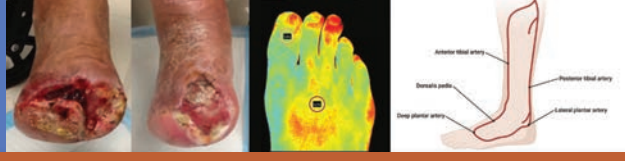

Tips for Charting the Diabetic Patient

Avoid these documentation deficiencies.

BY LAWRENCE F. KOBAK, DPM, JD

This article will provide advice geared toward the diabetic patient, but is equally applicable to all patients. Diabetic patients have laboratory and radiology results. Diabetic patients are seen in the hospital and are treated by various specialists from endocrinologists to vascular specialists to ophthalmologists. All your other patients may be seen by other non-podiatric healthcare providers. The general principles for medical record documentation do not change by the patient or by the insurance company. What may change is what is required to be documented to be reimbursed.

Many auditors still find that medical records are not signed by the provider! Many attorneys encounter practices with providers who have not gotten to their patient charts yet. Unbelievably, more than one practice had providers that were a year behind on their patient documentation. This situation is not only totally unacceptable, but it can also lead to dire consequences with both insurance companies and government authorities. A medical record must be completed and signed prior to submitting it to an insurance company or government medical coverage for payment for services rendered.

The medical record must be current. That means it should be completed within 24 hours of the services rendered. When it comes to operative reports and test results, your comments concerning the tests should be entered within 24 hours of receipt whenever possible, or very shortly thereafter. Your comments should accurately report the date when entered. Electronic medical records will date your comments automatically; operative reports, on the other hand, are dictated and often take several days to come back for your approval. In any case, a copy of the operative report should be made part of your medical record within 24 hours of your approval of the dictation. Up-to-date records are most important for quality patient care.

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Amending a Record

Why would you ever amend a medical record? Is it legal? Does it "count"? Let us answer these questions one at a time. You are treating a diabetic patient with a decubitus ulceration on the plantar aspect of the right 5th metatarsal head. You composed a chart note, which the EMR closed out with your electronic signature that same day. You go home, have dinner, and realize that you forgot to document the ulcer's dimensions, including its depth. You also forgot to compare its dimensions to the prior treatments. What should you do? You should amend your chart note the next time you are at that facility. It should be dated on the date you are amending the record and, of course, signed by you on that date.

It will be entitled "Amendation of note of [supply date of original note]. Plantar ulceration under the right 5th metatarsal head was 1 cm by 0.5 cm with a depth of 'x' cm." You must also document if the ulceration was draining, if serosanguinous or purulent, or something else, if there was any odor, and any other relevant characteristics noted at the time.

Amending a note eight months later, when you are notified of an insurance audit or a malpractice lawsuit, while "legal", will carry little if any credibility.

Snowflake Records

Auditors will call out to the provider when their medical records are not unique for each patient. Every snowflake is unique. If records always seem to state that a physical examination for each patient was

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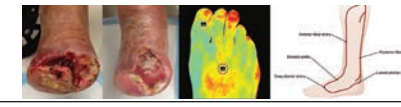

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WNL, they become suspicious. If 10 patients with diabetes were seen on Tuesday, and all 10 patients have a note stating, "patient doing well on current dosage of medication", that will arouse suspicion. If all 10 also have blood pressures of 120/80, with DP and PT pulses +1, regular and equal, that will set off the red lights. Our patients differ from one another, even if in small ways. Patient records should also note interval changes.

Copy and Paste

Lazy documentation is reflected by obvious copy and paste notes. As information does change, this is a path to inaccuracy. As an example, it is important to note that a patient quit smoking six months ago. However, when seen two months later, the patient did not quit smoking six months ago; the patient now has ceased smoking eight months ago. When reviewing the records of your patients, especially your diabetic patients, such a difference may be of importance.

Test Results

It will not suffice to merely initial a radiology report, a C&S or blood results, with a statement, "read and appreciated". Your chart should reflect the relevant findings and how that might affect your treatment plan. The effect might simply be to stay the course. Additionally, your record should note the reason why you ordered the test in the first place. Insurers continue to weed out "unnecessary" tests and treatment. "Routine" tests are frowned upon.

Legibility

If you use EMR, legibility will no longer be a factor. However, there are those of us who still manually write their charts. Insurers are robustly rejecting many of the handwritten notes as illegible. If you do not have decent handwriting, use dictation or a medical scribe. Illegible charts can result in dangerous treatment. In diabetic patients, accuracy is supremely important. An illegible chart entry could result in a wrong dosage of an antibiotic being used in the treatment of an infected decubitus ulceration.

When the results of the x-rays are obtained, explain how those results change or confirm your current treatment. Note interval changes in the x-rays, or in any other test.

Abbreviations

Auditors review medical records that include medical abbreviations. Frequently, when treating patients, and that includes patients with diabetes, those abbreviations will be unknown to the auditor or the other healthcare provider who is reading your record to factor in the treatment of the same patient in his/her specialty. An endocrinologist might not know what you meant using the abbreviation D/C. Did you mean discharge or discontinue? When you wrote HS, did you mean half strength or take at bedtime? Did you mean "not available" or "not applicable" when you wrote "n/a"? Keep abbreviations to a minimum. Consider having an abbreviation key at the end of your records.

Failure to Document Medical Necessity

You order an x-ray when a diabetic patient presents with a decubitus ulcer under the left 5th metatarsal head. You "assume" that anyone with a modicum of medical training would know that you want to see any anatomical pathology, such as a plantarflexed metatarsal to suggest osteomyelitis. Do not assume! Nobody wants to be a mind reader. State why you require the x-rays. Are you comparing them to prior x-rays? State that. When the results of the x-rays are obtained, explain how those results change or confirm your current treatment. Note interval changes in the x-rays, or in any other test. In this case, might you add a soft tissue supplement beneath the plantarflexed metatarsal? Consider surgery? Are you suspicious of osteomyelitis, which requires other tests or treatment? Do you need to obtain a consultation from the patient's primary provider or endocrinologist to

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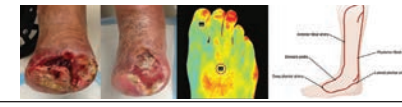

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make sure their treatment for their diabetes is being properly addressed? State that in your records!

Failure to Follow Up

Medical records are often reviewed that diagnosed a diabetic patient with a paronychia. The offending nail spicule is excised, with an incision and drainage being performed. The patient is next seen a month later for another reason. The paronychia is never referenced on the next visit. Did it resolve? Did the patient take the antibiotics prescribed? With diabetic patients, it is especially important to follow up. How they heal or do not heal is often indicative of how well their diabetes is being treated. Additionally, note if the patient followed up with your referral and what occurred because of that referral.

Failure to Document Coordination with Other Providers

It is important to be aware of all providers caring for your patients, how much more so for your diabetic patients! When did the patient last see the vascular specialist? Why? What occurred? What was that specialist's prognosis? Was the patient recently admitted to the hospital? Whenever possible, and relevant, obtain abstracts or summaries of such visits.

If you are going "outside" a treatment guideline, your medical record should state why.

Prescriptions

One of the areas of deficiency often seen is the failure to document all the patient's medications, as well as distinguishing between what you prescribed from what else is prescribed. If there is a possible drug interaction, what did you do to address it? Was the patient made aware of what to look for? Are the dosages and how to take the medications clearly stated? While it is important to know that the patient is taking Metformin prescribed by their family physician, it is equally important to know what the dosage is. Has it recently been increased? Why?

Clinical Practice Guidelines

Clinical practice guidelines rose to importance in the 1990s. They have only grown in the significant role assigned to them by insurance companies, governmental agencies, and litigation. Yes, they have helped in "standardizing" much of medical care, including the treatment of diabetes. If you are going "outside" a treatment guideline, your medical record should state why. A simple example might be choosing the second most effective antibiotic as per the results of your culture and sensitivity instead of the most effective antibiotic noted on the C&S results. Why would you do that? Perhaps the patient is allergic to the most sensitive antibiotic. Do not make anyone guess as to why it was prescribed or not prescribed.

Conclusion

This article was not meant to make perfect medical records; they do not exist. If these implementations are followed, it will help you improve your documentation. Diabetic patients, often, despite our best efforts, have amputations and other medical problems. As a profession, podiatrists save the limbs of many of their diabetic patients. Between investigations, audits and litigation, it is incumbent upon podiatric physicians to strive for accurate and relevant medical records for their patients. **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.