Medical Records; A Love/Hate relationship

Medical records and bills are a crucial component of any case involving health, injury or illness and serve as the foundation that can make or break any case. Medical records accurately illustrate what led up to an injury, how the injury happened, the extent of the injury and any ongoing challenges a person may face as a result of the injury. These records and bills are a means to fact check, recognize strengths and weaknesses, determine negligence, decide damages and decide on an appropriate expert witness.

Sometimes, retrieving a client's entire medical record can be time consuming and frustrating and can often delay a client's case. Even when medical records are obtained, they can be intimidating because of the copious amounts of information expressed in unfamiliar medical abbreviations and terminology. Often, an attorney is left wondering how to navigate through a medical record without any medical training or insight and how to tell if the record is complete.

For example, I screened a case for a medical malpractice attorney in which his client had heart valve replacement surgery for an infected heart valve. After reviewing the records, I discovered that the client had a urinary tract infection several months earlier for which there was a delay in treatment. Those abnormal lab results were missing from the medical record as were the office notes documenting notification by the lab of the abnormal results. Also missing was nursing documentation of the client being notified of the infection and the prescription for antibiotics (despite office nurse stating differently in deposition notes). With this discovery, the appropriate documentation was requested, and the case was settled.

The key to reviewing medical records and bills is not to read the records cover to cover with a medical dictionary at your side, but rather to focus on the main issue and work backwards. In the example that I gave, I looked for all abnormal lab results and compared them to the physician's orders, nursing notes and pharmacy orders. You can save time by focusing on the part of the medical record that is most applicable to your client's case. It is important to remember that medical records can contain duplicated information along with information that is not pertinent to a client's injury.

Once you locate the appropriate section(s) of the medical record, you can start to tell your client's story. For all the unfamiliar abbreviations (i.e.: KVO), terms, drug names, and treatments, an attorney can reference a variety of sources such as medical journals or online research especially Patient Education materials which are written in everyday terms (www.webmd.com). There are many ways to analyze and review records-there is no one correct way. It may be helpful to prepare a worksheet (chronology) outlining events for each day in question. Chronologies are thinking tools that logically organize the facts in to a clear picture making it easier to share case knowledge and brainstorm with other team members. Chronologies may also help identify discrepancies, missing information and pre-existing conditions.

The complete and accurate analysis of medical records is a key component in the success or failure of the case. Establishing a process for reviewing the medical records assures the best rate of success while decreasing the chance a critical piece of information will be missed. It's important to remember that clues can be buried deep in the medical records or in the notes you cannot read or decipher. This is one of many reasons why some cases may require extensive review of complex medical information by a knowledgeable healthcare practitioner. Not only does this person understand the medical jargon but they also understand the standards of care and the inner workings of the healthcare industry. Next time you find yourself frustrated or overwhelmed with deciphering medical records, give Michele Webber RN, CLNC a call and let her make dollars and sense out of those records.