Tampering with Medical Records: Red Flags

What are the red flag warning signs that someone may have tampered with medical records? This is Pat Iyer with *Iyer’s Insights*, one of the twice weekly shows of Legal Nurse Podcast. I’ve spotted altered medical records and want to share some of the clues with you. You may be suspicious when:

- the result of the injury is not consistent with the documentation;
- the plaintiff’s complaints are consistent with the missing information;
- there is a delay in or an inability to obtain medical records;
- there is too good to be true documentation such as perfectly stable weights or vital signs which do not vary;
- a provider learns that a plaintiff’s attorney is seeking a copy of the medical record;
- the plaintiff’s story is different or conflicts with the documentation;
- the medical record is missing or incomplete;
- there is little or no documentation about an event or incident that resulted in harm to the plaintiff;
- an unexpected event occurred, such as an escape from a healthcare facility, an injury, fracture, birth injury, surgical error, death, burn, or whenever there is a medical catastrophe;
- a hospital-acquired condition develops such as a stage III or IV pressure sore, air embolism, retained sponge, and so on.

Responsibility for Preserving Medical Records

What are the responsibilities of facilities for maintaining records?

Here are the guidelines. “The health records of patients involved in potentially compensable events and claims should be completed as soon as possible after the patients are discharged. The primary and secondary records should then be copied for use by the risk manager and the originals secured in a locked storage place. Any written incident reports, investigative reports, peer review records, and credentialing files relevant to the case also should be protected.

State laws and findings in past legal cases dictate what kinds of information must be provided to the parties in a lawsuit, and risk managers should maintain the
confidentiality of sensitive documents until it is determined exactly what kinds of information must be turned over to the injured party’s representative. Patients and their legal representatives have automatic access to the patient’s health records, and so copies of internal incident reports must not be placed in health records.”

Why Do Healthcare Providers Alter Records?

Just why do healthcare professionals tamper with medical records? There are many reasons why a person would tamper with records. Here are some motivations:

- there is an intention to commit fraud, such as billing for services not performed
- the provider feels fear or guilt when an untoward outcome occurs
- there is fear of being exposed or harmed by damaging information
- the provider wants to cover up a mistake when notified of being sued

Any additions or deletions to records will be detected if the attorney requests a second set later in the litigation. Many plaintiff attorney clients make this a practice and some have been amazed by what they’ve discovered.

It is imperative that you understand how you can participate in the detection of tampering with medical records.
Just imagine you are analyzing a medical record. Suddenly, you see a chart entry that does not make sense – or can’t find an entry that should have been there. You look away, bewildered. You begin to form a thought – “Someone tampered with these records.” Your medical knowledge may make you the only person on the legal team to recognize the tampering.

Today’s highly charged atmosphere with its focus on financial survival of healthcare organizations and medical malpractice increases the temptation to alter records when something goes wrong.

There are many reasons why a person would tamper with records, including an intention to commit fraud, such as billing for services not performed, or fear or guilt when an untoward outcome occurs. How often do you find yourself saying, “I wish I knew how to identify fraudulent records?”

Tampering with medical records skyrockets the implications of a case. You’ll learn why this act so profoundly affects a medical malpractice case. This program contains what every legal nurse consultant should know about altered medical records. You will get the truth about how you can help an attorney with suspicions of altered medical records.

In this 60-minute online training called Fraudulent Medical Records, you will learn how to:

- Differentiate between substandard documentation and altered medical records
- Recognize the factors that lead to altered medical records
- Identify the implications of tampering with medical records
- Detect altered medical records

Obtain the details about this online training at the show notes for this program, by going to podcast.legalnursebusiness.com. You qualify for a 25% discount when you use the code listened in the coupon box.

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Altering Medical Records Consequences

Legal nurse consultants may detect tampering with medical records. What happens to healthcare providers who get caught? What are the altering medical records consequences? The Joint Commission, state and federal regulations address the need to maintain accurate and complete records. Boards of licensure can discipline healthcare providers for documentation errors. Also, the providers may lose insurance coverage, or be charged with a crime. The stakes are high.

Shame and embarrassment

Let’s explore the consequences. Loss of reputation, shame, guilt, and being exposed as a wrong doer can all have a profound impact on the individual who altered medical records. It is terribly awkward and difficult to be caught. But it gets worse.

Criminal/civil offenses

In many states, falsification of medical records is also a criminal offense punishable by fines and incarceration.

Altering medical records consequences also include insurance coverage

A medical malpractice claim that includes an allegation of alteration of records may not be covered by a commercial professional or individual’s liability policy. The insurer may reserve its rights to not pay any judgment that might be entered against the provider.

Institutional providers participating in self-insured trusts may have similar coverage limitations. Some states recognize a separate cause of action for alteration of medical records, whereas other states deal with it as a jury charge.

If the provider admits that he or she has made the alteration, the policy may be completely voided.

An individual who has his or her own insurance policy may find the carrier refusing to renew the policy the following year.
Regulatory agencies and privileges

Some state regulatory or licensing boards may investigate the healthcare provider. Disciplinary action may follow. The healthcare system that has provided privileges to the healthcare provider may be reluctant to allow that individual to continue the staff. Those who falsify medical records risk more than just the loss of a malpractice case.

Medical boards have suspended or revoked the licenses of healthcare professionals caught tampering with records.

Consider this scenario. A physician gets a notice that he is being sued. He gives into the temptation to review his office records. He decides to change an entry to

1. More completely describe events
2. Make it look as if he did something that he did not.

But it is way too late. The plaintiff attorney and her legal nurse consultant already have the record and spot the change when they receive a second set of medical records. A charge of spoliation of evidence is added to the suit.

Most healthcare providers who tamper with medical records have a mistaken belief that their actions cannot be detected. The guilt or fear of being found negligent swamps their good judgment. Altering medical records consequences take over.

And that is where you come in. Gain more skill at spotting altered medical records by investing in our online training called Fraudulent Medical Records. You’ll find the ordering button in the show notes for this podcast by going to podcast.legalnursebusiness.com.
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