Combating Health Care Fraud with Audits and Education

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# Combating Health Care Fraud with Audits and Education

## Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Abstract</td>
<td>1</td>
</tr>
<tr>
<td>II. Introduction</td>
<td>2</td>
</tr>
<tr>
<td>III. Fraud Concepts</td>
<td>4</td>
</tr>
<tr>
<td>IV. Internal Controls and Auditors</td>
<td>7</td>
</tr>
<tr>
<td>V. Medicare, Medicaid, and Common Frauds</td>
<td>11</td>
</tr>
<tr>
<td>VI. Current Statutes and Agency Initiatives</td>
<td>13</td>
</tr>
<tr>
<td>VII. Auditing the Control Activities of Providers</td>
<td>17</td>
</tr>
<tr>
<td>VIII. Educating Victims and Qui Tam Lawsuits</td>
<td>23</td>
</tr>
<tr>
<td>A. Qui Tam Lawsuits</td>
<td>24</td>
</tr>
<tr>
<td>IX. Conclusion</td>
<td>27</td>
</tr>
</tbody>
</table>

## Abstract

Fraud disrupts any and all operations in which it plagues. The disruptions manifest financially in increased costs and waste, and also by impairing trust and honesty that should base transactions within a system. Health care fraud acts like any other fraud in these regards, but it can be resisted like any other fraud. The financial world relies on audits to ensure that corporate financial statements accurately reflect what they intend to illustrate. Auditing a health care provider’s control activities would reveal whether the providers have reliable control activities to prevent and detect fraud. In addition, any policy to audit health care providers should be supplemented with educating the populace.
to detect and report any red flags that could indicate fraud. Auditing control activities and informing patients would directly combat fraud because fraudsters operate within the procedures and policies of the provider (which control activities monitor) and utilize transactions that involve patients (who are in the best position to know, understand, and evaluate the entire transaction).

**Introduction**

Federal investigators estimate that health care fraud costs taxpayers between $60 to $100 billion dollars a year.¹ However, the cost to recover $7.3 billion in fraudulent health care losses was $443.8 million from 2000 to 2004, nearly a 15 to 1 recovery rate; for every one dollar spent, nearly fifteen dollars are recovered.² Though the exact numbers may be questionable, the substantial fraud estimate and impressive recover ratio illustrate the need to add more resources to combating fraud. Black’s Law Dictionary defines fraud as “a knowing misrepresentation of the truth or concealment of a material fact to induce another to act to his or her detriment.”³ This definition encompasses the basics of fraud regardless of the transaction or industry.

Examiners should audit the control activities of all health care providers to ensure that the health care providers do not engage in fraudulent activities.⁴ Control activities

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1 http://www.texaslawyers.com/coomer/healthcarefraudquitamclaims.htm
2 http://www.taf.org/FCA-2006report.pdf, pg 4
3 Blacks law dictionary, fraud
4 Current laws (such as in the Health Insurance Portability and Accountability Act) and legal scholarship mention audits in a cursory fashion. See Altshuler, Matt, et al., Health Care Fraud, 45 AMCRLR 607, 641 (2008) (describing HIPAA’s impact on the private health care sector); Morris, Lewis. Thompson, Gary A., Reflections of the Government’s Stick and Carrot Approach to Fighting Health Care Fraud, 51 ALLR 319, 319-324 (1999) (mentioning audits as a practice to combat fraud without detailing the nature of the audits). The current legal scholarship only reference audits as a possible remedy but fail to complete the point with a thorough analysis on how and why audits are important and how they should be implemented. This paper
(which will be described in detail later) are procedures that control how a company manages its transactions.\(^5\) The corporate world accepts audits as necessary evils to assure investors that corporate financing statements are accurate. Sarbanes Oxley, Section 404 requires auditors to scrutinize a company’s internal controls, which enhance corporate reliability.\(^6\) This template should be applied but tailored to the health care sector. Currently, only public entities file audited financial statements. Some private hospitals or providers do audits in order to placate and encourage investment. But these audits may not conform to auditing standards and practices required for public audits.

Audits of health care providers do not need to be as sophisticated as corporate audits nor must they be done by prestigious firms. The Department of Health and Human Services (HHS) should require all health care providers to create and submit a narrative that details and explains all the control activities for their various transactions. HHS can formulate a simple auditing procedure and even supply several templates to providers in order to reduce the audit’s complexity and cost. In addition, the audit should predominantly, if not exclusively, focus on the provider’s control activities to assure that they are strong. Financial statements or business records could receive a cursory review to confirm that no irregularities exist to suggest that the internal controls are indeed inadequate.

In addition, officials should educate the populace about their role in preventing health care fraud. This education should inform patients about common types of fraud and how they can detect and report it. Patients are obviously on the front line because they

\(^5\) \url{http://www.osc.state.ny.us/localgov/pubs/internal_controls.pdf}, pg 2

\(^6\) See \url{http://www.shsu.edu/~aac_cwb/control1.htm}
receive the medical treatment and can best review the transaction to detect fraud. The education should also explain and detail qui tam lawsuits because these lawsuits empower citizens to bring legal action against health care fraudsters and provide a monetary incentive to do so.

**Fraud concepts**

Successful investigators often try to ascertain what a criminal would do or think in order to anticipate the crime or the criminal’s next step. Dr. Donald Cressey, a noted criminologist, studied fraud while working on his doctorate at Indiana University during the 1950s.\(^7\) He particularly focused on the factors that lead otherwise honest individuals to fall to temptation. Dr. Cressey interviewed around 200 inmates throughout Midwest prisons who were serving embezzlement sentences. His conclusions have been refined (but not materially changed) to form the Fraud Triangle\(^8\).


\(^8\) Id. at 8
According to Dr. Cressey, all three elements must arise in order for an honest person to succumb to fraud. This remains an important premise because it applies only to honest people and not the professional con artist. However, as will be shown later, preventing honest people from committing fraud should also spill over into thwarting the professionals through the use of strong control activities. In addition, Dr. Cressey surmised that professional thieves composed a minor number of offenders during his study. It is unclear whether this belief remains true, even among health care providers or affiliates.

The first leg of the triangle is a “perceived, non-sharable financial need.” The offender must believe that this financial pressure could not be revealed to anyone else, even someone whom the offender loves or trusts and could help, such as a spouse or close friend. Generally, the pressure carries a stigma that the offender does not want publicize, gambling. This perceived pressure is completely subjective; that is, one offender’s gambling debt may have no affect while another offender views that same debt as non-sharable. The pressure can be genuine (medical or mortgage bills) or simply greed (desire to sustain a certain quality of life).

The second corner relates to perceived opportunity. In order for this burdened offender to commit the fraud, he must believe that he is able to secretly solve his financial

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9 Id. at 7
10 Id. at 7
11 Id. at 7
12 Id. at 9
13 Id. at 9
14 Id. at 9
15 Id. at 9
16 http://www.boisestate.edu/internalaudit/pdfs/FraudTriangleRedFlags.pdf, pg 1
need without getting caught.\textsuperscript{18} A common thief only burglarizes targets that maximize success.\textsuperscript{19} However, most fraudsters, especially those in the health care industry, do not simply flee the scene, never to return. They have work tomorrow at the same employer. In this case (fraud in the work place), perceived opportunity correlates with the risk of detection.\textsuperscript{20} High detection risks lead to punishment, humiliation, and loss of job and freedom as opposed to alleviating that non-sharable financial need.\textsuperscript{21}

The final angle is rationalization, which allows a former honest person to convince themselves that the action they swore that they would never commit is actually ok to commit.\textsuperscript{22} Cressey discovered offenders normally rationalize their actions by characterizing their actions as noncriminal, justified, or something outside of their control.\textsuperscript{23} In order for honest people to commit acts against their nature, they must have a reason to placate themselves and others if caught in order to maintain their moral image or avoid guilt.\textsuperscript{24}

The Fraud Triangle provides an insightful synopsis of the general nature of fraud and offenders. The Triangle insinuates that fraud is two parts subjective and one part objective.\textsuperscript{25} The perceived pressure and rationalization occurs exclusively in the mind of the offender.\textsuperscript{26} Absent extreme measures like 24 hours surveillance or polygraph tests, fraud examiners cannot control or prevent a potential offender’s thoughts or beliefs. However, fraud examiners and employers can control how potential offenders perceive

\begin{flushleft}
\textsuperscript{18} Id. \\
\textsuperscript{19} Id. \\
\textsuperscript{20} Id. \\
\textsuperscript{21} See Id. \\
\textsuperscript{22} Id. \\
\textsuperscript{23} Id. at 11 \\
\textsuperscript{24} Id. at 11 \\
\textsuperscript{25} See Id. at 9, 11 \\
\textsuperscript{26} See Id. at 9, 11
\end{flushleft}
potential opportunities. A carefully and intelligently designed system of internal controls (control activities in particular) can limit or eliminate a potential offender’s belief that an opportunity to defraud exists.

**Internal Controls and Auditors**

Internal controls protect a company from fraud and enhance confidence in its reputation and output. If internal controls are effective, then they decrease the perceived opportunity of fraud by increasing the risk of detection. In the 1990’s, the Committee of Sponsoring Organizations (COSO) presented a report that defined internal controls and identified five key components. It defined internal controls as “a process affected by the entity’s board of directors, management, and other personnel, designed to provide reasonable assurance regarding the achievement of objective in effectiveness and efficiency of operations, reliability of financial reporting, and compliance with applicable laws and regulations.”

Sound internal controls do not provide absolute assurance, only reasonable assurance.

Internal controls enable an organization to efficiently and effectively pursue its mission while preventing fraud, waste, and abuse. An organization committed to reducing and detecting fraud should primarily focus on these controllable policies as opposed to reaching inside a potential offender’s head (pressure and rationalization). In 2002, Congress passed Sarbanes Oxley in response to numerous corporate and accounting

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27 See http://www.osc.state.ny.us/localgov/pubs/internal_controls.pdf, pg 7
28 See Id.
29 See http://www.osc.state.ny.us/localgov/pubs/internal_controls.pdf, pg 2
30 See http://www.osc.state.ny.us/localgov/pubs/internal_controls.pdf, pg 2
31 Id.
32 http://www.nsula.edu/internalaudit/Internal%20Control%20Narrative.htm
33 Id.
scandals to combat fraud.\textsuperscript{34} Sarbanes Oxley regulates publicly traded companies with respect to their financial statements and the processes that produce the statements.\textsuperscript{35} In addition, Section 404 particularly requires the company to provide an internal report that assesses the effectiveness of the internal controls, and dictates that auditors must attest to the company’s assessment.\textsuperscript{36} Now, auditors must analyze the company’s internal controls and determine their efficacy. Sarbanes Oxley generally doesn’t apply to nonprofit corporations.\textsuperscript{37}

The five components of internal control are control environment, risk assessment, control activities, information and communication, and monitoring.\textsuperscript{38}

1. **Control Environment.**\textsuperscript{39} Most people refer to this control as ‘tone at the top.’ It bases the other controls because the function of an organization depends on leadership. If the leadership is disciplined and competent, then this will trickle down to the rest of the organization. If the leadership is lax and negligent, then the organization will adopt that culture. Organizations that want to detect fraud need leaders and managers who adopt that mindset and commitment.

2. **Risk assessment.**\textsuperscript{40} Risk assessment requires identifying, measuring, and evaluating risk factors. It determines the likelihood of occurrence and impact. This information is necessary in order to review internal control’s effectiveness and efficiency in conjunction with the idea that internal controls only provide reasonable assurance. If there is a good possibility of fraud but the impact is slight, then the response may depend on cost, alternatives, etc. If there is a low possibility but the impact is devastating, then greater effort should be directed to correct this.

\textsuperscript{35} Id.
\textsuperscript{36} 18 USC 7262
\textsuperscript{37} *Law of Health Care* at 575
\textsuperscript{38} http://www.osc.state.ny.us/localgov/pubs/internal_controls.pdf, pg 3
\textsuperscript{39} Id. at 5
\textsuperscript{40} Id. at 6
3. **Control activities.** The organization or supervisors adopt these policies in order to control risks, conform to laws, govern processes or transactions, and meet any other need or desire. Once adopted, individuals tasked with carrying out the activities develop procedures to ensure the policies performed.

4. **Information and Communication.** This area relates to the reporting process of the organization. Financial reports are the most common reports, but any report that details the organization’s activities are relevant. The reports should contain credible and accurate information necessary to competently operate the organization. Examiners must ensure that these systems operate properly and the inputs are accurate themselves.

5. **Monitoring.** The organization should periodically scrutinize all the policies and procedures of the organization.

   The control activities provide the best avenue for determining if an organization can effectively detect fraud. The control environment is tough to control as it depends on the leadership’s willingness to exude integrity and moral aptitude. Risk assessment greatly depends on judgment and represents more art than science. Information and Communication greatly depends on the inputs into the system and the inputs represent the areas of potential fraud. Monitoring is the general supervision of the whole process. The procedures within control activities protect the company from fraud and abuse. The basic theme for sound control activities revolves around segregation of duties. Control activities generally diffuse the control of business transactions from one

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41 Id. at 7  
42 Id. at 8  
43 Id. at 8  
44 See Id. at 7  
45 See Id. at 5  
46 See Id. at 6  
47 See Id. at 8  
48 See Id. at 8  
50 See Id. at 32
individual to two or more individuals.\textsuperscript{51} This dispersion in control dissuades potential fraudsters by increasing the risk of detection and decreasing the chance of success. The risk of fraud increases when an individual has complete control over several processes or procedures because the individual’s work is not supervised or supplemented and secrecy can be achieved.\textsuperscript{52} Typical procedures include independent authorization or review, physical controls and records, reporting and independent reconciliations, periodic verifications, and analytical reviews.\textsuperscript{53} By requiring authorization or simply including another person into the procedure, the risk of detection increases because secrecy is lost and another person must be included in the fraud.

As stated earlier, Section 404 of Sarbanes Oxley requires external auditors to attest to the company’s assessment of their internal control system.\textsuperscript{54} Since companies generally assess their system as competent and effective, auditors essentially determine the system’s overall effectiveness. The auditors’ review process provides an interesting paradigm that could be incorporated into preventing health care fraud.

Auditors performing internal control attestations first review the internal control narrative prepared by management.\textsuperscript{55} This narrative details a specific procedure from start to finish outlining all the related activities and systems, like a flow chart.\textsuperscript{56} Then auditor ascertains possible flaws and weaknesses of the framework and brainstorms other possible ways to commit fraud.\textsuperscript{57} Next, the auditor visits each particular section of the framework to either interview employees or examines systems or processes to determine effectiveness.

\textsuperscript{51} See Id.  
\textsuperscript{52} See Id. at 32  
\textsuperscript{53} http://www.nmsu.edu/~audit/Internal\%20Control\%20Fundamentals.pdf, pg 15, 16  
\textsuperscript{54} Law of Health Care at 575  
\textsuperscript{55} http://www.nysscpa.org/cpajournal/2004/804/essentials/p52.htm  
\textsuperscript{56} Id.  
\textsuperscript{57} Id.
Finally, the auditor concludes whether the framework is effective or not, and if not, then listing the deficiencies.58

**Medicare, Medicaid, and Common Frauds**

The Fraud Triangle certainly applies to Medicare and Medicaid. Providers may feel a financial pressure from the lower than market fixed rates per service or other sources (gambling, maintaining a life style, etc.).59 Opportunity arises in the programs’ complexity and size such that there is a small chance of being detected.60 This is especially true with Medicaid as federal and state laws apply, which legislatures often modify routinely. Finally, fraudsters may rationalization that defrauding the system only compensates them for services provided and that defrauding Medicare will only slightly impair the taxpayers like a dust particle bothers an elephant.

Health care fraud involves a variety of schemes and offenders.61 The possible offenders range from doctors and hospitals to ambulance and pharmacies.62 The phantom series of frauds revolve around the fraudster corrupting transactions to reflect something did not occur.63 Phantom Billing refers to billing for tests or services not performed. Phantom Employees relates to expensing hours that an employee did not work or

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58 Id.
59 See Law of Health Care at 423
60 See Id. at 465
61 Other known fraud schemes not explained within this section are: 1) performing unnecessary or inappropriate procedures, 2) reflexive testing, 3) defective testing, 4) offering free services in exchange for the patient’s Medicare/Medicaid number, 5) improper cost reports, 6) kickbacks or self referrals, 7) grant or program fraud
   http://www.quitamonline.com/fraud.html; http://www.warrenbensonlaw.com/medicare-fraud.jsp#false2; http://www.aging.state.ks.us/SHICK/Fraud_Abuse/Fraud_Abuse_Schemes.htm
63 http://www.quitamonline.com/fraud.html; http://www.warrenbensonlaw.com/medicare-fraud.jsp#false2; http://www.aging.state.ks.us/SHICK/Fraud_Abuse/Fraud_Abuse_Schemes.htm
attributing work to an employee that does not exist. Finally, phantom patients are patients that a provider cites as being treated when that patient was not seen or is not a patient of the provider.

Another common health care fraud revolves around billing. Providers may improperly bill Medicare or Medicaid for a treatment or equipment but either not provide the treatment or supply something inferior. For example, the provider may bill Medicare for a new wheelchair, but actually give the patient a used one; or the provider may bill Medicare for an ankle brace but not actually give the patient one or suggest that the patient need one.

Providers often rely on billing codes to process bills. Many policies attach to these codes to instruct the providers as to which codes to use to sufficiently bill for the services provided. Providers may ‘up code’ so that it exaggerates the severity of the patient’s treatment and inflates the bill. Potential fraudsters may ‘unbundle’, which means that they use two or more codes instead of an inclusive code as the policies require. Finally, providers could use ‘code jamming’ where they insert (or jam) certain codes in order to gain coverage.

**Current Statutes and Agency Initiatives**

Congress and state legislatures combat health care fraud through a variety of different laws and agencies. Each state has an agency charged with overseeing health care in general and exposing fraud. HHS administers Medicare, Medicaid, and investigates health care fraud. In addition, the legislatures have passed a variety of applicable criminal and civil laws to combat fraudsters. However, these laws and policies only combat fraud
when it is detected but do not prevent or actually detect the fraud. Requiring health care providers to describe their control activities and then auditing the control activities would efficiently and proactively prevent and detect health care fraud.

Criminal laws may provide the best disincentive for health care providers not to defraud the health care industry.\textsuperscript{64} As mentioned earlier, most fraudsters start off as good people faced with dilemmas. If the Fraud Triangle is examined in light of the possibility of criminal offenses, the potential fraudster may view the opportunity differently if imprisonment is the punishment; the risk of detection and punishment is not worth the benefit. In addition, it is hard to rationalize the stigma of a criminal conviction when the potential fraudster starts off as honest, law abiding citizens.\textsuperscript{65} Finally, most of these criminal laws are of general application and not health care related.\textsuperscript{66} This enables prosecutors to use these laws to add leverage to deal making because of their potential punishment and they are not complicated cases to establish. These statutes are, but are not limited to:\textsuperscript{67}

- Federal and state false claims statutes under Medicaid or Medicare, federal is 42 USC §1320a-7b(a)
- Federal and state false claims statutes in general, 18 USC §287
- Mail fraud, 18 USC §1341
- Wire fraud, 18 USC §1343
- False or fraudulent statements or representations, 18 USC §1001
- Money laundering, 18 USC §1956-57
- Racketeer Influenced and Corrupt Organizations statute, 18 USC §1961

\textsuperscript{64} \textit{See} http://www.acfe.com/documents/small-business-fraud-2008-excerpt.pdf, pg 10
\textsuperscript{65} \textit{See Id.}
\textsuperscript{66} \textit{Law of Health Care} at 673
\textsuperscript{67} \textit{Law of Health Care} at 673
If fraudsters submit multiple claims through an enterprise in interstate commerce.

- Aiding and abetting, 18 USC §2
- Conspiracy, 18 USC §371
- Theft of government property, 18 USC §1961-68

Governments also utilize civil statutes in order to recoup fraudulent losses. The obvious benefits of civil suits are no showing of mens rea, lower burden of proof, and recovering losses and possibly more. The most common federal civil law is the Civil False Claims Act, 31 USC §3729-33. The federal government can recapture $5,500 to $11,000 from individuals who knowingly submit false claims plus three times the amount of losses that the government sustains. 31 USC §3730(b) establishes the private qui tam suits which was analyzed earlier.

The Ethics in Patient Referrals Act (commonly known as the Stark Law) utilizes a transactional approach to regulate doctor referrals for Medicare or Medicaid covered services in which the doctor has a financial interest. This concept differs from traditional regulations in that Stark Law elaborately list and describe transactions that are legal or not. Stark law applies solely to referrals and kickbacks. Centers for Medicare and Medicaid has issued three rounds of Stark laws (Stark I, II, and III) that provide doctors with hundreds of pages of regulations and commentary that interpret and explain the law.

Other statutes affect health care fraud detection by increasing resources to that end or providing incentives to do so. The Health Insurance Portability and Accountability Act

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68 Id.
69 Id.
70 Id. at 730
71 Id. at 730
72 Id. at 730
73 Id. at 730
of 1996 (HIPAA), the Balanced Budget Act of 1997 (BBA), and the Deficit Reduction Act of 2005 (DRA) have increased the resources to exposing and prosecuting false claims.\footnote{Id. at 685} The statutes also provide for data collection programs and have afforded additional prosecutorial tools to prosecute fraudsters.\footnote{Id. at 685} The DRA created the Medicaid Integrity Program, which is the primary weapon of the Centers of Medicare and Medicaid Services to detect and prevent fraud.\footnote{Id. at 685} The additional prosecutorial resources certainly compliment the various criminal and civil laws, but also in their reactive and indirect nature. The data collection program and other initiatives offer more direct measures to hoist some red flags of fraud, but their effectiveness is questionable considering that do not delve into the transactions that fraudsters utilize.\footnote{See Id. at 685}

Finally, the Department of Health and Human Services (HHS) maintains the overall management of agencies charged with maintaining health.\footnote{http://www.oig.hhs.gov/organization/oi/} The two relevant sub-departments are the Centers for Medicare and Medicaid Services (CMS) and the Office of the Inspector General (OIG).\footnote{Id.} Both agencies encompass fraud detection and prevention services.\footnote{http://www.oig.hhs.gov/organization/oi/; http://www.cms.hhs.gov/MDFraudAbuseGenInfo} The CMS has the Medicaid Integrity Program, which increased the resources devoted to combating fraud.\footnote{http://www.cms.hhs.gov/MDFraudAbuseGenInfo/} The OIG provides audit functions to benefit the department and beneficiaries.\footnote{http://www.oig.hhs.gov/organization/oi/} The OIG ensures that the department as a whole is functioning efficiently and effectively in its operations and providing the necessary and accurate data.
for decision makers and the public.  The OIG also provides external investigations of fraud and waste for all the programs of HHS, including Medicare and Medicaid. This department, Office of Investigation, coordinates with other investigatory and law enforcement agencies within the federal and state governments.

These laws and agencies supply necessary regulations and actions in order to decrease and expose frauds against the health care industry. However, they are either reactive as opposed to preventive or attack fraud indirectly and inefficiently. The various laws and regulations listed above provide good guidance for proper behavior and decent deterrents (the criminal laws certainly are more effective in this area), but the laws inherently react to fraud when it is exposed. They do not directly expose fraud and only indirectly prevent it through deterrents. Requiring and auditing control activities directly prevent, expose, and combat fraud. The laws and initiatives merely oversee the health care industry as a police helicopter watches for cars running red traffic lights in a city, while control activities act as video cameras at every light. The control activities are amidst the transactions where the fraud is being committed. It is irrational and inefficient to try to combat fraud but not permeate the area where fraudsters operate.

The accounting scandals of Enron and WorldCom represent the ineffectiveness of combating fraud without internal monitoring. Regulations required corporations to file accurate and reliable financing statements for investors and the corporate world knew of these requirements. But this did not prevent scandals because the regulations only mandated an outcome but did not sufficiently assure the effectiveness of the steps that

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83 Id.
84 Id.
85 http://www.cms.hhs.gov/FraudAbuseforProfs/02_MedicaidGuidance.asp#TopOfPage
86 See http://www.osc.state.ny.us/localgov/pubs/internal_controls.pdf, pg 7
87 See Id.
would reach that outcome. It is synonymous to a school prohibiting students from cheating but then not monitoring how an exam is administered. Eventually, Congress rectified this logical flaw by passing Sarbanes-Oxley and requiring a corporate evaluation of internal controls. HHS should take a similar approach either through their regulations or lobbying Congress to pass a law requiring health care providers to provide an evaluation of their control activities and then auditing those control activities.

**Auditing the Control Activities of Providers**

Auditing health care providers’ control activities scrutinizes the arena where potential fraudsters operate, the business transactions of the health care providers. The principal emphasis of this new initiative should focus on control activities to combat fraud. These activities provide the best way to prevent and detect fraud because they govern a provider’s transactions and procedures. The templates would primarily offer control activities for various business models or transactions, such as ordering tests or inputting billing codes.

Providers should assess and explain their control activities in writing and submit this narrative to HHS in order to qualify as Medicare and Medicaid providers. HHS, in conjunction with states and their Medicaid agencies, would then randomly audit the provider’s internal controls, focusing on the control activities. HHS can employ the auditors or hire independent, local auditors. The audit procedure should be set in advance. The auditors’ predominant focus should be on ensuring that the provider’s control activities are sound and no other serious red flags are evident with other internal controls.

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88 Law of Health Care at 575
89 See http://www.osc.state.ny.us/localgov/pubs/internal_controls.pdf, pg 7
90 See Id.
A cursory check of business records could be done, but less intrusion into the provider’s practice would be preferred. By focusing on control activities, the initiative shifts a small burden onto providers to redesign their business model and policies to institute control activities and submit a narrative of the control activities.

HHS can offer templates of proper and strong control activities to inform and guide providers. The templates should focus more on the principle of the control activities rather than laboriously describe how control activities should be applied. Simplicity should be sought so as to avoid thousands of regulations concerning proper health care control activities. The templates should be instructive and not burdensome. This would give providers freedom and flexibility to incorporate control activities without substantially altering business models or policies. HHS could offer suggestions on how to implement control activities, but they should not be mandatory.

The other internal controls should be included but more in an educational manner to providers. The central theme is preventing and exposing fraud, not increasing unnecessary regulations on providers. This initiative should not base government intrusion into the business activities of the providers. HHS can distribute literature relating to fraud, fraud prosecution, and how managers should develop an honest and ethical culture within their offices (control environment). The literature can also include ways to perform risk assessment and the importance of this examination for identifying areas that are high risk for fraud. Information and communication should not be required in the form of financial statements to HHS, but rather something internal to inform managers of the wellbeing of their organization. Finally, monitoring should not be mandatory except for the benefit of the organization.
Providers are not generally investment vehicles like public companies. They afford medical treatment and should be treated differently than public companies. If fraud is the target, then a scalpel should be used and not a grenade. This explains why some internal controls should be relaxed. It may be necessary to mandate public companies to comply with all internal controls because financial reporting and corporate activities should be reliable and the costs to assure reliability are merely costs of business. Providers, on the other hand, supply a necessary public need, medical treatment. Increased regulations on their business practices only increase the cost of medical treatment in general. Control activities are slight alterations in business activities to ensure that fraud is prevented or detected.\footnote{See http://www.osc.state.ny.us/localgov/pubs/internal_contols.pdf, pg 7}

The common criticism with a detailed audit revolves around cost, especially with Sarbanes Oxley’s Section 404.\footnote{http://www.cfo.com/article.cfm/3982049?f=related} The obvious problem with extending audit requirements to health care providers would be the added expense and regulation, which will impair or burden a provider’s business or increase the patient’s cost for medical treatments. However, these expenses can be limited by restricting the scope of the audits, shifting the cost from the providers to taxpayers, or some combination. The focus of the audits revolves around reducing fraud not impeding a provider’s business through increased regulations or costs. The costs should not be a major deterrent considering that the costs can be limited or shifted, the high estimates of fraud losses, and the impressive recovery rate.\footnote{See http://www.taf.org/FCA-2006report.pdf, pg 4; http://www.texaslawyers.com/coomer/healthcarefraudquitamclaims.htm}
Assume that there is a hospital or doctor’s office where there are many employees. Control activities for preventing and exposing billing for services not rendered would include the following. First a doctor and nurse would meet with the patient at the same time. Both would take notes as the doctor examined the patient. After the meeting, both would give their notes to another nurse for that nurse to compare them for accuracy. Once they are determined to be the same, one would go on file while the other went to billing. The billing agent would create a billing statement, which is then reviewed by another person who compares to the other document filed away and authorizes the billing statement. The billing statement would be sent to the patient and include the relevant information that comprises the bill so the patient can review the bill. The billing statement goes on a report and the statement and two other documents are filed away for future reference. All the documents are pre-numbered, reference each other, and include the names of the patient and person filling them out. This narrative includes (but is not limited to):\(^{94}\)

1. Segregating duties- person who creates billing statement doesn’t make the initial record
2. Independent review- person who reviews the initial records and person who reviews the billing statement to initial record
3. Independent authorization (person who authorizes the billing statement
4. Physical controls- the pre-numbered records that reference each other
5. Periodic verification- billing statement goes on another report, and billing statement and records filed away for future reference

\(^{94}\)See http://www.osc.state.ny.us/localgov/pubs/internal_controls.pdf, pg 7. This citation extends to the control activities listed.
This type of narrative could also be applied (with immaterial modifications) to the various abuses with billing codes, cost reports, and other similar frauds where monetary amounts are being determined.

Assume the same environment but with the reflexive testing problem. This narrative might look like this. Doctor asks for a particular test for a particular patient. He submits a request form in duplicate, or it is copied. Ideally, after the test is performed, then it goes straight to the doctor for review. However, the results may take some intermediary steps where someone may automatically schedule another test because the first test results showed something that normally leads to the test now being requested. The intermediary asks for the second test but doesn’t consult the initial doctor. The first lab request must be attached to the second request. This ensures that the lab attendant knows that this is a second test for the same patient and who the treating doctor is. If the treating doctor does not sign off on the test, then it is not performed assuming it is not life threatening. This narrative involves (but is not limited to) the following control activities:  

1. **physical controls- the records**

2. **independent verification- the doctor must review the lab results before asking for another set, and the lab technician review the second lab request to determine if the treating doctor authorized it**

3. **segregation of duties- the intermediary who reflexively asked for the second test cannot authorize the test**

The preceding narratives assumed that there was a sufficient staff to carry out the control activities. However, many health care providers do not employ enough people to sufficiently establish an effective set of control activities. Some may only have a doctor

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95 See Id. This citation extends to the control activities listed.
and secretary. Control activities are relatively ineffective in small environments because the employees can easily circumvent the control activities either because the employees control more aspects of the transaction or collude to defraud. This could be lessened through audit requirements that instruct the office to organize records for an auditor (external or HHS agent) to review; or there could be a peer review system where doctors go to different offices to appraise the records of another. This represents a policy decision that should balance the amount of intrusion into the business of a health care provider with the desire to combat fraud. Regardless even small offices should provide a narrative of their control activities or how transactions are handled in order for a reviewing person to evaluate their effectiveness and detect any frauds.

**Educating Victims and Qui Tam Lawsuits**

Government agencies and other private institutions should develop literature and programs to adequately inform, even train, patients and taxpayers to be diligent fraud examiners. This part of the initiative supplements the auditing of a provider’s control activities because informed and diligent patients increase a fraudster’s risk of detection. The fraud originates from the patient’s underlying medical condition and subsequent pursuit of medical treatment. A patient maintains an intimate but nonparticipating role with the fraud and can thereby identify possible red flags.

Patients partake in medical treatment decisions and ultimately can review the entire experience better than any third party reviewer. Providers do present bills and other

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96 See Id.
documents for patient’s files and these bill and documents evidence a committed fraud. An informed and attentive patient can review the bill and identify errors that can be red flags for fraud, such as double billing or receiving old equipment or generic drugs as opposed new equipment or brand name drug. In addition, patients should never give out their Medicaid or Medicare card number or medical record to anyone besides their health care provider, especially for free drugs or tests that ‘sound too good to be true.’ Finally, patients should learn about qui tam lawsuits and how they operate. These lawsuits certainly provide a generous monetary incentive to search for and rectify possible fraud.

98 Id.
100 See http://www.quitam-lawyer.com/false_claims_act.htm
101 See Id.
 Qui Tam Lawsuits

Qui tam lawsuits offer a legal avenue for people to battle Medicare and Medicaid frauds and a monetary incentive to do so, thereby increasing patient attentiveness and the fraudster’s risk of detection. These legal actions originate from the Federal Claims Act. Under this legislation, private individuals may bring suit on behalf of the government against those who defraud Medicare and Medicaid. Qui Tam suits facilitate exposure, punishment, and possibly prevention of healthcare frauds because private citizens can pursue these proceedings and enjoy generous rewards upon a successful suit. Since these individuals report wrongdoings, they retain whistleblower status, and receive all the protections associated with whistleblowers.

The term, “qui tam”, refers to a Latin phrase that means, “Who brings the action for the King as well as for himself.” In this way, the person who files the lawsuit (also known as the “relator”) acts on behalf of the government. The relator must only know of the fraud to have standing to bring the lawsuit. The relator does not need to be employed by the defrauding company, have first hand knowledge or experience, or have been personally injured by the fraud.

The relator submits a complaint to a United States Federal District Court to initiate the suit. The court seals the case and only discloses it to government prosecutors for

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102 Id.  
103 Id.  
104 Id.  
105 Id.  
106 Id.  
107 Id.  
108 Id.  
109 Id.  
110 Id.
their review and investigation. The seal normally lasts for 60 days, but it can be extended. While sealed, the accused defendants are not notified and the identity of the relator is not revealed. In addition to the complaint, the relator also presents a disclosure statement to the local United States Attorneys Office and the Department of Justice. The statement is not filed in court. The disclosure statement differentiates a qui tam lawsuit from a regular suit.

The disclosure statement provides evidence that supports the allegations made against the defendants, which the government utilizes to commence and develop its investigation. In a normal case, the complaint does not contain the evidence that verifies the accusation. Rather prosecutors develop and produce the evidence during the discovery process of a lawsuit. In a qui tam case, the disclosure statement articulates not only the complaint, but supplies evidence as well. This presents the government with a starting point and guides the government’s investigation.

Upon the government’s completion of its investigation, it decides whether or not to join the relator in the suit. The government’s participation enhances the lawsuit’s probability of success; however, the relator can still pursue the case even if the government declines to join. If the case progresses (with or without the government’s endorsement),

111 Id.
112 Id.
113 Id.
114 Id.
115 Id.
116 Id.
117 Id.
118 Id.
119 Id.
120 Id.
121 Id.
122 Id.
123 Id.
then defendants are notified of the accusation. If a settlement is not reached, then court breaks the seal of the case. The identity of the relator is only disclosed when the seal is broken.

Guilty verdicts impart monetary settlements to both the government (assuming they joined the case) and the relator. Upon a guilty verdict, the statute demands that the defendant pay the government three times its losses. In addition, the defendant forfeits $5,500 to $11,000 for each false claim. Settlements can be made out of court, and even before the court breaks the seal of the case. Normal settlements amount to two to three times the government’s losses, and the government does not seek civil penalties. The relator receives 15% - 30% of the amount that the government recovers. In addition, the guilty defendant reimburses the relator and the relator’s counsel for all legal expenses incurred throughout the process.

Qui tam lawsuits should be encouraged and advertised in any literature given to the populace. Limited governmental resources may be inadequate to detect and prosecute all fraudulent activities. If decreasing health care fraud is the ultimate goal, then a monetary incentive may inspire the populace to learn about health care fraud and diligently supervise providers in order to detect fraud. Recruiting private parties to aid in this battle would greatly expose more frauds and deter future fraudsters. Although the allure of civic duty and good for good’s sake sound adequate, the promise of a monetary reward will likely inspire more help.

124 Id.
125 Id.
126 Id.
127 Id.
128 Id.
129 Id.
130 Id.
131 Id.
Conclusion

Health care fraud materially impairs the health care industry by driving up costs and wasting money. Auditing a health care provider’s control activities provide a direct and efficient way to combat fraud. It delves into the transactions that fraudsters rely on to perpetrate fraud. There are certainly downsides to this idea, such as increased costs, intrusion into health care providers’ businesses, and privacy concerns. These potential drawbacks can certainly impair the overall benefit of this concept, but they can be limited or expunged with proper controls and implementation. As cited earlier Federal investigators estimate that health care fraud costs taxpayers between $60 to $100 billion dollars a year\textsuperscript{132}; and $443.8 million has been expended to recover $7.3 billion.\textsuperscript{133} Considering the drastic losses to fraud and excellent recovery ratio, more emphasis and resources should be applied to eradicate this unnecessary evil.

\textsuperscript{132} http://www.texaslawyers.com/coomer/healthcarefraudquitamclaims.htm
\textsuperscript{133} http://www.taf.org/FCA-2006report.pdf, pg 4