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## Alteration of Medical Records: Turning a Winner into a Loser

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Accurate and complete medical records are essential for quality of care, compliance with payment requirements, and for use in legal proceedings. There is a tremendous amount of pressure on providers to timely document all facts surrounding their patient interactions. Unfortunately, at times, the medical record is unclear, incomplete, or inaccurate. A provider may not realize the inadequacies in his/her documentation until faced with a patient complaint, a professional misconduct investigation, or lawsuit. At such times there can be a strong temptation to add to the medical record to “clarify” what actually occurred, or remove potentially damaging information, or even create a completely new record.

As this article will discuss, alteration of a medical record can carry serious consequences for the practitioner. Proof that a medical record has been intentionally altered can result in the cancellation or non-renewal of an insured's professional liability insurance policy. Amendment or correction of a medical record may, on an occasional basis, be legitimate, but in such cases the change must be accomplished in an appropriate manner.

The legal guidelines for maintaining medical records are found in New

York licensing statutes and other state and federal regulations. They are general in nature. New York law defines professional misconduct in the health professions as “failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient.”<sup>1</sup> Under state law, hospitals are required to maintain “an accurate, clear and comprehensive medical record” for every person evaluated or treated as an inpatient, ambulatory patient, emergency patient or outpatient.<sup>2</sup> Nursing homes must maintain clinical records for each resident in accordance with accepted professional standards and “shall safeguard clinical record information against loss, destruction or unauthorized use.”<sup>3</sup> These requirements are echoed in the federal Medicare Conditions of Participation for hospitals and long term care facilities.<sup>4</sup> The Medicare COPs for hospitals state “[m]edical records must be accurately written, promptly completed, properly

1. Education Law § 6530(32); 8 NYCRR § 29.2(a)(3)
2. 10 N.Y.C.R.R. 405.10.
3. 10 N.Y.C.R.R. 415.22.
4. 42 C.F.R. §§ 482.24, 483.75.

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filed and retained, and accessible.”<sup>5</sup> Aside from these general guidelines, there are no specific laws or regulations which speak to the subject of medical record entries. One must turn to other legal sources to gain insight on the potential consequences when a medical record is altered.

### **Malpractice Litigation**

If a provider is sued for medical malpractice, an improper alteration of the patient’s medical record may very well destroy his or her ability to defend the case. This is true even if the medical care in question was entirely appropriate.

The medical record is one of the most essential tools in the defense arsenal. It documents the patient’s history, the provider’s thought process, the basis for the diagnosis and treatment, and communications with the patient. Often, the patient’s version of events conflicts with what the provider has documented and, in such cases, the contemporaneous documentation is likely to be more persuasive. Documentation of the facts supporting the provider’s reasonable judgment will offer protection in showing that the standard of care was followed. Moreover, the record will show if the patient cancelled or failed to keep appointments, or if he/she was non-compliant in following treatment recommendations.

It is natural for a professional to become nervous and feel a bit panicked when sued for malpractice. It may be tempting to revisit the

medical record documentation and add facts to cast yourself in a more favorable light, erase or delete entries which conflict with your defensive posture, or even create a new record entirely. Even if the alteration is truthful, such impulses must be controlled. Any change in the record can easily be discovered during the course of pre-trial discovery investigation. For example, an earlier, conflicting version of the record may have already been sent to other providers or insurance companies, which will become evident when the attorneys begin gathering the plaintiff’s medical history. An altered medical record may conflict with previously submitted diagnostic codes in billing submissions. In a hospital setting, there may be several providers or nurses making entries in the record, which may highlight an inconsistency in altered documentation.

If the plaintiff’s attorney suspects that the record has been tampered with, the attorney may retain forensic consultants to analyze the record. Experts can detect changes to paper records through ink-dating, fingerprinting, and DNA analysis. Moreover, with an electronic medical record system, entries are tracked and audits will show the precise date and time of the original entry, the date and time of any changes, every instance where the physician logged into the system, and any changes to the content of each entry. It is virtually impossible to contradict what the system has electronically stored.

Medical records which are undated, illegible, incomplete or clearly erroneous can be used by a plaintiff to cast doubt upon the

quality of care the patient received from the provider. Proof of medical record alteration, without good cause and proper authentication, has serious consequences in malpractice litigation. Altering a medical record implies tampering with the evidence. Such proof will destroy the defendant’s credibility before a jury and will leave the strong impression that he or she is trying to hide the truth. Evidence indicating that a record has been altered can force the settlement of an otherwise defensible case.

Medical record alteration or destruction may also result in sanctions by the court for “spoliation of evidence.”<sup>6</sup> Penalties for spoliation may be imposed for the intentional or inadvertent alteration of medical record information that is relevant to litigation. Penalties can include monetary fines, including the payment of attorneys’ fees, a missing document or spoliation charge to the jury,<sup>7</sup> a preclusion order and an order striking a party’s pleading. Which sanction will be imposed in any particular case is largely unpredictable

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5. 42 CFR § 482.24(b).

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6. *Ahroner v. Israel Discount Bank of New York*, 79 A.D.3d 481 (1st Dep’t 2010).

7. The pattern spoliation charge states as follows: “If you find that defendant has destroyed an item that relates in an important way to the case, and no reasonable explanation for the destruction has been offered, you may, although you are not required to, infer that the destruction of the item had a fraudulent purpose and that if produced it would have been against the defendant’s interest. Moreover, such destruction casts doubt upon defendant’s position and may be considered against the defendant.” (New York Pattern Jury Instructions, 1:77.1).

and rests entirely within the prerogative of the trial judge. No matter what sanction the judge chooses to employ, a finding of spoliation will likely prevent your ability to successfully defend the case against you.

The dangers of altering a record after the fact are illustrated in the case of *Gomez v. Cabatic et al.*<sup>8</sup> There, the allegation of malpractice was a failure to diagnose Type 1 diabetes. The patient had been seen for three office visits, the last one on December 12, 2009. The critical issue in the case involved a discrepancy as to when the decedent was instructed to come back for follow up for blood testing. This testing would have shown her elevated blood sugar levels and prevented her death. When the doctor received a request from an attorney to send the patient's medical records, she prepared typewritten copies of her "scribbled" handwritten office notes and did not retain the original note from the last, most important patient visit.

In her typed notes, the doctor indicated she had instructed the patient to return in four weeks. However, at the time of the visit, the patient was given an appointment for February 2010, eight weeks later. This discrepancy became a pivotal issue in the case. The doctor testified that nothing had been changed from the original notes. The plaintiff argued, however, that the doctor



intentionally discarded her handwritten notes to hide the consequences of her inadequate care in order to avoid a malpractice claim.

The jury agreed with the plaintiff. A verdict was returned for \$650,000 in compensatory damages, but an additional award of \$7.5 million in punitive damages was returned against the doctor for altering the records. The trial court let the punitive damages finding stand, but reduced the award to \$1.2 million. Although this case is currently on appeal due to the magnitude of the punitive damage award, it stands as a frightening message of the potential consequences for a provider who makes changes to an original medical record. By law, punitive damages cannot be paid by an insurance policy, so any award must be paid out of the provider's own personal assets.

### **Criminal Penalties**

A provider who intentionally alters or destroys a medical record with the intent of committing a fraudu-

lent act can be charged with a crime and sentenced accordingly. Section 175.05 of the New York State Penal Law defines falsifying business records in the second degree as

[w]hen, with intent to defraud, [a person] makes or causes a false entry in the business records of an enterprise; or alters, erases, obliterates, deletes or destroys a true entry in the business records of an enterprise; or omits to make a true entry in the business records of an enterprise in violation of a duty to do so which he knows to be imposed upon him by law or by the nature of his position; or prevents the making of a true entry or causes the omission thereof in the business records of an enterprise.

Falsifying business records in the second degree is a class A misdemeanor, punishable by up to a year in jail. If the alteration/destruction is done with the intent to commit another crime, then the level of the

8. This case is an unreported decision of the Supreme Court, Queens County, April 7, 2014. It is currently on appeal to the Appellate Division, Second Department.

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# Case Study

## *Altered Medical Records Leads to Settlement*

*Helen Granich*

*Claims Unit Manager*

*Medical Liability Mutual Insurance Company*

A 23-year-old male plaintiff with a history of drug and alcohol abuse voluntarily presented for detoxification services for heroin and alcohol abuse at approximately 1:40 p.m. at a rehabilitation facility insured by MLMIC. He advised that he had hepatitis C. He reported that his last intake of alcohol consisted of four 22 oz. cans of beer at approximately 9:00 p.m. the previous night. His last reported drug intake was four bags of heroin which he had administered intravenously at approximately 4:00 a.m. that morning. His physical complaints included hot and cold sweats, joint pains, tremors, and abdominal pain.

The patient was 5 ft. 11 in. tall and 200 lbs. With the exception of a finding of gynecomastia, his vital signs and physical examination were normal. There was no documentation in the chart that laboratory studies were either ordered or performed. The admitting physician described the plaintiff's symptoms of withdrawal as "mild," with no significant physical findings. He ordered a combination of methadone and Librium for detoxification in accordance with the facility's protocol. According to the medical record, this was the plaintiff's first admission to this facility. The clinical summary

and progress notes both indicated that he was fully mobile both when he presented and during his stay at the facility.

On the first day of his admission, he received a total of 30 mg of methadone and 30 mg of Librium. The following morning, the physician's progress note read "Body aches persist unabated with headache and joint pain. Vital signs are stable. The patient is reportedly afebrile." Extra doses of methadone and Librium were ordered for him. Over the course of the second day of his admission, he received a total of 35 mg of methadone and 70 mg of Librium. No complaints or problems were documented that day.

The following afternoon, the physician's progress note stated: "body aches slightly diminished, moderate joint pain, slight headache, vital signs stable, afebrile." Once again, he ordered extra doses of methadone and Librium and continued the detoxification process in accordance with their protocol. The medical record reflected that the plaintiff received a total of 30 mg of methadone and 40 mg of Librium on the third day of his admission.

Later that same evening, the plaintiff complained to the nurses of having hiccups for at least 30

minutes. One of the nurses offered to send him to the emergency department. However, the plaintiff declined. He reported that his hiccups were "okay" and that he "sometimes gets hiccups which last 2-3 hours." He did not appear to be in distress and made no other complaints.

That same evening, after the change of shift, he again approached the nursing station complaining that he still had hiccups. He requested medication to stop them. He again declined going to the hospital. Instead, he requested a sleeping pill. At approximately 11:30 p.m., the plaintiff was given 50 mg of Vistaril.

According to an entry in the record timed between 3:00 a.m. and 4:00 a.m., the plaintiff was found to be asleep on rounds, "lying on his abdomen." The next entry was made at approximately 4:40 a.m. This entry noted that the patient was "lying on his abdomen" and "breathing." Finally, at 6:40 a.m., when his name was called, the plaintiff did not respond and did not have a palpable pulse. 911 was called and CPR started. At 7:15 a.m., EMS arrived. Shortly thereafter, the plaintiff was pronounced dead.

His body was sent to the medical examiner's (ME) office, where



an autopsy and toxicology tests were performed. The cause of death documented in the autopsy report was “acute intoxication” due to the combined effects of methadone and chlorthalidopoxide (Librium).

The ME noted that the medical record reflected that the plaintiff had received his last dose of methadone at 9:00 p.m. on the third evening of his admission. The nursing notes indicated that the plaintiff was sleeping between 3:00 a.m. and 4:00 a.m. However, the toxicology tests revealed that he had a very high concentration of methadone with a very small concentration of the products of the breakdown of methadone. The ME believed that if the plaintiff had in fact received methadone at 9:00 p.m. and was still alive shortly before 5:00 a.m., his blood would have contained very little methadone and much more of the products from the breakdown of methadone. In fact, the ME felt so strongly about what had occurred, he wrote a scathing letter to the Division of Legal Affairs at the Office of Alcohol and Substance Abuse Services. He outlined the poor care and treatment the facility had provided and, further, questioned the authenticity and credibility of the medical



record. He copied the mother of the deceased plaintiff on this letter.

Although he was not married to the child’s mother, the decedent was survived by a then 2½ year old son. After an administrator for his estate was appointed, a lawsuit was commenced. The allegations included negligence, the administration of a lethal dose of medications, conscious pain and suffering, failure to properly monitor the decedent, and wrongful death.

Multiple expert reviews were secured on behalf of the treatment facility. Many of the experts disagreed with the ME’s position that the methadone and Librium levels were toxic. However, all agreed that there was a serious problem with the credibility of the nursing documentation. A review of the medical record revealed that the staff of the facility always charted by exception. Only one baseline note would be documented during an entire shift.

However, if there was a problem or complaint, another note would be documented. At no point in the record did the nurses ever document hourly rounds or benign patient assessments. This was particularly true during the early morning hours of the night shift. However, the nursing notes on the third night of the plaintiff’s admission reflected an entry at 4:50 a.m. which appeared to have been altered from what originally appeared to be a 6:40 a.m. entry. Additionally, the documentation that the plaintiff was “lying on his abdomen” and “breathing” was highly suspicious because there was no similar documentation during the two previous nights.

Based upon the fact that the record appeared to be both inaccurate as well as altered, it was recommended that the lawsuit be settled. Eventually, the lawsuit was settled on behalf of the young son of the deceased for \$175,000. ❖

# *MLMIC and Berkshire Hathaway – What You Need to Know*

**M**edical Liability Mutual Insurance Company (MLMIC) recently announced that it has entered into a definitive agreement, pending regulatory and policyholder approval, to be acquired by National Indemnity Company, following the completion of the conversion of MLMIC to a stock company from a mutual company. National Indemnity Company is a subsidiary of Berkshire Hathaway Inc., one of the world's leading insurance organizations. The transaction is expected to close in the third quarter of 2017, subject to customary closing conditions and regulatory approvals.

## **Questions and Answers about MLMIC's Sponsored Demutualization**

### **1. What is occurring?**

MLMIC, as a mutual insurance company, is currently owned by its policyholders. Policyholders' ownership interests in MLMIC are known as "Policyholder Membership Interests." These Policyholder Membership Interests include the right to vote on matters submitted to a vote of members (such as the election of directors) and the right to participate in any distribution of surplus, earnings and profits.

Demutualization is the process by which a mutual insurance



company converts from a company that is owned by its policyholders into a stock insurance company that is owned by its shareholders.

In a sponsored demutualization, the stock of the converted mutual is acquired by a sponsor. National Indemnity Company ("Sponsor"), a subsidiary of Berkshire Hathaway Inc., is the sponsor of the proposed demutualization of MLMIC. If the proposed demutualization of MLMIC is approved by both policyholders and the New York State Department of Financial Services (the "Department"), and the conditions are satisfied or waived in accordance with the plan of conversion and the acquisition agreement, all Policyholder Membership

Interests will be extinguished, and Sponsor will become the sole owner of MLMIC.

### **2. Why is MLMIC demutualizing?**

After careful deliberation, the Board of Directors of MLMIC determined that becoming a wholly owned subsidiary of the Sponsor following the completion of the demutualization, and thereby becoming a member of the Berkshire Hathaway group of companies (the "Berkshire Hathaway Group") is in the best interests of MLMIC and its policyholders because, among other things: such affiliation will help ensure the continuity of MLMIC's medical

professional liability insurance and other business and will enhance the competitiveness of MLMIC; MLMIC will become a member of a group that includes other insurers that specialize in providing liability insurance coverage to healthcare providers. The affiliation will provide additional healthcare contacts and insights for MLMIC; such affiliation will enhance MLMIC's financial strength and will provide MLMIC with greater resources to back its obligations to policyholders and to underwrite additional business; and such affiliation will provide MLMIC with increased flexibility to support the growth of existing product lines.

### **3. Why is Berkshire Hathaway interested in acquiring MLMIC?**

Berkshire Hathaway values our operations, Board of Directors, staff and endorsed partners and is committed to MLMIC's future success and its dedication to serving policyholders. Berkshire Hathaway's CEO Warren Buffett said, "MLMIC is a gem of a company that has protected New York's physicians, mid-level providers, hospitals and dentists like no other for over 40 years. We welcome the chance to add them to the Berkshire Hathaway family and enhance their capacity to serve these and other policyholders for many years to come."

### **4. Will MLMIC get a rating from A.M. Best?**

MLMIC is currently not rated by A.M. Best but will seek a rating from

them once the transaction closes. National Indemnity Company is rated A++ by A.M. Best.

### **5. Will policyholders receive a payout?**

Once the transaction is completed, each owner of an eligible policy will be entitled to receive a proportionate share of all of the cash consideration paid by National Indemnity Company. In most cases, the person or entity that paid the premium will be considered as the owner of the eligible policy. As required under the New York Insurance Law, proportionate shares will be determined by dividing the premium paid on each eligible policy from July 14, 2013, through July 14, 2016, by the total premium MLMIC received for all policyholders during that period. Such proportionate share will then be multiplied by the cash consideration received from National Indemnity Company to determine the amount of cash allocable to such policyholder. We currently estimate that each owner's cash entitlement will be approximately equal to the sum of the premiums paid to us on the applicable eligible policy during such three-year period. Please note that this is an estimate only and that the actual amount will be determined as of closing and in accordance with all applicable New York insurance law and regulatory requirements. Policies issued with an effective date on or after July 15, 2016, will not be eligible for this cash payout.

### **6. Is the receipt of cash by owners of eligible policies taxable?**

The receipt of cash by owners of eligible policies will be a taxable transaction for U.S. federal income tax purposes.

### **7. Will any MLMIC director, officer or staff member receive a payout?**

No MLMIC director, officer or staff member will receive any of the cash consideration payout from National Indemnity Company in connection with the transaction other than any proportionate share such person is entitled to receive in their capacity as an eligible policyholder.

### **8. Will policyholders continue to be owners of MLMIC?**

Following the conversion from a mutual to a stock company (and subsequent acquisition by Sponsor), policyholders will no longer have an ownership interest in MLMIC and all Policyholder Membership Interests will be extinguished.

### **9. How will the demutualization and acquisition affect my insurance policy?**

Policyholders will see no change in MLMIC's operations and commitment to policyholder-first service. Consummation of the sponsored demutualization will not increase premiums or reduce the coverage under your Policy.

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# Creating a Welcoming Clinical Environment for Lesbian, Gay, Bisexual, and Transgender Patients

Mark Ambrose

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The lesbian gay bisexual and transgender (LGBT) patient population often faces unique challenges in obtaining medical care. Issues such as access to healthcare coverage and providers, identification of appropriate restrooms, and the limitations of some electronic health record systems to properly identify gender are just a few of the challenges this population faces when seeking routine healthcare.

For many LGBT patients, it is difficult to reveal their sexual orientation to providers due to perceived or actual biases within the medical community. Conversely, medical personnel may simply feel uncomfortable asking about sexual orientation or gender identity. Whichever the case may be, this lack of communication can result in sub-standard care. It may even lead LGBT patients to delay care, avoid care all together, or even receive inappropriate care.

Healthcare providers can take positive steps to promote the health of their LGBT patients by examining their practices, offices, policies, and staff training for ways to improve access to quality healthcare for LGBT patients. Implementing policies and practices conducive to the needs of LGBT patients will foster better communication, assist in the

identification of an appropriate care plan, enhance access to necessary studies, and improve patient relations. Here are a few resources to assist providers to take positive steps to improve the health of their LGBT patients.

- The American Medical Association has published guidelines that will assist you, including creating an LGBT-friendly office practice and guidelines for effectively communicating with LGBT patients, as well as offering additional resources to consider when caring for this patient population. You can find these sources on the AMA website at: <http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glbt-advisory-committee/glbt-resources.page?>
- Lambda Legal has published “Creating Equal Access to Quality Health Care for Transgender Patients: Transgender-Affirming Hospital Policies.” This publication offers guidance to hospitals looking to develop LGBT-affirming policies and practices. The publication can be found at: [http://www.lamdalegal.org/sites/default/files/publications/downloads/fs\\_20160525\\_transgender-affirming-hospital-policies.pdf](http://www.lamdalegal.org/sites/default/files/publications/downloads/fs_20160525_transgender-affirming-hospital-policies.pdf)

[www.lamdalegal.org/sites/default/files/publications/downloads/fs\\_20160525\\_transgender-affirming-hospital-policies.pdf](http://www.lamdalegal.org/sites/default/files/publications/downloads/fs_20160525_transgender-affirming-hospital-policies.pdf)

- The National LGBT Health Education Center provides background information on transgender people and their health needs as well as tips and strategies to improve communication and create a more affirming environment. The publication “Affirmative Care for Transgender and Gender Non-Conforming People: Best Practices for Front-line Health Care Staff” can be accessed at [http://www.lgbthealtheducation.org/wp-content/uploads/13-017\\_TransBestPracticesforFrontlineStaff\\_v6\\_02-19-13\\_FINAL.pdf](http://www.lgbthealtheducation.org/wp-content/uploads/13-017_TransBestPracticesforFrontlineStaff_v6_02-19-13_FINAL.pdf) ❖





## *The Benefits of Maintaining a Long-Term Relationship with Your Medical Malpractice Insurance Carrier*

Robert Pedrazzi

Assistant Vice President, Underwriting  
Medical Liability Mutual Insurance Company

As indicated in our previous Underwriting Update, *The Importance for Policyholders to Insure with a Financially Sound Insurance Company—Just How Important is an Insurer's Financials to its Insureds?*, medical malpractice insurance (more formally known as medical professional liability insurance or MPLI) is a highly volatile line of business that is cyclical in nature. Unknown to many, this characteristic commonly induces new players to enter the market in an effort to profit handsomely during the opportune times which occur in “soft market” cycles.

Not surprisingly, many of these new and oftentimes inexperienced entrants to this specialized marketplace are not hesitant to withdraw from the market when upward cycle tics lead to a “hard market” and they witness a corresponding rise in indemnity payments and legal defense expense costs. History has repeatedly proven that, under such circumstances, many newcomers to the marketplace tend to withdraw from this line of business or even succumb to insolvency. Either scenario results in policyholders having to rapidly search for replacement coverage under a certain deadline; a stressful situation that may lead to uncertainty regarding the handling



of their known and unknown future claims. Even established carriers may sometimes offer unwarranted “discount” pricing, jeopardizing their solvency, for the sake of nothing more than a gain in market share.

Earlier this year, various media sources had reported on the questionable finances of an admitted (licensed) NYS carrier as well as the effect that a large influx of Risk Retention Groups (RRG) was having on the entire admitted NY MPLI marketplace. The articles raised awareness of their overall impact, highlighting the disconcerting financials of the referenced admitted carrier as well as pointing out the concerning fact that RRG's

may exit the market whenever they desire as they are solely governed by the state in which they are licensed. Aside from these concerns, and often overlooked by many policyholders, healthcare practitioners should be cognizant of the benefits of maintaining a long-term relationship with their trusted and proven carrier. It is equally important to understand the downsides of frequently changing MPLI insurers for what is often nothing more than short-term premium relief. Such a tempting course of action could eventually result in many unanticipated ramifications for practitioners, including

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## Long Term Relationships *continued from page 9*



the possibility of a loss of insurance protection should their insurer become insolvent and not eligible to participate in the NYS Property/Casualty Insurance Security Fund, as is the case for RRGs (for additional information on RRGs, see the article *Risk Retention Groups: Weighing the Risks* in the Spring 2013 edition of *Dateline*). The protection of this fund, which is only afforded to admitted NYS carriers, steps in to provide limited payment of covered claims on behalf of insolvent insurers.

Practitioners who opt to insure and maintain a relationship with a financially strong and stable insurer reap many benefits by “partnering” with them. This business strategy affords a more stable and secure financial environment, ensuring the

company’s ability to meet obligations to its insureds through hard markets without jeopardizing solvency. MPLI companies that adhere to this balanced approach, which is the proven formula to properly address the cyclical nature of this line of business, have stood the test of time. MLMIC’s over forty years in operation are testament to this fact. Those MPLI carriers who opt to “chase pricing” after their competitors are more prone to fail, to the detriment of their insureds.

One other point worth considering in this matter is the prospective handling of either existing or future lawsuits after an insured is no longer covered by their prior carrier. MPLI lawsuits, from the inception of a case to its closure, generally take years to

resolve and require ongoing communications between the policyholder and their insurer. Those practitioners who maintain a consistent relationship with a financially sound carrier such as MLMIC can rest assured, knowing that their claim is being handled with the utmost level of service and integrity that they had originally signed-up for. Unlike MLMIC, a practitioner’s previous carrier, with whom they are no longer insured, may not have the incentive or resources to vigorously defend ongoing cases. In the absence of a current relationship, insurers may be more inclined to opt for the most cost saving approach when handling these claims.

Given the facts presented in this article, it would be a shortsighted view for practitioners to cease a successful relationship/partnership with their proven MPLI insurer for nothing more than the potential for short-term premium savings. Practitioners should be very cautious before considering such a move and should fully examine not only the financials of a prospective insurer, but their service track record as well. ❖



## *Alteration of Medical Records* continued from page 3

offense rises to falsifying records in the first degree, a class E felony, with exposure to an even longer jail sentence. If the loss or destruction of physical evidence was willful for the purpose of preventing its use in an official proceeding, such as a lawsuit, the provider can be charged with the felony of tampering with physical evidence under Penal Law § 215.40.

Although criminal charges may seem far-fetched, the possibility is not to be taken lightly. For example, in *People v. Smithtown General Hospital*,<sup>9</sup> an orthopedic surgeon and a registered nurse permitted a salesman of prosthetic devices to participate in a meaningful way in a surgical procedure being performed at the hospital without the knowledge or consent of the patient. The surgeon failed to make an entry in the operative report regarding the salesman's participation, and the supervising nurse similarly did not make an entry in the operating room log. Both were indicted and charged with falsification of business records in the second degree, alleging an intent to defraud and conceal the crime of unauthorized practice of medicine. The defendants asked the court to dismiss the indictments, which the court denied, finding that the evidence was legally sufficient to support the crimes charged.

### **Professional Misconduct**

As noted above, New York defines professional misconduct as “failing to maintain a record for each patient which accurately reflects the evalua-



tion and treatment of the patient.” Violation of this standard can result in proceedings against a physician's license. Generally, this allegation of professional misconduct is charged in conjunction with other patient care failures. One example is *Pearl v. NY State Board for Professional Medical Conduct*,<sup>10</sup> where a doctor was charged with 24 specifications of professional misconduct arising out of his treatment of 6 patients, together with altering the medical records of one of the patients and making false statements on his application for hospital privileges. The evidence showed that the physician had retrieved a closed record from the medical records room and inserted a notation that the “risks, alternatives, and benefits” of certain treatments had been explained to the patient. However, an unaltered

copy had already been sent out to the patient's attorney. Upon learning that the record had already been sent out, the physician then attempted to use “white out” to obliterate his previous alteration. Based upon all of the allegations of wrongdoing, the Board for Professional Medical Conduct revoked the physician's license.

### **Amendments and Corrections to the Medical Record**

Occasionally, upon review, a provider may discover that certain entries were not properly documented and need to be corrected after rendering the service. From time to time it may be necessary to correct a mistake or enter more accurate information. As illustrated above, any changes to the original documentation must be

9. 93 Misc. 2d 736 (Supreme Court Suffolk County 1978).

10. 295 A.D.2d 764 (3d Dep't 2002).

*continued on page 12*



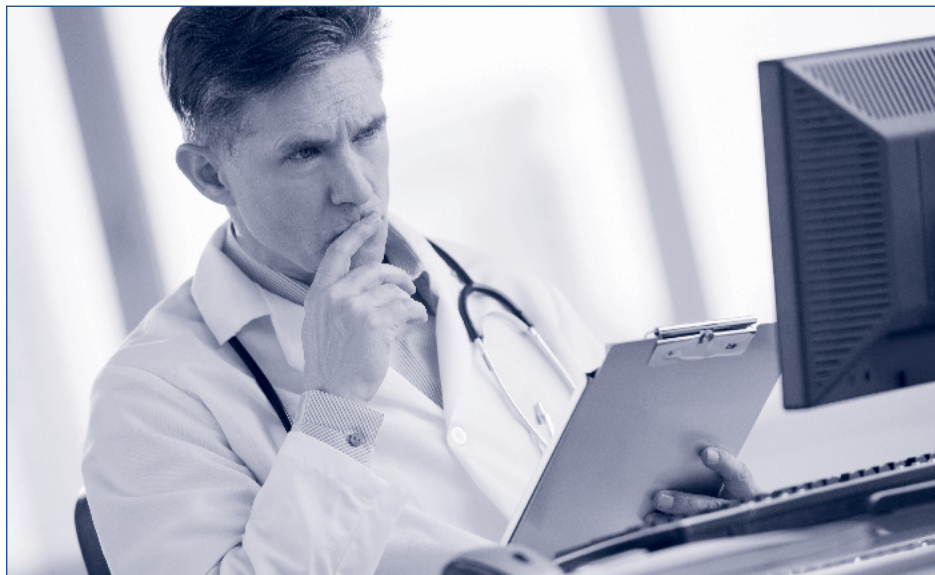
legitimate and must be accomplished in an appropriate manner. All changes must be clearly labeled as such so that there can be no allegation of fraudulent conduct or an intentional cover up. If corrections are required, the provider should:

1. clearly and permanently identify any amendment, correction, or delayed entry;
2. clearly indicate the date and author of any amendment, correction, or delayed entry; and
3. not delete, but clearly identify all original content.<sup>11</sup>

With a paper medical record, correction of misinformation is usually accomplished by a single line strike out of the original text so that the original content is still legible. The correct information should then be entered above, below, or next to the entry which was crossed out. The person making the entry must date and sign the change next to the corrected information.

If it is necessary to include additional information in the record, this should be done by means of an addendum. Any addendum should refer to the original note being amended. There should be a heading titled “Addendum” or “Late Entry,” with the new information appearing underneath. Once again, the entry must be dated and signed.

The concept is exactly the same with electronic medical records, although the manner in which changes can be made in an EMR are



highly dependent upon the system.<sup>12</sup> As with paper records, the overriding principle is that the correction or addendum must be clearly identified, and there must be a reliable method to clearly distinguish between the original content versus the modified content. In all cases, the author must date and sign the correction or amendment. If the original documentation has been signed and “locked” from further editing, then the correction must occur through an addition to the record. At times, when the note has been locked and the correction involves deletion of erroneous information, EMR systems personnel may be the only ones who can eliminate information. In this instance,

the audit/tracking function within an EMR will identify when changes were made and by whom. Further, the original information must still be retrievable, although the error would not be visible upon regular viewing of the patient’s medical record. The displayed record should still reflect that a correction was made to delete erroneous information in the patient’s chart.

### **Conclusion**

All corrections to a medical record should be handled on a case-by-case basis to ensure the integrity of the patient’s chart and avoid the appearance of misconduct. A provider must act deliberately, carefully, and thoughtfully when inserting additional information to a medical record, altering what was previously documented, or eliminating information. Organizations should have clearly defined guidelines regarding when and how changes may be made in order to protect against perilous consequences. ❖

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11. Medicare Program Integrity Manual, Chapter 3 – Verifying Potential Errors and Taking Corrective Actions, issued 12-07-12.

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12. The American Health Information Management Association has published a guidance document and sample policies for making addenda, amendments, corrections, and deletions in an electronic medical record. [http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1\\_044678.hcsp?dDocName=bok1\\_044678](http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_044678.hcsp?dDocName=bok1_044678)



**10. Will policyholders continue to receive dividends?**

After the transaction is completed, policyholders will no longer have an ownership interest in MLMIC and, as such, will not receive any dividends.

**11. What will happen to MLMIC rates?**

MLMIC will remain a licensed insurer of New York State, regulated by the Department. Premium rates for physicians will continue to be set by the Department. Premium rates for hospitals, dentists, mid-level providers and other lines of business

will continue to be approved by the Department.

**12. If I have a claim, what will happen?**

There will be no change in our claim handling, operations or philosophy of providing a strong defense against claims brought against our policyholders.

**13. What are the next steps?**

The parties will work with the Department to complete the transaction and provide policyholders with the required notices at the appropriate times. The approval process will include both a public hearing and a

meeting of policyholders to approve the transaction. In the meantime, MLMIC will continue to provide the policyholder-first service it has delivered to healthcare providers in New York State for over 40 years. ❖



## *Dateline...* Not Just for Physicians!

From risk management tips and illustrative case studies to analyses of emerging exposures, *Dateline* provides valuable, timely information for healthcare practitioners of all types. We encourage you to share it with your coworkers and staff.

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# RISK MANAGEMENT Tips

## Tip# 20: Reducing the Risk of the “Copy and Paste” Function in Electronic Health Records

**The Risks:** The “copy and paste” function of electronic health record systems (EHRs) allows users to easily duplicate information such as text, images, and other data within or between documents. While this function offers convenience and efficiency to healthcare providers, it also poses unique liability risks when the information copied and pasted is either inaccurate or outdated. Further, redundancy within the new entry may cause difficulty in identifying current information and may create overly lengthy progress notes.

### Recommendations:

1. Develop a comprehensive policy and procedure for the appropriate use of the copy and paste function. The policy should include a process to monitor and audit both the staff and providers’ use of this function.
2. Educate all EHR users about:
  - the importance of verifying that the copied and pasted information is correct and accurately describes the patient’s current condition;
  - the risks to patient safety in the inappropriate use of this function; and
  - the importance of adhering to all regulatory, legal, and compliance guidelines.
3. Determine what portions of the record should be copied and pasted. At a minimum, the healthcare provider’s signature(s) should not be copied and pasted.
4. Confirm that the source of information which has been copied and pasted can be readily identified and is available for review in the future.
5. Confirm that the history of the present illness is based upon the patient’s description during that visit.
6. Use the medical, social, or family history from a previous note only after it has been reviewed with the patient to confirm it is relevant to the current appointment.
7. Verify that the diagnoses in your assessment are only those addressed at that visit. Although some EHRs allow the copying of all diagnoses in the problem list, some may either have already been resolved or are not the reason for this particular encounter.
8. Contact your EHR vendor as necessary to help you and your staff comply with established policies. This may include the vendor making modifications which disable the copy and paste function in designated fields, and assisting in performing audits of the use of the copy and paste function by staff and providers.

## 2016 Event Calendar

MLMIC representatives will be in attendance at the following events:

### OCTOBER 2016

- |             |  |
|-------------|--|
| 10/14-15/16 | MSSNY Third & Fourth District Fall Retreat<br>(Saratoga Springs) |
| 21-22       | ACOG Annual District II Meeting (NYC)                            |
| 22          | Queens County Medical Society Physician Expo & Gala              |

### DECEMBER 2016

- |       |  |
|-------|--|
| 10-12 | New York State Society of Anesthesiologists Post Graduate Assembly (NYC) |
|-------|--|

*For more information on MLMIC’s participation at these events and others, please contact Pastor Jorge, Manager, Marketing Services, at 212-576-9680.*

# THE MLMIC Library

## Fall 2016 Update

The MLMIC Library's services are available to all policyholders on a complimentary basis and may be accessed via MLMIC.com by selecting the MLMIC Library link at the bottom of the home page under Risk Management. In-depth research services are also available to all policyholders.

The following resources are newly acquired and/or pertain to topics featured in this issue of *Dateline*. Visit the MLMIC Library to learn more about these titles and borrow up to five items from our extensive collection. Or, contact Judi Kroft, Library Services Administrator at 800-635-0666, ext. 2786 or via e-mail at [jkroft@mlmic.com](mailto:jkroft@mlmic.com).

- **Assessing the competency of low-volume practitioners: Tools and strategies for OPPE and FPPE compliance.** Mark A. Smith and Sally Pelletier. HCPro, Inc.; 2009 (Med Staff 113-080 2009).
- **CMS compliance crosswalk, 2016.** Cheryl A. Niespodziani and Beth A. Hepola. HCPro, Inc.; 2016 (Hosp Adm 312-041 2016).
- **HIPAA compliance handbook 2016.** Patricia I. Carter. Aspen Publishers, Inc.; 2016 (Medicolegal 330-019 2016).
- **Joint Commission survey coordinator's handbook, seventeenth edition.** Patricia Pejakovich, et al. HCPro, Inc.; 2016 (Hosp Adm 312-037 2016).
- **Managing problem practitioners: Leadership guide to dealing with impaired, disruptive, aging, and burned-out clinicians.** Todd Sagin. HCPro; 2015 (Phys 539-074).
- **Medical record auditor: Documentation rules and rationales with exercises.** Deborah J. Grider. American Medical Association; 2014 (Med Rcds 500-036 2014).
- **Root cause analysis playbook: An enterprise risk management approach and implementation guide.** ASHRM; 2015 (R M 151-146 2015).
- **Serving residents with dementia: Transformative care strategies for assisted living providers.** Kerry C. Mills. HCPro; 2015 (LTC 104-147).
- **Telemental health: Clinical, technical and administrative foundations for evidence-based practice.** Kathleen Myers and Carolyn L. Turvey. Elsevier Inc.; 2013 (Medicolegal 330-047).
- **Verify and comply: Credentialing and medical staff standards crosswalk.** Carol S. Cairns, and, Kathy Matzka. HCPro, Inc.; 2014 (Med Staff 113-060 2014).
- **Strengthening nurse-physician relationships: A guide to effective communications.** HCPro; 2005 (DVD 002-551).
- **Strengthening nurse-to-nurse relationships: A guide to ending horizontal hostility.** HCPro; 2007 (DVD 002-550).
- **Taming disruptive behavior.** William "Marty" Martin, Phillip Hemphill. American College of Physician Executives; 2013 (R M 151-141).

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*The attorneys at Fager Amsler Keller & Schoppmann, LLP are available during normal business hours to assist MLMIC insureds with a wide range of legal services, including, but not limited to, advisory opinions concerning healthcare liability issues, liability litigation activities, lecture programs, and consulting services.*

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The screenshot shows the MLMIC.com Blog homepage. At the top is the MLMIC logo and navigation links: HOME, ABOUT, PHYSICIANS, HOSPITALS, DENTISTS, BLOG, and CONTACT US. Below the navigation is a large image of medical professionals. The main content area features two blog posts:

- AUG 19 CDC to Release New *Vital Signs* Report on Sepsis**  
The CDC is offering six opportunities for you to learn more about sepsis from the new Vital Signs report and show your support during September in honor of Sepsis Awareness Month.
- AUG 3 New Risk Management CME Module: High Exposure Liability**  
MLMIC's newest online risk management CME modules explore issues and risks associated with high exposure liability claims.

On the right side of the blog page, there is a search bar labeled "Search Blog", a "GET A QUOTE" button with the text "Plus, see what discounts you may qualify for.", and a section titled "Stay up-to-date with our latest blog posts:" which includes an email sign-up form and a checkbox for "Physicians".