Your Podiatric Charts: Avoid the Pitfalls

These common documentation mistakes can be costly.

BY LAWRENCE F. KOBAK, DPM, JD

A malpractice case once hinged upon an electronic medical record signed by the practice owner, not the alleged provider. The practice owner signed the dated note that the patient was given a nerve block. It turns out that the patient had an untoward reaction to the nerve block. According to the plaintiff's attorney, the patient truly suffered because of this nerve block. The reason for this story is that there was real confusion as to who provided the treatment. The provider's name was not on the bill or the chart. Takeaway number one: sign your chart when you are the provider.

A podiatrist ordered x-rays on many of her patients. In fact, a CMS audit felt that statistically, she was way outside the bell-shaped curve. Her podiatric records were not very clear as to why each x-ray was ordered. Additionally, her charts did not have an x-ray report of findings. Her charts did not reveal how the patient's treatment changed or was confirmed due to the x-ray findings. Because of this, the CMS MAC decided to extrapolate her use of x-rays over a couple of years. She was asked to return over $85,000 to Medicare.

A podiatrist billed for a "4" level subsequent office visit with regularity. He appeared to be unaware of the requirements of documentation and examination for a "4" level visit. It is not enough to ask about or examine a certain amount of body systems. If the body system you asked about or examined was irrelevant to the diagnosis, it will not count. For example, if a patient has an intertriginous monilia infection, your inquiries about the patient's neurologic system are probably irrelevant to the diagnosis. If there is some relevance, your medical record should reflect that, even if it is relevant as a "rule-out".

Takeaway number one; sign your chart when you are the provider.

© Elnur | Dreamstime.com

Similarly, ordering irrelevant tests will not be looked upon well during an audit. There may not be a good reason to order a CT scan of the ankle for a patient with that same intertriginous monilia infection. If this is done with frequency, Medicare might extrapolate every time you ordered a CT scan, and assume it was incorrectly ordered. Besides being inappropriate care, such behavior will become very expensive.

Sometimes, Medicare and Insurance company complaints, based upon statistics, are not based on reality. For example, years back, a podiatrist was investigated by Blue Cross because she did more bunionectomies than any provider in her

Continued on page 36

Pitfalls (from page 35)

county. When asked, any provider meant any MD, DO, NP or PA, in her county. As only podiatrists and some orthopedists perform bunion surgery, this was a valueless statistic, and a foolish conclusion that this podiatrist was a high provider of bunionectomies.

Another example of this is a podiatrist who runs a wound care practice. Most of the patients are being treated for various types of ulcerations. Debridement of ulcerations will be commonly billed for in this practice. Medicare and insurance companies work with the data. They may not know that your practice is predominantly wound care. If audited, this should be made known to them as early as possible in the audit process. In other words, they will see a lot of debridement of ulceration codes, because this is what you do.

Okay, so you have notified the carrier that you debride ulcers. You are still not off the hook. Does your chart state the size of the ulceration? That includes the width, length, and depth. How has it improved since the last visit? Did it improve since the last visit? Is there any drainage? Has it been cultured? If so, what are the results of the culture? It is important to note that most carriers want you to show the results of the C&S within the body of your medical record, not just on the attached lab C&S report. In your results note, show what is important to your treatment of the patient. How did your treatment change or remain the same, because of the C&S being taken?

You are treating a patient who is diabetic, absent DP and PT pulses with delayed capillary refill time on the pedal digits. The toes appear cyanotic. You order a segmental Doppler. It shows PAD, but no actual blockage. Does this change your treatment of the patient? If so, how? Your chart should reflect this. If you ruled out an actual blockage, the chart should state that too. Perhaps with absent DP and PT pulses, as well as a cyanotic look and delayed CFT, along with diabetes, you needed this information to appropriately treat and/or refer the patient to a vascular specialist. Your chart should reflect what you were thinking when the test was ordered. This not only can be helpful in defending an audit, but this can also be very helpful in defending a medical malpractice suit. Most important, a complete chart is good medicine!

Another pet peeve of auditors is the failure to demonstrate follow-up in your medical records. Some charts read as if there are a series of diagnoses, so that each visit will be allowed by the insurance company. If there was a paronychia, what occurred after the I&D? How was the patient's bursa one week after its injection? Do not leave your treatments just hanging. The prior diagnosis should be dealt with on the next visit chart note. Auditors get suspicious of "one and done" diagnoses.

Unbelievably, many healthcare providers do not always sign their medical records, or they only initial them. Additionally, sometimes the date of service in the chart differs from the date on the bill to the insurance carrier or Medicare. Often this difference is the day or two that it takes to generate the insurance bill. The law is clear, your records must be signed. Additionally, the bill must reflect the actual date the services were performed. Especially in CMS Medicare audits, this is often used as justification in the recoupment of money from the provider.

While it is admirable that your chart has details about your patient, irrelevant information in your patient record is not advisable. Notes about your patient's gambling habits might not be appropriate in a podiatric chart. Favorite restaurants might be appropriate if you were treating a patient for food poisoning. The key to what goes into your records is what is reasonably relevant to your treatment of the patient.

A favorite of plaintiff attorneys is the referral. You refer a patent to another physician. The medical record is silent after that concerning the referral. Perhaps it was to a vascular specialist. A patient's toe is later lost to amputation. Did you note that the patient never went to the referred physician? Did you fail to note that the patient did go to the vascular specialist who made a diagnosis and a treatment plan. What was the plan? How were you involved in the plan? Did you ever receive a written letter from the vascular specialist with her findings?

If you take your own x-rays, the relevant results of the x-rays should be in the body of the chart. It is not sufficient to say the x-rays are in your chart and they speak for themselves. If you have referred the patient for x-rays or a scan of some kind, the radiologist's report should be part of your chart. Incorporate the findings into your treatment plan, even if the x-rays confirm your diagnosis.

If you take your own x-rays, the relevant results of the x-rays should be in the body of the chart.

Here are some commonly seen mistakes in medical records you want to avoid. Often, the history is obviously incorrect. You might want to double check your records if they state your patient had a hysterectomy in 1998, when your patient was not born until 2003. You might also want to check that same surgery if it was supposedly performed on a biologically male patient. Medication names and dosages are often incorrect in medical records. They also often change. It behooves you to check that on each patient visit. Make certain that the James Smith you have just treated is the James Smith in whose chart you just made an entry.

Continued on page 38

Pitfalls *(from page 36)*

People who often review medical records comment on the frequency that vital signs are not entered into the medical record. What is sometimes seen is that the vital signs were taken and were within normal limits. That will not do. Input the numbers. The importance of recording vital signs often is in showing trends. Is the blood pressure trending upward, even if the values are still in what is currently considered acceptable? The same is true with blood laboratory values; the trend can be as important, if not more important, than a reading that is within normal limits. That is only known by evaluating the numbers.

At this stage, most podiatrists are using EMR. Copy and paste is often used. One must take special care not to copy and paste currently inaccurate information. Auditors look for this. Additionally, they look for identical chart entries, visit after visit. Your entries in your charts should be like snowflakes; no two are exactly alike.

What is sometimes seen is that the vital signs were taken and were within normal limits. That will not do. Input the numbers.

We have now reviewed over a dozen scenarios where the quality of many medical records stands to be improved. Higher quality medical records can only improve the overall care of your patients. Better quality medical records increase the credibility of your medical records. If any of you have ever read Department of Health licensure decisions, or have ever spoken to a jury after a trial, "credibility" is of the utmost importance to their decision. **PM**

Dr. Kobak is Senior Counsel in Frier Levitt's Healthcare Department in 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, Healthcare 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.