CHART DOCUMENTATION

Bill Tullo, OD, FAAO
Vice President of Clinical Services
TLC Laser Eye Centers

Patient Chart

• Legal Document
• Jurors view as most important evidence
• Poor chart documentation increases risk of a case going to litigation
• Poor chart documentation increases risk of successful litigation against a surgeon
• Discrepancies, sloppiness and carelessness can be made to appear as dishonesty

Problem

• Refractive Surgery is self-pay and not insurance based procedure
• Often not subject to insurance audits
• Leads to less complete charting due to lack of need to prove medical necessity for level of office visit
Most common missing data

- Assessment
- Diagnosis
- Plan
- Medications
- BCVA
- Biomicroscopy
  - Evidence of surgeon’s physical examination

Plaintiff Attorney’s Top 4 Favorite Strategies

- Lack of Informed Consent
- Inadequate examination/testing
- Proof of surgeon review
- Intent to deceive

Informed Consent Process

- Pre-printed Form – minimal requirements
  - Common risks, benefits and alternatives
- Hand written addendums
  - For all findings outside norm
  - All physician discussions
  - All questions answered
- Document all phone and e-mail correspondence
- Surgeon meet with patient prior to day of surgery
### Inadequate Testing

- **Dilated Retinal Examination**
  - Retinal holes/tears
  - Vitreous Detachments/Degeneration
  - Pre-existing retinopathy
    - Central Serous
    - RP
  - Glaucoma Suspect
    - Optic nerve cupping
    - Elevated IOP
    - Lack of VF or OCT
- **Macular Edema**
  - Delay in diagnosis = Delay in effective treatment

### Inadequate Testing

- **Binocular Vision Testing**
  - Identify pre-existing dysfunction

- **Dry Eye Testing**
  - Document pre-existing condition

- **BCVA**
  - Medical necessity – Cataracts
  - Timely identification of reduced BCVA

### Proof of Review

- **Topography**
  - Rule out risk factors for increased ectasia risk

- **Treatment Plan**
  - Proof of surgeon approval

- **Ocular/Systemic Health History**

- **Medications/Allergies**
Intent to Deceive

- Missing testing or examination visits
- Altered records
- Ectasia
  - Document exact diagnosis – not description
  - Document prognosis
  - Document non-surgical and surgical treatment options

Avoid

- Poor handwriting
- Undefined abbreviations
- Non-black ink
- White-out
- Sticky notes
- Altering content

Recommendations

- Quality Assurance
  - Peer Review Process
  - Self-audits
- Medications
  - Flow sheet
  - Treatment orders
  - Narcotic log
- Co-management
  - Transfer of care