SPARTA COMMUNITY HOSPITAL

Compliance Matters

November 2025

COMPLIANCE & ETHICS WEEK SUCCESS

THANK YOU!

Thank you for participating in and helping us to recognize and celebrate Compliance and Ethics Week! Thank you for all that you do to support, maintain and demonstrate our culture of compliance.

COMPLIANCE IS A CULTURE, NOT JUST A POLICY

Contact Compliance if you have a concern, complaint or wish to obtain guidance on issues such as HIPAA, conflicts of interest, standards of conduct, gifts, or regulatory compliance.

- Confidential Helpline: ext. 1724 or 1SCH
- PHP Incident and Event Reporting System
- Email: compliancedepartment@spartahospital.com
- Susan Gutjahr, Compliance & HIPAA Privacy Officer: ext. 1431
- Holli Dethrow, Compliance & Risk Management Associate: ext. 1769

Effective Date: 1/1/2026

Illinois HB 1431 (P.A. 104-0181) - Facility Fee Transparency

Amends the Fair Patient Billing Act to require hospitals that charge separate facility fees for outpatient services to develop a policy informing patients of the potential fee, including how they will be notified, what the fee covers, why it's charged, and who to contact for more information. Provides that for violations involving a pattern or practice of not providing the information to patients, the civil monetary penalty shall not exceed $50 per violation.

THE CRITICAL ROLE OF MEDICAL DOCUMENTATION: A CASE STUDY IN RISK MANAGEMENT

Why Documentation Matters

Accurate and thorough medical documentation is a cornerstone of quality patient care and healthcare operations. It serves multiple essential functions, including:

- **Care Coordination**: Facilitates continuity and coordination of care among healthcare providers.
- **Professional Communication**: Ensures clear communication between multidisciplinary teams.
- **Billing and Reimbursement**: Supports claims for services rendered and ensures appropriate reimbursement.
- **Regulatory Compliance**: Demonstrates adherence to accreditation, licensure, and regulatory standards.

However, one of the most critical - yet often overlooked - reasons for thorough documentation is medical-legal protection.

Proper documentation can prevent litigation or serve as a strong defense in the event of a malpractice claim. Conversely, poor documentation can undermine even the most defensible case.

Consider the real-world malpractice claim involving a podiatric physician on the next page. The case illustrates how documentation errors can significantly hinder legal defense.

See Case in Point: A Documentation Breakdown.

CASE IN POINT: A DOCUMENTATION BREAKDOWN

A 50-year-old female patient presented with a painful bunion. The podiatrist scheduled a modified McBride bunionectomy with metatarsal osteotomy and screw fixation. Postoperatively, the patient experienced pain and swelling, which she attributed to walking without crutches, contrary to medical advice.

At a one-month follow-up, X-rays revealed lipping on the metatarsal head and a backing-out screw. The podiatrist attributed these findings to overuse and performed a second surgery to remove the screw and revise the bunionectomy. Despite continued non-compliance, the patient was provided with a CAM walker and monitored over four visits. At the final visit, the podiatrist noted improvement and advised continued use of the walker. The patient did not return but instead sought care from an orthopedic surgeon, who diagnosed a “pin track infection.” She later underwent a joint fusion and pain management procedures.

The patient filed a lawsuit alleging:

- Failure to attempt conservative treatment before surgery.
- Improper surgical technique.
- Failure to diagnose and treat an infection.
- Failure to refer to an infectious disease specialist.

Documentation Deficiencies Identified

Upon review, the defense team uncovered several critical documentation issues:

- **Inconsistent Laterality**: Initial records referenced the left foot, while the patient’s complaint involved the right. This inconsistency persisted in subsequent notes.
- **Template Overuse**: The podiatrist admitted to using unmodified template language, resulting in inaccurate and vague entries.
- **Inadequate Operative Report**: Although the correct foot was noted, the report lacked detail about the procedure performed.
- **Antibiotic Use Unexplained**: Keflex and later Clindamycin were prescribed without documented rationale or clinical justification. No prescription records or sample logs were included.

These documentation gaps made it impossible to determine whether an infection was present at the time of the second surgery or why antibiotics were prescribed. The podiatrist could not recall his clinical reasoning, and the records failed to support his decisions.

Outcome

Due to the weak documentation, the case could not be strongly defended and was ultimately resolved by payment of a settlement.

Conclusion

This case underscores the importance of accurate, individualized, and comprehensive documentation. Providers must avoid over-reliance on templates, copy/paste, and bring forward documentation to ensure that every entry reflects the specific clinical scenario. In the event of litigation, the medical record becomes the primary evidence of care provided. As this case illustrates, poor documentation can turn a defensible case into a liability.