



# INSIGHTS

THOUGHT LEADERSHIP, ARTICLES, CASE STUDIES & MORE

BY: MEDICAL & LIFE CARE CONSULTING

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## MEDICAL CHART REVIEWS & CHRONOLOGIES SEVEN BEST PRACTICES AND WHY THEY'RE IMPORTANT

Documentary evidence is a critical component of all litigious matters. Thinking specifically about retrospective chart reviews, also known as a medical record review, a thorough understanding of the information within medical records can make or break a case. In this month's **INSIGHTS** article, we explore medical chart reviews and chronologies and share seven best practices for attorneys and paralegals when reviewing medical records, interpreting the information, and when to engage a medical professional for expert review and analysis.

### ARTICLE HIGHLIGHTS

- WHAT IS A MEDICAL CHART REVIEW, AND WHAT IS A CHRONOLOGY?
- WHEN SHOULD A MEDICAL CHART REVIEW AND CHRONOLOGY BE COMPLETED?
- WONDERING WHETHER IT'S TIME TO ENGAGE A MEDICAL PROFESSIONAL? LOOK FOR THESE RED FLAGS

## WHAT IS A MEDICAL CHART REVIEW, AND WHAT IS A CHRONOLOGY?

Medical records include various components and documentation of patient history, clinical findings, diagnostic test results, preoperative care, operation notes, post-operative care, and daily notes of a patient's progress and medications after an injury or illness.<sup>[1]</sup> "The medical record frequently is the most important document available in defending against or preventing legal actions, including but not limited to personal injury suits, criminal cases, workers' compensation actions, disability determinations, and claims of negligent or improper healthcare (medical malpractice), and is generally admissible at a trial."<sup>[2]</sup> A medical record chronology organizes medical records, treatment history, and

***...frequently, the most important document available in defending against, or preventing legal actions...***



medication history from the injury or illness date to the present.

## WHEN SHOULD A MEDICAL CHART REVIEW AND CHRONOLOGY BE COMPLETED?

A medical chart review and chronology is completed either before or after a lawsuit is initiated. Before filing a case, a medical chart review and chronology is a great resource to reveal the story, gain a deeper understanding of the injury or illness, and determine whether liability is attributed to the opposing party. A medical chart review might also be completed after a lawsuit is filed by either the plaintiff or the defense. The complexities and long-term implications of an injury or illness, the necessary treatment, and the attorney's experience generally inform whether a review and chronology is completed before or after initiating legal action.

To get the most from a medical chart review and chronology, we share seven best practices for reviewing and understanding medical records and the stories they tell.

## 1. UNDERSTAND THE INFORMATION YOU'RE LOOKING FOR AND HOW IT GETS INTO THE CHART

A foundational understanding of who adds information to a medical record and how that information is added is paramount to completing a thorough medical chart review. Many health care providers can add information to an individual's medical chart, including the medical transport team, physicians, nurses, laboratory technicians, physical therapists, and any other health care professional providing care. Consider an automobile accident with 12 months of post-injury treatment; at the very least, records should be reviewed from the accident's scene or initiation of injury to the present time. In this instance, records include those of the EMT team that assist the scene, emergency room records, in-patient acute hospital records, rehabilitation hospital records, and outpatient care and physician visit records. And each encounter with a professional may include the chief complaint, physical exam, history of present illness, an assessment and plan, lab or radiological orders, prescriptions, progress notes, and test results.

It is also essential to understand how the information gets into the record – is it dictated and transcribed, or handwritten, as the method used for charting can

affect the accuracy of the information. According to Air Medical Journal, "...the process of dictation and transcription has been shown to introduce more inaccuracies into the medical record, such as in recording childhood immunizations."<sup>[iii]</sup> Electronic health records add yet another layer of complexity and may be confusing for the untrained eye to review and understand.

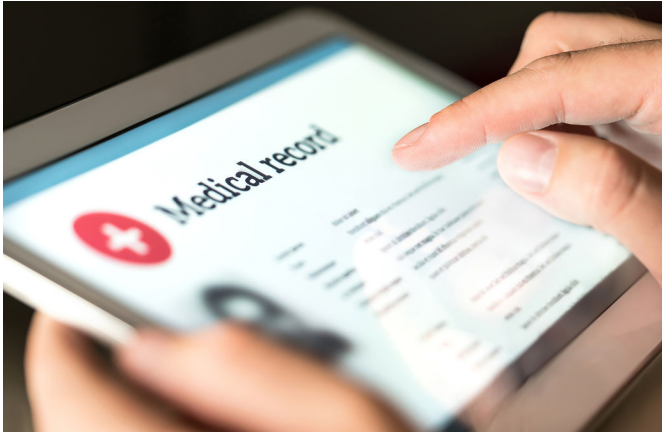
## 2. ASK QUESTIONS

The more questions you ask, the more information to factor into your case, including pre-existing injuries or illnesses, medications, and prior and current treatments. When interviewing your client, ask open-ended questions to learn as much as you can about the patient's health history. The goal is to uncover any other illnesses or conditions and when they might have begun, medications they are presently taking or may have taken in the past, or any information which may factor into how the individual is healing.

## 3. LOOK FOR GAPS

The strength of the medical record review and chronology lies in the story uncovered. Gaps in medical record information and treatments or missing medical records may indicate that you do not have the full story. So, how do you fill those gaps? Revisit Step 1 - the foundation of your review - 'Understand





what you're looking for and how it gets into the chart.'

#### 4. EFFICACY OF TREATMENT

After an injury or illness, the treatment plan aims to rehabilitate, recover, and help the individual attain maximum medical improvement. With this in mind, it's essential to understand whether the treatments, interventions, or medications prescribed are, in fact, an effective intervention, or if the patient is still having problems or if new issues have developed.

#### 5. BE PREPARED FOR WHAT YOU MIGHT FIND

Whether plaintiff or defense, you may uncover information and records which work against your case. In this instance, you must be prepared to address each issue. You may also discover new information that works in your favor and may change your case's focus or direction. In either circumstance, a comprehensive understanding of the

information uncovered is usually accomplished by retaining medical experts that understand the nuances of treatment and patient care.

#### 6. ORGANIZATION IS KEY

Organizing the information date by date and item by item creates a clear and comprehensive chronology of events. The goal is to recreate a very detailed story to strengthen your understanding and explanation of the individual's experience, assess liability issues, and collect evidence critical to your case. As a best practice, chronicling should begin from the claimant's pre-injury medical history and extend to the most recent medical record. Date by date and item by item, track and manage every request and stay organized.

#### 7. QUICKLY IDENTIFY RED FLAGS AND WHEN TO SEEK HELP

Time and resources are not unlimited and must be efficiently managed by attorneys and paralegal staff. While the prior best practices assist in attaining a comprehensive understanding of the injury or illness, it is equally important to quickly identify red flags and seek a medical professional's help. A medical professional, such as a nurse consultant, helps assess the information discovered and quickly identifies unusual practices, improper care or treatment, missing data, and non-compliance. The nurse

consultant's review empowers the legal team with a medical understanding of injury or illness and long-term implications for the individual.

## WONDERING WHETHER IT'S TIME TO ENGAGE A MEDICAL PROFESSIONAL?

### LOOK FOR THESE RED FLAGS:

- **Pre-existing conditions and comorbidities** – These are an immediate red flag that your medical chart review needs an expert. Diabetes can develop into neuropathy or numbness when untreated. Still, it can also be a baseline for reference when a patient has a motor vehicle accident and now reports numbness related to the accident. Pre-existing conditions and comorbidities can make matters unclear and cloud the story and are best reviewed and addressed by a medical expert such as a nurse consultant.
  - **Lack of treatment or treatment gaps** – While lack of treatment or gaps in treatment may seem like an individual's defiance to care, that may not be the case. Lack of treatment may be due to a multitude of reasons, from the individual being conflicted about the care and refusing to adhere, to simply not having the resources (transportation, family member assistance, etc.) to stick to their treatment plan. Lack of treatment or gaps in treatment will quickly stand out to a medical expert, and they will know the specific questions to ask and where to seek additional information.
  - **Inappropriate treatment** – Treatment that appears excessive or inappropriate in relation to the diagnosis and timing is another red flag that a medical professional is necessary.
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At **Medical and Life Care Consulting**, our nurse consultants have experience in all areas of medicine and diagnoses. Our experience treating patients from all backgrounds and ethnicities facilitates our ability to determine deviations of care, why they may have occurred, and how they impact patients and the case.

## HAVE A QUESTION?

Give us a call or submit a question. Our initial consultations are completely free.

## REFERENCES

[i] Medical records and issues in negligence

[ii] Legal Issues in the Medical Record | Effective Documentation for Physical Therapy Professionals

[iii] Performing chart review studies