 P.S. § 271.11(c); 63 P.S. § 271.15(c); 63 P.S. § 2205(b)(4), (5) (Act 48).

72

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Example

Medical Board

SUMMARY: ER Doctor saw a patient in ER. ER doctor did not make proper notations of Patient's suicidal thoughts or refer Patient for further assessment. Patient leaves hospital and kills estranged wife and two daughters, sets his wife's residence and his residence on fire, and attempted suicide by lacerating both wrists. ER Doctor is charged in Order to Show Cause for departing from standard of care for failing to ensure that Patient's medical chart was accurate and complete, and for failing to appropriately evaluate Patient regarding his suicidal and homicidal statements, request a psychiatric consult of patient, refer Patient for a psychiatric evaluation by another health professional and/or instruct Patient to seek counseling after his discharge.

OUTCOME: Consent Agreement and Order (Settled with Prosecution). Within sixty (60) days of date of agreement, Respondent shall attend and successfully complete ten (10) hours of remedial education – 5 hours on topic of documentation and record keeping and 5 hours on topic of evaluation and treatment of patients who present with a mental health symptomology.

73

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Example

Medical Board

SUMMARY: Physician practices medicine in the specialty of internal medicine. Male patient was initially prescribed 60 tablets of Hydrocodone/Acetaminophen 7.5/750 mg. Shortly thereafter, physician prescribes Oxycodone to patient. Then, physician prescribes Morphine extended-release to patient. Physician increased Oxycodone dose to 30 mg tablets. Physician then prescribed Opana ER 40 twice daily. Physician prescribed a few other medications. Physician did not document any urine drug screens or pill counts or acknowledge added risk of Zolpidem to medication regimen of patient. Patient MRI only showed mild degenerative disease and no significant instability. Physician continued to prescribe controlled substances to patient in number, frequency and potency that was inappropriate in the clinical circumstance. Patient presented to physician with opioid withdrawal. Physician did not document that he diagnosed Substance Use Disorder as a medical diagnosis for Patient.

OUTCOME: Consent Agreement and Order (settled with Prosecution) $4,000 civil penalty and remedial education (24.5 credits) at Case Western Reserve University School of Medicine titled "Intensive Course in Controlled Substance Prescribing."

74

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Example

Osteopathic Medical Board

SUMMARY: Physician practices osteopathic medicine as a specialist in family medicine. Physician treated 7 patients between January 2007 through June 2008 with large quantities of various controlled substances. Physician failed to perform physical examination of several patients who were given a prescription for controlled substances. Physician failed to document justification on medical record of many patients of why he prescribed the controlled substances. Patients consistently renewed prescriptions prior to end of current prescription. Physician increased doses of controlled substances for patients and did not document pill counts, a narcotic agreement, or whether urine drug screens were provided.

OUTCOME: Initially – Consent Agreement & Order, 2012 (settled with Prosecution): $2,500 civil penalty and 31 hours of continuing education at Case Western Reserve University School of Medicine titled "Intensive Course in Controlled Substance Management." **Then**, hearing occurred related to another OTSC with other patients - case dismissed. **Current: Order of Temporary Suspension issued on December 27, 2017. Grand jury issued Indictment in criminal matter in U.S. District Court, Middle District of PA, on or about December 20, 2017.**

75

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Osteopathic Medical Board

Example

SUMMARY: Physician practiced osteopathic medicine as a specialist in obstetrics-gynecology. Patient presented to hospital when approximately 37 weeks pregnant. Patient placed on fetal monitor with baseline at 135 beats per minute (BPM). Appeared irregular contraction pattern. Baseline changed at different intervals to 150 BPM, 160 BMP, 165 BMP, 170 BMP, 180 BMP. During that period of time, contraction pattern clear and every 2 minutes. Accelerations, long-term variability, short-term variability, decelerations noted in records. Ampicillin ordered for GBS. Pitocin ordered to expedite delivery. Delivery occurred. Child found to have significant delays in speech. Alleged that physician failed to 1) identify a non-reassuring fetal heart rate tracing; 2) provide the requisite interventions to mange the non-reassuring fetal heartrate tracing; 3) identify chorioamnionitis as a possible etiology for fetal tachycardia; 4) empirically treat patient AB for presumed chorioamnionitis; 5) determine if Pitocin should have been utilized to expedite delivery despite a non-reassuring fetal heart pattern; and 6) properly manage the Pitocin by not adjusting the dose or discontinuing the drug despite tachystole and loss of short term variability. Also alleged that physician failed to create an entry in the medical record for patient AB reflecting a differential diagnosis for fetal tachycardia in violation of Board regulations at 49 Pa. Code § 25.213(a). Underlying civil action in matter.
OUTCOME: Order to Show Cause dismissed. In Proposed Adjudication, 297 findings of fact. Physician documented fetal tachycardia and addressed it, identified chorioamnionitis as a possible etiology for fetal tachycardia, responded appropriately to that consideration with GIBBs standard with delivery imminent, managed the Pitocin properly, and conformed to the standard of acceptable and prevailing osteopathic medicine by an OB/GYN to an obstetric patient in providing care to Patient.

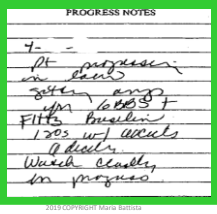
76

Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Osteopathic Medical Board

Example

Medical Record at issue in OB/GYN Case:


PROGRESS NOTES

77

Thank you!

Maria Battista, J.D., Ed.D.

mcbattista@gmail.com
814-221-3028

78

Questions & Answers

79