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NEW PERSPECTIVES

on Healthcare Risk Management, Control and Governance

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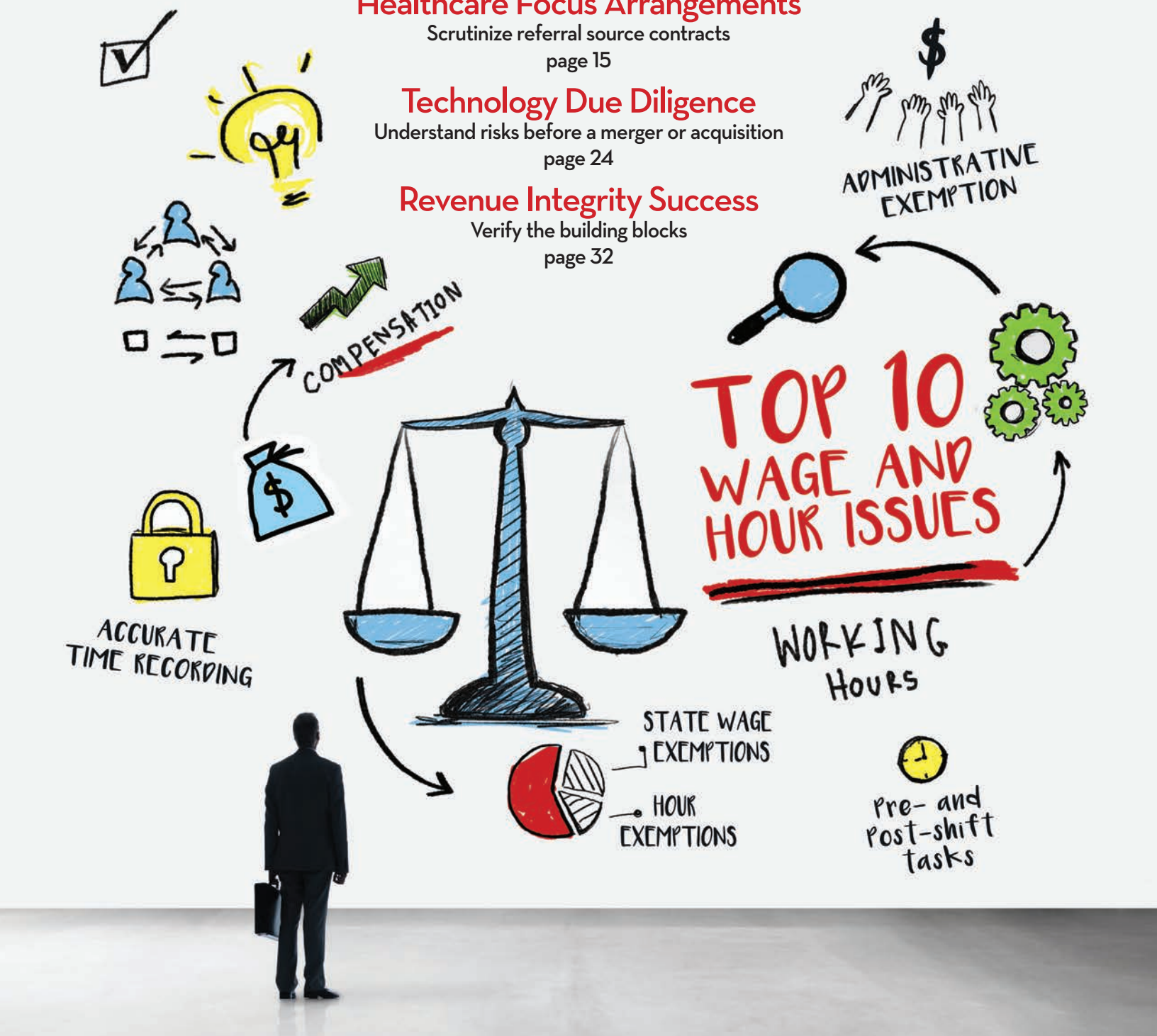

HEALTHCARE FRAUD

How Much Do You Know About Fraud?

Try this pop quiz

By Victor Hartman, JD, CPA, CFF, CFE, and Jim Wanserski

Internal auditors are expected to provide independent assurance on an organization's internal controls to prevent and detect fraud. Internal auditors' awareness of fraud-related issues will enhance their ability to perform this responsibility.

Test your fraud awareness with the following questions. The answers follow the quiz.

1. Losses due to healthcare fraud in the United States are estimated to be around:
   A. $1 billion
   B. $10 billion
   C. $75 billion
   D. $250 billion
   E. $1 trillion

2. The Stark Law, named after Congressman Pete Stark and codified at 42 U.S.C. §1395nn, generally prohibits what type of conduct?
   A. A physician referral of a Medicare patient to an entity in which the physician has an interest
   B. Upcoding of reimbursement codes for more expensive diagnoses or procedures than the provider diagnosed or performed
   C. Unbundling groups of procedures commonly performed together
   D. A scheme to bypass a state's Certificate of Need procedures prior to the construction of a new hospital

3. According to the Association of Certified Fraud Examiners survey findings,[1] which of the following fraud prevention methods is the most effective?
   A. Reducing rationalization
   B. Having an open-door policy
   C. Increasing the perception of detection
   D. Screening employees
   E. Annual reminders and re-signing code of ethics forms by employees

4. A federal law enforcement action involving fraudulent genetic cancer testing resulted in charges against 35 defendants. The defendants allegedly participated in one of the largest healthcare schemes to date by billing Medicare more than $2.1 billion for fraudulent genetic testing results. Among those charged were 10 medical professionals, including nine doctors. Regarding this fraud, which of the following is true?

[1] https://s3-us-west-2.amazonaws.com/acfepublic/2018-report-to-the-nations.pdf

The fraud triangle is rationalization, perceived financial need and perceived opportunity.

A. This is an example of a predatory fraud scheme targeting a vulnerability in an insurance program.
B. An essential element of this fraud is that licensed physicians ordered medically unnecessary tests.
C. The fraudsters used specific current procedural terminology (CPT) codes when billing Medicare and Medicaid for genetic testing.
D. Medicare will generally not cover screening tests, including genetic testing, unless a beneficiary has certain signs or symptoms of an illness.
E. All of the above.

5. What U.S. organization is aimed at preventing healthcare fraud with the mission statement, "To protect and serve the public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution, and prevention of health care fraud and abuse"?
   A. NHCAA
   B. ACFE
   C. FBI
   D. HHS-OIG
   E. IIA

6. What is the best source for uncovering fraud?
   A. Law enforcement
   B. Tips
   C. Auditors—internal, external and forensic
   D. Proactive management actions and artificial intelligence tools
   E. A sophisticated and effective internal control environment

7. Revenue recognition schemes would include all the following except:
   A. Recording fictitious sales
   B. Procurement kickbacks
   C. Round tripping
   D. Channel stuffing
   E. Bill-and-hold

8. *Qui tam* is the Latin phrase for "he who sues in this matter for the king as well as for himself." A legal action under the United States federal *qui tam* statute involves a plaintiff, known as the relator, who is often an internal whistleblower. The plaintiff can be awarded a substantial bounty for alerting the Department of Justice to false claims presented to the U.S. government. False claims defraud the government's procurement processes and beneficiary programs.

   Which of the following statements regarding a *qui tam* action is false?
   A. The *qui tam* provisions are found in the Federal False Claims Act.
   B. *Qui tam* lawsuits are filed under seal in order to protect the identity of the whistleblower.
   C. A low percentage of *qui tam* lawsuits involve healthcare fraud compared to other government programs.
   D. Unlike other whistleblower lawsuits, only the first to file can benefit from any award action.
   E. During an inquiry by management, a *qui tam* relator cannot be retaliated against.

Answers

1. D: $250 billion

The U.S. healthcare sector incurs an exceptional amount of loss due to fraud. The Centers for Medicare and Medicaid Services estimates that 17.9 percent of the U.S. gross domestic product (GDP) of $20.41 trillion in 2018 pertains to healthcare related expenditures. Accordingly, the U.S. is estimated to have spent $3.65 trillion on healthcare.

The dollar loss attributable to healthcare fraud is more difficult to assess. The Association of Certified Fraud Examiners estimates that organizations lose an estimated five percent of revenues to fraud.[2] By analogy, this percentage can at least be used as a baseline when assessing the percentage that the healthcare industry loses to fraud, which puts the dollar amount attributable to fraud at $182.5 billion.

The amount of fraud is likely higher than five percent as the insurance industry—private pay, Medicare

[2] Page 9, Ibid.

and Medicaid—is more vulnerable to fraud than other industries. In addition to fraud, the dollar losses associated with waste, abuse and defensive medicine, could easily add another five percent.

If five to ten percent of healthcare expenditures in the United States are attributable to fraud and abuse, the losses would be $182.5 to $365 billion, respectively, on $3.65 trillion of healthcare spending. Answer D is in the calculated range.[3]

2. A: Conflict of interest in referring Medicare patients

The Stark Law refers to the prohibition of a physician making a referral to certain designated health services payable by Medicare or Medicaid when a physician, or an immediate family member, has a financial relationship with the entity, unless one of several exceptions apply. The Stark Law has significant civil penalties. Criminal antikickback laws can apply when a physician receives something of value in connection with a referral to a federal healthcare program.

Upcoding is a fraudulent medical billing practice in which the bill is inappropriately expensive because the provider billed for a more expensive examination, test or procedure than was performed.

Unbundling is a fraudulent medical billing practice in which a provider bills for services individually instead of submitting them at a bundled rate. By submitting the services piecemeal, the provider will be paid more. Fraud of this type is often found in laboratory billing schemes.

A Certificate of Need (CON) is issued after a state regulatory body has reached a finding that a medical facility acquisition, expansion or creation is appropriate to fulfill the healthcare needs of a community. One purpose of CON is to prevent excess hospital capacity in a community, which could encourage fraudulent billing.

3. C: Increasing the perception of detection

Rationalization is just one side of the fraud triangle and is a contributing factor. But reducing rationalization does not totally prevent fraud. The other sides of the fraud triangle are perceived financial need and perceived opportunity.

A 2010 article posted on CFO.com quotes Michael Roberto, professor of management at Bryant University: "[B]ad news does not come through an open door… [A] CFO must walk out the door and hunt for it."

If employees, vendors and customers are made aware of fraud detection efforts, fraud prevention is increased. Reminders of employee/vendor/contractor responsibilities also contribute to effective fraud prevention. Dan Ariely, a researcher in behavioral economics, made up a test that is easy to cheat on, to see how social situations might affect students' choices to cheat or not. In his book, *Predictably Irrational*, Ariely found that students who had been asked to recall the Ten Commandments or an honor code, did not cheat at all.[4]

Human resource screening activities have experienced some success in ferreting out poor candidates and employees but remain less effective than hot lines and other techniques.

Annual reminders and re-commitment requirements represent a subset of an organization's fraud detection perception efforts.

4. E: All of the above

All the answers are true. The fraud is an example of a predatory genetic testing scheme targeting Medicare and Medicaid. Early awareness of both the schemes and the spikes in funding associated with the corresponding CPT codes can detect and stop these frauds.

5. A: Organization for healthcare fraud

The National Health Care Anti-Fraud Association (NHCAA) is the U.S. organization with the mission: "To protect and serve the public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution, and prevention of health care fraud and abuse." NHCAA offers a credential, Accredited Health Care Fraud Investigator (AHFI®), for anyone with a responsibility for healthcare fraud issues.

The Association of Certified Fraud Examiners (ACFE) is the world's largest antifraud organization with more than 85,000 members. However, the ACFE specializes in fraud more generally than just healthcare fraud.

The Federal Bureau of Investigation (FBI) is focused on the investigation and prosecution of individuals that prey on private pay and federal healthcare programs.

The United States Department of Health and Human Services – Office of Inspector General (HHS–OIG) is primarily focused on the investigation and prosecution of individuals that prey on the Medicare and Medicaid programs.

[3] Victor E. Hartman, *The Honest Truth About Fraud: A Former FBI Agent Tells All*, (Pennsauken, NJ: Bookbaby, 2019).
[4] https://whistlinginthewind.org/2013/01/19/predictably-irrational-chapter-11-12-the-context-of-our-character/

False claims defraud the government's procurement processes and beneficiary programs.

The Institute of Internal Auditors (IIA) is an organization focused on the interdisciplinary corporate functions including internal auditing, risk management, governance, internal control, information technology audit, education, and security, but not exclusively fraud.

6. B: Tips

Law enforcement ranks at or near the bottom for uncovering fraud sources according to the ACFE "Report to the Nations."[5]

A tip from one of several groups—an employee, customer, vendor or anonymous—is the best source for revealing fraud. Tips can serve as a good source of information for uncovering fraud because a tipster may be aware of questionable information and activities, have been solicited for participation in a scheme, and/or have relevant insider knowledge.

While audit professionals share a combined 30 percent success rate, they remain less successful than tips.

Proactive management actions and artificial intelligence tools are growing in their success rate, but they are far below tips.

The internal control environment is important but ranked well below tips.

7. B: Procurement kickbacks

Recording fictitious sales is a common type of revenue recognition scheme.

Procurement kickbacks involve costly inventory, fixed assets, or service schemes rather than revenue recognition fraud.

Round tripping involves the sale of a product between two conspiring entities to inflate revenue. The sale lacks economic substance but makes the seller's revenue look bigger. When the reciprocal sale of the product back to the seller is completed, both organizations return to their financial position before their round tripping. If the sale straddles a reporting period, financial results can be misleading. Where organizations have publicly traded stocks or bonds, tax exempt or not, market prices could be affected.

Channel stuffing is a scheme where a company induces customers to purchase extra products by offering deep discounts, favorable terms or other concessions, often at the end of the period. The practice is fraudulent when the terms, such as buyback agreements, are not disclosed to the accounting department when accounting staff are making revenue recognition decisions.

Bill-and-hold is an improper revenue recognition scheme whereby revenue is recognized at the point of sale, but the goods are not delivered to the buyer until a later date.

8. C: A low percentage of *qui tam* lawsuits involve healthcare fraud

A, B, D and E are true. C is false since a very high percentage—number and dollar awards—of *qui tam* lawsuits involve the healthcare industry.

Summary

The losses incurred due to waste, fraud and abuse in our healthcare system are staggering. You play a key role in preventing and detecting fraud as well as in educating your organizations about occurrence, detection and prevention. Help heighten fraud awareness by using these questions to test your colleagues' knowledge. **NP**

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[5] Page 17, https://s3-us-west-2.amazonaws.com/acfepublic/2018-report-to-the-nations.pdf