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Reduce Malpractice and Fraudulent Claims Risk By Following Best Practices in Creating Medical Records

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The importance of proper documentation of medical services provided can not be understated. Failing to follow best practices can expose a health care provider to professional liability claims as well as claims of fraudulent billing and potential liability under Federal laws regarding false claims. To avoid these exposures health care providers, and their staff, need to be diligent in properly managing how they create and manage patient medical records.

1. **Treatment Records**. Clarity and timeliness of record creation are two key factors to remember in a health care practice. Medical records should be created at the time of, or shortly after, treatment to ensure their accuracy. They also need to be legible so the provider who created the record, as well as third parties, can read and understand them. Poorly documented medical records can be the basis for why a lawsuit is filed or increase the value of a claim that is made.

   Be careful when modifying or creating an addendum to a medical record. Think twice before making changes. If you determine, for whatever reason, that a medical record is not accurate and needs to be edited, remember these points:

   a. Clearly document any changes made. That includes the date when the change was made, as well as the nature of the reasons for the change. To the extent there are inaccuracies in the record, when making the change do not obliterate the original entry. Cross it out, initial the change, and document the reason for the modification of the record. Legibility is important in the original record as well as any modifications to it.

   b. Don't modify a medical record after receiving notification that a claim is being made against you by that patient. Doing so can lead to a claim that records have been falsified as a cover up of a potential error. Before taking any action regarding a record on that patient contact the attorney defending you to obtain legal guidance on the issue you have identified.

   c. Avoid any actions that may appear to be a cover up or falsification of records. Perception can overpower the reality of the circumstances when dealing with a potential legal situation, so avoid taking steps which an adverse party can use to imply bad intent.

2. **Billing Records**. In today's environment where more backup information is required to bill for services, ensuring accurate documentation of those services has become more challenging. Various factors have given rise to the challenges, such as the expansion from ICD-9 to ICD-10 codes, changes in filing requirements by health plans or federal programs (such as Medicare), or dealing with a new and unfamiliar Electronical Medical Record system. When submitting a claim or bill you are certifying to the accuracy of the information provided. If the claim is not accurate you are exposed to claims of fraudulent billing and potential criminal penalties.

   Consider the following to reduce risks of fraudulent billing:

   a. Claims submitted to Medicare need to reflect the fact that the services were: actually rendered; medically necessary; performed by an appropriately skilled and licensed individual;

of suitable quality; not billed for on a prior claim; and not performed by a person excluded from federal health care programs.

b. If a record needs to be changed, do it carefully and avoid doing it in a manner that may give rise to claims that you are improperly doing so.

c. See information at the following CMS websites which give additional guidance on how to comply with proper medical record documentation requirements, and generally how to avoid potential claims of Medicare fraud.

Complying With Medical Records Documentation Requirements
www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CERTMedRecDoc-FactSheet-ICN909160.pdf

Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians
www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Avoiding_Medicare_FandA_Physicians_FactSheet_905645.pdf

3. **Electronic Medical Records (EMRs)**. The sea change in record keeping from paper to electronic medical records created new issues to consider that don't apply to paper records. EMRs benefit health care services in many ways, including improving the ability to track a specific health condition and expeditiously share health care information among various providers treating a patient. However they can also increase the risk that records may be improperly disclosed or shared with third parties, corrupted, or contain errors caused by improper use of the EMR. Providers want to be sure that their records accurately reflect a patient's health condition, the services provided to the patient, and why they were provided.

a. Operational risks associated with the use of EMRs include :

- the use of "copy and paste" to replicate prior entries or entries used for other patients, where the data being copied is not accurate for the new patient's bill or medical record
- technical malfunctions in the software which can corrupt or wipe out the healthcare or billing information of a patient
- automatic text entries, like auto-correct in word processing software, creating erroneous entries
- the existence of metadata in the electronic records. Metadata provides background information related to the record. This is underlying information that is not seen in a printout or normal electronic view of a document, but which can be identified within the electronic file to see prior revisions to a document, or who drafted various parts of the document, and when it was created and modified. Forensic reviews of metadata in a record can be used to identify whether documents were tampered with to cover the actions taken by a person relative to that record.

b. How to Minimize Risks Associated with EMRs

- Staff Training and Awareness Initiatives – EMRs are new tools to many and all staff members need to be aware of how to properly use them. Education in the use of EMRs will improve the performance of your officeand minimize the risk of claims related to poor patient care or improper billing. The importance of staff training is well documented in many articles on this topic since the passage of HIPAA, and HHS's promotion of the use of EMRs. Training in the use of the EMR is an important service you should receive from your EMR vendor.

- Understand Templates & EMR Functionality – Many EMRs come with templates that can be used to document patient treatment. Templates can reduce time in documenting treatment, remind you to capture certain data, and help you standardize your recordkeeping. However, if the template is not properly used you may find yourself inadvertently documenting services (as well as submitting a claim) with inaccurate data, which can lead to claims of fraudulent billing or malpractice.

c. Additional Resources Related to EMRs

- More detailed information on EMR benefits and pitfalls may be found at the AHIMA article, "Integrity of the Healthcare Record: Best Practices for EHR Documentation" http://library.ahima.org/doc?oid=300257#.WW9ksIgrKM9 and the Experix article, "Electronic Medical Records: Litigation Experience and Risk Management Tips" www.experixllc.com/file_view.php?download_key=996e38c65d2be92f2be1e7ba42a0be0153d7e1f8929b23.68203192 .

4. **Artificial Intelligence and Future Technologies Operational Risks**. Artificial Intelligence (often abbreviated as "AI") has already entered the healthcare environment as clearly reflected by the IBM Watson initiatives with a number of healthcare organizations. AI will provide improvements in healthcare, but it will also add further complexity (and potential risks) in the healthcare world's electronic infrastructure. Consider what happens if an AI tool, developed for use in a health care setting, has programming flaws which result in the creation of inaccurate healthcare data or the destruction of pertinent health care data. As AI becomes a more prevalent tool in the practice of medicine it is important to recognize that it's another area that needs to be diligently managed in real world clinical settings.

Health care provider offices are busy seeking to ensure they provide their patients with the best healthcare. Its easy, in today's fast paced office environment, to lose focus on ensuring that document creation and management processes are properly and effectively implemented. Its helpful to regularly remind yourself and all office staff of the need to pay attention to the details of properly documenting the treatment and billing records of your health care practice.

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