**Liability issues related to illegible physician documentation**
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Compliance and Health Information Management professionals often tell stories about attending physicians who have handwriting that is difficult to understand. Poor handwriting results in illegible documentation creating liability and risk issues for hospitals and physicians. These include False Claims Act issues, quality assurance issues, risk management issues, JCAHO accreditation issues, increased audit potential from public and private payers, as well as medical malpractice risks. In addition, illegible documentation can have a direct negative impact on patient care resulting in improper medical treatment or the dispensing of the wrong medication.

More specifically, illegibility can lead to:

- Improper treatment of the patient
- Negligence on the part of the physician and the health care organization
- Medical malpractice on the part of the physician and the health care organization
- Dispensing of wrong medications
- The assumption that the service was not provided
- High error rates in documentation and coding audits
- No payment for services provided
- Allegations of “under documentation” or “insufficient documentation”
- Claims of medically unnecessary services being provided
- Poor continuity of patient care
- An impact on quality of patient care overall

Medicare Carriers and intermediaries often review medical charts to ensure that the documentation is consistent with the reimbursement received. The audits

and medical chart reviews are performed by medical record professional and/or clinicians. These auditors will not spend an inordinate amount of time attempting to decipher the handwriting of the attending physician. When handwriting is illegible, the auditor will not give any credit to that portion of the documentation. Although the service was legitimately provided, the illegible documentation creates a substantial legal risk. Illegible documentation is of *no value* in verifying medical necessity or coding accuracy for services billed. (Medicare Policy Manual, DOC-1, "Documentation of Services", Para. 2, Rev. 3/97.)

In addition to issues of illegible documentation and their impact on reimbursement, JCAHO Hospital Accreditation Standards also address issues of medical record legibility. Indeed, IM.7.10.1 states that the review of medical records must address the “presence, timeliness, ***legibility,*** and authentication” of the following:

- Identification data;
- Medical history, including the chief complaint; details of the present illness; relevant past, social, and family histories (appropriate to the patient’s age); and an inventory by body system;
- A summary of the patient’s psychological needs, as appropriate to the patient’s age;
- A report of relevant physical examinations;
- A statement on the conclusions or impressions drawn from the admission history and physical examination;
- A statement on the course of action planned for the patient for this episode of care and of its periodic review, as appropriate;
- Diagnostic and therapeutic orders;
- Evidence of appropriate informed consent;
- Clinical observations, including the results of therapy;
- Progress notes made by the medical staff and other authorized staff;
- Consultation reports;
- Reports of operative and other invasive procedures, tests, and their results;

- Reports of any diagnostic and therapeutic procedures, such as pathology and clinical laboratory examinations and radiology and nuclear medicine examinations or treatment;
- Records of donation and receipt of transplants or implants;
- Final diagnosis(es);
- Conclusions at termination of hospitalization;
- Clinical resumes and discharge summaries;
- Discharge instructions to the patient of family; and
- When performed, results of autopsy.

Case law has been very informative on the issue of illegible physician documentation in the areas of Social Security Income (SSI) benefits and physician disciplinary and licensure issues. For example, in the case of Holle v. Barnhart, Commissioner of Social Security, 2002 WL 1770535 (N.D.Ill.), the court denied plaintiffs Social Security Disability claim based in part upon illegible medical record documentation. The court stated:

> "Plaintiff's medical records do not indicate any objective medical evidence supporting Plaintiff's complaints of disabling pain. This court also notes that the treatment notes submitted by Dr. Johnson were illegible. This court attempted, mostly unsuccessfully, to decipher the notes and was unable to make out any diagnosis or find any evidence supporting Plaintiff's allegations. Dr. Johnson's opinion that Plaintiff is totally disabled is therefore unsubstantiated as it is not otherwise supported by objective medical evidence."

A second excellent example of illegible physician documentation is the case of Balmir v. DeBuono, Commissioner of the New York State Department of Health, et.al., 237 A.D.2d 648, 655 N.Y.S.2d 113 (1997). There, the Bureau of Professional Medical Conduct charged Dr. Balmir with 19 specific acts of misconduct in an effort to revoke his license to practice medicine.

In upholding the physician's revocation of his license to practice medicine, the court noted that Dr. Balmir failed to

maintain adequate medical records. This included "making terse, incomplete and often illegible notations of physical findings....."

In conclusion, it is very critical for Compliance and Health Information Management professionals to understand the liability and risk areas related to illegible physician documentation. Moreover, it is critical to review physician handwriting legibility as functions of internal compliance monitoring and external compliance auditing.