Critical Thinking on Privacy, Medical Records, Documentation – Part One

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Privacy and Social Media, Filming Staff
Tina, the ward clerk in the long term care unit at your hospital, loves the third Saturday of the month; she always signs up to go on the “outings” that Drew, your LTC activities director, organizes for the residents and is looking forward to the trip to the farm this weekend. Tina enjoys the short trips (she tells her co-workers they are a “hoot”) and the “work” is really nothing more than making sure no one wanders off, or falls as they are getting into, or out of the van; it is an easy way to make an extra $50 to pay down her credit card debt, plus she also has a bit of a crush on Drew.
• Tina has told her friend Mollie Moveillot, that although she would LOVE to help her move this weekend, in fact she has to fly up to Portland for the weekend to see her sister Portia.

• Drew is writing an article for the Hospital Howler, the quarterly newsletter that the volunteers publish, and plans to take pictures of this month’s “trip to the farm” to accompany the article – Drew takes lots of pictures of the residents petting the farmer’s lambs and tossing feed into the chicken pen (taking care not to include images that could be used to identify any of the residents).
Tina Toubizy and the Trip to the Farm (cont.)

• Drew picks a great photo that clearly captures the enjoyment of the day for the newsletter. Unfortunately, even though none of the residents can be identified, one person’s face is clearly pictured in the photo – Tina’s!

• The article is published and distributed widely in the community and on the hospital’s Facebook page and website.
Mollie Moveillot sees the picture and is now furious with Tina – she was in town this weekend after all!

And … now Tina is furious with Drew and the editing staff of the Hospital Howler.
What are Some of the Issues Here?

• Does Tina need to consent to the publication of her picture in the Hospital Howler?

• Is the hospital responsible for something its Volunteer Auxiliary publishes?

• Should Tina have said something if she didn’t want to be in the pictures? Should Drew have said something about what the pictures might be used for?

• If Tina sues, what are her damages? Would it be different if the same thing happened, but the person in the picture was a resident of the LTC unit?
Late Entries, Requests for Amendment of the Records
Marianne Mannick has been involved in a serious but non-fatal auto accident (it appears that she may have intentionally run another car off the road before losing control of her own car).

She is extremely agitated when she is brought to the ED by paramedics and tells Trixie the triage nurse that she is allergic to Seroquel, Penicillin and Olanzapine. Upon further inquiry she tells Trixie that she was treated “about ten years ago” for bipolar disorder. Trixie is known for her good charting.
Marianne Mannick and Her Visit to Your ED

• Two months later Marianne calls your hospital and demands that the entry in her chart about being treated for bipolar disorder be redacted because it wasn’t true.

• Her husband, Mick, who is on the school board and is contemplating a mayoral run, also calls and threatens to “cause big trouble” if the problem isn’t fixed immediately.
What Should the Hospital Do?

- **Nothing** – what Trixie charted was exactly what her patient told her – it doesn’t matter that what Marianne said was true or not; what matters is that it was relied upon by the ED staff in providing care to Marianne.

- **Change the record** as demanded by Marianne and Mick – Mick knows lots of attorneys, and he is a powerful member of the community who could cause the hospital a lot of trouble, and besides, what difference would it make now?
What are Some of the Issues to Think About?

- HIPAA – 45 CFR 164.526 gives patients the right to amend their PHI in a hospital record unless it is already “accurate and complete” – **who gets to say whether it is accurate and complete?**

- Can the hospital demand that the request be put in writing? Can the hospital demand that the patient provide a reason to support the requested amendment?

- Is the hospital allowed to discuss this with Mick even though he isn’t the patient? What would need to be done to make that ok?

- If the request is granted what does the hospital have to do? If it is denied what does the hospital have to do?

- What does your hospital policy say about this? Does your Notice of Privacy Practices list this as a “patient right” and does it tell the patient the conditions that might result in a denial of a request to amend?
Late Entries: Bob Bilder’s Injury

- Bob Bilder was seen at your walk-in clinic last week for a tetanus shot, after suffering a puncture wound on his foot that he said he suffered when he was walking barefoot in his son’s dark bedroom while checking on him late at night (the chart notes that he “stepped on a Power Rangers Super Megaforce Mega Cannon”)

- Bob actually stepped on a nail while working on the “tiny house” he is building for his girlfriend’s Grandma, but he is ashamed to admit that he was wearing flip-flops instead of work-boots when the injury occurred.
• He has now returned to the clinic two weeks later with pain in his foot; Patrick Peaye is concerned because the injury site looks puffy and red, and is warm to the touch. He is recommending x-rays to check for a foreign body, and plans to order antibiotics.

• Bob finally “comes clean” and admits that he actually stepped on a nail on a construction site.
What Should Patrick Peaye Do?

- Should Patrick simply explain in today’s note the true cause of the injury and prescribe appropriate antibiotics?

- Should he also make a late entry that amends what was written in the chart during the first visit two weeks ago?

- Would it be better to just “re-write” the prior entry to more accurately describe the injury?

- How should he handle this?
What are Some of the Issues?

- Would diagnosis/treatment have been different at the time of the first visit? How might changing the chart affect a quality assessment at a later date, or legal review of the standard of care?

- What if Bob begs Patrick not to write down the actual cause of the injury? He doesn’t want his boss to know he has been moonlighting, and also doesn’t have a permit for the tiny house he is building for his girlfriend’s Grandma on her parent’s property. Can Patrick assure Bob that no one would ever see his chart without his permission?
Issues Regarding: Late Entries (cont.)

• How should the new note be flagged so that future treatment will be based on the actual injury rather than the first-noted description of the wound?

• Do all of your providers know how to make addendums to chart notes in your particular system?
Legal Record –
The Challenge of Records From Other Providers
Betty arrived for her outpatient surgery promptly at 7:00 a.m. She brought with her a fat file filled with records from her 9 previous surgeries, visits with her doctors over the years, prescriptions she had filled or not filled, and correspondence regarding her disability insurance claim.

She tried to hand the file to the admitting clerk, who said she should keep those records and go over them with the outpatient surgery intake nurse.

The outpatient surgery intake nurse met Betty and as she started to ask the routine questions about her history and health, Betty handed her the file and said: “It is all in there. I cannot remember all my medical history so I am bringing it to you to review. But I need it back because it is my only copy.”
Questions on the Records

• Should the outpatient surgery nurse accept the records?

• Who is supposed to review the 500 pages that are in no particular order?

• Do you need to keep a copy?
Any Licensing Guidance? Title 22?

§70749. Patient Health Record Content
• (a) Each inpatient medical record shall consist:
  • (2) History and physical examination.

§70527. Outpatient Service General Requirements
• (d) A medical record shall be maintained for each patient receiving care in the outpatient service. The completed medical record shall include the following, if applicable:
  • (2) Medical history including:
    • (A) Immunization record.
    • (B) Screening tests.
    • (C) Allergy record.
    • (D) Nutritional evaluation.
    • (E) Neonatal history for pediatric patients.
    • (14)Referral information from other agencies.

Consent Law Manual, Chapter 14
Joint Commission or Medicare CoP?

The Joint Commission:

- “The Hospital defines the components of a complete medical record”
- The medical record includes the following clinical information:
  - Any findings of assessment and reassessments

Medicare Conditions of Participation:

- § 482.24 Condition of participation: Medical record services.
Who Decides

- These records may be relevant, but may not

- Is it wise to have an all or none policy? Always accept and keep the records or never accept them?

- Should someone review the records and decide what is relevant and should be copied and kept in the medical record and what goes back to the patient? If so, who:
  - Admitting clerk
  - Outpatient surgery nurse
  - Surgeon
  - Anesthesiologist
  - HIM Staff after the discharge?
Dealing With Patients Using Stolen Identities
Dealing with Patients Using Stolen Identities: Sally Snickerdoodle, Single Mom, and Her Baby

• “Sally Snickerdoodle” just had a baby at your hospital and is now getting ready to leave; Nancy Needles, the discharge nurse provides Sally with a gift bag that includes booties, some disposable diapers and baby wipes, and some coupons from Johnson & Johnson. She reminds Sally that her baby should always travel in a backward-facing car-seat in the back seat of her car.

• Sally is feeling happy to be a new mom, and yet something is troubling her. Just as Nancy wheels her through the doors out to her friend’s waiting car, she asks, “How would I go about changing the name on the birth certificate?”
Nancy frowns and says, “Oh, Sally, I think “Snookums” is a perfectly sweet name for your new little Snickerdoodle baby; why would you want to change it?”

As “Sally” places her new baby into the car seat with the help of her friend, she looks over her shoulder and says to Nancy, “oh, no, not the baby’s name...my name. I’m not Sally Snickerdoodle. She is (pointing to her friend). I’m Frannie Frodd and I want to make sure my name is on Snookum’s birth certificate.”
What Should Nancy Do?

- Pretend she didn’t hear it, and just say, “Good luck, now. Bye”
- Call child protective services
- Call the MediCal fraud line
- Call local law enforcement
- Notify the attending physician
- Notify the hospital risk manager
- Call her friend at the local TV station who is (coincidentally) doing a series on health insurance fraud
What Does Nancy Need to Think About?

• Mandated reporting, contractual agreements, *Conditions of Participation*?

• Confidentiality?
  
  o HIPAA “operations” – 45 CFR 164.506 permits disclosure to records room staff, healthcare provider, hospital risk manager, hospital administration, and attorney

  o HIPAA (45 CFR 164.512(d)(1) and Civil Code 56.10(14) permits disclosure to report Medi-Cal fraud

  o HIPAA (45 CFR 164.512(f)(5) and Civil Code (56.10(c)(14) permit report to law enforcement of “crime on the premises” – but does that anticipate only “911” types of calls?
Medical Identity Theft
(From the CMS Fraud, Abuse and Waste Toolkit)

• “Medical identity theft involves the misuse of a person’s medical identity to wrongfully obtain health care goods, services, or funds. More specifically, medical identity theft has been defined as ‘the appropriation or misuse of a patient’s or [provider’s] unique medical identifying information to obtain or bill public or private payers for fraudulent medical goods or services.’”
• “A person who shares his or her card to help another may not mean to cause harm to the Medicaid program. No matter the intent, card sharing is considered fraud, hurts the Medicaid program, and can also hurt the person who shares their card.”

More Issues?

• What if Frannie waited to disclose the fraud until her baby’s first visit with the pediatrician (would it matter whether it was “discovered” at the hospital clinic or in a private physician’s office)?

• What if this means Frannie will be deported or put in jail, and her baby will end up in foster care? (She seemed like a very loving mother and you fear that the baby will not do as well.)

• What if Nancy says nothing and the hospital bills Medi-Cal for Frannie’s care under Sally’s name? Can hospital be liable for False Claims Act violation even if employee didn’t report it? If the fraud is discovered will they have to return the money even if there is no finding of fault on the hospital’s part?
Concurrent Surgeries – Consent, Physician Supervision, Billing, and Operative Reports
• Dr. Bonecutter prided himself on production: eight joint replacements every operating day. His team was a model of efficiency; patients were given excellent pre-op education and knew what to expect during recovery. The doctor was clear and honest in explaining the expected benefits of the procedure, as well as the risks, including the rare but significant complications that did sometimes happen. Following the excellent discussions, the hospital staff asked the patient to sign the informed consent form. It said:
1. Your doctors have recommended the following operation or procedure: **right hip replacement** and the following type of anesthesia: **general**.

Upon your authorization and consent, this operation or procedure, together with any different or further procedures which, in the opinion of the doctor(s) performing the procedure, may be indicated due to any emergency, will be performed on you. The operations or procedures will be performed by the doctor named below (or in the event the doctor is unable to perform or complete the procedure, a qualified substitute doctor), together with associates and assistants, including anesthesiologists, pathologists, and radiologists from the medical staff of (name of hospital) to whom the doctor(s) performing the procedure may assign designated responsibilities.

2. Name of the practitioner who is performing the procedure or administering the medical treatment: **Dr. Bonecutter**.
CONSENT TO SURGERY OR SPECIAL PROCEDURE

1. Your doctors have recommended the following operation or procedure: ______________________

   and the following type of anesthesia: ______________________

Upon your authorization and consent, this operation or procedure, together with any different or further procedures which, in the opinion of the doctor(s) performing the procedure, may be indicated due to any emergency, will be performed on you. The operations or procedures will be performed by the doctor named below (or in the event the doctor is unable to perform or complete the procedure, a qualified substitute doctor), together with associates and assistants, including anesthesiologists, pathologists, and radiologists from the medical staff of (name of hospital) ______________________ to whom the doctor(s) performing the procedure may assign designated responsibilities.

2. Name of the practitioner who is performing the procedure or administering the medical treatment: ______________________

The hospital maintains personnel and facilities to assist your doctors in their performance of various surgical operations and other special diagnostic or therapeutic procedures. However, your doctors, surgeons, and the persons in attendance for the purpose of performing specialized medical services such as anesthesia, radiology, or pathology are not employees, representatives or agents of the hospital or of doctor(s) performing the procedure. They are independent medical practitioners.

3. All operations and procedures carry the risk of unsuccessful results, complications, death, or other adverse effects. ______________________
Concurrent Surgeries —

• Unfortunately for Bill, the hip replacement did not go so well. As the procedure was ending, there was a serious complication, in that a nerve was nicked or some operative debris was set loose causing sciatic nerve palsy.

• The record was pulled for quality review and copied for the attorney service (Bill’s lawyers).

• Oddly, Risk Management noticed the op report was dictated 30 minutes before the procedure ended according to the times noted in the anesthesia and hospital op record.

• What gives?
Consent for Concurrent Surgery

- What right does a patient have to know who is doing what during a surgery?
- Should the consent form list the assistant who will open and close?
- Does the surgeon have to go over all that?
- Can the patient object?
Physician Supervision

Assume the surgeon is not present: who can open and close without the surgeon there?

• Assistant surgeon?
• Physician assistant?
• Nurse first assist provided by the hospital?
• Resident?
• First-year intern?
Documentation

- Who can dictate the op report?
- Can a surgeon who was not present dictate the details of the opening and closing?
- Can the assistant dictate the entire op report?
- Does it have to say who is doing what?
Billing

- Can the hospital bill for concurrent surgeries?
- Can the surgeon bill for concurrent surgeries?
- Does it matter for the billing who was the assistant?
Concurrent Surgery: Guidelines

What do professional associations say about “concurrent surgery”?

• American College of Surgeons
• American Hospital Association
• Specialty Surgery groups

What do payors say about “concurrent surgery”?

• Medicare
• Medi-Cal
• Private Insurance
Concurrent Surgery

- After the Boston Globe Spotlight story, certain hospitals received a letter from the US Senate Finance Committee (reportedly 20 hospitals)
- Basis for request for information: jurisdiction over federal health care programs
- Several telephone calls have taken place with discussion that this letter is for information only and that there has been no CMS involvement
Senate definition of “concurrent surgery”:
• “Also known as double-booking, staggering, and sequential surgery”
• Medical community has called the definitional issues to the attention of the Committee and asked for clarification and limitation of scope
Senate Letter Request for Information

- Per the Senate’s letter:
  - CMS requirement that surgeon be present for “key or critical” portions of a surgery is not clearly defined
  - CMS requirement that surgeon be “immediately available” also not clearly defined
  - Stay tuned for further communication
Information Requested

- Limits on multiple surgeries
- How does the hospital determine “key or critical portions”?
- How does the hospital define “immediately available”?
- How does the hospital arrange for a “back up surgeon”?
- Any and all relevant policies
Information Requested

- Same questions related to anesthesia
- Patient disclosure
- Do you log your physicians’ entry and exit from OR?
- Penalties for non-compliance
Data Requested 2011-15

- Number of surgeries; number of concurrent
- Number of surgeries with procedural overlap
- Length of times of concurrent and non-concurrent surgeries
- Number of surgeons who perform concurrent surgeries
I understand that _____ is a teaching institution and that associates or assistants involved in the operation or procedure may include residents, fellows, medical students or other allied healthcare professionals. I authorize that such associates or assistants may perform portions of the operation or procedure under the direction of the physician identified in paragraph 1 above. That physician may be out of the operating or procedural room for some or all of the surgical tasks done by the associates and assistants if the physician identified in paragraph 1 decides it is safe to do so.
Disclosures to Patients

I understand that Doctor(s) ________ will be present during the key portions of the procedure or surgery and at all times will be immediately available or will ensure another qualified surgeon is immediately available. I will be advised if the surgeon is scheduled to perform surgery in two operating rooms at the same time.
Purpose of Concurrent Surgery

- To manage access to care for high demand and specialized surgeries
- Team surgery
- To provide urgent surgical services
  - To restore sensation neurologically
  - To clip an aneurysm
  - To relieve an obstructed airway
- Policies can be put in place to manage concurrent surgeries safely and efficiently
Mid-Level Supervision, Documentation Challenges
George had 2,567 incomplete records. HIM staff were sick of reminding him to counter-sign the orders, and George was sick of HIM reminding him, daily, of the growing queue of unfinished work. Finally he dropped by HIM and confronted the HIM director, shouting: “I just looked at the stuff you expect me to counter-sign and it is all the notes of my nurse practitioner. Show me where it says I have to counter-sign all of that.”
Hospital licensure regulations: Title 22?
§70706.2. Standardized Procedures
• (b) Each standardized procedure shall:
  ...
  • (2) Specify the standardized procedure functions which registered nurses are authorized to perform and under what circumstances.
  ...
  • (10) Specify any special requirements for procedures relating to patient recordkeeping.
Where Does it Say Counter-Signatures are Required?

• Scope of practice?
• Privilege forms?
• Medical staff bylaws or rules?
Questions?