



PERSPECTIVES

Understanding the Complexities of Medical Records Review In Legal Cases

Our perspectives feature the viewpoints of our subject matter experts on current topics and emerging trends.

INTRODUCTION

Before we can discuss why medical records review is important in legal cases, we must first understand what a medical records review is, who performs such a review, and why it is vital to the outcome.

In the clinical setting, Clinical Documentation Improvement (CDI) professionals have a significant responsibility in ensuring that patient records are accurate and complete. By reviewing an average of 16 to 24 patient charts daily, CDI specialists help maintain the integrity of medical records, which is essential for continuity of care, accurate data collection, and proper reimbursement.

This article examines the role of CDI professionals, noting that it is quite intricate and demanding, and what guidelines and laws they need to adhere to in order to lawfully secure the proper documentation for an effective legal case – whether that be for the plaintiff or the defense.

These CDI professionals essentially act as [medical detectives](#), piecing together information from various sources to create a comprehensive and accurate patient story. This involves:

- **Clinical Acumen:** Understanding medical conditions, treatments, and outcomes.
- **Critical Thinking:** Analyzing and synthesizing information to resolve discrepancies and ensure completeness.
- **Knowledge of Coding Guidelines:** Ensuring documentation aligns with coding standards and quality measures.
- **Efficient Workflow:** Managing time and resources effectively to review numerous charts daily.

Their work is crucial for maintaining high standards in patient care and guaranteeing accurate data for quality metrics and reimbursement.

CDI specialists must adhere to various guidelines and policies, including organizational bylaws, Uniform Hospital Discharge Data (UHDDS) guidelines, and International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) Official Guidelines for Coding and Reporting. They must also adhere to internal documentation and coding policies. Their work

impacts several key areas:

- **Quality Measurement:** Ensuring documentation is clear, validated, and impacts quality measures, patient care, outcomes, and public reporting.
- **Compliant Coding:** Identifying and clarifying diagnoses and conditions for accurate coding, including acuity, specificity, and clinical validation. This also involves ensuring the present on admission (POA) status is correctly documented.
- **Communication Tracking:** It's essential to document interactions between CDI and coding professionals to ensure clarity and efficiency.
- **Concurrent Review:** This involves capturing the patient's admission details and monitoring co-morbid conditions throughout the stay. CDI specialists must validate conditions, query unstated but clinically supported conditions, and address clinically unsupported stated conditions.
- **Timing of Reviews:** Typically, reviews start 24 to 48 hours after admission or initial assessments. It's best to begin when there's sufficient information to base a query, such as after the history and physical examination and initial diagnostic tests.

This process ensures that the medical record accurately reflects the patient's condition and treatment, which is crucial for quality care and proper reimbursement.

THE IMPORTANCE OF CLINICAL DOCUMENTATION IN PERSONAL INJURY CASES

Whether plaintiff or defense, preparation is the key to successful personal injury outcomes. Understanding the medical records process, where to request medical records from, and how to determine if medical records are missing or incomplete is only one component of the medical records review process in personal injury cases.

It is imperative that during the evidence gathering phase of a personal injury case, all relevant medical records, witness statements, and expert opinions related to the medical records are obtained.

Hospitals and insurance companies know that 99% of people don't understand the complexity of the laws surrounding documentation compliance and coding and billing practices. That's why a [legal nurse consultant](#) can help explain the importance, processes, and challenges of medical records review.

ENSURING COMPLIANCE WITH FEDERAL LAW FOR MEDICAL RECORDS RELEASE

Medical records release is governed by a set of Privacy Rules (Standards for Privacy of Individually Identifiable Health Information) which implemented the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

HIPAA established what information was protected and what information was considered part of the medical records. Both medical and billing documentation are considered part of an individual's medical records. The Privacy Rules also established that an individual shall have access to their medical records when legally requested.

A [HIPAA release form](#) must be obtained from a patient ***before*** their protected health information is disclosed ***for any purpose other than those detailed in 45 CFR §164.506***, which are specifically covered in [45 CFR §164.508](#) and summarized below:

- Prior to the disclosure of the protected health information (PHI) to a third party for reasons other than the provision of treatment, payment, or other standard healthcare operations – e.g. disclosing information to an insurance underwriter,
- Prior to PHI being used for marketing or fundraising purposes,
- Prior to PHI being provided to a research organization,
- Prior to psychotherapy notes being disclosed,
- Prior to the sale of PHI or sharing that involves remuneration.

In order to obtain medical records, an individual must complete and sign a HIPAA compliant medical release of information form. The HIPAA compliant medical release form must contain:

- A description of the information that will be used / disclosed,
- The purpose for which the information will be disclosed,
- The name of the person or entity to whom the information will be disclosed,
- An expiration date or expiration event when consent to use / disclose the information is withdrawn. For example, an expiration event may be when a research study is completed.
- A signature and date that the authorization is signed by an individual or an individual's representative. If a representative is signing the form, the relationship with the patient must be detailed along with a description of the representative's authority to act on behalf of the patient.

The HIPAA release form must also include statements that advise individuals of:

- Their right to revoke their authorization,
- Any exceptions to the individual's right to revoke the authorization,
- Details of how the authorization can be revoked,
- To the extent that an individual's right to revoke authorization is included in the notice required by § 164.520 (Notice of Privacy Practices),
- That the covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs the authorization,
- That there is potential for information disclosed under the terms of the authorization to be redisclosed by the recipient and no longer protected by 45 CFR Part 164, Subpart E,
- A HIPAA release form must be written in plain language,
- A copy of the signed HIPAA release form should be provided to the patient.

The HIPAA release form ensures that patients have control over their PHI and can specify exactly what information is shared, with whom, and for what purpose. This form is crucial for maintaining privacy and complying with HIPAA regulations.

Patients or their personal representatives have the right to revoke a HIPAA authorization at any time. The revocation must be in writing and will generally take effect immediately. However, there are exceptions, such as if the covered entity has already acted on the authorization in a way that can't be

undone, or if the authorization was required for obtaining insurance coverage.

KEY CHALLENGES WHEN REVIEWING MEDICAL RECORDS IN PERSONAL INJURY CASES

- The volume of the medical records. Sometimes there are thousands of pages to organize and analyze.
- The complexity of the medical terminology or medical abbreviations, illegible handwritten records, shorthand, or incomplete paragraphs and narrative notes.
- Disjointed records that are out of order, out of sequence, or don't pertain to the injury in question.
- Records that lack physician observations or narrative data.
- Unusable or unrelated records.

CONCLUSION

The most common factors related to the medical records that can impact the final settlement amount of a personal injury case are:

- The severity of the injuries,
- The long-term impact on the patient's quality of life.

An effective and efficient medical records review is where the expert evaluates the plaintiff's healthcare records for legal purposes. A Legal Nurse Consultant can assist in obtaining the medical records and confirming their completeness. The accuracy and completeness of the records is crucial to assist in the determination of liability, causation, and potential compensation in litigation.

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