ARMANINO

Fraud in Healthcare

HFMA Lone Star Chapter
Winter Conference 2025

AGENDA

- Fraud Defined
- Fraud in Healthcare
  - Unique Characteristics
  - Impact of Fraud
  - Texas Law Highlights
  - Federal Law Highlights
- Red Flags of Healthcare Fraud
- Fraud Prevention and Deterrence
- Case Studies – Interactive

Association of Certified Fraud Examiners

Fraud Defined:

Any intentional act or omission designed to deceive others, resulting in the victim suffering a loss and/or the perpetrator achieving a gain.

Fraud Triangle

RATIONALIZATION

- ✓ They won't miss it
- ✓ I deserve this; I'm underpaid
- ✓ Just this once

OPPORTUNITY

- ✓ Lack of Controls
- ✓ No Segregation of Duties
- ✓ No "Tone at the Top"

PRESSURE

- ✓ Debt or Life Circumstances
- ✓ Pressure to Perform
- ✓ Illicit Activities

FRAUD IN DOLLARS

- NASDAQ 2024 Global Financial Crime Report estimates that fraud costs $458 billion each year, worldwide.
- U.S. General Accounting Office estimates healthcare fraud losses can be up to 10% of annual healthcare spend each year.
- U.S. Department of Justice reports annual healthcare expenditures now exceed $1 trillion > more than $100 billion could be lost to fraud each year.

Fraud in Healthcare

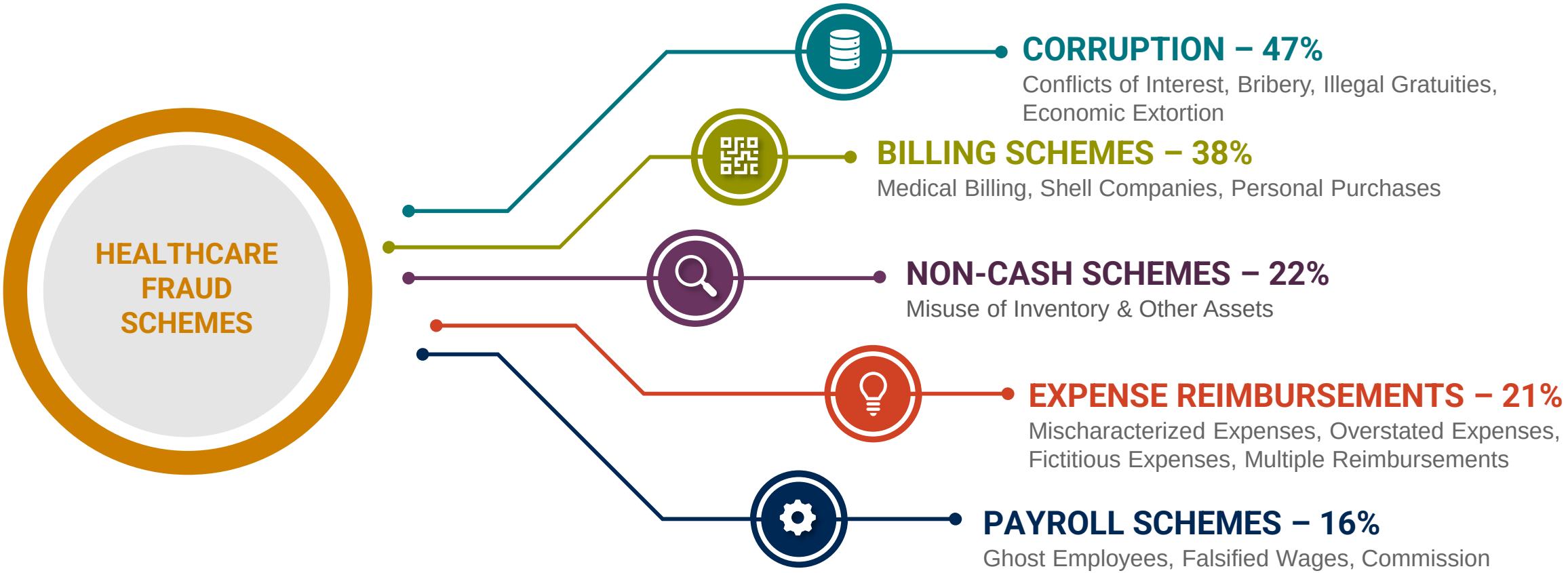
HEALTHCARE FRAUD

Unique Characteristics

- Complexity and indirect nature of revenue recognition in healthcare
- Immense volume of transactions processed daily
- Many additional layers of transactions
- Collusion is often involved
  - Among management, employees, or third-parties.
- Vast range of medical conditions and procedures requires a specialized knowledge & training for medical auditing
  - Opportunity to apply AI to big data to identify anomalies

ACFE 2024 Report to the Nations

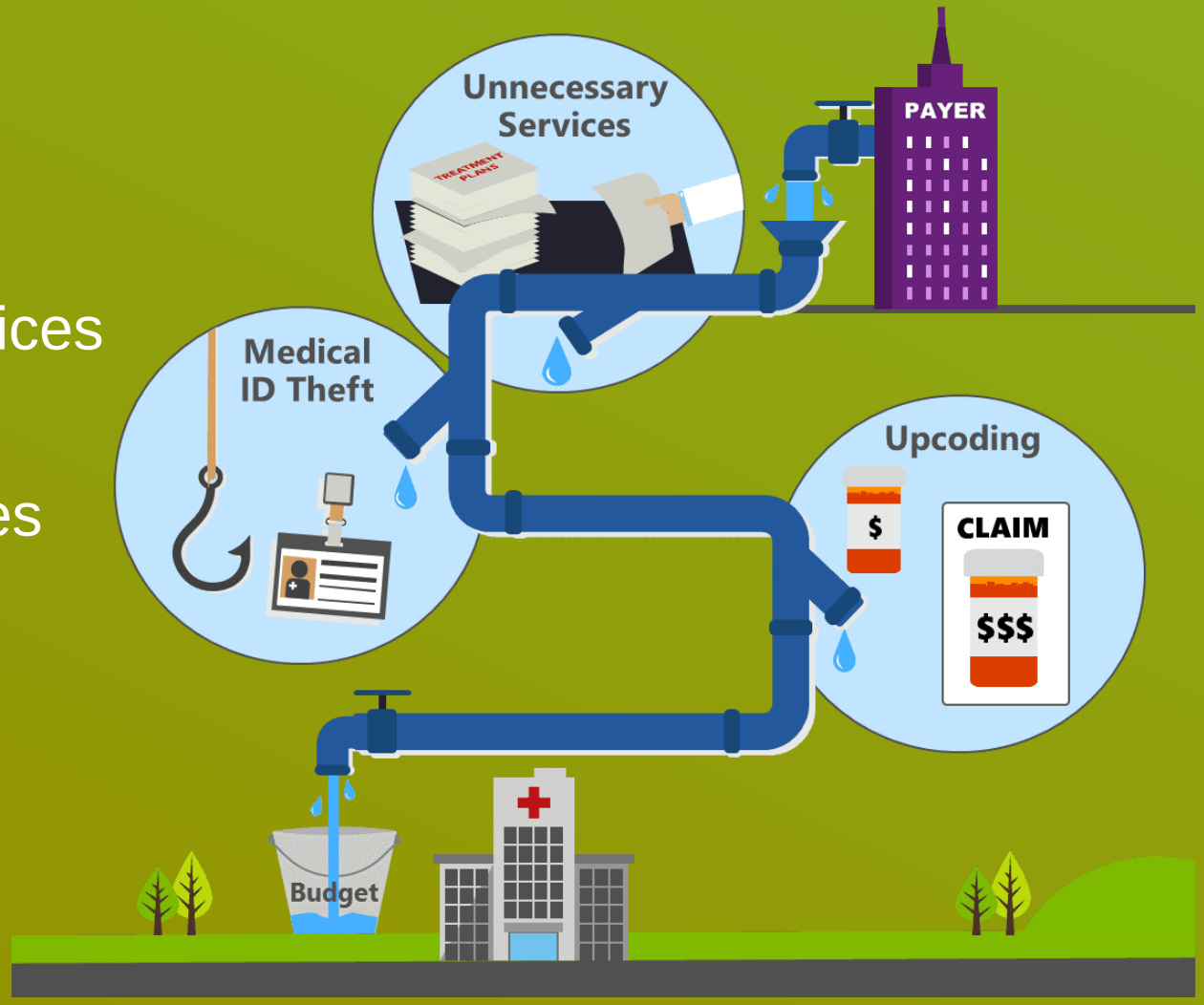
Most Common Schemes



HEALTHCARE FRAUD

Common Types

- Fraudulent Billing of Medical Services
- Illegal Patient Referrals
- Vendor Managers Receiving Bribes
- Check or Credit Card Schemes
- Fraudulent Invoices



HEALTHCARE FRAUD

Impact of Healthcare Fraud

- Higher Insurance Premiums & Out-of-Pocket Costs
- Reduced Benefits of Coverage
- Higher Costs to Employers to Provide Employee Benefits
- Medical Identity Theft > could lead to victims receiving incorrect medical treatment or potential problems obtaining future coverage
- Potential for creation of a falsified medical history

HEALTHCARE FRAUD

Impact to the Organization

- Financial Impact
  - U.S. Sentencing Commission reported median losses from healthcare frauds was $1.4 million in 2023
  - Legal Fees
  - Fines & Penalties
- Reputational Impact
  - Loss of stakeholder confidence
  - Increased scrutiny by regulatory bodies and law enforcement
  - Public Relations Disasters
- Penalties under the Law

Texas Law Highlights

A person commits an offense if the person:

1. Knowingly makes or causes to be made a false statement or misrepresentation of a material fact to permit a person to receive a benefit or payment under a health care program that is not authorized or that is greater than the benefit or payment that is authorized;

2. Knowingly conceals or fails to disclose information that permits a person to receive a benefit or payment under a health care program that is not authorized or that is greater than the benefit or payment that is authorized;

3. Knowingly makes, causes to be made, induces, or seeks to induce the making of a false statement or misrepresentation of material fact concerning:

   (A) the conditions or operation of a facility in order that the facility may qualify for certification or recertification under a health care program; or

   (B) information required to be provided by a federal or state law, rule, regulation, or provider agreement pertaining to a health care program;

4. Except as authorized under a health care program, knowingly pays, charges, solicits, accepts, or receives, in addition to an amount paid under the health care program, a gift, money, donation, or other consideration as a condition to the provision of a service or product or the continued provision of a service or product if the cost of the service or product is paid for, in whole or in part, under a health care program;

5. Knowingly makes, uses, or causes the making or use of a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to this state or the federal government under a health care program.

Texas Penal Code: Chapter 35A – Healthcare Fraud

PUNISHMENTS BY OFFENSE

Texas Penal Code

Misdemeanor	• Payment or benefit provided is < $100 up to $2,500 • Imprisonment up to one year • Fines from $500 to $4,000
State Jail Felony	• $2,500 to $30,000 or cannot be reasonably ascertained • Imprisonment of 180 days to 2 years • Fines up to $10,000
Felony (2nd or 3rd Degree)	• $30,000 to $300,000 –*OR*– Involved > 25 fraudulent claims • Imprisonment between 2 and 20 years • Fines up to $10,000
First Degree Felony	• Amount of payment or benefit is $300,000 or more • Imprisonment of 5 to 99/life • Fines up to $10,000

HEALTHCARE FRAUD

Federal Law Highlights

- Federal False Claims Act
  - Allows private citizens to file “qui tam” suits on behalf of the government
  - Whistleblowers can be awarded up to 30% of proceeds
  - “Knowingly” submits false claims to the government
- Stark Law – prevents physicians (& family members) from making referrals based on financial relationships (beyond bribery)
  - No referrals to surgicenters, therapy, imaging, lab services, home health, etc.
  - Intent is not required
- Exclusion Statute

Red Flags of Healthcare Fraud

POTENTIAL INDICATORS OF FRAUD

Red Flags – Fraudulent Billing

- Unusual frequency of visits or procedures (by patient or by facility)
- Patient address is far from the provider address
- Time coded and level of procedure does not align with diagnosis
- Provider notes do not contain typical keywords related to certain diagnosis codes
- Frequent adjustments, credits, or reversals to patient accounts
- Lack of follow-up visits or treatments
- Reimbursement rates that do not align with contracted rates
- Long lag time between DOS and bill date
- Single provider billing more than the maximum units of service on a given date

POTENTIAL INDICATORS OF FRAUD

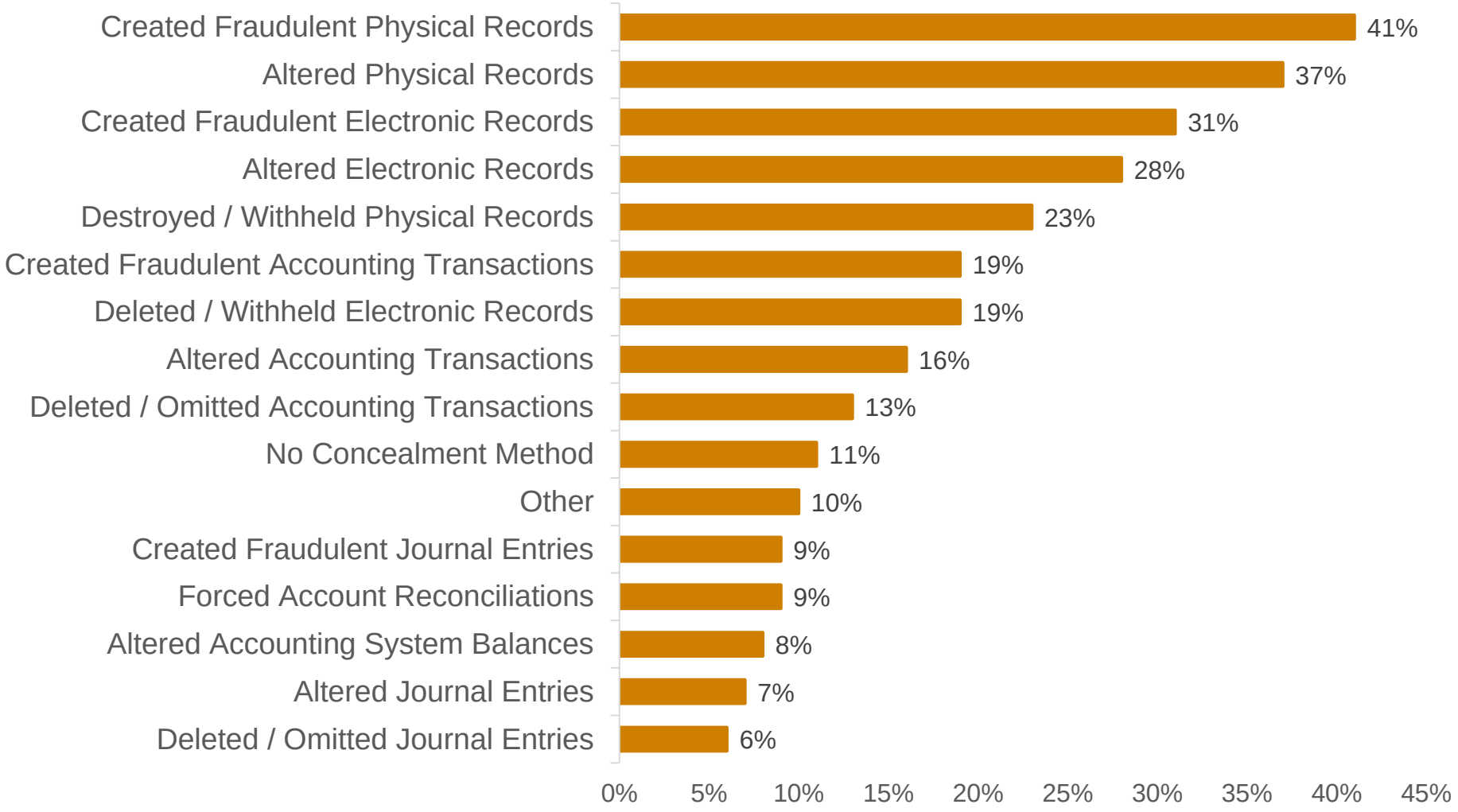
Red Flags – Accounting

- Information across various data sources does not reconcile
- Check sequencing is out of order; gaps in check sequencing
- Returned checks or NSF fees charged by the bank
- Incomplete or missing information in the Master Vendor Listing
- Vendor and Employee information overlap
- Complaints from vendors on outstanding payables
- Count and timing of transactions
- Continuous use of the same vendors or contractors
- Large number of transactions just below certain approval thresholds
- Frequent adjusting entries to patient accounts / bad debt write-offs

ACFE 2024 REPORT TO THE NATIONS

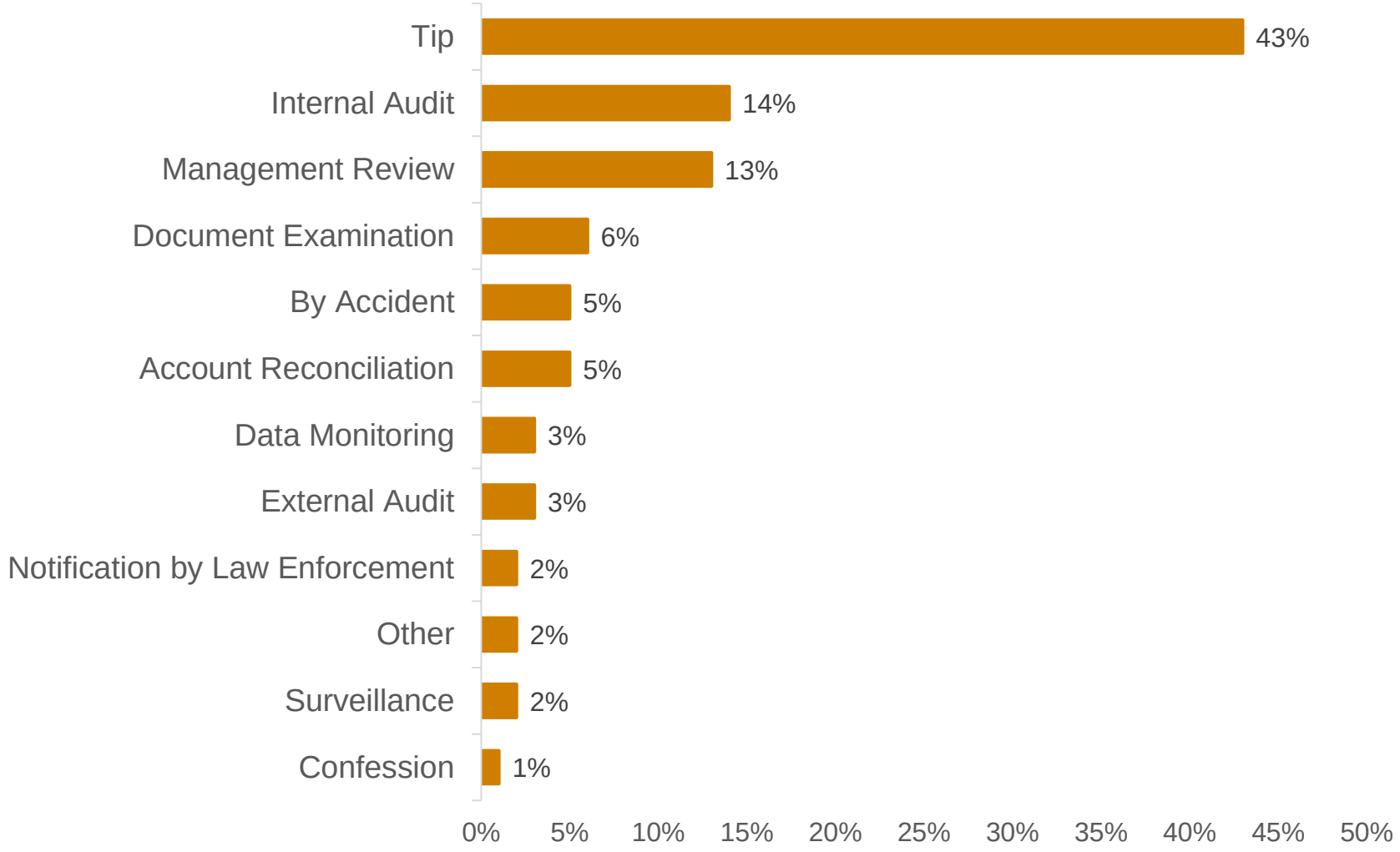
Key Behavioral Red Flags

HOW DID THEY DO IT?



METHODS OF FRAUD CONCEALMENT -- ACFE 2024 REPORT TO THE NATIONS

HOW DID WE FIND OUT?

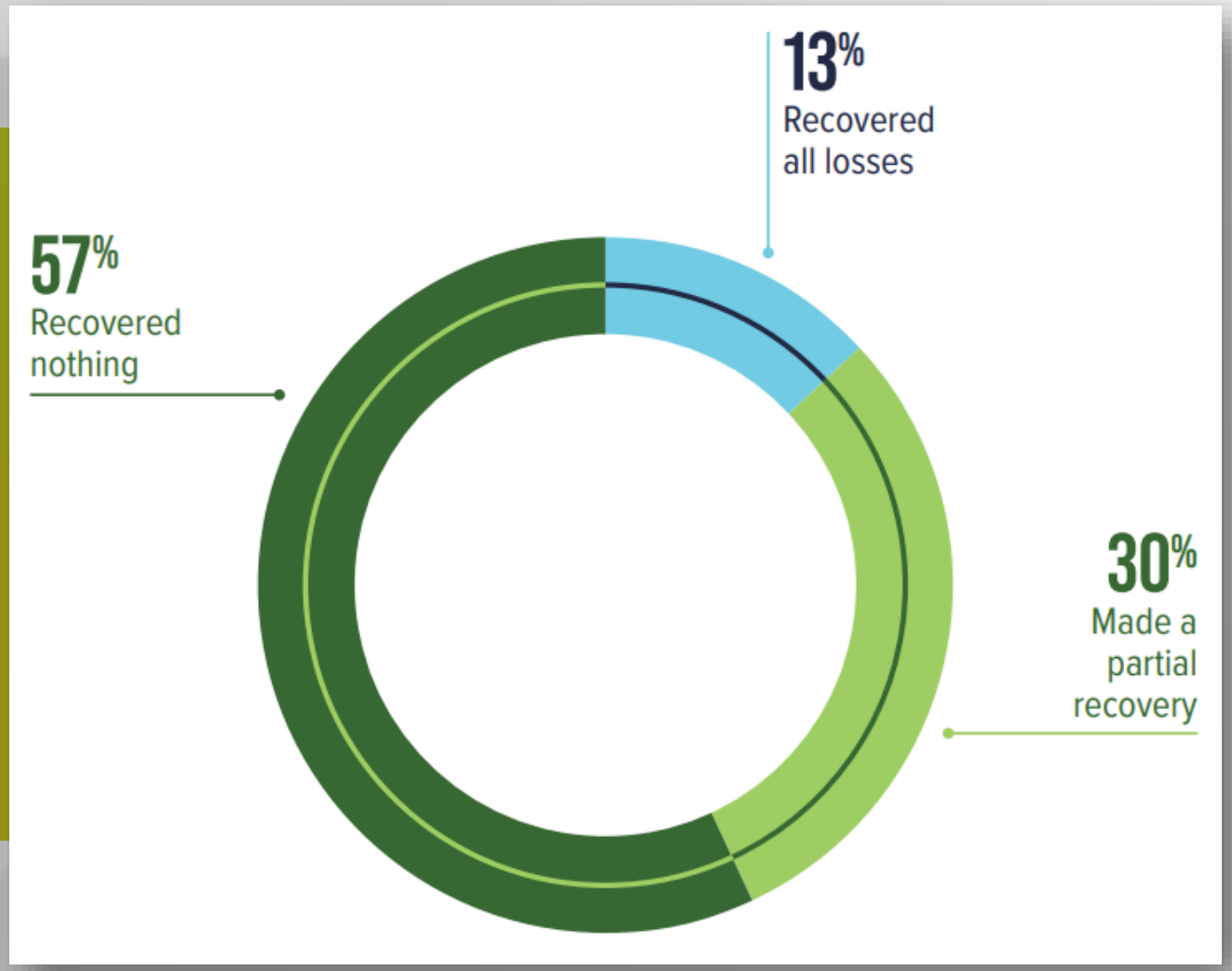


METHODS OF FRAUD DETECTION -- ACFE 2024 REPORT TO THE NATIONS

Fraud Prevention & Deterrence

Fraud losses are expensive to investigate, and full recovery is rare.

This substantiates the importance of prevention & deterrence.



FRAUD PREVENTION & DETERRENCE

Impact of Anti-Fraud Programs

- Reduce the duration of fraud schemes
  - Early identification significantly reduces fraud losses
- Better your chances of recovery
  - Fraud Loss Coverage – potentially also covers legal and investigative fees
- Avoid penalties
- Ensures resources are used to enhance quality of patient care
- NOTE: Lack of enforcement undermines any anti-fraud controls in place

FRAUD PREVENTION & DETERRENCE

Anti-Fraud Controls

- Transaction monitoring
- Fraud Risk Assessments – reviewed and updated regularly
- Conduct fraud awareness training
- Documented anti-fraud policies with clearly defined consequences of violations
- Create plans for cyber crisis management & data breaches
- Reporting Mechanisms
- Accounting Controls
  - Separation of duties
  - Regular and surprise audits
  - Physical and electronic access controls

FRAUD PREVENTION & DETERRENCE

Enterprise-Wide Fraud Risk Assessments

- Know your weaknesses & understand how frauds can be concealed
- Identify Risk Types
  - Internal vs. External Risks
- Map Risk Controls
  - Physical Access Controls
  - Data Security
  - Checks and Balances / Separation of Duties
- Assess Risk Controls for Effectiveness
- Prioritize and allocate resources appropriately

Headlines on Healthcare Fraud

Doctor Sentenced for $54M Medicare Fraud Scheme

XYZ Company will pay $47 million to settle whistleblower allegations of billing fraud

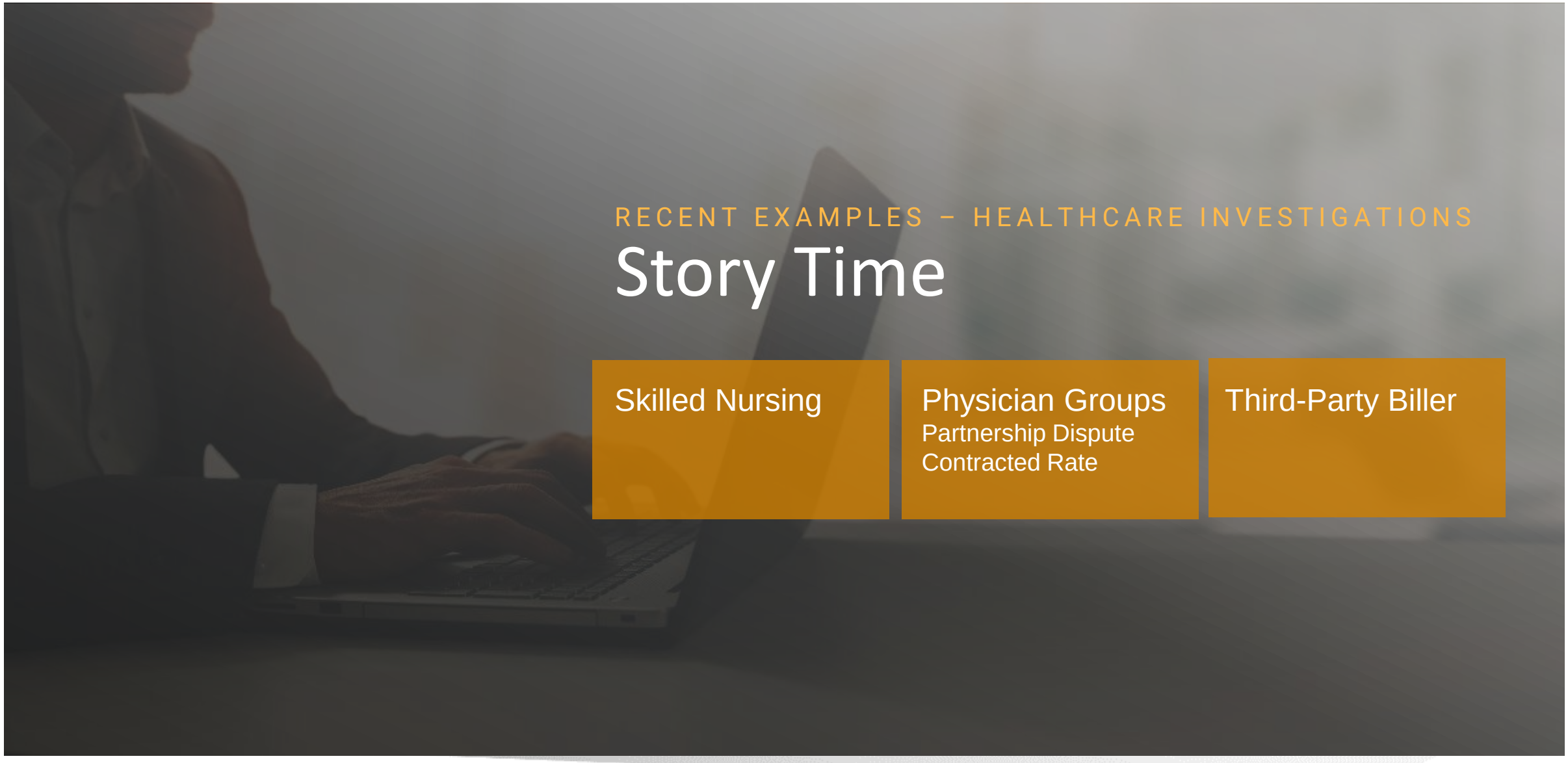
Hospital CFO one of three charged with $15M fraud scheme

ABC Company under federal investigation for fraud and corruption, sources tell CBS news

Three charged in $1 billion Medicare fraud scheme

… woman admits fraud, ID theft charges in scheme using hospital patient records

Texas Physician Convicted in $16 million Medicare Fraud Scheme



RECENT EXAMPLES – HEALTHCARE INVESTIGATIONS

Story Time

Skilled Nursing

Physician Groups
Partnership Dispute
Contracted Rate

Third-Party Biller