The Top Seven Reasons Clinical Documentation Is More Important Now Than Ever.

Accurate and timely clinical documentation by physicians has always been the cornerstone of quality patient care and reimbursement. There are also a myriad of other reasons that a comprehensive medical record, that includes a detailed history and physical, progress notes, and consults, is vital. Incomplete or missing subjective, objective, assessment, and plan (“SOAP”) notes have the potential to adversely impact the physician and the hospital from legal, financial, and reputational standpoints.

In relation to clinical documentation, hospital executives, employees and fellow medical staff members often express two scenarios. First, the documentation is inadequate and untimely. Sometimes, inadequacy equates to no history and physical or progress notes. Second, because of the revenue a particular physician is generating, his/her disregard for completeness and/or timeliness of clinical documentation is “overlooked.” By not addressing these issues, both the hospitals and physicians are taking significant risks.

Therefore, the top seven reasons clinical documentation is more important now than ever are: (1) establishes the standard of care; (2) impacts physician state licensing; (3) basis of hospital/medical staff bylaws and Joint Commission accreditation; (4) implicates the False Claims Act for improper billing; (5) public notice of inadequate medical record maintenance by state boards; (6) adverse financial consequences for the physician and hospital; and (7) increased negative outcomes in relation to RAC audits.

**Reason 1: Standard of Care**

The legal standard of care or the required practice standards in a given situation, form the basis of a legal claim, which is often a state negligence or deceptive trade practice claim, or a component of a federal claim such as the Anti-kickback or False Claims statutes. These guidelines can take the form of federal or state statutory or regulatory requirements, professional association and accreditation standards, and health care organization internal policies, protocols and procedures. Failure to conform to an established protocol, may, standing alone, constitute enough evidence that the healthcare provider breached the standard of care.

**Reason 2: Physician Licensing**

Physician licensure is administered through individual state boards that have the duty of oversight and healthcare consumer protection. The Board’s oversight duties do not end with the initial administration of a license, but rather continues as long as a physician or other health care professional (Physician Assistant or Nurse Practitioner) continue to practice in the state.
practice. Investigation of complaints, hearings and disciplinary sanctions are all within the purview of the board.iii A physician’s license may be revoked or suspended for failing to keep proper medical records.iv In turn, this negatively impacts a physician’s HealthGrades score.v

Reason 3: Hospital/Medical Staff Bylaws and Joint Commission Standards

Medical staff bylaws, hospital bylaws and Joint Commission standards set parameters that promote and ensure quality patient care. Medical record documentation is a cornerstone to achieving compliance and optimal patient care. Professional association standards, such as those set forth by the American Academy of Orthopaedic Surgeons (AAOS) are often relied upon and incorporated into the healthcare providers guidelines. Furthermore, a hospital may request a survey that can be used both by a hospital for an internal review and a court.vi

Reason 4: The False Claims Act

Initially created in 1863, the False Claims Act (FCA) enables the federal government to combat waste, fraud and abuse against those who are reckless, deliberately ignorant, or knowingly make false representations to the government.vii The financial penalties are significant and enable the government to be awarded treble damages plus civil penalties ($5,000-$11,500 per claim). Furthermore, if a private citizen brings a claim and the government intervenes, the qui tam plaintiff may collect anywhere from 10-30% of any amount recovered by the government and reasonable attorney fees.

Since 2009, two important laws, Fraud Enforcement and Recovery Act of 2009 (“FERA”)viii and the Affordable Care Act of 2010 (“ACA”)ix expanded whistleblowers’ protections and their ability to bring FCA suits. With FERA amending the FCA, a new basis for liability emerged – knowing retention of an overpayment, regardless of the cause of overpayment.x The caveat is that the information cannot be publically available information.xi

Reason 5: Public Notice of State Medical Board Disciplinary Actions

Medical Boards publically release the findings of disciplinary hearings and can order an administrative penalty for failure to meet the standard of care for not maintaining adequate medical records.xii

Reason 6: Adverse Financial Consequences

In addition to fines and penalties physicians and hospitals may be required to pay if claims were submitted without adequate documentation, medical errors were made, False
Claims Act violations, or a licensing board or Joint Commission imposes a fine, there are other areas that are impacted.

First, coders cannot rely upon items absent from the record. By not documenting, opportunities to capture CCs and MCCs are lost. Second, if a condition is not documented as present on the first admission and is included in the Hospital-Acquired Conditions list set forth by CMS, if a patient is readmitted for an item on the list, then the healthcare provider does not get reimbursed.xiii

**Reason 7: RAC and Other Audits**

During the course of an audit, Recovery Audit Contractors (RACs) are required to relay suspected fraud to the government.xiv Target areas for auditors include: DRG assignment, medical necessity, contractor approved issues, and procedures unrelated to the primary diagnosis. The top audit trigger is improper or inaccurate billing.

In order to avoid having to pay back previously reimbursed claims plus interest or going through a lengthy appeals process, better documentation decreases RAC findings. Because RAC auditors can also file a *qui tam* suit, there is an additional incentive.xv Therefore, it is imperative that accurate documentation be provided in a timely manner.

Overall, it is imperative for hospitals and physicians to collaborate in relation to appropriate and timely clinical documentation. Aside from an adverse patient outcome, there are numerous ways that healthcare providers are subject to adverse legal, financial, and publicity in relation to clinical documentation.

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iii See Delaware Board of Medical Licensure and Discipline ([http://dpr.delaware.gov/boards/medicalpractice/index.shtml](http://dpr.delaware.gov/boards/medicalpractice/index.shtml)); The Medical Board of California ([www.medbd.ca.gov/](http://www.medbd.ca.gov/)); Texas Medical Board ([www.tmb.state.tx.us](http://www.tmb.state.tx.us)); Pennsylvania Department of State, State Health Licensing Boards ([www.licensepa.state.pa.us/](http://www.licensepa.state.pa.us/)); and Florida Board of Medicine ([www.doh.state.fl.us/qa/medical/me_faq.html](http://www.doh.state.fl.us/qa/medical/me_faq.html)).

iv *Pinellas County Medical Association*, available at [http://www.pinellascm.org/medrecords.html](http://www.pinellascm.org/medrecords.html). "According to Section 458.331(1)(m), Florida Statutes, a physician may be disciplined for "failing to keep written medical records justifying the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered, and reports of consultations and hospitalizations." Moreover, Rule 64B8-9.003, Florida Administrative Code, in addition to the above, mandates that the records be legible and contain sufficient information to "identify the patient, support the diagnosis, justify the treatment and document the course and results of treatment accurately..." Finally, the physician should be aware that failure to keep
written medical records could subject the physician to penalties ranging from a mere reprimand to a combination of a two-year suspension, followed by probation and a $5,000 fine. Section 456.057(14), Florida Statutes."


**Issued To:** Dr. Jeffrey Wade Heitkamp; License # F4064, **State:** Texas, **Nature of Complaint:** The physician failed to adequately document a complete examination and history that would justify surgical intervention in a patient with back and leg pain or discussions of alternatives to surgery. The physician's three surgeries on a patient contributed to the patient's final condition of disability. **Action Taken:** The physician has entered into an Agreed Order with the board for a period of two years subject to the following terms and conditions:

- The physician's practice shall be monitored by a board designated **physician monitor** who shall review selected patient medical and billing records.
- The physician shall successfully complete eight hours each of **continuing medical education** in medical recordkeeping, risk management, and lumbar surgery complications and outcomes within two years.

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viii 31 U.S.C. 3731(c), 3732(a)(1), and 3729(a)(2), (a)(1)(B).

ix 42 U.S.C. §§1396a(a)(42)(B) and 1395ddd(h).


xi 31 U.S.C. 3730(4)(A); *U.S. Ex. rel Holmes v. Consumer Ins. Group*, 318 F.3d 1199, 1214 (10th Cir. 2003); *Ex. rel Burns v. A.D. Roe Co.*, 186 F.3d 717, 722 (6th Cir. 1999); *U.S. ex rel Hagood v. Sonoma County Water Agency*, 929 F.2d 1416, 1419 (9th Cir. 1991) (holding that information is not considered publically disclosed if “the communication does not release the information into the public domain such that is accessible to the general population.”).

xii Texas Medical Board, www.tmb.state.tx.us (Feb. 17, 2010). Example: “Bacon, Robert J., Jr., MD, Lic. #F0861, Houston, TX – On February 5, 2010, the Board and Dr. Bacon entered into an agreed order requiring Dr. Bacon to pay an administrative penalty…within 90 days. The Board’s action was based on Dr. Bacon’s failure to meet the standard of care and maintain adequate medical records.”


xv 31 U.S.C. §§ 3729–3733, also called the "Lincoln Law."