FRAUD CASE STUDY – FALSE MEDICAL CLAIMS

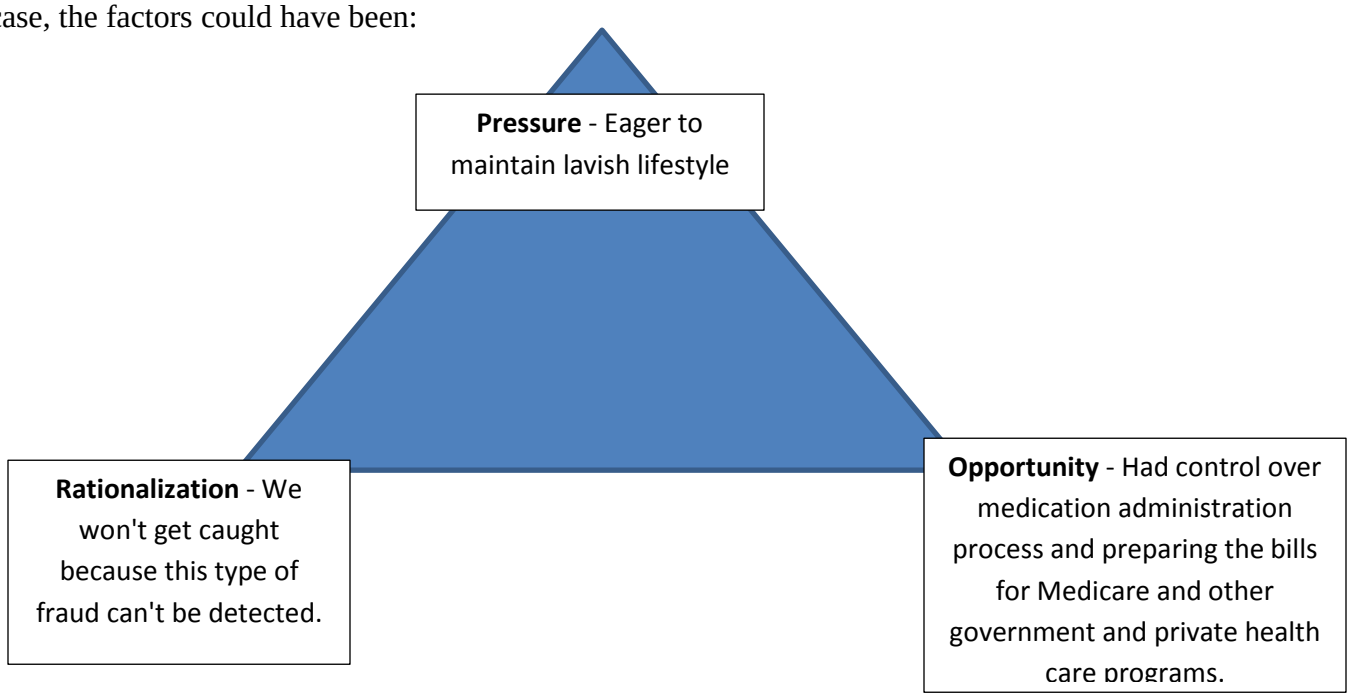
Case

A doctor and his wife were indicted by the grand jury for twelve counts of healthcare fraud. The couple was part of a network of civilian providers administered through regional contracts with the Department of Defense to service active duty personnel, retirees, survivors, and their dependents. The indictment alleges the couple conspired to bill Medicare and other DoD healthcare programs for larger amounts of medicine than were actually delivered to patients. In order to maintain the scheme, the couple entered false information into patient records. The conduct first came to light when a whistle blower, a former employee of the couple's clinic, brought suit under the qui tam provisions of the False Claims Act which allows private parties to sue alleging fraud against the government.

According to the indictment and the civil litigation, the doctor would make patient treatment notes on individual slips of paper which were given to his nurse. The notes specified the amount of drugs to be provided to a specific patient. After the nurse had provided the drugs to patients by injection or infusion, the slips of paper were returned to the doctor who shredded them. The doctor then made entries into another form, recording the amount of medications the patients had received. However, evidence in the case indicates the doctor recorded more medication administered than actually received by the patient, and claimed more time spent administering the medication than actually occurred. The doctor's wife then prepared the bills for Medicare and other government and private health care programs, using the inflated amounts, substantially increasing the amount of money owed to the clinic for medication. Also, the doctor made false entries on patients' medical records so that they matched the billing, and the records indicated that patients had received larger doses of various drugs than they had actually received. The government alleges the scheme illegally boosted the clinic's income by $1.1 million.

Fraud Triangle

According to the Association of Certified Fraud Examiners, the fraud triangle is a model for explaining the factors that cause someone to commit fraud. It consists of three components (pressure, opportunity and rationalization) which, together, lead to fraudulent behavior. In this case, the factors could have been:



Control Activities – Would They Have Worked in This Case?

Segregation of Duties

Management divides or segregates key duties and responsibilities among different people to reduce the risk of error, misuse, or fraud. This includes separating the responsibilities for authorizing transactions, processing and recording them, and reviewing the transactions so that no one individual controls all key aspects of a transaction or event.

Even though the doctor's wife, and not the doctor, prepared the billing documents, there was the risk that she was involved in the fraud scheme too. The segregation of duties did not work in this situation and there are several factors the disbursing agency could have looked out for to prevent or reduce the fraudulent activity. The factors include:

- The doctor and the person preparing/authorizing the billings had the same last name
- Unusual entries in patients records
- Tips from others that fraudulent activity is or has occurred

If segregation of duties is not practical within an operational process because of limited personnel or other factors, the disbursement agency should design alternative control activities to address the risk of fraud, waste, or abuse in the operational process.

Responding to False Medical Claims

Prepayment Reviews

When fraud has been detected, entities should consider the potential for fraud to occur again when identifying, analyzing, and responding to risks. Entities should always remember that those who commit fraud deliberately try to circumvent the control system and exploit any perceived weaknesses.

In response to fraudulent activity, some entities in the healthcare industry conduct prepayment reviews to prevent payment for questionable billing practices or fraudulent services. Providers with atypical billing patterns may be placed on prepayment review, and once on prepayment review, their claims and supporting documentation are subject to screening to verify that the claims are free of billing problems. The results of a review may result in a reduction of what was claimed or a complete denial of the claim.

The prepayment reviews are management responding to fraud risks. Management has designed specific actions for responding to fraud risks in which it may be possible to reduce or eliminate certain fraud risks by making changes to an entity's activities and processes. In addition to responding to fraud risks, management may need to develop further responses to address the risk of management override of controls. Further, when fraud has been detected, the risk assessment process may need to be revised.

What to Monitor

- Those who prepare/authorize the billing documents – Look for similar last names between the doctor and person who prepares/authorizes billing documents (family members can be involved in the fraud scheme with the perpetrator).

- Medical Records – Check to see if the records have been altered or include false entries (smeared or smudged writing; unclear, illegible writing)

Fraud Indicators

- Billing for services not rendered;

- Falsifying information on medical records, billing statements, and/or cost reports filed with the government.