# Preventing Fraud and Abuse in Clinical Documentation



By Mary Butler

**The HIM Problem:** The US Department of Health and Human Services' Office of the Inspector General (OIG) is expected to increase enforcement activities surrounding clinical documentation and fraud. Training and awareness are key in preventing penalties.

**The HIM Problem Solver:** Felicia E. Heimer, Office of Counsel to the Inspector General, Office of Inspector General, US Department of Health and Human Services

Felicia Heimer is a senior attorney with the Office of Inspector General, US Department of Health and Human Services (OIG), where OIG attorneys are engaged in a very broad range of work with teams that focus on very specific areas of practice. She works within the Administrative and Civil Remedies Branch of the OIG, where attorneys represent the OIG in all administrative and civil fraud enforcement actions. In addition, they negotiate and monitor compliance with corporate integrity agreements (CIAs), and defend administrative appeals of exclusions. They also work with the Department of Justice to develop and pursue healthcare fraud cases under the False Claims Act.

Heimer spoke with the *Journal of AHIMA* to help give HIM professionals an idea of how the federal government is approaching healthcare fraud, and to offer advice on steps to take to maintain compliance with the law.

***JAHIMA:* What are some of the biggest documentation issues that OIG is giving the highest level of scrutiny?**

**Heimer:** With the advent of the electronic health record (EHR), certain documentation practices—notably copying and pasting documentation—could potentially create fraud and abuse concerns. As the OIG highlighted in a 2013 audit report, when providers engage in cloning (copying portions of an existing record and adding it to another), inaccurate information may be entered into the patient's record which could result in inappropriate charges being billed to patients and third-party payers.

The OIG's Annual Work Plan, which identifies the OIG's investigative and audit plan for the fiscal year, has consistently identified documentation reviews as a major priority. In the 2014 Work Plan, the OIG indicated its plans to review providers' use of EHR. In the most recent 2015 Work Plan update, the OIG identified a number of projects in which the OIG will be reviewing the sufficiency or adequacy of documentation to support claims under the home health prospective payment system, for physical therapy services, power mobility devices, ambulance services, anesthesia services, and chiropractic services, to name just a few.

***JAHIMA*: What are the most commonly perpetrated examples of healthcare/documentation fraud?**

**Heimer:** Billing for services not rendered and billing for services that are not medically necessary are activities that continue to form the basis of a high number of healthcare fraud cases each year. Obviously, the sufficiency and accuracy of medical record and other claims-related documentation is the core issue under review when the government is working to substantiate allegations of False Claims Act violations.

***JAHIMA*: What can providers do to ensure that they're not making these documentation mistakes? More physician education? More CDI training?**

**Heimer:** With respect to documentation, there can never be enough training! The OIG, through the issuance of its compliance program guidance, targeted educational initiatives, and CIAs, has affirmed the importance of training within a provider's compliance program function. In recent years, the OIG has produced a number of educational materials, such as the HEAT Provider Compliance Presentations and Videos and the document entitled "A Roadmap for Physicians: Avoiding Medicare and

Medicaid Fraud and Abuse," to help providers with their compliance efforts and to stress the importance of proper documentation by all those involved in the medical record and claims submission processes.

***JAHIMA*: How much interaction do you have with health information management professionals?**

**Heimer:** In my position, I interact most often with HIM professionals as I monitor providers' compliance with their CIAs. When I conduct on-site visits to providers' facilities to evaluate compliance with CIA obligations, I routinely ask to speak with HIM staff so that I can have a better sense of how the organization is really implementing all required policies and procedures that relate to proper and accurate claims submission. HIM professionals also provide me with some insight as to the manner in which independent auditors conduct the claims reviews that are often required under CIAs, and how the organization implements corrective action as a result of those auditors' findings.

***JAHIMA*: What advice do you have for healthcare professionals in general and HIM professionals in particular?**

**Heimer:** As rudimentary as it may seem, my advice to HIM and other healthcare professionals is: do the right thing. Do the right thing to prevent violations from happening in the first place, and do the right thing when a violation has come to light. At some point, the government may come to learn about a provider's non-compliance with federal healthcare program requirements—either through an audit, a whistleblower, or the government's data-mining efforts. The costs associated with responding to a government's investigation or defending against a lawsuit, and the tolls that those activities take on employees and on an organization's reputation—are great. I am fairly sure that, in most cases, doing the right thing saves money in the long run.

***JAHIMA*: How do you see your job evolving within the next 5-10 years? Do you anticipate an increase in fraud or a decrease in fraud? Do you think fraud is lower when awareness is higher?**

**Heimer:** Predicting increases or decreases in the level of fraud may be impossible. There is no baseline since there will always be fraudulent activity taking place that the government is not aware of. What I can tell you is that the government will continue to increase and refine its enforcement efforts. The OIG has recently announced the formation of a litigation team that will solely focus on levying civil monetary penalties and excluding individuals. The healthcare provider community should expect to see an increase in the number of enforcement cases, particularly kickback cases that are initiated—not only against the payer of the kickback, but also the recipient of the kickback, which tends to be a physician.

We certainly hope that levels of fraud are lower when levels of compliance awareness are higher—this goes to the core of the OIG's mission to promote compliance so that the integrity of the federal healthcare programs, and the health of those programs' beneficiaries, is protected to the greatest extent possible.

*Mary Butler is the associate editor at The Journal of AHIMA.*

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