

HM ANTI-FRAUD TRAINING COURSE



It's our policy to protect.SM

Welcome!

This training is presented by the Special Investigations Unit (SIU) at HM Insurance Group (HM).

The SIU investigates any claim or application for insurance that seems to be **suspicious** or indicates that **fraud is being committed**.

How Much is Lost to Fraud?

The National Health Care Anti-Fraud Association estimates that **3%** of the health care industry's expenditures in the United States are due to fraudulent activities, amounting to a cost of about **\$51 billion**.¹

Other estimates attribute as much as **10%** of the total health care spending in the United States to fraud, or about **\$115 million**.²

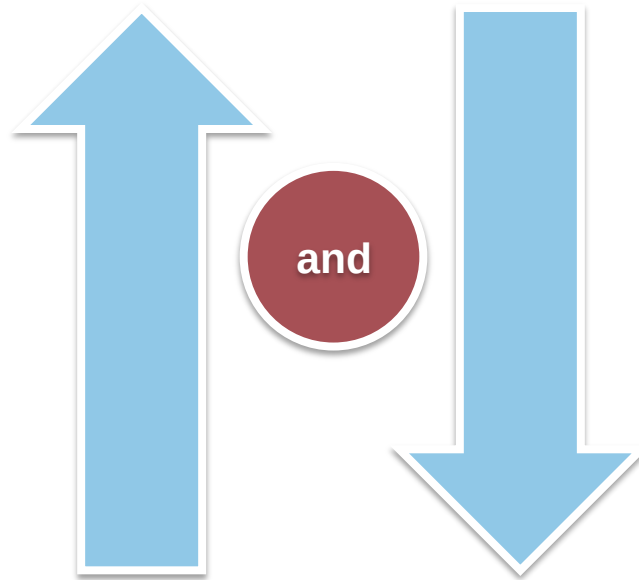


Sources: ¹National Health Care Anti-Fraud Association. "The Problem of Health Care Fraud"; ²Hyman, David A. "Health Care Fraud and Abuse." p. 532

Higher Premiums and Lost Jobs

Insurance fraud is not a victimless crime. It **affects** everyone in the form of:

- **Higher premiums** which reduces your net income
- **Higher prices** in goods and services as the costs of higher premiums are passed on to the consumer.



- **Job loss** due to financial burdens placed on employers as a result of the increased cost of workers' compensation, property, casualty and health insurance.

Why Fraud Training?

HM is licensed in 50 states, as well as in the District of Columbia.

Six (6) of these states (California, Florida, Kentucky, Maryland, New Jersey and New York) have laws that mandate training.

According to state law, the training has to be at least **two hours** in duration.

Since HM is licensed to conduct business in those states, we need to adhere to their laws concerning fraud training.

New Jersey Fraud Training



Since our covered lives exceed the established threshold in New Jersey, claims and underwriting are required to take an **additional two hours** of fraud related training every year.

Course Objectives

Do you know how to recognize and combat fraud?

- A physician orders unnecessary lab tests and receives payment for these services
- A pharmaceutical company offers free training or other benefits to a doctor who prescribes their drug

After taking this training, you'll be able to answer these questions and determine the appropriate action to take to help prevent fraud.



FRAUD AND ABUSE

Employee Fraud Scenario

Scenario: An employee who was injured at work has been out of work collecting lost time. Although he's feeling better, he's been enjoying his time off; so he tells his doctor that he's still in too much pain in order to remain out of work for a longer period of time.

It's fraud!

It's abuse!

It's both!

It doesn't affect me, so I don't care what it is.

Is this fraud or abuse?

Employee Fraud Scenario

Is this fraud or abuse?

It's fraud!

Do you know what type of fraud it is?



It's fraud!

It's abuse!

It's both!

It doesn't affect me, so I don't care what it is.

Lesson Objectives



Knowing the difference between fraud and abuse can be confusing!
Your objective in this lesson is to find out more about the differences
between these two terms.

Definition of Fraud

Fraud is defined by Federal law (42 CFR 455 2) as “an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.”



Fraud also can be called
“larceny by trick.”

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To be more specific, the Coalition Against Insurance Fraud states that insurance fraud occurs when people deceive an insurance company to collect money to which they are not entitled.



Two Classifications of Fraud

Hard Fraud

- Premeditated, planned, deliberate
 - Slamming on your brakes with the intention of causing a car accident
 - Developing a scheme to create the need for an insurance claim (i.e. arson)
 - Faking a death to collect life insurance

Soft Fraud

- Opportunistic of legitimate claim
 - Claiming your injuries are more severe than they are
 - Claiming stolen property is worth more than it is
 - Exaggerating claims that would otherwise be legitimate

Hard Fraud

Hard fraud occurs when someone **deliberately or intentionally** plans, stages or invents an accident or illness to gain from the insurance company.

Usually, hard fraud involves complex schemes that are the most costly and widespread forms of insurance fraud. Individuals who would commit hard fraud are the same individuals who would steal your identity.



Give me an example

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Give me an example

Example

An employee, feeling unappreciated at work and who was angry with his boss for not getting a pay raise, stages an accident and pretends to have injured his head when he fell over boxes. This takes the employee out of work with pay.

Soft Fraud

Soft fraud occurs when someone **stretches the truth or tells “white lies”** on a claim or application in order to gain from the insurance company. Soft fraud is also known as opportunistic fraud.

The most common type of soft fraud is when someone malingers or exaggerates an injury in order to stay out of work longer.



Give me an example

Soft Fraud

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Give me an example

Example

An employee alleged she injured her neck/shoulder while helping a resident where she worked. The employee was taken out of work until her appointment with a neurosurgeon. During surveillance prior to her upcoming appointment with the neurosurgeon, the employee was seen bowling multiple games without appearing in pain. During her appointment, the employee stated that she still had bad neck/shoulder pain, which would make it hard for her to return to work.

10 Different Types of Insurance Fraud

All insurance is susceptible to fraud. For every type of insurance, there is a different type of fraud.

Each type of insurance obviously deals with a different problem; it's a "bet" based on a different "game." Insurance fraud, then, has to adapt itself to each different type of insurance, in order to fix that "game" appropriately.

The various insurance frauds include: Auto, Health, Life, and Property.

10 Different Types of Insurance Fraud

1. Stolen Car

- There are **two ways** that criminals perpetrate the stolen car insurance fraud scam. The **first type** of stolen car fraud is when a car owner sells his car to a body shop to be cut up for parts and then reports the car as stolen. The body shop is in on the fraud, so the authorities are never told about the sale for parts.
- The **second most common way** that criminals commit stolen car fraud is to sell the car to an overseas buyer, make the transaction without any paperwork, ship the car overseas and then report it stolen.

2. Car Accident

- The next time you see a **car accident**, you could be watching insurance fraud in action. In most cases, the driver and accident victim are the only ones in on the scheme. In other cases, the driver, victim, insurance investigators and even some of the bystanders that give statements are in on the fraud. The value of the vehicles is greatly inflated and the insurance payoff is for two totaled vehicles.

10 Different Types of Insurance Fraud

3. Car Damage

- Any form of insurance fraud is illegal and damaging to the insurance company. Some people will report a small car accident, get an estimate for damages, collect the insurance check and then not get the car fixed. **This is single most common form of auto insurance fraud going on**, and it happens constantly. The people doing it see no harm in it, but the money the insurance company pays out comes from premiums paid by other customers, which will go up the more often this fraud is committed.

4. Health Insurance Billing Fraud

- Unfortunately, health care professionals will sometimes get in on the insurance fraud act. One form of health insurance fraud is for **health care providers to bill** health insurance companies a high fee for a standard procedure, or to bill for services that were never rendered.
- For example, you may go in for a regular check-up but your doctor decides to bill your insurance company for an in-office surgical procedure that never happened. The patient is the victim of fraud and does not even know it.

10 Different Types of Insurance Fraud

5. Unnecessary Medical Procedures

- If it seems like your doctor is ordering you to go for **unnecessary testing**, then you may be the victim of insurance fraud. If you go to the doctor for a sore arm but your doctor orders a series of blood tests that have nothing to do with your arm, then that could be a common form of insurance fraud.

6. Staged Home Fires

- Homeowners insurance fraud costs insurance companies and their customers billions of dollars each year. One of the most common form of homeowners insurance fraud is the **staged fire or act of vandalism**. This can be done in one of two ways. The homeowner either removes important family items before the fraud takes place, or the homeowner makes sure that the insurance company knows the value of the expensive items and then has them destroyed.
- In almost every case of a staged home fire, the homeowner is not home and can account for his whereabouts when the event took place. Criminals are hired to set fire to the home, or break in and vandalize the home to make it look like the homeowner was victimized.

10 Different Types of Insurance Fraud

7. Storm Fraud

- Criminals will take advantage of any situation to commit insurance fraud, including a major storm. A common form of fraud that happens in the wake of major storms is homeowners will either **enhance the storm damage** to their home to get more of a settlement, or the homeowner will take advantage of how busy the insurance company is and **call in a claim**, even if there was no storm damage.

8. Abandoned House Fire

- One of the most common forms of homeowners insurance fraud is the **abandoned house fire**. It can happen for a variety of reasons, but the end result is always fraud. The homeowner could have been transferred to a different city because of his job and cannot sell his property, or a landlord owns a home in a neighborhood that is no longer popular and cannot get tenants to help pay the mortgage.
- If you have ever been at the scene of an abandoned house fire after the flames have been put out, you will see at least one fire inspector for the insurance company on site. This is an extremely common kind of insurance fraud that not only causes premiums to go up, but it also puts the buildings next to the abandoned home in jeopardy as well.

10 Different Types of Insurance Fraud

9. Faked Death

- This form of insurance fraud is so common that it has been the plot of many movies, television shows and books. A criminal will take out a life insurance policy on himself and make his spouse the beneficiary. After the policy has been in effect for several months, the insured criminal **fakes his death** and his spouse is paid the death benefit. When the funeral is over, the spouse suddenly disappears and the insurance company is out the death benefit.

10. Renter's Insurance

- People who rent homes or apartments will often take out inexpensive renter's insurance policies to cover the cost of their possessions. Prior to moving out of the home or apartment or when financial times get bad, the insured will **sell their possessions and then report them stolen** to collect the insurance money.

Four Elements of Fraud

There are four basic elements of fraud as set forth in the Pennsylvania office of the Attorney General Insurance Fraud Manual:

1. Someone makes or presents a material **statement** in support of an insurance claim
2. The **statement** contains false information
3. The **statement** is material
4. The **statement** is made with the intent to defraud an insurer

Definition of Statement



I wonder...why the emphasis on "statement" in that last slide?

The Pennsylvania Office of Attorney General defines a **statement** as "any oral or written presentation or other evidence of loss, injury or expense, including but not limited to, any notice, statement, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of property damages, bills for services, diagnosis, prescription, hospital or doctor records, X-ray, test results or computer generated documents."

Difference between Fraud and Abuse

Abuse is similar to fraud, but it is **not the same thing**.

Abuse usually involves questionable services that are not consistent with accepted medical or business policies within the community. While it is a misrepresentation, it is not intentional; however, the actions will lead to unnecessary costs.

For example, a physician orders x-rays even though the x-rays were not medically necessary. Although the physician received payment for these services, it was not fraud because there was no misrepresentation. It was abuse for services rendered that were not medically necessary.



Difference Between Fraud & Abuse



Fraud is a criminal act.
Abuse is **NOT**!

What's the difference between
fraud and abuse?



Who Commits Insurance Fraud?

While fraud can be committed by anyone from all walks of life (claimants, applicants, policyholders, groups, and providers), each one is broken down into four different population segments as identified by the Insurance Fraud Prevention Authority (IFPA):



- **Monetary Necessity:** These are low-income individuals who view food, rent, and creature comforts as necessary expenses. Insurance, to them, is an unnecessary expense and they feel that the insurance company makes too much money. They justify filing false claims as a way to support their family.



- **Social Victims:** The basic premise of the social victim and how it relates to insurance is that insurance is a system set up by society designed to protect people within that society. Since social victims feel that they are not protected or benefiting from that system, they feel that they do not have to pay. These individuals feel some people have an advantage in life and that the playing field is not even. In addition, they feel that the insurance company makes too much money which is likely to justify the act of committing insurance fraud.

Who Commits Insurance Fraud?

While fraud can be committed by anyone from all walks of life (claimants, applicants, policyholders, groups, and providers), each one is broken down into four different population segments as identified by the Insurance Fraud Prevention Authority (IFPA):



- **Motivated by Anger:** These individuals feel that they have been personally victimized by the insurance company. Their rationalization is that they are receiving a benefit that they should have been receiving all along.



- **Economic Sophisticates:** These are individuals that are seeking to maintain and obtain wealth at the expense of the insurance company. They view fraud as a calculated risk.

Why People Commit Fraud: The Fraud Triangle



The Fraud Triangle is the oldest and most basic concept in deterring fraud.

In the 1950's, Dr. Donald Cressey, a criminologist and sociologist who focused on embezzlement, created the Fraud Triangle. He believed that **three identifiers** needed to be present for fraud to occur.

The Fraud Triangle looks to explain what must be present for fraud to occur, but the triangle does not fit all cases.

The Fraud Triangle



1. **Perceived Need** - Incentive or pressure to commit fraud is a force driving the individual to commit fraud. The incentive for committing the fraud is frequently created by high debt or an addiction (greed, debt, bad credit, financial losses, any unexpected financial need, extra marital affairs, alcohol and drugs).

The Fraud Triangle



2. **Opportunity** - In order for fraud to occur, there has to be the ability to commit fraud. One example is when there is a weakness in internal controls or the person is in a position of trust. Opportunity is the one area that the employer can control to prevent occupational fraud (lack of controls, lack of audit trail, failure to discipline others, and ignorance).

The Fraud Triangle

Rationalization



3. **Rationalization** - Justification for one's actions. It depends on the individual and the circumstances that he/she is facing as to whether or not he/she actually commits the fraud. The employee tries to justify his/her actions by trying to convince himself/herself that this will only happen once and that he/she is entitled to steal because of a raise or promotion he/she did not receive (lack of recognition, job dissatisfaction, and fear).

Rationalizing Fraud

So, criminals rationalize the need for insurance fraud, which helps them break the law.

You got it!



Why Fight Insurance Fraud?

1. Because it is our **corporate and civic duty** to report insurance fraud
2. For **financial gain and recovery**
3. Because of **government requirements** (37 states have mandatory reporting laws)
4. To help **reduce costs**. The cost comes out of your pocket in the form of higher premiums and higher healthcare costs

How Do We Fight Insurance Fraud?

1. Complete **anti-fraud training** and **understand** the possible types of fraud
2. Learn to **identify Red Flag markers** which generally indicate potential fraud
3. **Review data and information** provided to ensure validity
4. **Report** any suspected fraud

Red Flags



A **Red Flag** is a warning sign that the fraud may be present on a claim or application and further investigation is warranted.



Areas Where You Can Identify Red Flags

 **Red Flags** can be identified in the following HM lines of business and vendor relationships:

- Workers' Compensation
- Stop Loss
- Underwriting
- Agent/Broker
- Provider
- Kickbacks
- Illegal Gratuities

How can I tell
the difference?



Workers' Compensation

Workers' Compensation fraud occurs when an individual makes **a false or misleading claim or statement** about an accident or injury for financial gain.

Workers' Compensation fraud is a large crime in America today. Tens of billions of dollars in false claims and unpaid premiums are stolen every year. Some of these claims are out right fraud, such as the claimant working while collecting lost time benefits, while others are exaggerated or malingering claims.

Workers' Compensation Red Flags

The most common **Workers' Compensation Red Flags** include:

- Delay in reporting
- Monday morning or late Friday afternoon reporting
- Claimant cannot recall specific details about the accident
- Conflicting description of the mechanism of injury
- Refused medical treatment
- New employee
- Disgruntled employee
- Claimant is involved in hobbies, sports, home improvement or auto repair activities
- Claimant is knowledgeable about WC procedures and rules
- Tip from employer, co-worker, ex-husband/wife, anonymous, etc.

Workers' Compensation Red Flags

Example

Mr. Smith alleges that he sustained an injury to his right shoulder from ongoing use of a tow truck machine. Mr. Smith sought treatment, had surgery and remained out of work due to intense pain. HMIG received an **anonymous tip** that the individual saw Mr. Smith working at a different job site. Mr. Smith was shown during surveillance to be working at another job site carrying loads of lumber on his shoulders. Mr. Smith had completed the LIBC form stating that he was not working anywhere else while collecting workers' compensation benefits. This case was filed to the Attorney General's Office for further investigation.

Stop Loss

Stop Loss is a product that provides protection against catastrophic or unpredictable losses.

It is purchased by employers who have decided to self-fund their employee benefit plans, but do not want to assume 100% of the liability for losses arising from the plans.

Under a Stop Loss policy, the insurance company becomes liable for losses that exceed certain limits called deductibles.



Two Types of Stop Loss

1. Specific Stop Loss

- The form of excess risk coverage that provides protection for the employer against a high claim on any one individual
- This is protection against abnormal severity of a single claim rather than abnormal frequency of claims in total. Specific Stop Loss is also known as Individual Stop Loss

2. Aggregate Stop Loss

- Provides a ceiling on the dollar amount of eligible expenses that an employer would pay in total during a contract period
- The carrier reimburses the employer after the end of the contract period for aggregate claims

Stop Loss Red Flags

The most common **Stop Loss Red Flags** include:

- The employer misrepresents the employee's status
- The provider bills for services not rendered, falsifies bills, overbills, and upcodes or unbundles charges
- The employer intentionally does not disclose individuals with potential catastrophic events during the underwriting process
- Claims costs unexpectedly increase and it is identified that multiple individuals in the same family are incurring costs for the same drug
- Information provided warrants further investigation as to cause and cost of claim (injury may have been sustained while performing an illegal act)

Stop Loss Red Flags

Example

An employer allowed an **ineligible employee** to enroll in the plan without disclosing that the employee was enrolled as an exception. A stop loss claim was then submitted for reimbursement even though the employee was not eligible.

Underwriting

While we normally focus on claims fraud, fraud can start during the insurance application process.

Underwriting is the component of insurance that involves assessing risk.* Underwriters ensure that the correct amount is charged for insurance coverage.

Underwriting fraud can also be called “**rate evasion**” due to the simple fact that the rating factors are misrepresented in order to obtain a better rate.

Underwriting Red Flags

The most common **Underwriting Red Flags** include:

- The group wants to backdate the effective date
- The group's principal place of business is a P.O. box, suite number, or room number
- The claimant's occupation is inconsistent with the employer's stated business
- The number of employees, classifications, and payroll are inconsistent
- On-going large claims information is not provided during underwriting process

Underwriting Red Flags

Energy Solutions' home office address is:



Digital Products' home office address is:



Which address is a **red flag**?

Underwriting Red Flags

Energy Solutions' home office address is:



Digital Products' home office address is:



Which address is a **red flag**?

The Digital Products address is a red flag since its home office address is a P.O. box.

Premium Fraud

Another component of Underwriting fraud is **Premium Fraud**, which occurs when an employee knowingly misrepresents payroll, number of employees and class codes in order to obtain a lower rate.

Premium Fraud is also known as “**larceny by false pretense**.”

Consequences of Premium Fraud:

- Financial loss as collected premiums do not reflect the risk presented
- The incorrect premium tax is remitted
- The consumer picks up the difference in the form of higher costs for goods and services
- Loss of jobs

Premium Fraud Red Flags

The most common **Premium Fraud Red Flags** include:

- **Inconsistencies with Prior Policies** - Past insurance policies indicate significantly more payroll or premium than the insured is currently reporting.
- **Hidden Ownership** - The insured lists common owners on applications for other carriers or lines of insurance. The officers, shareholders or control people are different from those listed on the workers' comp application.
- **New Business** - The insured is a new business with significant payroll or multiple-state exposure.
- **Certificates of Insurance** - The number of certificates of insurance the carrier is asked to issue exceeds the number usually anticipated for a business of that size and type.
- **Misinformation** - Incorrect information is shown on the application about the number of employees, their duties, location of operations or the number of entities included for coverage.

Premium Fraud Red Flags

- **Business Location** - Multiple businesses are shown at the same address, the location visited is the same as previously visited for a different risk, or the business logo is not present at the location.
- **Non-Cooperation** - The insured refuses or delays access to appropriate personnel. The insured refuses to provide records, documents or files for audits or claim adjusting. Records are located somewhere other than the principal place of business.
- **Business Operations** - Requested coverages are inconsistent with the type of work being performed. Marketing materials or business name are inconsistent with operation. Company letterhead allows author to choose employer. Certificates or licenses for operations reflect a name other than that of the insured.
- **Safety** - Employer is not concerned with employee safety, even though there is a high rate of loss.
- **Claim Reporting** - Insured fails to report claims, or number and type of claims reported are inconsistent with payroll and classification information.

Agents & Brokers

I'm a **broker**. I represent the client, but also can receive commission from the insurance company for selling a policy.

I'm an **agent**. I represent the insurance company.



Before we begin the “fraud” portion of agent/broker fraud, it is important to remember that an agent and a broker **are not the same person**. They are two different individuals that have a common goal of selling insurance.

Agent & Broker Fraud Categories

1. **Application Fraud** - The agent or broker fills out the insurance application on behalf of the client and misrepresents the client's answers in order to obtain a certain level of coverage.
2. **False Advertising** - The agent or broker uses false statements in their advertisement which leads the client to make decisions based on those false statements. False advertisement can occur on business cards, brochures, newspaper ads or direct mail advertisements.
3. **Misrepresentation of Coverage** - The agent or broker misrepresents the coverage that they are selling.
4. **Improper Replacements** - The agent or broker misrepresents the difference between coverages in order to convince a client to replace a policy with one that is the same just to earn a commission. There are two types:
 - **Churning** takes place when an agent or broker replaces the coverage of his/her current clients without regard to need in order to earn a new commission.
 - **Twisting** happens when an agent or broker aims for new clients in order to replace their current coverage without regard to need so they may earn a commission.

Agent & Broker Fraud Example

I wish I could have another example.



EXAMPLE

A dishonest insurance agent collects premiums from a customer without forwarding them to the insurance company. The customer believes that its premiums are being properly handled while the insurance company thinks the policyholder is not paying its premiums and, therefore cancels or does not renew the customer's policy .

Provider Fraud

It's not only the most expensive fraud, it's the most common.



10 Common Types of Provider Fraud

1. **Services not Rendered** (the most common type of provider fraud) - The provider bills for and receives payments for services he did not perform.
2. **Non-Covered Services as Covered Services** - The provider performs treatments that are not covered by insurance but then uses codes on the bills to insurance carrier for services that are covered.
3. **Misrepresenting Dates of Service** - Providers might make more money by reporting they visited with or treated the same patient on two separate days rather than one day. Each “office visit” is usually considered a separate billable service.
4. **Misrepresenting Locations of Service** - Providers will provide one injection in the office or clinic and then provide the patient with syringes filled with medicine to inject themselves at home while still billing as if all injections were done at the clinic.
5. **Misrepresenting Provider of Service** - Medical doctors sign insurance forms showing they performed the care or service but in reality, lesser educated or even unlicensed individuals actually conducted the service.

10 Common Types of Provider Fraud

6. **Waiving of Deductible and/or Co-Payments** - Providers will waive deductibles or co-payments and then submit other false claims to insurance companies to make up the dollar difference and in some instances, add other false services knowing patient is unlikely to complain because the deductible or co-payment was waived.
7. **Incorrect Reporting of Diagnosis or Procedures** (includes unbundling) - Unscrupulous providers can bill for extra services if they report false serious diagnoses or procedures performed. One of the most popular incorrect reporting of procedures is unbundling. Unbundling occurs when a provider charges a comprehensive code plus more component codes.
8. **Overutilization of Services** - This typically involves billing for services that are not really necessary, including tests and exams. Alcohol and drug rehabilitation facilities are ripe for overutilization.
9. **Corruption** (kickbacks and bribery) - Like all industries, the potential for corruption in health care industry is great. Providers have been known to unlawfully pay for and/or receive payment for referrals.
10. **False or Unnecessary Issuance of Prescription Drugs** - Prescription drug abuse is sometimes defined as taking prescription medication (prescribed or not) for reasons beyond physician's intentions.

Provider Red Flags



The most common **Provider Red Flags** include:

- Records, bills, etc. related to the claim are missing
- Sudden increase in provider's billing and payment levels
- The provider repeatedly uses identical treatment and coding of each patient
- The provider disguises medical procedures; for example, listing cosmetic as medically necessary
- The frequency or duration of service is greater than expected for the treatment
- The signature of the member and/or provider is not on the claim form
- The provider routinely waives co-pays
- The provider makes house calls
- Great distance between provider and patient

Provider Red Flags Example

Example

A pharmacist stole large quantities of painkillers from his employer's inventory and then electronically submitted false claims to insurance companies using names of other beneficiaries' and their insurance policy numbers, which he obtained from his employer's computer. The pharmacist was smart enough to slip cash co-payments out of his own pocket into the cash register so there wouldn't be a financial shortage for his employer. To further avoid detection, he regularly submitted only a few claims for low quantity under each beneficiary's name.

Kickback vs. Illegal Gratuity

Kickbacks and illegal gratuities
are very similar, but they are
not the same thing.

What's the difference?



Kickback vs. Illegal Gratuity

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What's the difference?

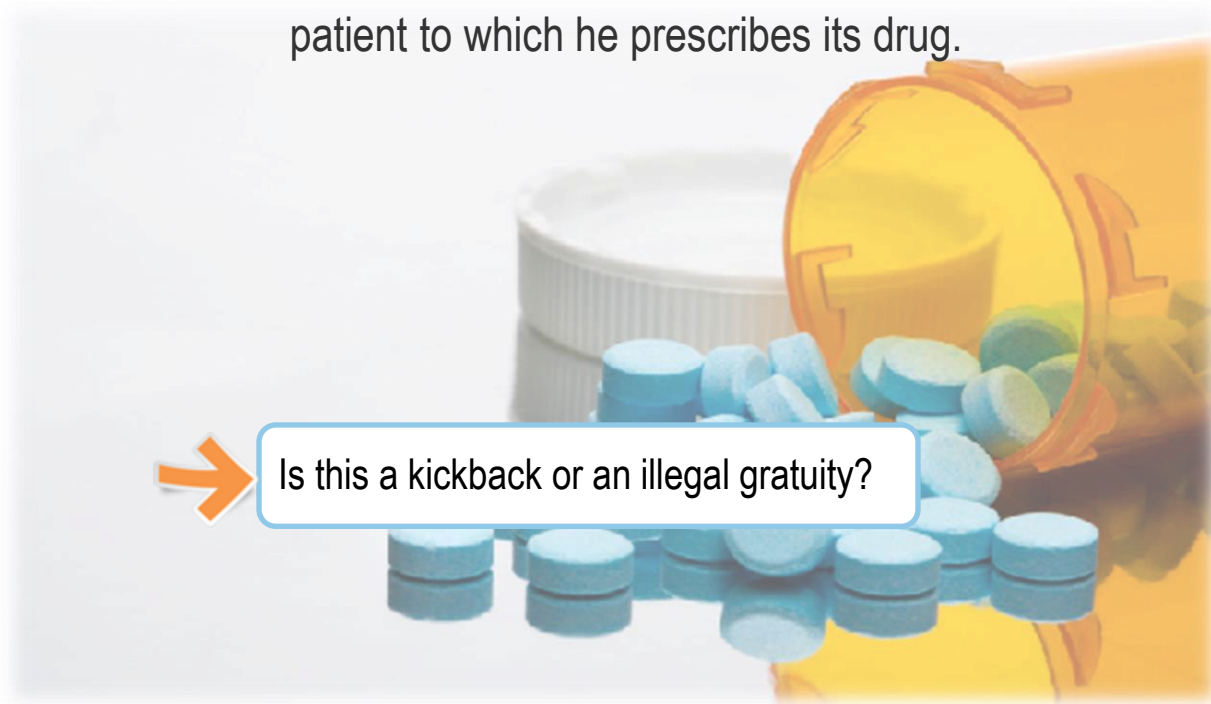


A **kickback** occurs when an illegal or secret payment is made in exchange for services or goods. A kickback can also be considered a bribe and a demand for a kickback can be considered extortion.

An **illegal gratuity** is the offering, giving, receiving or soliciting of something of value for or because of an official act. Certain gifts or functions are permissible such as food and sporting events to maintain the relationship with the business partners.

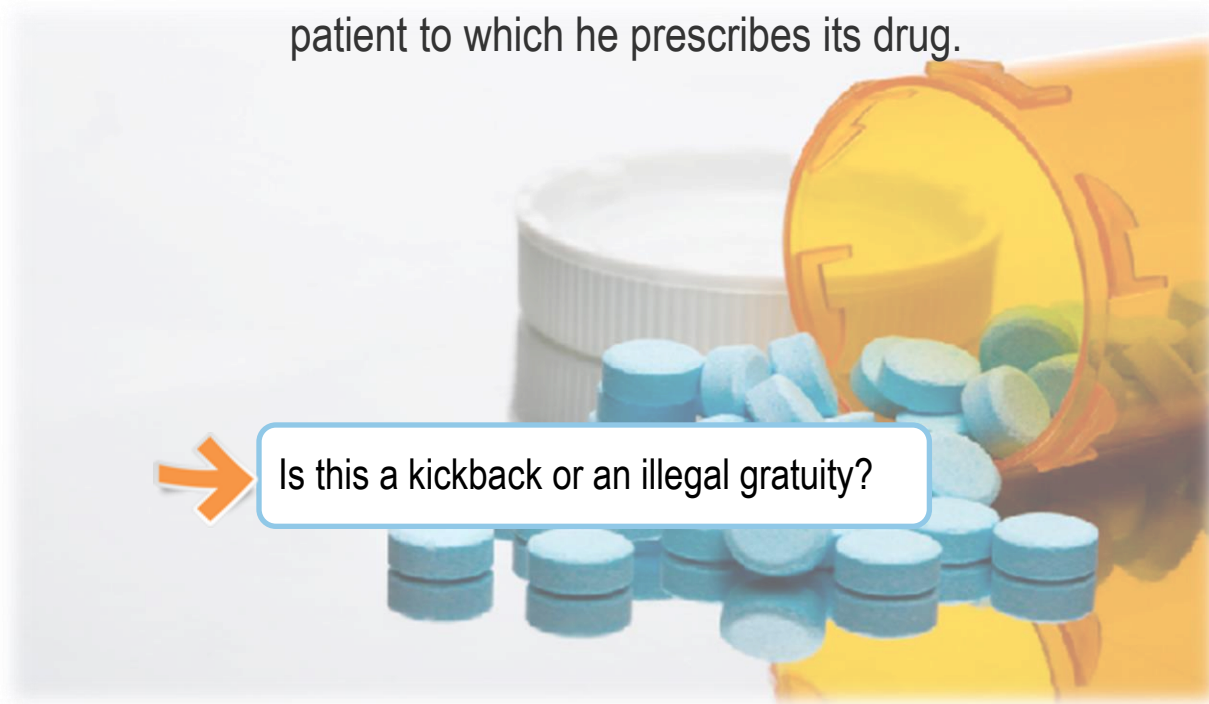
Kickback or Illegal Gratuity?

A pharmaceutical company pays a doctor a bonus for each patient to which he prescribes its drug.



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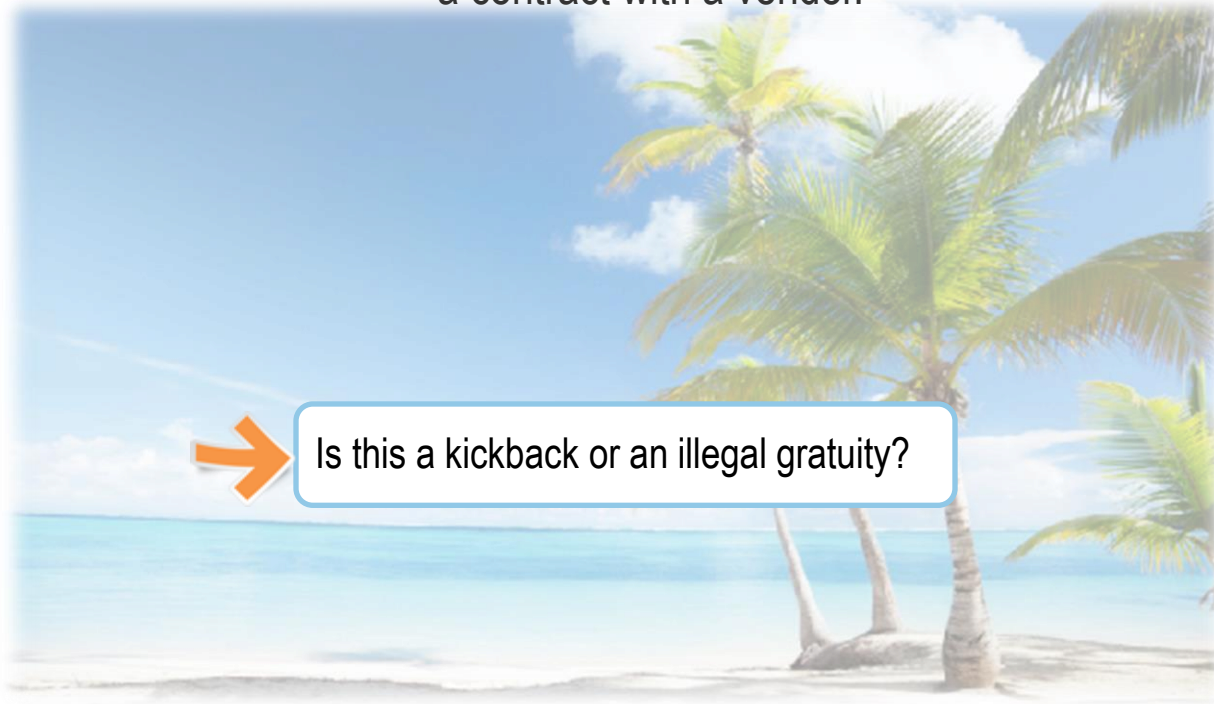


Is this a kickback or an illegal gratuity?

This is an example of a **kickback**. The bonus is an illegal payment made in exchange for the doctor prescribing the pharmaceutical company's drug.

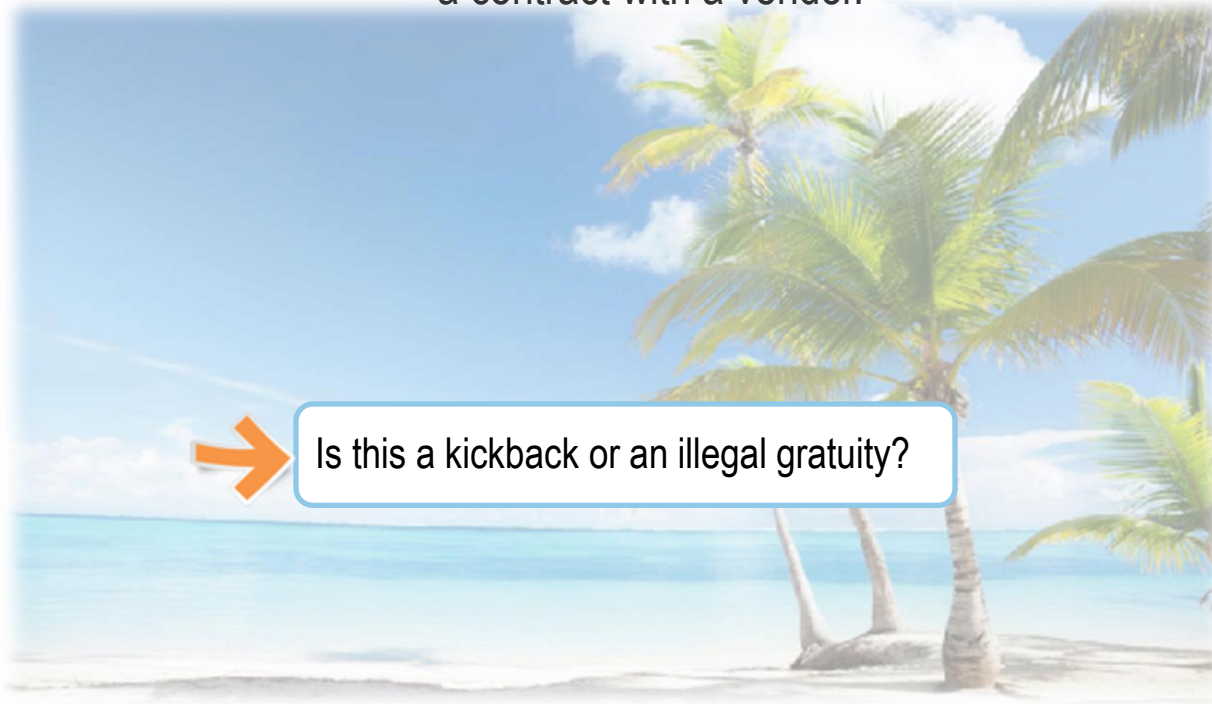
Kickback or Illegal Gratuity?

A provider is rewarded with a Caribbean vacation for approving a contract with a vendor.



Kickback or Illegal Gratuity?

A provider is rewarded with a Caribbean vacation for approving a contract with a vendor.



This is an example of an **illegal gratuity**. The provider is receiving something of value, the Caribbean vacation, for the official act of approving a contract with the vendor.

Kickback vs. Illegal Gratuity

Do you see the difference between the two? It has to do with the word “reward.”

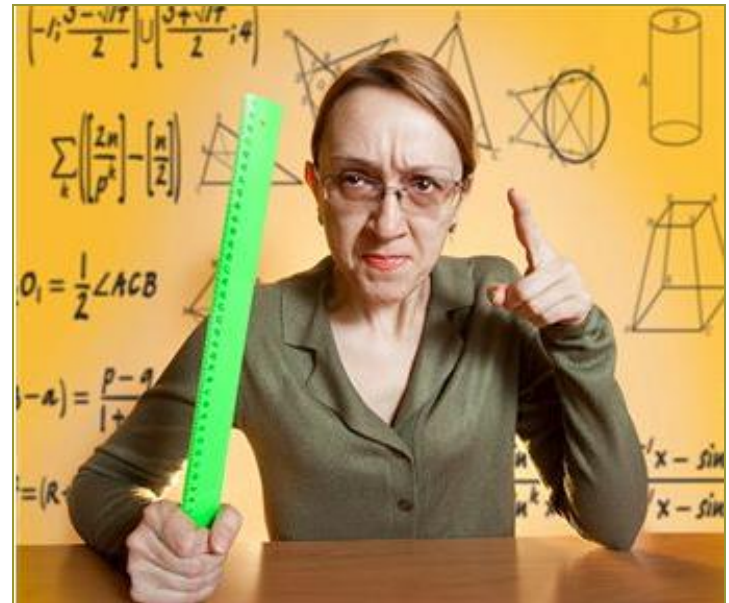
Yes, I see. Thanks to your explanation and my super-cool glasses! An illegal gratuity is used as a reward and a kickback is used to influence an action.



Pennsylvania Fraud Penalties

Statute of limitations:

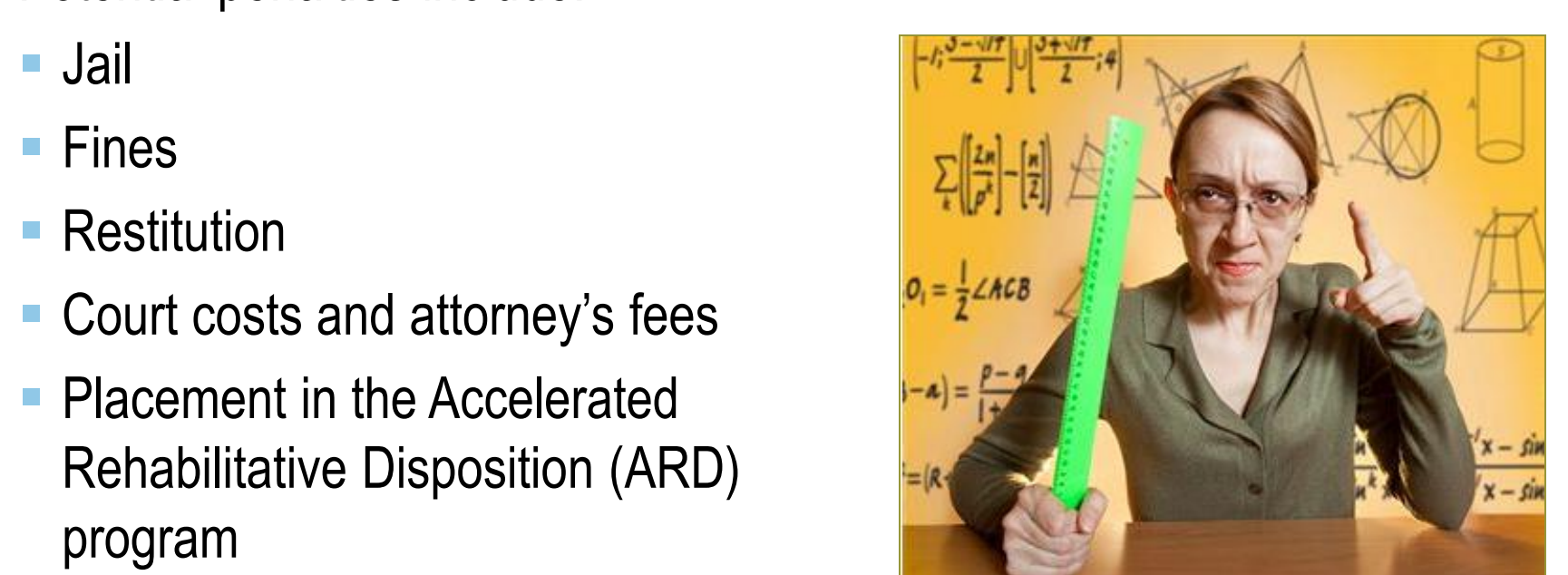
- Once fraud is identified, there is a time frame in which to prosecute
- The statute of limitations for the crime of insurance fraud varies by state
- In the Commonwealth of Pennsylvania, the statute of limitations for fraud is 5 years, meaning law enforcement has 5 years from the date the fraud was identified to file criminal charges



Pennsylvania Fraud Penalties

- Jail
- Fines
- Restitution
- Court costs and attorney's fees
- Placement in the Accelerated Rehabilitative Disposition (ARD) program

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- Fines
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- Court costs and attorney's fees
- Placement in the Accelerated Rehabilitative Disposition (ARD) program



Pennsylvania Fraud Penalties

ARD Program:

- Helps divert first-time offenders from entering the criminal justice system. ARD is not just for DUI offenders, it is for all first-time offenders
- It is not a conviction
- Keeps one's record clean and increases employment opportunities
- Once the requirements of the program are met (restitution, community service), the charges are dismissed



Lesson Summary

After reviewing this lesson, you should be able to answer the question in this scenario:

An employee who was injured at work has been on disability. Although he's feeling better, he's been enjoying his time off; so he tells his doctor that he's still in pain to remain on disability for a longer period of time.



Is this fraud or abuse?

Lesson Summary

After reviewing this lesson, you should be able to answer the question in this scenario:

An employee who was injured at work has been on disability. Although he's feeling better, he's been enjoying his time off; so he tells his doctor that he's still in pain to remain on disability for a longer period of time.



Is this fraud or abuse?

This scenario is an example of **fraud**, specifically **soft fraud**, or **opportunistic fraud**

Go to Next Lesson

You also should be able to answer the following questions:

1. Does this scenario incorporate the four basic elements of fraud?
2. How is it different from abuse?
3. Does the claimant fit into one of the four population segments?
4. What is the red flag in this scenario?
5. What are the penalties if this employee is caught?

If you can answer these questions, you're ready to move on to the next lesson!



DRUG DIVERSION

Drug Diversion

The epidemic of drug diversion has spread at an alarming rate over the last twenty years. According to the Coalition Against Insurance Fraud, insurance fraud is the **main financier and enabler** of drug diversion and costs insurers approximately \$72.5 billion a year.



Source: Prescription for Peril Coalition Against Insurance Fraud, December 2007

Drug Diversion

What is **drug diversion**?

- Drug diversion occurs when prescription drugs are deviated from their intended path or original purpose. For example, diverting a prescription intended for an injured worker is sold on the street for monetary value.
- Drug diversion is one of the major drug crimes in the United States today. It represents approximately 30% of the overall drug problem. Drug diversion can include theft of drugs, doctor shopping, forged prescriptions, counterfeit drugs and selling drugs. However, doctor shopping is the largest form of drug diversion. Doctor shopping occurs when a patient deceives several doctors simultaneously in order to obtain a prescription for painkillers.
- Overdoses, deaths and injuries continue to grow at a disturbing rate as a result of drug diversion.

Most Common Types of Diverted Drugs

The Drug Enforcement Agency (DEA) has created Controlled Substance Schedules which are regulated under Section 812 of the Controlled Substances Act. (21U.S.C. §801 et seq.) The most common diverted drugs fall into one of the five Controlled Substance Schedules:

1. **Opioids**: which include morphine, hydrocodone (Vicodin and Lorcet), oxycodone (OxyContin, Percocet) and Codeine. These are all Schedule II and Schedule III Controlled Substances. A Schedule II drug has a high potential for abuse and can lead to severe psychological or physical dependence while a Schedule III drug may lead to moderate or low physical dependence.

Most Common Types of Diverted Drugs

2. **Pseudoephedrine or ephedrine**: an active ingredient in Sudafed, used in the illegal manufacturing of methamphetamine. Pseudoephedrine or ephedrine are not listed on the Controlled Substance Schedule, but they are regulated by the Combat Methamphetamine Epidemic Act of 2005 which requires a signature in the log book and a valid ID to purchase from all retailers. The amount of how much pseudoephedrine or ephedrine that an individual can purchase in one transaction is also limited.

Most Common Types of Diverted Drugs

3. **Dextromethorphan (DXM)**: which is the active ingredient in cough medicine, like Robitussin DM or Mucinex DM. These are abused for their effects which are similar to ketamine and PCP. These are Schedule V Controlled Substances due to their low potential for abuse.
4. **Non-opioid depressants**: which are mainly benzodiazepines such as diazepam (Valium), temazepam (Restoril), clonazepam (Klonopin) and alprazolam (Xanax). These are all Schedule IV Controlled Substances due to their low probability for abuse.
5. **Stimulants**: are amphetamine (Adderall) and methylphenidate (Desoxyn). These drugs have similar effects to cocaine but are Schedule II stimulants.

Who Diverts?



There is no typical profile of a prescription drug abuser. Drug abuse happens in all walks of life regardless of race, neighborhood, income or workplace.

The majority of prescription drug users began taking the drug for genuine medical purposes.

However, the fastest growing demographic abusing prescription drugs is the 12-17 year old age group.

Who Diverts? Example

Former mayor of Pratt pleads guilty to selling oxycodone:

CHARLESTON, W.Va. – Gary Fields, 68, the former mayor of Pratt, West Virginia, admitted to selling the powerful prescription painkiller oxycodone. Fields pleaded guilty in federal court in Charleston to distribution of oxycodone, announced U.S. Attorney Booth Goodwin.

As part of the plea, Fields admitted that he sold six 15 mg oxycodone pills to a confidential informant on April 23, 2015.

The investigation was conducted by the Kanawha County Sherriff's Department. Assistant United States Attorney Haley Bunn is handling the prosecution.

The prosecution is part of an ongoing effort by the United States Attorney's Office for the Southern District of West Virginia to combat the illicit sale and misuse of prescription drugs and heroin. The U.S. Attorney's Office, joined by federal, state and local law enforcement agencies, is committed to aggressively pursuing and shutting down illegal pill trafficking, eliminating open air drug markets, and curtailing the spread of opiate painkillers and heroin in communities across the Southern District.

Common Schemes of Drug Diversion

- Forged prescriptions by using stolen prescription pads
- Pharmacists who are part of an organized ring selling drugs on the black market
- Doctors selling prescriptions to drug dealers
- Individuals doctor shopping to obtain prescriptions

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Example

Dr. Norman Werther was found guilty of over 300 counts which included distribution of a controlled substance related in death, drug conspiracy and money laundering stemming from his involvement in an illegal prescription drug ring. Dr. Werther consciously dealt prescription drugs to drug dealers who in turn sold them on the street. In order to obtain additional drugs, fake patients were created and paid a fee in order to obtain a prescription for Oxycodone.

Employee Occupational Fraud

Scenario: An employee takes office supplies for her children's school supplies.

Is this employee fraud?

It's employee fraud!

It's not employee fraud!

It depends!

Employee Occupational Fraud

Scenario: An employee takes office supplies for her children's school supplies.

Is this employee fraud?



It's employee fraud!

It's not employee fraud!

It depends!

But what type is it?

Employee Fraud



Employee Fraud is growing and all organizations of all sizes face the challenges of combating it.

It is a crime of opportunity--some of the worst fraud is caused by employees.

Employee fraud fits into an example of the Fraud Triangle discussed earlier.

Managers and Executives

Employees of all levels can commit fraud. However, manager and executive-level fraud is the most costly. The reasons employees commit fraud could be due to the **financial pressures, vices, work related pressures** and **lack of controls**.

I don't know what happened!
One day I just lost my head and
committed costly employee fraud!



Types of Employee Fraud

1. Theft of time
2. Theft of supplies
3. False expenses or exaggerated expenditures
4. Embezzlement of funds

Theft of Time

Theft of time usually happens when an employee is paid for time they did not work.

It is estimated that average employee “steals” 4.5 hours per week and that it costs American business billions of dollars every year.

In addition, office employees tend to steal more time than manufacturing employees.



Theft of Time



Example

An employee lists on his time sheet that he worked an extra 30 minutes prior to his scheduled start time. However, the employee was never there.

Theft of Time

Forms of theft of time include:

- Late arrivals or early departures
- Long lunches or breaks
- Taking your time on a project in order to create overtime
- Too much socializing or personal calls



Theft of Supplies

Theft of supplies happens when an employee takes office supplies for their own personal use.

Don't look in my purse.



Theft of Supplies



Example

An employee takes home pens, pencils and notebooks for her home based business.

False Expense Reports

This type of fraud occurs when an employee manipulates or files a false expense report.



False Expense Reports

Example

An employee expensed her personal dinners with family members totaling over \$3,000. She listed her family members as co-workers.



False Expense Reports

There are four (4) types of Expense Report Fraud:

1. **Mischaracterized expenses:** claiming a personal trip as a business expense
2. **Inflated expenses:** inflating the cost of an item by altering the receipt, invoice or other document
3. **Falsified claims:** the report was filed with false documentation
4. **Multiple claims:** submitting a report months after it was approved in the hopes it would be paid again and the approvers would not notice

Embezzlement of Funds

Embezzlement is an act of dishonestly withholding assets for the purpose of conversion (theft) of such assets, by one or more persons to whom the assets were entrusted, either to be held or to be used for specific purposes.

Embezzlement is a type of financial fraud.



Embezzlement of Funds



Example

A lawyer might embezzle funds from the trust accounts of his or her clients; a financial advisor might embezzle the funds of investors; and a husband or a wife might embezzle funds from a bank account jointly held with the spouse.

Preventing Employee Fraud

Four ways to prevent employee fraud:

1. Segregate responsibilities
2. Offer fraud training for management and employees
3. Conduct random audits
4. Use an anonymous reporting system

Employee Fraud Statistics

- It takes **18 months** before the average fraud scheme is detected
- Employee fraud is more likely to be detected **by a tip** than by any other method
- **Forty-nine percent** of the victims do not recover their losses.
- The median loss when fraud is committed in the workplace:
 - \$573,000 by **executives**
 - \$180,000 by **managers**
 - \$60,000 by **employees**

Penalties of Employee Fraud



When people are caught committing fraud on the job, they can face the following penalties:

- Termination
- Restitution
- Jail time
- Probation
- Court costs and fines

Is This a Way to Prevent Fraud?

Which is **not** a way to prevent employee fraud?

Do not conduct random audits

Use an anonymous reporting system

Offer fraud training for management and employees

Segregate responsibilities

Is This a Way to Prevent Fraud?

Which is **not** a way to prevent employee fraud?

Do not conduct random audits



Use an anonymous reporting system

Offer fraud training for management and employees

Segregate responsibilities

If I had paid more attention to last year's anti-fraud training, stripes wouldn't be part of this year's dress code.



Lesson Summary

After reviewing this lesson, you should be able to answer the question in this scenario:

Sean realized he was out of printer paper for his home computer and didn't have time to go to the store. Sean decided to take some paper from work instead.



What type of employee fraud is this?

Lesson Summary

After reviewing this lesson, you should be able to answer the question in this scenario:

Sean realized he was out of printer paper for his home computer and didn't have time to go to the store. Sean decided to take some paper from work instead.



What type of employee fraud is this?

This scenario is an example of **theft of supplies**.

Go to Next Lesson

You also should be able to answer the following questions:

1. Can you name the two other types of employee fraud?
2. What are some of the reasons that employees commit fraud?
3. Which employees commit the most costly fraud?
4. What are the consequences of committing employee fraud?

**If you can answer these questions, you're ready to
move on to the next lesson!**



COMPUTER SECURITY AND INTERNET USAGE

Computer Security Scenario

Scenario: The employee who sits at this desk has walked away without protecting private information. Move forward to learn each security risk violated.



This employee forgot to lock his computer.

Computer Security Scenario

Scenario: The employee who sits at this desk has walked away without protecting private information. Move forward to learn each security risk violated.



This employee's password is posted on his monitor, leaving his computer unsecure.

Computer Security Scenario

Scenario: The employee who sits at this desk has walked away without protecting private information. Move forward to learn each security risk violated.



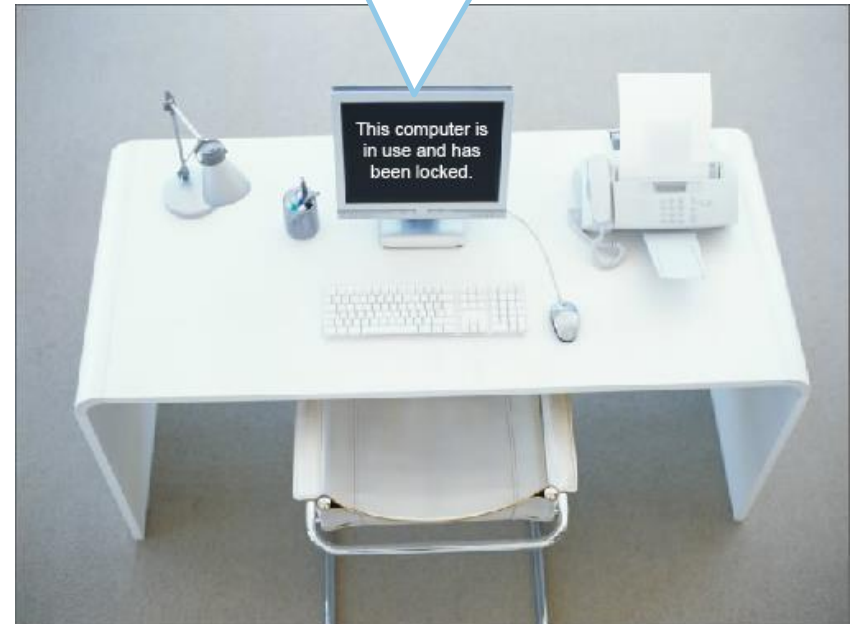
This employee left a customer's confidential information on display for anyone to see.

Lesson Objective

There were **three risks** in the scenario.

After reviewing this lesson, you'll be able to identify more ways to protect the integrity and confidentiality of corporate information and computer assets.

Ah! Now I feel more secure!
Confidential information should be hidden
when you're not at your desk.



Management's Responsibilities

So many responsibilities...
so little time.



1. Ensuring that individuals have **authorized access** needed based on job responsibilities to corporate information, networks, and computing equipment
2. Ensuring that all individuals are aware of the requirement to **protect the integrity and confidentiality** of corporate information and computer assets
3. Ensuring that all individuals complete **privacy and security training**

Management's Responsibilities

So many
responsibilities...
so little time.



4. Notifying System Security Services promptly of all **separations, terminations of employment, or reassignments of individuals**
5. Implementing departmental data **security practices and procedures** consistent with this corporate policy

Employees, Contractors, Consultants and Other Approved Individuals' Responsibilities

1. Safeguarding **company information and computer assets** entrusted to him or her and for complying with this policy and all other information security policies, standards and procedures
2. Being responsible and accountable for work done under his/her **user ID**
3. Establishing a **password** to authenticate his/her user ID and gaining **access** to company systems; these passwords must be kept confidential and are not to be shared, revealed or accessible to other employees

Safeguarding Your Laptop

If you have a laptop,
you must be careful that it
doesn't end up in the
wrong hands.



Do you take precautions
with your laptop?

Creating a Secure Password

Passwords shouldn't
contain the name of family
members.



Or pets!
Even I know that.

Creating a Secure Password

When you create a password, try using a combination of numbers and symbols along with letters of varying case.

Creating a Secure Password

When you create a password, try using a combination of numbers and symbols along with letters of varying case.

Example

Make a hard password easier to remember by changing “Penguins” to “3en87ins”. Change the P to 3, use the number 8 instead of the letter g, and change the u to 7.

Protect Personal Health Information (PHI)

Do **not** pay a claim on a relative, friend, neighbor or anyone you know.

If you receive a claim or an underwriting request for someone that you have a personal relationship with, refer it to your supervisor.

Lesson Summary

After reviewing this lesson, you should be able to answer this question:

Which is NOT a way to protect the integrity and confidentiality of corporate information?

1. Restrict Internet searches to business activity
2. Create a password that you'll remember using a family member's name
3. Refer a relative's claim to your supervisor for processing



What do you think?

Lesson Summary

After reviewing this lesson, you should be able to answer this question:

Which is NOT a way to protect the integrity and confidentiality of corporate information?

1. Restrict Internet searches to business activity
2. Create a password that you'll remember using a family member's name
3. Refer a relative's claim to your supervisor for processing



What do you think?

The correct answer is **2**. Using a family member's name is not secure.

Go to Next Lesson

You also should be able to answer the following questions:

1. How can you create a password that is secure?
2. Is it OK to share your password with anyone?
3. Can you give at least two examples of Internet usage that are prohibited?
4. What's a safe way to discard documents containing PHI?

If you can answer these questions, you're ready to move on to the final lesson!



ROLE OF THE SIU

SIU's Responsibilities

1. **Prevention:** The SIU helps prevent fraud by maintaining, developing and distributing an anti-fraud plan that has been filed in mandated states as well as creating annual anti-fraud training.
2. **Detection:** Claims personnel, underwriters, and all other employees are our main source for detecting fraud. A successful anti-fraud effort is when all employees come together by using the “red flags” to identify potential fraud and reporting any and all suspicious activity to the SIU.
3. **Investigation:** Any and all claims that are referred to the SIU are thoroughly investigated. This is done by reviewing each claim, identifying witnesses and relevant documentation and preparing a summary of the investigation.

SIU's Responsibilities

4. **Prosecution:** Presently, 37 states mandate that all suspicious claims be referred for further investigation. Pennsylvania is one of these states. In Pennsylvania, the dollar value of the claim is insignificant and the SIU has a duty to refer any claim that has a reasonable suspicion that fraud has occurred.
5. **Training:** Anti-fraud training is conducted every year based on state requirements. The training is to educate employees of how to identify potential fraud through use of red flags and how to refer a case to the SIU.

The Role of the SIU

- Conducting the annual Fraud Awareness Day
- Providing annual anti-fraud training (**this is it!**)
- Availability to review real SIU cases and outcomes
- Working collaboratively with all departments within HM
- Active in fraud fighting and awareness organizations such as CFE (Certified Fraud Examiners) and IASIU (International Association of Special Investigations Units)



If You Suspect Fraud...

1. **Document what you see** – The more that is documented, the better; but personal opinions should never be used
2. **Refer the case to the SIU** – Call the HM Fraud Hotline at 1-888-842-5699 (all calls to the HM Fraud Hotline will remain anonymous upon request)



After Making a Referral...

1. The referral will be entered in and tracked through the SIU database
2. A thorough review of the referral will be conducted and additional information will be obtained, if needed, by working closely with the referring department
3. If necessary, a background check may be completed which includes but is not limited to review of social networking sites and conducting criminal background searches
4. Once we gather all the pertinent information on the case, we will then create a “Document Summary”, which is the single source of data to summarize all information and sources used in investigation of the claim
5. Once our investigation is complete and there is reasonable suspicion that fraud is identified, the case will then be referred to: local law enforcement, the Attorney General’s office, or the Insurance Department’s fraud bureau. The SIU then will work closely with the law enforcement agency and provide them with any additional information requested

HM's SIU Team

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Lesson Summary

After reviewing this lesson, you should be able to answer this question:

What should you do if you suspect fraud?

1. Call the HM Fraud Hotline
2. Look up the statute of limitations for fraud
3. Refer the case to the SIU
4. Do nothing



What do you think?

Lesson Summary

After reviewing this lesson, you should be able to answer this question:

What should you do if you suspect fraud?

1. Call the HM Fraud Hotline
2. Look up the statute of limitations for fraud
3. Refer the case to the SIU
4. Do nothing



What do you think?

The correct answers are **1 & 3**.



VENDOR MANAGEMENT

Vendor Management

Using outside vendors is not avoidable and is actually a necessity at HM. A vendor can range from an attorney to a surveillance investigator. Each one has different responsibilities, but they still need to be managed. The following is important when determining who to use for an important assignment:

1. A majority of the states require licenses for certain experts; if the vendor is not licensed, it may prevent them from testifying, if applicable. For example, a private investigator should be licensed and bonded in the Commonwealth of PA.
2. One particular vendor should not be used exclusively. It could be perceived that this vendor is biased.
3. The vendor should understand what its task is and be directed to perform only that task.

Vendor Management

Using outside vendors is not avoidable and is actually a necessity at HM. A vendor can range from an attorney to a surveillance investigator. Each one has different responsibilities, but they still need to be managed. The following is important when determining who to use for an important assignment:

4. Work that can be performed internally should not be performed by a vendor, such as legal questions and background checks.
5. The vendor is an agent of our organization. Its actions reflect on our organization. HM Insurance Group is responsible for the actions of all its vendors.
6. **Always** review their billing statement and make sure that they are billing for services that were rendered in order to avoid double billing.

Surveillance

Surveillance is an area where outside vendors are utilized. It is defined as the “**planned observation of people, places or objects**.” Surveillance helps to uncover fraudulent or exaggerated claims.

Surveillance should be requested on the merits of the case and should not be used routinely when it cannot be justified.

Some of the reasons on **when to order surveillance** include:

- Determining the extent of the claimant's injuries as well as their activity level
- Locating witnesses
- Verifying if the claimant is working or not
- Locating a residence

Surveillance Best Practices

- Get to the know surveillance **investigator**; ask questions concerning training for its investigators, standards, do they have insurance and if they are licensed to perform surveillance in the state.
- **Double check** their references.
- Request a copy of their **vendors' certificate**; this can be verified online at www.crimetime.com/licensing.htm.
- Make sure its **technology** is current and not obsolete
- Ask questions about **staffing**, such as, is there enough investigators to meet our needs and complete the assignment in the timeframe requested.



Surveillance Best Practices

- What is **not** permitted:
 - **Intrusion!** A surveillance company should not intrude on the subject or invade someone's privacy!
 - Surveillance should **never** be conducted on private property
 - Investigators should **never** climb trees or roofs, use a flying drone or physically alter another's property
 - Audio is **forbidden**



Surveillance Best Practices

- Background checks, including criminal records, Facebook and Internet searches can be performed by the SIU at **no additional cost**.
- If surveillance is ordered, the case should always be **referred to the SIU** for additional investigation; copies of surveillance videos can be made by SIU at no additional cost.
- Remember to always refer to your **department guidelines** for procedures and selection.
- While surveillance is a very useful tool when used appropriately, it is not the most common method for reporting fraud. The most common method is by a **tip**.



Lesson Summary

After reviewing this lesson, you should be able to answer this question:

Which of these circumstances helps one to handle a Vendor?

- 1. A vendor is an agent of ours**
- 2. Surveillance always invades a person's privacy**
- 3. Always review the vendor's billing statement**



What do you think?

Lesson Summary

After reviewing this lesson, you should be able to answer this question:

Which of these circumstances helps one to handle a Vendor?

- 1. A vendor is an agent of ours**
- 2. Surveillance always invades a person's privacy**
- 3. Always review the vendor's billing statement**



What do you think?

The correct answers are **1 & 3**.

Congratulations!

You have completed the HM Anti-Fraud Training Course.



Questions?

Contact HM's SIU at HMSIU@higmark.com or

call the HM Fraud Hotline at **1-888-842-5699**

(all calls to the HM Fraud Hotline will remain anonymous upon request)

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