

The Old Adage: If It Is Not Documented, It Was Not Done

Elizabeth E. Hogue, Esq.

Office: 877-871-4062

Fax: 877-871-9739

E-mail: ElizabethHogue@ElizabethHogue.net

The old adage, “If it is not documented, it was not done;” is unfortunately often true. The consequences of failure to document may be severe in terms of allegations of fraud and abuse. The Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services has repeatedly stated that providers carry the burden of proving that care was actually rendered to patients. If practitioners are unable to prove that they rendered appropriate care because it is not documented, the OIG and other fraud enforcers may conclude that claims submitted by these providers are false claims.

The consequences for submission of false claims are potentially severe. The amount of the false claims may, for example, be tripled and providers may be required to pay this amount. Millions of dollars and sometimes the ability of providers to continue their businesses may be at stake.

Consequences of submission of false claims also include suspension or exclusion from participation in the Medicare and Medicaid Programs, including Medicaid waiver programs, and other federal and state health programs such as Tri-Care. Few providers can survive the loss of all reimbursements from both federal and state healthcare programs.

Providers also risk liability for negligence or malpractice when they fail to document care provided. Risks are greatly enhanced when providers make recommendations to patients that they reject, and neither the recommendation nor refusal are documented. A recent case, Amos v. Louisiana Med. Mut. Ins. Co., No. 41, 302-CA (La. Ct. App. August 4, 2006) illustrates this point.

In this case, Dr. Rebecca L. Crouch treated Mr. Joseph Lee Amos for bleeding after bowel movements. Mr. Amos eventually sought a second opinion from a different doctor. The second physician Amos saw diagnosed colorectal cancer.

Amos sued Dr. Crouch and her professional liability insurer, Louisiana Medical Mutual Insurance Company. He claimed that Crouch breached applicable standards of care when she failed to recommend and conduct diagnostic testing indicated by Amos’ symptoms. Amos claimed that Crouch’s breach of standards of reasonable care caused a delay in diagnosis and treatment of his cancer.

In response, Crouch argued that she had, indeed, recommended to Amos that he undergo appropriate tests, but that he refused to allow such testing. Crouch, however, had not documented the recommendation or Amos’ refusal. Crouch testified that she remembered the conversation with Amos in which she recommended tests that he refused.

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The Court concluded that the “absence in Mr. Amos’ medical records of any notations indicating that Dr. Crouch recommended he undergo either a proctoscopy or colonoscopy is circumstantial evidence from which the trier of fact could reasonably conclude that Dr. Crouch never made any such recommendations.” In other words, because it was not documented, it is reasonable to conclude that it was never done.

If allegations of fraud in the form of false claims had also been made against Dr. Crouch because the care she provided to Amos was substandard, it is likely that the allegations against her would have been substantiated.

A word to the wise should be sufficient: Documentation is crucial to avoid fraud and abuse and to manage risks.

(To obtain an 80-minute video on fraud and abuse compliance presented by Elizabeth E. Hogue, Esq; send a check for \$105.00 that includes shipping and handling made out to Elizabeth E. Hogue, Esq. to: Fulfillment, 107 Guilford Drive, Summerville, SC 29483.)