The "Significant Seven" Issues About Medical Charting and Diabetic Patients

Proper documentation is the key to protecting you.

BY LAWRENCE F. KOBAK, DPM, JD

Does treating diabetic patients pose challenges in charting? Diabetes is among the most common diagnoses seen in people who sue podiatrists. Treating diabetic patients, which almost all of us do, substantially increases our risk of being sued. All the obvious rules of charting apply. Certainly, do not change your chart, unless the change is dated, signed, and what is being changed is not blacked out or deleted. All entries should be contemporaneous. If the chart is handwritten, it should be legible. We are now ready for the "Significant Seven".

1. Peripheral Vascular Examination

The status of your diabetic patient's peripheral vascular circulation is the single most often probed area by the plaintiff's attorney in malpractice litigation. What was the status of the circulation when the patient first came to your office? Photographs can be very helpful. Today, you can use a digitally dated camera to take the photos.

In your records, as well as your examination, distinguish between small vessel and large vessel circulation. Capillary return, a rather simple test, is often only performed on the hallucis. It should be performed on all 10 lower extremity digits and the results should be recorded for all of them. If there was a loss of the third digit on the left foot, capillary return results on the left hallux will not be particularly helpful.

If any part of the lower extremities is particularly cold or warm to the touch, record it and its specific location. Attempt to correlate that result with other parts of your record. An obvious example is if a toe feels cold, looks blue, and has a delayed capillary return; another is if a warm area of the ankle has an odor and a purulent exudate. Your chart should tie the various findings together, not keep them in isolation, making others guess their potential significance.

As for the major arteries of the lower extremities, the pulses should be palpated, comparing one extremity with the other. "Palpable, regular, and equal" are not enough. The pulse in question could have been severely diminished, yet still be palpable, regular and equal! Use a grading system as to the strength of the pulse being palpated. Take a note of your patient's blood pressure. "Normal BP" is not enough. Comment on any trend up or down in the last few months.

Do not forget the peripheral venous system. Is there edema? Bilateral? Pitting? The various answers to these inquiries suggest differing diagnoses. Is the edema lateral or medial? Is the edema bilateral, suggesting a possible systemic origin? At what level?

Finally, do any of the areas of the lower extremities look "sick"? We have all seen that digit that looks like it is about to become gangrenous. Note it in the record. Refer appropriately. Note any referrals in your chart contemporaneously and the reason for the referral.

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2. Neurologic Examination

It is insufficient to simply note that a neurologic examination was performed and was found to be within normal limits. What was really examined? Be specific. What reflexes were tested? Were they equal bilaterally? On what part or parts of the body was the sharp dull test per-

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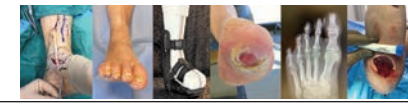

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formed? Same with the vibratory response. Are any areas of the lower extremities numb? Which areas? Mapping them would be an excellent idea so that you can later ascertain if areas of anesthesia or paresthesia have spread and by how much. See if this corresponds to times of greater elevation with your patient's blood glucose. Does neuropathic pain worsen upon standing, walking, or lying down? Note that in the chart. Does the pain or burning seem to be coming from the lower spine?

3. Dermatologic Examination

A thorough examination of the skin of the lower extremity is of the utmost importance in the diabetic patient. Often, there is a decubitus ulceration unknown to the patient, as the area is numb and not easily visible to the patient due to location or poor vision secondary to diabetic retinopathy. Any dermatologic abnormalities must be noted as to size and depth as well as location. Note the same from visit to visit. Record areas of dry skin, hypo- and hyper-pigmented skin. Note areas of erythema, edema, or cyanosis. Take photographs of pre-ulcerations, ulcerations, darkened areas due to hydrostatic pressure, irritated areas, and even "normal" base-line photographs of the extremities. Comment on the photos within the body of your records.

4. Biomechanical Examination

Remember that the biomechanics of a diabetic, due to peripheral neuropathy, may markedly differ from that of your other patients. However, do not assume it does. Test all the joints of the lower extremities for degenerative changes, crepitus, and range of motion. It is not enough to simply state reduced range of motion left foot. Which joint or joints have a reduced range of motion? How much is that motion reduced? Was pain elicited upon dorsiflexion? Plantarflexion? Inversion? Eversion? Abduction? Adduction? If there are hammertoes, are they flexible, semi-flexible or rigid? Is sufficient dorsiflexion available at the ankle? Is there any significant limb length discrepancy?

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An area often forgotten in your records is the subject of shoe wear patterns. Unless the patent is wearing new shoes, the shoe wear patterns act as a type of time-action video in recording how a person ambulates. Is there scuffing on the upper of a shoe? Is the lateral aspect of the heel worn out? Significant wearing down under the first metatarsal? Since all these findings, especially in a diabetic, could and should significantly affect your treatment plan, it should be recorded in your patient's podiatric medical record.

5. Primary Care Provider

Contact the patient's primary care provider as well as her endocrinologist. You must know what is and isn't being done by the healthcare providers that are responsible for treating their diabetes. Are they diet controlled? Insulin dependent? Has their dosage been going up? Exercise regimen? What about the patient's compliance with their diabetic doctor's treatment plan? What about YOUR compliance with their diabetic doctor's treatment plan? Record any correspondence or phone conversation with the patient's diabetic healthcare provider(s). Alert this physician of your findings. Cooperate with this physician to enhance your patient's care. If something about the physician's treatment plan is puzzling you or inconsistent with your findings and recommendations, bring it to their attention. You each might find it very enlightening. It may also have a very beneficial effect as to future referrals going both ways. Most important, your records of these physician contacts demonstrate that you, as the podiatrist, were aware of the "big picture" while treating your patient's feet and ankles.

Test results by themselves are not enough. Your chart should explain how a test's results will influence your treatment plan.

6. Consultations

It is important to refer diabetic patients for vascular evaluations. More than being good defensive medicine, it is good medicine. The vascular specialist will be happy to discuss his or her findings with you. Request the consult in writing, and why the patient needs a consult. Get the results of the consult in writing and place it in your records. If you are using electronic medical records, scan the consultation letter into your EHR.

With the patient's permission, obtain records from their nephrologist, if they have one. If the patient has "diabetic kidney disease", this can influence your prescriptions. Obtain records from their ophthalmologist. Know your patient, medically. Keep a copy of these records within your records. Comment in your chart about anything in these other records that you feel may be particularly relevant to your treatment of this patient. A last point… if your patient does not have a primary care provider treating their diabetes, refer them to a primary care provider or an endocrinologist. Note this in your records.

7. Test Results

Test results by themselves are not enough. Your chart should explain how a test's results will influence your treatment plan. If you have performed or obtained the re-

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sults of a peripheral arterial Doppler scan, or an x-ray, CT scan, or any other test, it is insufficient to simply keep a copy in the chart. Do not forget to perform culture and sensitivities if purulent exudate is seen. Make sure to note in the chart that the prescription you are writing is consistent with the C&S results. Never hesitate to biopsy when in any doubt. It is important to comment in the body of your patient notes on the test results and how the result will or will not change or modify your treatment plan. If the test you ordered or performed was of no relevance, it was not medically necessary!

When you order radiologic exams, be kind to the radiologist and let them know what you might be looking for. Do not hesitate to confer with the radiologist. Often, they will be quite pleased to talk to someone else as opposed to reading films all day. They may impart advice that is not readily apparent in their written report. Please note this conversation in your chart. The same advice goes for patients that you send to a vascular laboratory for testing.

Conclusion

Plaintiffs' attorneys use the deficiencies in the physician's records to hurt them in court. Most prefer records that are sparse, non-detailed, and with no rhyme or reason. The purpose for tests is not explained and the results of the tests and the significance of examination findings are ignored. The results of a treatment plan, if there is a treatment plan, are often overlooked in the chart. Lack of patient cooperation is often not sufficiently documented. The plaintiffs' attorneys love bare-bone patient histories. Why give it to them? Follow the suggestions in the "significant seven" areas and you will not only significantly reduce your legal exposure, but you will also be practicing better, more detailed podiatric medicine. That is a win for podiatry and that is a win for our patients. **PM**

Dr. Kobak is Senior Counsel in Frier Levitt's Healthcare Department in the Uniondale, New York. Larry has extensive experience representing physicians in connection with licensure issues, as well as successfully defending physicians before Medical Boards, OPMC, OPD investigations, as well as Medicare Fraud, Fraud & Abuse, Hospital Actions, RAC Audits, Medicare Audits, OIG Fraud, Health Care Fraud, Medical Audits, and Health Plan Billing Audits. As a licensed podiatrist prior to becoming an attorney, he served as the international president of the Academy of Ambulatory Foot and Ankle Surgery.