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Health Care Fraud— An Accountant's Perspective



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Fraud is increasing and represents a hidden cost to health care plans. With declining reserves and increased financial pressure on plans, trustees need to scrutinize plans more carefully than ever. Trustees should monitor reports on the internal control system over the health claim processing and have personnel be aware of potential fraud areas. The author recommends trustees meet with their plan's outside auditors to discuss audit work performed, exceptions noted and recommendations to improve the internal control system.

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Health care fraud is a crime that likely has become much more prevalent due to the economic crisis and difficulty in obtaining affordable health coverage. In addition to having a financial motive, perpetrators of fraud may be motivated by the desire to help an ailing or terminally ill loved one without adequate coverage. This emotional motivation may allow the perpetrator to rationalize that he or she is saving a life, thereby justifying—in the perpetrator's mind—additional fraud.

When fraud occurs, three conditions generally are present:

1. Incentive/pressure to perpetrate the fraud
2. Opportunity
3. Attitude/rationalization to justify.

The first and third conditions are beyond the scope of this article. Instead, the article focuses on the second condition—opportunity—and encourages trustees to devote their efforts and energies to limiting and/or eliminating the opportunity for members to commit fraud.

Typically, health care fraud involves the filing of dishonest health care claims. This may take the form of duplicate claims, improper prescriptions, billing for services that were not performed or were performed but were unnecessary, altered service codes and/or a noncovered service billed as a covered service. Obviously, these improper reimbursements result in decreased health plan reserves—a growing problem in today's economy.

Health plans face increased pressure from rising health care costs, fraud and competition for dollars. The economic crisis resulted in many pension plans transitioning from a *green zone* (financially healthy) to a *red zone* (critical status), requiring certain financial actions. The employer company may have also been unfavorably affected by the economy, making union wage increases and benefit contributions more difficult to achieve. In the resulting competition for the dollar, health plans often end up being a lower priority.

In accordance with Department of Labor instructions, large health plans (for example, those with 100 or more partici-

pants as of the beginning of the plan year) are required to be audited each year by independent, qualified public accountants. While there may be a perception that an audit will catch fraud, this is not necessarily true. The author believes it is extremely important that trustees and participants understand that a properly planned and performed audit may not detect fraud. An absolute assurance that fraud does not exist is not attainable.

Management (the board of trustees) is responsible for establishing antifraud programs and controls to prevent, deter and detect fraud. Even though trustees may delegate this action to a third-party administrator or other personnel, the fiduciary liability *remains* with the trustees. The auditor does not have a higher responsibility for determining whether financial statements are free of material misstatement due to fraud than due to error.

Strengthen Internal Controls

Knowing that the plan wants to limit opportunity, trustees need to address the characteristics of a fraud. The trustees' input and approval revolve around the strengthening of the internal controls over the handling and processing of health claims. During the audit, the outside auditor will attempt to understand the internal control system, will perform a "walk-through" of the claims-processing system and will test the system by observation and inspection of a sample of claims.

Characteristics of fraud may include:

- **Concealment through collusion.** A common method to deter collusion among employees is to segregate work duties among claims-processing and accounting employees (although this may not be practical or cost-efficient for many plans) and require mandatory vacations, with another employee performing the vacationing employee's duties and handling his or her case load.
- **Withheld or falsified documentation.** Trustees need to recognize that software and hardware readily available to the general public have made it easier to falsify documents.

- **Ability of management to override controls.** Management can employ additional safeguards to make it more difficult to override controls over the operating system.

Following are some of the signs and methods of health care fraud, as well as safeguards trustees can put in place to try to eliminate opportunities to override controls in the operating system.

Erroneous Cash Disbursements

With the widespread use of computers and superior software and scanning devices, it is not difficult to create fraudulent checks. The author has a client whose checks were duplicated from a four-year-old check. These checks can be duplicated by providers, participants or other vendors. To safeguard against this fraud:

- Be sure the plan prepares **timely** bank reconciliations and these reconciliations are reviewed by someone other than the preparer. Reconciling items, such as differences between disbursements from the book and the amount recorded on the books, should be immediately investigated.
- Change check signers (even the facsimile plate) annually or every few years.
- Have someone make a unique mark on each check, such as an "x" or other distinguishing mark, before checks are mailed. If checks are returned by the bank, the mark may make it easier to isolate the fraud.

Once the perpetrator stops using fraudulent checks, he or she may attempt automated clearing house (ACH) transfers. To prevent this, notify the bank that no ACH transfers should be made from the plan account except to preauthorized vendors.

Large Monthly Claim Disbursements Outlay

Sometimes there is an abnormally high amount of cash disbursements during a month. This may be due to the time of the year or a decrease in claims backlog. (The author recommends that the months or days backlog figure is a key statistic that should be available to trustees.) However, if there is no logical explanation for the

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abnormally high amount, there should be an analysis of the claims by participant, provider or even diagnostic code. This analysis can usually be performed with computer software applications and, if utilized properly, could isolate:

- Duplicate claims by claims department personnel, provider or participant
- Inappropriate use of certain diagnostic codes
- Payment for noncovered services.

Prescriptions

Since there are many prescription plans in use, trustees may inadvertently take the attitude, "Out of sight, out of mind." Due to the misuse of many prescription drugs, trustees should inquire of the internal audit procedures performed by the prescription provider or by plan personnel.

The provider should make a presentation to the board of trustees (or its designated representative) highlighting the internal controls to prevent abusive use of prescriptions and, when medical advice allows, to encourage use of lower cost prescriptions rather than higher priced ones.

Claims-Processing Systems

Because mechanization of claims processing is now the norm, the upkeep of the system (whether internal or that of a third-party administrator) is extremely important. Trustees should obtain assurance that the internal controls over the system, including revisions and updates, are adequate. The outside certified public accountant (CPA) should probably be included in discussions to determine the worthiness of the procedures. If an outside provider is used, trustees should consider hiring outside information technology personnel to evaluate the provider's system. The additional cost may be very worthwhile.

Participant Documentation

This documentation plays an important role in providing evidence that a claim is being paid for an eligible participant or appropriate dependent. The plan needs to verify that the participant has met all the eligibility requirements and that the covered service was incurred after the eligibility date. With many differ-

ent extended families, it is important that the plan maintain and monitor dependent eligibility. Proof of dependency should be retained by the plan, and the plan should consider some type of verification on a cycle or annual basis.

Hospital Billings

Although hospital bills generally are not fraudulent, the accuracy of billings from hospitals ranges from excellent to poor. Usually, hospital bills are quite large, and the claims processor needs to have a full understanding of all of the charges and if they are reasonable. The processor should contact the hospital directly with questionable charges including room charges, special equipment, medication, ancillary items (such as tissues and Q-tips) and special services.

Data Mining

Data mining generally refers to the extraction of information from large data sets on databases. A health plan database is a natural for this application, and the type of information that can be gleaned is limited only by one's imagination.

For example, a plan could utilize an application that would extract, by diagnostic code, the charges of all medical providers. Those charges then could be reviewed for reasonableness. Or a plan could utilize an application to look for duplicate billings (and payments) or an abuse of certain codes such as constantly billing for a comprehensive office visit and never a lesser office visit.

Ask the CPA

Many times the plan's outside auditor makes a presentation before the board of trustees. Trustees should take the time to question the CPA regarding health care fraud. Here is a list of ten questions they may want to ask:

1. Did you perform a walk-through of our claims-processing system? Did you find any significant weaknesses? What are some of the strengths?
2. Do we have any other internal control weaknesses that merit correction?
3. Upon reviewing a test sample of our health care claims, what omissions and/or errors did you note?

4. After doing your fraud inquiries with our personnel and your testing of claims, did you note any significant weaknesses? Did anyone convey any fraud discovery to you?
5. Were there any spikes in our health care payouts? If so, what was the explanation given to you? Was it reasonable?
6. Were bank reconciliations prepared timely and accurately? Were reconciling items promptly investigated?
7. Is our computer system working adequately? Do you recommend an outside expert to evaluate it?
8. Do our claims processors take mandatory vacations or switch desks with other processors occasionally?
9. Has the plan discovered any fraud during the year? How was it discovered? Has the plan taken remedial actions?
10. Have you reviewed the provider contracts? When was the last time they were negotiated? Are we being billed in accordance with the contract? What audit procedures are involved to verify that we are properly billed?

Conclusion

Fraud is an ever-increasing cost to health plans. Financial pressures on participants and the possibility of caring for ill loved ones may provide an environment for a higher incident of fraud than in the past.

Plans should adopt, maintain and monitor stringent internal controls over the processing of claims. Also, trustees should consider adopting a formal fraud policy and publicizing it to participants. They may also want to educate plan participants to carefully review providers' explanation of benefits statements to ensure that the services that are billed were actually performed.

Trustees should be aware that although an audit of the plan is not designed to detect fraud, they should discuss with the outside auditors the audit work done, results and suggestions for improvements. Fraud is everyone's problem. **B&C**

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