The Origin of Fraud

We hear so much about what constitutes health care fraud: false billing, upcoding, unbundling, kickbacks, self-referrals, substandard care, etc.

Is the health care industry fraudulent?

How does fraud **begin?** What is its origin? Do we really have an industry of greedy professionals as the OIG and the media would have us believe? Do we really have an industry comprised of dishonest human beings or of uninformed health care practitioners making choices that the OIG considers fraudulent? To hear the OIG speak of it, the entire health care industry is corrupt, just waiting for opportunities to rip off the system. I am particularly affronted by the thought that the OIG thinks health care practitioners are spending time and money with their lawyers dreaming up new ways to maneuver around the fraud and abuse laws and regulations in an effort to maintain high profit margins. I think not.

Fraud grows within a particular type of corporate environment

I submit that true "fraud", as opposed to accidental mistakes, in the health care industry, starts and grows within a particular type of corporate environment. This corporate environment can be found throughout the provider field: physician office, long-term care nursing facility, sub-acute facility, hospital, home health care agency, surgicenter, out-patient rehab facility, etc.

Illustration: The successful long-term care nursing facility

To illustrate, let's take a long-term care nursing facility in New Jersey. This particular nursing home has been successfully and quickly growing into diversified areas, including sub-acute and outpatient rehabilitation. All of this was initiated and neared completion under the old Medicare cost-based reimbursement system. Everything has been going great for this nursing home. It even has a history of NJDOH deficiency free surveys for two consecutive years.

The problem: Balanced Budget Act Of 1997

There is, however, a problem. The Balanced Budget Act of 1997 has become law and our nursing home is faced with severe cutbacks based upon Prospective Payment System ("PPS"). Ill prepared for this, the administrator begins to worry. She worries about the impact PPS, coupled with Medicaid cutbacks, will have on the ability of the nursing home to sustain cash flow and to continue with its diversification projects. The administrator, however, has difficulty explaining these concerns to the Board of Directors. The Board of Directors is made up, primarily, of owners who are neither familiar with our industry nor familiar with day-to-day operations.

Mismatched expectations: Board of directors v. administrator

As a result, there is a mismatch of expectations. The Board of Directors continues to expect growth and positive cash flow. The administrator, however, sees that growth and positive cash flow are not likely to continue, at least for a few years. For the first time in years, the administrator is facing the very real possibility of failing to meet the Board of Directors' expectations. To make matters worse, the Board of Directors has clearly communicated to the administrator that its expectations must be realized. Or else!

Fear of failure

Very experienced administrators in the health care industry would recognize that this nursing home needs to suck in its breath, tighten its belt, dig into cash reserves and expand its revenue source to include managed care payers. Experienced administrators would anticipate that Congress' initial overreaction in the Balanced Budget Act of 1997 would be met, a year or two down the road, by a second overreaction but in the opposite direction in the form of relief (which is exactly what has happened). But this nursing home does not have an experienced administrator. This administrator is terrified that she will not be able to meet her Board of Directors' expectations for continued growth and positive cash flow. In fact, the Board of Directors is putting even more pressure on her to grow nursing home revenues, to add a new wing and to increase the already positive cash flow. The administrator worries about failing.

Corporate environment: Pressure, aggressive targets and "must do" message

We now have a corporate environment that includes intense pressure, aggressive targets for growth and a clear message that the growth targets must be reached.

The dilemma

The administrator, despite her lack of experience, realizes that the growth targets are not going to be reached. No way, no how. The reimbursement from Medicare is simply not going to be there, at least over the next few years. Added competition from Assisted Living facilities has increased the difficulty in filling beds and admitting sicker patients cost more to care for. Staff has already been reduced as much as possible in an effort to maximize profits. Group purchasing opportunities, too, have been maximized. What else can be done?

Choices: Notify board of directors or fudge the financials

Our administrator has two choices: The first is to notify the Board of Directors that she anticipates failing to achieve the clear goals that are demanded of her. This is, of course, totally unpalatable, especially after the success that she has enjoyed the past few years. The other choice is to fudge the financials just a bit. In order to make it look like, for this financial quarter only, that the nursing home is on target to meet its goals. She chooses this latter option.

Fraud: Increase RUGS categories

But how does she do this? She decides to meet with her rehab director to ensure that the RUGS categories are being maximized for billing purposes. After all, doesn't the nursing home have a new group of therapists? The previous therapists who had worked for a national company were not rehired when their employer was fired last year. PPS had certainly brought about a lot of changes. Perhaps these new therapists, many of whom are recent graduates, are not really skillful enough in maximizing legitimate opportunities to bill through the RUGS program. So the administrator meets with the rehab director. The rehab director gets the message loud and clear: if in doubt, record the patient in the higher RUGS category. We'll work out the supporting documentation later, if necessary. This seems to work. Invoices go out with increased charges and the nursing home population, when looked at from a RUGS category perspective, appears to be getting the amount of therapy that it deserves. The administrator is pleased because the Board of Directors is pleased.

Fraud: Works at first but then makes matters worse

For the first quarter this approach appears to work. In fact, what started out as a strategy for the first quarter only has spread into the second and third quarters also. The administrator found it difficult to rescind her directive to the rehab director once the increased revenues begin to flow into the facility. The administrator also thought the other strategies, including increasing revenue from managed care payers, would have worked by now. The other strategies have not worked. Unfortunately, because of PPS, something beyond the administrator's control, cash flow continues to weaken, albeit at a slower rate of decline had the administrator not taken her extraordinary steps. So, despite the increases in the RUGS categories, PPS continues to have its effect. But now, not only is there the anticipated decreased cash flow problem, but there is also a new problem in having inappropriately increased the RUGS categories.

Fraud: The problems become compounded

The administrator begins to worry. How likely is it that the OIG will knock on her door during this, the fourth quarter? Or ever, for that matter? She did hear, however, that a nursing home in the northern part of New Jersey was recently visited by the OIG and the investigation was not pretty. Nevertheless, she decides that her more immediate concern is meeting the expectations of the Board of Directors. But she is now into the start of the fourth quarter and her revenues are continuing to drop despite her best efforts and, as she now admits to herself, her unlawful strategy of increasing the RUGS categories.

Fraud: The periodic behavior becomes a consistent pattern of behavior

The administrator further becomes alarmed by her suspicion that the therapists have stopped struggling with the question of what is the proper RUGS category to use and are, instead, upgrading the RUGS category one full grade automatically. After all, the

therapists have been heard to claim that the RUGS categories are just a matter of degree anyway.

Fraud: The treadmill effect

As the fourth quarter begins almost a year after the administrator began to "fudge the financials just a bit", the administrator is panicking. She finds herself facing continued cash flow declines and possible patterns of intentional misrepresentations in the therapy department. To make matters worse, the outside accounting auditors are coming in shortly to do the annual cost reports. Surely they will see what has happened. She finds herself directing her rehab director to directly change the patient's rehab records in order to support the higher RUGS categories that the therapists have placed the residents into for billing purposes. More and more, the administrator feels as if she is on a treadmill. She has to run faster and faster in order to just stay where she is.

Fraudulent participation: now includes the accounting and rehab departments

Let's step back to see what has happened at this point. What started out as just the administrator's efforts to maximize billing during the first quarter has spread to include fraudulent participation by the rehab department and, unknowingly, by the accounting department. The nursing facility is ripe for a qui tam (whistleblower) action to be filed or, with more immediate and severe consequences, a telephone call to be made directly by an anxious employee to the Office of the Inspector General ("OIG"). The therapists misrepresenting the proper RUGS categories and the rehab director changing and falsifying hours on the patient's rehab records - they all know they are doing something wrong. They all are anxious about the pressure they are under to continue their patterns of fraud and yet are even more anxious about getting caught. After all, they have their families and careers to be concerned with. What started out as a way to help the administrator and the nursing home they care about has turned into serious issues of potential civil and criminal liability. Unfortunately, these employees have now participated in what will clearly be considered fraud. They are all in too far to extricate themselves.

The administrator considers an exit strategy

Had a corporate compliance program been in place, one of two elements would have prevented, or at least limited, this fraudulent behavior. First, an auditing system to review and compare medical records and billing statements. Second, the availability of a Corporate Compliance Officer to whom these anxious employees could turn with their concerns. However, in this illustration, there is no system or officer because there is no corporate compliance plan in place. The Board of Directors had earlier declined to put such a plan in place because it believed it had an honest staff of employees. But now the administrator is looking for an exit strategy of some sort.

Corporate compliance plan: Too late

The administrator calls a health care attorney who specializes in developing and implementing corporate compliance programs. She explains briefly and desperately that the nursing facility provides good care for its residents and is run by honest people, but that she nevertheless recognizes the need to have a corporate compliance program in place should the OIG ever knock on the door. She confirms with the health care attorney that such a compliance program, if effective, may minimize any civil and criminal penalties should the government impose such penalties on a nursing home. The health care attorney agrees to begin work immediately. However, before the attorney can begin his assignment, the dam breaks.

The OIG: Busted

The word gets out to the OIG that something is wrong and that altered documents are about to be destroyed. The administrator is faced early one morning with FBI agents, brandishing guns, holding out search and seizure warrants for all patient data. Computers are loaded into the backs of trucks. Filing cabinets are carted off. Medical records by the cartload are taken away. Anything of questionable value to the investigation is taken. The nursing home is left in a complete financial and clinical shambles. The attorney who was called in to begin a compliance program, having just arrived, is standing at the front door, helpless to intercede and realizing the administrator's effort to initiate a corporate compliance program was too little, too late.

Conclusion: Why bad things happen to good providers

1. Fraud does not start with dishonesty.
2. Fraud starts with pressure.
3. Fraud starts out one small step at a time.
4. Fraud starts with areas that might be considered by some to be areas of "gray".
5. Fraud increases, in its complexity and scope, over a long period of time.
6. Fraud locks its participants in so that there is no escape.

The solution: Corporate compliance plans

Fraud starts out with good intentions: to continue to build the organization and to continue to provide jobs for the employees. But the slope is slippery from there. What often begins as a one-person effort eventually involves many people in the organization. A corporate compliance program, seriously initiated, implemented and maintained, is the only way to ensure that nascent fraud does not begin and spread throughout an organization. Once fraud begins and spreads throughout an otherwise "honest" organization, without the benefit of a corporate compliance program in place, the only option often available to the organization is to confess. The organization must seriously consider approaching the OIG before the OIG and / or the Justice Department (on the basis of a qui tam - whistleblower action) approaches the organization.

Visit other areas of our website for overview of our services, our experience and our attorney profiles