Charting and Controlled Substances— A Primer

Proper documentation is the key to protecting you.

BY LAWRENCE F. KOBAK, DPM, JD

It often comes up about what should be reflected in your medical records concerning controlled substances. The obvious parts include the name of the substance you are prescribing, the dosage, the frequency and how it is taken. However, many podiatrists' charts fail to have even this information written into the body of the physician's chart. It is not enough to simply state "the prescription is in my EMR system." It must be spelled out. Is it taken after meals? What warnings accompany the prescription? If the prescription does not allow driving, your chart should state it. This is to protect you! Does the medication involve a risk of addiction or tolerance? The patient must be warned that unless it is taken as prescribed, and even if it is taken as prescribed, there is such a risk. You want these warnings and any relevant advice given to your patient memorialized in your medical records.

Here is something that seems even more obvious, if you can believe it. Why are you prescribing the controlled substance in the first place? Post-operative pain? State it! Post-traumatic pain? State it. Nerve compression? State it. Which nerve? Name it. Where does it hurt? Be specific. It is not enough to state that the patient reports in the right foot. We are podiatrists—surely we can be more specific than that. If the pain shoots over an area, describe it. If the pain covers a dermatome, describe it. If the pain appears to be coming from a certain level from the spine, describe it (e.g., L5-S1, the most common for podiatry).

What kind of pain is it? Nerve pain? Throbbing pain? Arthritic type pain? What kind of arthritis? Psoriatic? Rheumatoid? Gouty? Degenerative? Is it due to a sprain? A strain? If due to trauma, of what nature? Was it an automobile accident? Go into detail as to the mechanism of the accident. That is of utmost importance in substantiating your treatment plan. Make sure your records have a treatment plan. Some states require a written treatment plan if you are using controlled substances for certain amounts of time. It is a best practice to have a treatment plan in your medical records.

What exacerbates or triggers the pain? Extension? Flexion? Inversion? Eversion? Put the painful part through a range of motion. At what point does the pain kick in? Become intolerable? Is this done on each visit as the patient is healing? Make sure your record reflects that.

Most states have an on-line prescription registry for controlled substances. Most states require the prescribing party or their appointed agent, to access the registry prior to each prescription of a controlled substance. It is a best practice to acknowledge in your chart that you have accessed the registry each time.

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Even more important, you should be stating what you found upon accessing the registry. This is analogous to checking the results of a culture and sensitivity. The actual findings should be written within the body of the patient's medical record; it is not enough to just have a copy of the registry printout in your records. Are any other practitioners prescribing opioids? Benzodiazepines? Are there any contraindications? Is the patient getting analgesics from more than one source? This is to be dealt with immediately. How might this affect your treatment of the patient? The fact that you are aware of this re-

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quires some type of action. This must all be memorialized in the patient's medical chart.

If the patient was on a prescription for controlled substances prior to seeing you, and you are continuing that prescription, please insist upon obtaining a copy of the prior provider's chart. Abusers and addicts often make up stories that the doctor has retired, moved, died, or took a rocket to Mars. Often, the patient forgets the name of the prior prescriber. These are warning signs that cannot go unheeded. Physicians who expire, relocate, or retire must have a caretaker of some kind for their patient charts. Persist and record what is going on. Again, this is for YOUR protection. These are the very points that various types of investigators will ask about. Your obtaining the record or your good faith attempts to obtain prior records go far in your defense. What is even better is obtaining the records. Then, read them. If something is "fishy" deal with it and deal with it in writing.

We have already established that your chart must reflect the patient's diagnosis. How did you determine the diagnosis? What tests or observations were made? Was there crepitus upon dorsiflexion of the first MP Joint? Was there a positive Tinel's sign? What did your x-rays show? Please do not rely on someone else's x-ray or CT scan report. What do YOU see? Your chart should reflect that.

If you are taking serial x-rays, what are the changes in each as time progresses? Are they expected? Are they unexpected? Why? Is the pain increased, decreased, or the same as the prior visit? Did the patient forget to do something that you ordered? Did they ignore your order to have a test taken? Are they performing the exercises you prescribed as you prescribed them? Are they taking the medication as you prescribed it? Are you sure? Do you perform pill counts every so often? Require your patient to bring the pill bottle in with them. Are you charting these items?

The next "obvious" suggestion involves the actual purpose of why you prescribed the medication to begin with. Of course, it is to decrease pain, as that is the subject of this article. Is it also to increase function? As podiatrists, function usually involves walking. Your chart should reflect if the patient is walking at all and the length that (s)he can walk when taking the medication as prescribed. Is that length increasing over time? *Is the medication doing what you want it to do?* If not, stop it or taper it, as safety and prudence permit. Do not allow your patient to become the doctor; you are.

Of course, there is more to function than just the amount a patient can walk. What about the range of motion? At what point of dorsiflexion does the Achilles begin to hurt? How much inversion is achievable at the subtalar joint? If the inversion had decreased due to a painful inversion sprain, over time, is it now increasing? By how much?

Healthcare providers tend to be deficient in documenting uncooperative patients. What did they fail to do? Why did they fail to do it? If they failed to go for your referral to another specialist, was this noted? Were they told of the possible consequences of ignoring your suggestion? If they did go, did you make sure that you received the report from the referred physician? You spoke to the physician on the phone? Did you accurately and completely note the time of the phone call? The results of the consult? Did it affect your treatment/diagnosis of your patient? How did it impact upon the patient's care and treatment? Nobody can read your mind; you must state this in your chart.

Unless you are treating a patient for chronic pain, your care and treatment of a patient in pain should have a beginning, a middle, and an end. Referrals for patients not making the progress you would expect are a wise thing. As you can tell, this article is about documentation and the patient who is prescribed controlled substances like opioids. However, never lose sight that your function as a health care provider is to do what must be done to benefit the patient. With that disclaimer, let's get back to your chart.

We are all taught that the purpose of the chart is to accurately memorialize your care and treatment of a patient, such that another healthcare provider will know what is being done for your patient. However, your chart should be self-serving. Your medical record is Exhibit A to either defend you or bury you in a malpractice action, an insurance audit defense, a licensure action; you name it. An accurate and complete chart is self-serving by its very nature. It serves your interests by explaining why you did what you did when you did it or why you didn't do it. It makes it easier for a prosecutor or attorney or investigator to understand your rationale and not have to guess. We have all heard that if you did not write it, you didn't do it. Maybe, but if you did write it, there is a presumption you did do it. To quote the boxing referee, "Protect yourselves at all times!" **PM**

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