"Practices need to vastly improve data accuracy in records, attorney says"

Isabelle Bibet-Kalinyak | Thursday, October 17, 2019

The processes of medical recordkeeping continue to change, as regulators more frequently set new requirements, and many healthcare organizations struggle to keep up with the changes.

But the big problem is that too many hospitals and practices still haven't managed the basics of collecting and reporting data for regulators and attorneys, Isabelle Bebit-Kilinyak, a corporate attorney in the McDonald Hopkins law firm in Cleveland, noted during an educational session at the Medical Group Management Association's annual conference.

"We still see too many errors in data," she asserted. "Signatures cannot be read, required information is omitted, and relevant information also is omitted. Who is keeping track of physical signature logs?"

Too often, providers are not ensuring that patients and families understand basic necessities, such as when a patient needs to take medication. These mistakes could end up resulting a lawsuit.

Many providers do not know that if the medical record is a combination of paper and the electronic health record, and that information is not scanned into the EHR, then all of the documentation has be given on paper. Further, providers are releasing information prematurely that should have first been assessed first under legal review.

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