

Association of
Certified Fraud Examiners
Greater Chicago Chapter



www.acfechicago.org

December 2008

A Message from the President

Greetings Greater Chicago Chapter Members,

Tis the season to be jolly-fa la la la la...How can we, as consumers, be jolly this holiday season? The economists have finally decided that we've been in a recession for the past year. Many of us could have told them that a year ago! Sky-high gasoline costs in the summer, the housing market collapse, the stock market plunge, rising food prices, and the credit crunch have been a fact of life for the American people this year. And, of course, the fraudsters thrive in times of financial chaos. We are seeing a rise in crime rates. Thankfully, we are also seeing the increase of financial felons paying their debts to society for the nefarious decisions that they've made.



Delena D. Spann, M.S., CFE, CCA

We've certainly had our fair share of disappointments for the year. The Black Friday Deals the day after Thanksgiving would have been comical if it hadn't turned deadly. A Wal-Mart employee was trampled to death by anxious shoppers as they stepped over his body in pursuit of "bargains". A shooting in a Toys R Us store also turned deadly as the holiday spirit took a turn for the worse. Have we allowed desperation and other antics to literally consume us that we lose sight of what the holiday season is suppose to represent? Whatever happened to "Peace on Earth and Goodwill to Mankind"?

The headlines in some of the major newspapers read this week: "Detroit's Desperate Big Three Asks for \$34 billion dollars". Wow!! I guess they *are* desperate. On one hand we have Sheila Blair, FDIC Chief Chairman saying, the bailout needs to end for the auto industry makers. On the other hand, the experts tell us that if the auto industry goes belly up, millions of people will be out of jobs. There are no easy answers here; no clear solutions. As I am writing this, the chiefs of the Big 3 auto makers are again appearing in Washington, this time with their hats in their hands, so to speak. They pledge to sell their corporate jets, discontinue redundant car models, cut down on excessive waste, and biggest shocker of them all—the CEO's will take a salary of only \$1 per year. One of them was even reported as having driven to Washington in a hybrid!

Many have voiced opinions on the aggressiveness of the government to step in and bail out the banks

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Mission Statement

The mission of the Association of Certified Fraud Examiners is to reduce the incidence of fraud and white-collar crime and to assist the Membership in its detection and deterrence. To accomplish our mission, the ACFE...

- Provides bona fide qualifications for Certified Fraud Examiners through administration of the CFE Examination
- Sets high standards for admission, including demonstrated competence through mandatory continuing professional education
- Requires Certified Fraud Examiners to adhere to a strict code of professional conduct and ethics
- Serves as the international representative for Certified Fraud Examiners to business, government and academic institutions
- Provides leadership to inspire public confidence in the integrity, objectivity, and professionalism of Certified Fraud Examiners

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and other corporate institutions. The suggestion is made perfectly clear that the government needs to decide which corporate institutions and banks will receive the financial support. And so the revolving door has reared its ugly head again. Chrysler secured a bailout in 1979; in 1981 Harley Davidson Motor Company was declared bankrupt and received \$80 million dollars from a group of Citibank Executives to bail them out; and General Motors made a bailout cry in 1982. Almost 40 years in the making, they're at it again with GM asking for a whopping \$18 billion dollars; Chrysler needs \$7 billion dollars and Ford Motor Company begging for \$9 billion dollars. Should we bail them out? Shouldn't the CEO's and COO's of these companies contribute a portion of their pension? Were they getting paid for failure?

I think that Alan Mulally (Ford CEO), Rick Wagoner (GM CEO), Bob Nardelli (Chrysler Chief) and Fritz Henderson (GM COO) should all give a percentage of their personal funds to help keep companies out of bankruptcy. Accepting only \$1 in salaries isn't enough—they should be made to give back their excessive paychecks from the past. It was *their* policies which drove the American auto industry into the dumps.

These individuals were considered the "movers and shakers" of industry. **Ho Ho Ho.** Not only have we as taxpayers been moved and shaken; we've been bamboozled to think that "it is our duty" to condone their insidious tactics. We are not only experiencing defaults in corporate venues; but also, some of the most major ethical dilemmas in American History. Bad business practices, lack of accountability, and theft are the norm.

As we progress into the holiday season and a new year, I challenge each of us as "fraud fighters", to conduct our due diligence in helping to secure our nation in getting back to its financial stability.

I wish you and yours a splendid holiday season!

****Let's not forget our holiday event will be held at Maggiano's on this coming Tuesday, December 9th. We look forward to seeing all of you.***

Our vision remains: "Let's Go Shopping For Fraudsters" (but no pushing and shoving please)

Best Regards,

Delena D. Spann, M.S., CFE, CCA

President, ACFE Greater Chicago Chapter

*ACFE Board of Regents

Editor's Note:

Like Oprah, Delena is a voracious reader, especially when it comes to the subject of the financial industry. These are some of the publications that Delena recommends for holiday gift subscriptions:

Smart Money Magazine
Crain's Business Chicago
Entrepreneur
Forbes
Business Week

Ring Around the White Collar

By Robert Quillinan, MBA, CFE

UPDATE:

The young man who claimed to have the inside track to Vatican real estate, Raffaello Follieri, was sentenced to 4 ½ years in Federal prison in October. His ex-girlfriend, actress Anne Hathaway, did not have any comment.

Once he had pled guilty, the Federal prison system had him transferred from the somewhat upscale Manhattan jail to the more low rent jail in Brooklyn. Follieri apparently didn't take into consideration that he would not be spending his sentence in the Manhattan facility. Poor planning on his part.

In a formal request for transfer to authorities, Follieri said that the Brooklyn prison has food that he can not eat and that the toilet and shower facilities are "unspeakably unsanitary". All of this has caused him to suffer from shortness of breath and intestinal problems.

Poor baby, I love when a con man gets conned. The days of "Club Fed" are apparently over.

Why you don't let employees stay after they resign.

How many of us have had employees that tender their resignation for a future date that includes unused vacation time or personal days, and we set their "termination" date in the future? Just a common practice at your company? We may want to rethink this process.

Biswamohan Pani tendered his resignation at Intel Corp and told the HR people that he was going to work at a hedge fund company, designing programs to trigger trading actions. What he didn't tell the HR types is that this was a little lie. He was, in fact,

going to work for Intel's rival, Advanced Micro Devices. (AMD)

Pani asked if he could burn up a few remaining vacation days, because his start date was a couple of weeks away. In reality, he had already started work for AMD. Pani is charged with copying Intel's design documents for future microprocessors. It is alleged that Pani did this to further his career at AMD. Federal authorities have said that AMD was not involved and had no knowledge of his acts.

In a statement released by Pani, he stated that he was just going to give them to his wife, a current Intel employee. He didn't explain what she was going to do with them.

Pani has only been charged and is presumed innocent. He is scheduled for trial in early 2009.

So if they want to resign, pay them and then cut their access to systems immediately. Don't let them "finish up a few things", because the things may not be in the company's best interest.

Let's go running for the shelter of mothers little helper.

Mick Jagger and the boys couldn't have said it better.

Something near and dear to my heart in my current job is prescription drug diversion. This form of fraud has exploded over the last several years.

The fraud comes in because most, if not all, of the diversion is based on fraudulent methods of obtaining the drugs from legitimate distribution channels.

Some of these are using computers to create phony prescription pads, Doctor shopping, and going to see a doctor and

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About ACFE

Newsletter

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6.1.09 for 7.15.09

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rifling through his desk in hopes of finding a prescription pad.

In the somewhat rural area of Asheville N.C., the sheriff's department has gone from issuing 40 arrest warrants for drug diversion in 2007 to 111 warrants through November 24th this year. Drug fraud now takes two full time detectives and other support personnel.

Sgt. Steve Fredrickson said that prescription drug diversion is the "white collar" fraud of the illegal drug trade. Often it involves working, middle class adults with no criminal background. Some like the controlled high, others have become addicted to pain killers through injury or disease. Some have determined that selling pain killers and psychotropic drugs has become very lucrative.

If rural America is having this problem, we can only imagine what the problem is on a national scale.

Bullet Point:

- I'll bet the police had a good time with this arrest.

The former head of the People United for a Better Oakland, Dawn Phillips, was arrested on three counts of forgery and one count of grand theft. Seems that the Oakland, CA., police watchdog group was the victim of several fraudulent activities by executive members, including Phillips. Phillips allegedly wrote several checks for thousands of dollars to himself. Not very imaginative, but effective.

Phillip's predecessor, Christopher Donaldson, was sentenced last month to a year in jail for fraudulently obtaining more than \$72,000.

Until next time, follow the money.

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DATA Analysis Series: Developing Prevention Models

By Rebecca S. Busch, RN, MBA, CCM, CFE, FHFMA

"I am a great believer in luck, and I find the harder I work, the more I have of it" Thomas Jefferson. The harder you work on the front end, the luckier you will be in materializing information that will generate productive results. In healthcare, it is a blend of luck generated from well-organized and structured audit and investigations. This part series of articles applies a sample series of data analysis models. These models are the results of output activity from data mining. In the data output world, we have a new continuum to monitor, understand, and use as a guide in audit and investigation of fraud. This is referred to as the anomaly continuum. View these as potential frameworks for building data warehouses of information for analysis.

The prior articles on data analysis introduced the series of detection, investigation, and mitigation models and its various components. This article will continue with prevention model for data analysis. The sample case flow is an actual case with hypothetical names.

Healthcare application:

Case Example: Dr. Healer

Case History

- **Who:** Dr. Healer, M.D.
- **What:** Radio host for a program *Medicine Man*; skilled healer with nontraditional practices
- **When:** growing practice over last five years
- **Why:** ?
- **Where:** five walk-in clinic services

Data Set

- **Billing data:** high percentage of complicated visits; Dr. Healer generated bills while traveling in Europe
- **Recent claim data:** visits to chiropractors, acupuncturists, massage therapists, nutritionists, and personal trainers at a gym billed under Dr. Healer's tax ID number and under M.D. CPT visit codes
- **Staff issues:** Dr. Foreign, staff physician, an unlicensed doctor was on staff for \$5 per hour; Dr. Gone continued to bill out of this clinic, although he no longer was associated with the clinic

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Continued from page 4.

Dr. Healer Statement

"I am just a caring doctor getting reluctant insurance companies to pay for alternative health treatments."

Pipeline Application

Health information pipeline (HIP) issues involved a higher-than-average complication rate. The physician evaluation management codes were statistically above average for the diagnoses being submitted as treated by the provider. The accounts receivable pipeline (ARP) issues noted a higher code rate submission in addition to an abnormally higher patient volume for just one doctor. The operational flow activity (OFA) issue involved the operational activities associated with the service market activity (SMA) being provided by the clinic.

The first series present data model concepts for detection analysis followed by investigation data models. This article will focus on mitigation data analysis models.

Prevention Model

The prevention model is about incorporating internal controls. For example, Dr. Healer had an unlicensed professional practicing medicine. He had vendors presenting wellness services as illness services. What controls can be placed in the management of HIP data that would prompt the claims adjustor to question claims that are similar to Dr. Healer's?

The following is an example of prevention with respect to a physician's license. Each facility or organization that employs a physician is supposed to have a credentialing process. This is the process to ensure that the individual hired to provide care actually has the appropriate credentials.

Nepokroeff's attitude toward the disabled was astonishing. He has stated, "There is no such thing as a totally disabled person," "Most people on workers' compensation just want a free vacation," and "Most people on workers' compensation are fraudulent." His response to hearing that one of his workers' compensation patients had jumped out of a top window of Erie County Medical Center was to laugh and say, "Well his problems are over." (www.injuredworker.org/Insurance_fraud.htm)

In this case, the credentialing process failed to identify the lack of licensure by this physician. In addition, the statement of "Well his problems are over" reflect an individual who most likely gave clues as to his lack of medical training, either by the records he maintained on patients or his lack of clinical judgment in his communications with other licensed professionals. He mostly likely had patient complaints that should have resulted in some type of peer review. In other words, if he was not trained as a physician, someone should have seen it in his care of his patients.

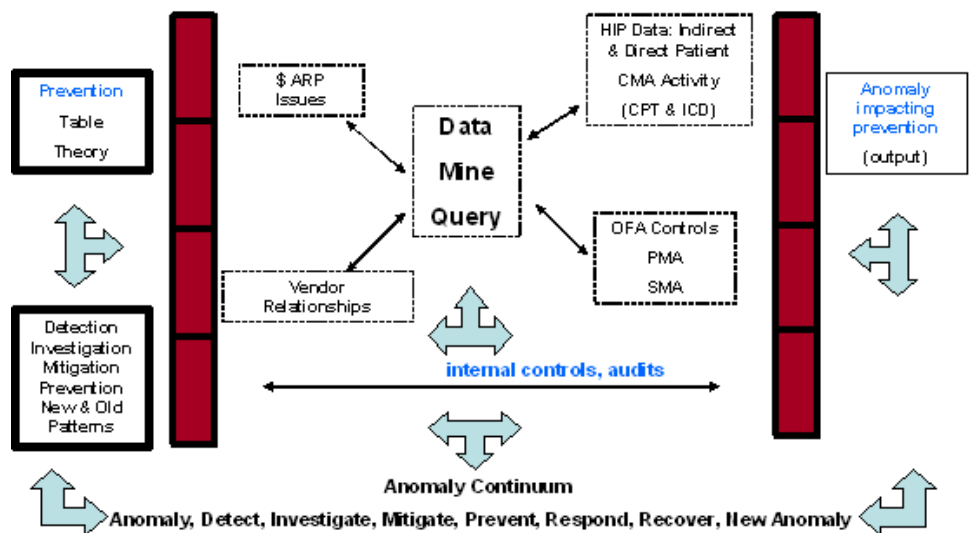
In Table 4, prevention model theory is added to the data collection and decision-making process. It is reconciled with previously collected detection, investigation, and mitigation data. The focus is on the HIP data edits. However, it is important to look at the ARP issues. If the TPA system missed the licensing issues and diagnosis issues, it has another opportunity to evaluate the fluctuations in monetary transactions. This was true in Dr. Healer's case, where the practice activity, the volume, and complication rate only went up.

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Independent Medical Examiner Practices for Ten Years without a Medical Degree

Mark Nepokroeff practiced medicine in Niagara County, New York without having completed medical school. His diploma was a fake. However, New York gave him a medical license, allowed him to perform IME exams and to treat workers' compensation claimants. The federal government had him doing disability eligibility exams for Social Security Disability and SSI. His punishment: four months in federal prison and \$233,439 in restitution.

Table 4: Prevention Model



Continued from page 5.

Prevention is about a complete review and audit of the adjudication procedures of the TPA. What about from a plan sponsor perspective? What internal controls should be in place and what accountability does the plan sponsor have? From a private market self-insured employer plan, the market history still indicates that these types of plan sponsors have very few internal controls. As of this writing, the market still has self-insured sponsored employer benefit plans that have never been audited. In an environment in which benefits are such a high line cost of doing business, simply no excuse exists.

The first question for any self-insured employer is to internally evaluate what role is responsible for negotiating the contract. Next, what role receives the invoices and reports that communicate the expenditures by the TPA and the request for vendor fees? Third, how does the employer representative verify the accuracy of the vendor fees and the expenditures made on behalf of its employees? If double-digit increases are the market trend for employers, they need to get a handle on how their money is being spent. If not, they will continue to be vulnerable for funding waste, fraud, and abuse in healthcare. Note the discussion at the beginning of this book. Waste, fraud, and abuse are generated by all legitimate and illegitimate (organized crime activity) players within the HCC. Finally, can the employer corroborate every monetary transaction noted in the contract? Can the employer audit for any monetary transaction that is not itemized in the contract? If the answer is no to any of these questions, the employer is at a significant risk and is extremely vulnerable to uncontrolled cost management in addition to healthcare waste, fraud, and abuse.

The government-sponsored benefit plans have a head start on auditing.

They audit their TPA vendors on a regular basis, and those audits and investigations have generated results. The concepts are no different than a private plan sponsored program. In fact, employers can learn from the government's audit and investigation activities. For example, if a TPA has been fined for misrepresenting performance guarantees as a government vendor to a Medicaid program, it is plausible for a self-insured private employer who is served by that same TPA to audit for similar issues.

The needs for all benefit plan sponsors are the same; however, the avenues are different. Government-sponsored plans have legislative mandates and

rights for participation in their programs. These mandates address items that are contained within the claim form as well as other cost type reporting activities. This is apart from any other regulatory requirement of Employee Retirement Income Security Act (ERISA) for self-insured employers. With respect to healthcare fraud, it was only the recent updates to Health Insurance Portability and Accountability Act of 1996 (HIPAA) legislations that took the definition of fraud in healthcare to a different level for private plans (Title XI, 42 U.S.C., Public Law 104-191)

HIPAA federalized the crime of healthcare fraud by making it illegal for anyone to knowingly and willfully

- defraud any health care benefit program or to obtain by means of false representations any money or property of a health care benefit program;
- make false statements, which criminalizes any false or fictitious statements in any matter involving a health care benefit program
- embezzle, convert or steal any funds, property or assets of a health care benefit program;
- obstruct, delay, prevent or mislead the investigation of federal health care offenses.

Note the statute's use of the term "health care benefit plan." It does not stipulate "government-sponsored benefit plan" or "privately sponsored employer benefit plan." The federal statutes cover "a health care benefit plan." With this in mind, take a look at these cases:

Payer Case #1 Conviction

On May 2, 1997, in the Northern District of California, Blue Shield of California agreed to pay \$12 million to settle allegations that it filed false claims for payment under its contract with the government to process and pay Medicare claims. The agreement resolves claims that the San Francisco-based Blue Shield covered up claims processing errors discovered by HCFA auditors in order to obtain more favorable scores under an agency program for grading the Medicare carrier's claims processing capabilities. A *qui tam* suit was filed by former Blue Shield employees in the Medicare division in Chico, and these relators will receive 18% of the settlement amount. This false claims settlement follows a May 1996 criminal conviction of Blue Shield for conspiracy and obstructing federal audits to evaluate the company's performance in the Medicare processing contract. Blue Shield paid a criminal fine of \$1.5

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million when it entered its guilty plea. Blue Shield ceased being a Medicare contractor in September 1996. (U.S. Department of Justice, Health Care Fraud Report, Fiscal Year 1997, www.usdoj.gov/dag/pubdoc/health97.htm)

Payer Case #2: Settlement with Abstract from the Corporate Integrity Agreement (CIA) the section on the Preamble

A. ACPA is a for-profit corporation located at all relevant times within the Eastern District of Pennsylvania.

B. The United States contends that, from September 1995 through June 1998, ACPA submitted or caused to be submitted claims for payment to the Medicare Program ("Medicare"), Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395ggg, and/or the Medicaid Program ("Medicaid"), Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396v.

C. The United States alleges **violations of the False Claims Act**, 31 U.S.C. §§ 3729-3733, by ACPA from September 1995 through June 1998, based on ACPA's *handling, processing and/or payment of claims submitted by providers (including its failure to process or pay claims in a timely fashion or at all), ACPA's inaccurate reporting of claims processing data to the Commonwealth of Pennsylvania* (including its failure to meet self-reporting requirements and impose self-assessment penalties as required under the managed care contract with the Commonwealth of Pennsylvania) and ACPA's **coverage of home health services to qualified beneficiaries (including its failure to do so)**, hereinafter referred to collectively as the "Covered Conduct."

D. ACPA does not admit the contentions of the United States as set forth in Paragraph C above.

E. In order to avoid the delay, uncertainty, inconvenience and expense of protracted litigation of these claims, the Parties reach a full and final settlement as set forth below..." (www.usdoj.gov/usaopae/News/Pr/2005/jun/ACPA%20settlement%20FINAL.pdf) (emphasis added).

Payer Case #3 Conviction

On July 16, 1998, BCBSIL pleaded guilty to Medicare fraud charges for the years 1985 through 1994 and agreed to pay \$144 million in fines to the federal government, the largest penalty assessed against a Medicare claims processor for fraud. As a result of

its fraudulent activities, BCBSIL received \$1.29 million in undeserved bonuses.

Blue Cross/Blue Shield of Illinois paid a record \$144 million to settle charges that the company had falsified claims and hid files from federal investigators. The company was also accused of turning off the phones to avoid taking calls from Medicare beneficiaries checking on the status of their claims. (www.consumersunion.org/conv/pub/stateilstates/000608.html)

None of these cases represents privately sponsored employer benefit plans—thus the basis for why the audit and detection of healthcare fraud of government programs is one step ahead of privately held employer benefit programs. Yet these are the same entities that are serving the privately held benefit employer sponsored market. Civil litigation has been found among various provider entities and payers. However, most of these cases are settled under the condition of tight confidentiality clauses. As a result, the final issues and their resolution do not become part of the public domain.

A comprehensive data warehouse includes data intelligence of anomalies by sponsored programs. The privately held marketplace has a great deal to learn from the government-sponsored programs. The reverse is also true. Government-sponsored programs have a great deal to learn from how healthcare episodes are processed in the commercial environment. All of these attributes feed the concept of prevention. They also feed the concept of response. What have we learned from detection, investigation, mitigation, and prevention? The next model expands by incorporating market variables into the equation.

The next data analysis series will focus on developing a response data analysis model.

Rebecca S. Busch, RN, MBA, CCM, CFE, FHFMA is President and CEO of Medical Business Associates, Inc and author of Healthcare Fraud Audit and Detection Guidebook. This is an excerpt from "Electronic Health Records An Audit and Internal Control Guide" published July 2008 John Wiley & Sons. She may be reached at 630.789.9000 or bbusch@mbanews.com.

IFRS Accounting and Potential Fraud

By Nitin Bhojraj

Like anyone else who is lucky enough to be a "South Sider," I consider myself a Chicago White Sox fan. That being said, it was at a White Sox game, when I saw someone wearing a Yomiuri Giants jersey that I realized that in six years, forensic accountants throughout Chicago might have to deal with more cases of fraud than they can handle.

Rules of the Game

Many Major League Baseball (MLB) fans are familiar with the characteristics of Japanese baseball that separate its Nippon Professional Baseball (NPB) league from the MLB. For instance, the Zen-like training that the players go through is unlike anything we see in the U.S; and the way controversial calls are dealt with through friendly discussions lasting up to an hour, rather than through screaming matches would never happen in a Lou Piniella/Ozzie Guillen world. Yet perhaps the most interesting differences in the MLB and NPB lie in the differences within the rules themselves.

In the NPB, the strike zone is larger near the batter, and smaller away from the batter. While it is essentially the same size, the effective shift of the strike zone forces Japanese players to develop different hitting stances and styles as compared to American players learning the same skills. This simple difference in one little rule creates a severe difference in how players learn the most basic action of the sport. Ultimately, despite the changes in the rules, players in the USA and Japan have the same goals: get hits and score runs. In the business world, countries have slightly different accounting rules that cause variance in basic financial reporting procedures. However, businesses all over the world have the same goals: make money, and show a profit.

Rules of Business

Within the first week of any Introduction to Accounting course, every student learns that if they want to avoid punishment from the IRS or the SEC, all corporate accounting they do must adhere to the United States Generally Accepted Accounting Principles (US GAAP). From everyday tasks such as recording the purchase of inventory, to large tasks like creating an annual report, all work must be backed up by the established rules of US GAAP.

This may not be the case for very long, however. Today, every country in Europe, and nearly 100 countries around the world require or permit the use of the International Financial Reporting Standards (IFRS, commonly pronounced EYE-furs), the rules of which are administered by the London based International Accounting Standards Board (IASB)¹. In August 2008, the SEC published their "Roadmap to IFRS," which is not a legal mandate, but rather a guide for publicly traded companies on possible deadlines on switching their accounting practices from US GAAP to IFRS. Under the guide, certain U.S. public companies with fiscal years ending on or after December 15, 2014 will have to start adhering to IFRS accounting².

The reason this switch is causing uproar in the accounting world is not because a few specific rules are changing, but rather accounting philosophy as a whole will be changing. US GAAP has a reputation, and deservedly so, on being very rule-based, while IFRS is considered principle-based.

Keith Friedlein- a partner at Wolf and Company, LLP (an Oak Brook, IL based Certified Public Accounting Firm) - states that this is biggest worry when it comes to adopting IFRS. According to Friedlein, "US GAAP is very rule-based, you can pretty much find a rule leading you how to account for something, IFRS is very principled, and there will be a lot of cases where there are no specific accounting standards, this can lead to confusion on how to handle a transaction, and can lead to a company trying to manipulate their bottom line."

One example of the different accounting philosophies is the treatment concerning lease classification. Without getting too deep into the accounting details, when leasing non-real estate assets (such as machinery), a company must classify the lease as either an operating lease, or capitalized lease. Depending on the company situation, classification one way or the other can severely manipulate their taxable income, and thus the bottom line. According to US GAAP, a lease must be classified as capitalized if the term of the lease lasts for 75% or more of the asset's useful life³. Under IFRS, a lease must be classified as capitalized if the term of the lease is a "major part" of the asset's economic life⁴. The question then arises, what is a "major part"? According to Friedlein, situations like these "will lead to a lot of conversation between corporate accountants and IRS auditors."

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Changes in the Game

In the late 1860s, Bobby Matthews perfected a new pitch that would change the game of baseball for years to come. By adding saliva to one side of the ball, Matthews discovered that it would turn sharply to that side just before reaching the batter's box⁵. Today, throwing the "spitball" is illegal, and any pitcher found doing so would certainly be suspended.

While the pitch was originally considered part of the game, the first major crackdown of the spitball came during the 1960s. Sports author Derek Zumsteg commented on this, stating that as the rules about spitballs "became increasingly strict, pitchers moved away from sweat and spit to greasier substances that could be smeared on their uniform. Now, instead of licking their fingers, they'd tug on a section of their jersey and come away with a little bit of Vaseline on their fingers to serve the same purpose"⁶. Throughout the history of baseball, rule changes aimed at improving the integrity of the game often result in rogue players figuring out new cheating methods.

Changes in the Law

When it comes to accounting scandals, the first company that comes to nearly everyone's mind is Enron. In the 2005 documentary "Enron: The Smartest Guys in the Room," the film-makers show how energy traders and marketers at Enron were able to take advantage of California deregulation laws to cause blackouts, drive up the price of energy, and sell it to the state. Whether or not the laws themselves were to blame is not necessarily the issue. The important lesson is that while California was attempting to adjust to their new deregulation laws, Enron officials were able to act quicker, and expose the uncertainty during the transition for their own immoral profit.

An IFRS Transition

Keeping in mind the challenges of a transition period, the question comes up, What will happen when public companies are required to switch their accounting methods from US GAAP to IFRS? Also, will we have a massive upswing in accounting fraud? Will accountants across the nation riot or panic? Dr. Barry J. Epstein, PhD, CPA, a partner at Russell Novak and Co., who also runs ifrsaccounting.com, an online tool for learning about IFRS, does not think so.

According to Epstein, "While there may not be a rise in fraud, there may be a rise in allegations of fraud...It only takes \$500 to file a lawsuit. So people

who are confused, angered, or disappointed by financial statements after the changeover may make allegations of fraud." While Epstein believes that fraud allegations will rise, he does not think that all the accusations will result in proven fraud convictions. The danger, if there is a rise in baseless fraud accusations for companies, is the ongoing legal battles they might face. "When you are sued, it costs you money whether you win or lose," says Epstein.

Those opinions are seconded by Elizabeth Kowalski, CPA, CFE- a fellow Russell Novak and Co employee, and a Manager in Litigation and Forensic Accounting. "I think ten years ago, people believed that IFRS would never happen here, but it seems that within the last year, corporations have been realizing that this is real...and practitioners are getting up to speed, so by 2014, we might be okay."

Kowalski also believes that ultimately, this transition is not a question of 'if' but 'when', and when it occurs, accounting fraud will still be present. "If somebody wants to get around the rules, whether it is US GAAP or IFRS, they are going to get around the rules...If stock option backdating is your intended mode of deception, you are going to figure out how to do it [with either accounting system]."

An IFRS Specific Fraud

It seems that neither US GAAP nor IFRS are safe from fraud. Epstein recounts how nearly five years ago, some Europeans blamed our rule-based system for the failures of Enron and WorldCom, and claimed that if we had principle-based system like IFRS, this would not have happened. "A year later, Parmelat, Royal Ahold, and other European frauds showed that [fraud] has nothing to do with principles vs. rules, it has to do with whether or not people follow the rules that already exist," commented Epstein. Under IFRS, firms like Parmelat and Royal Ahold were still able to invent fake assets, create non-existent bank accounts⁷, and incorrectly write-off allowances⁸.

Off-Season Training

While we may not know what exactly will happen with an IFRS changeover, the future does not necessarily look so bleak. Provided all of us who will be affected take advantage of the lag-time, and do the appropriate research into IFRS accounting methods, we can avoid any last minute confusion, prevent potential fraud, and avert all unnecessary fraud accusation. And after doing so, if there is

some extra time, we can sit and watch some Japanese baseball.

Nitin Bhojraj is currently pursuing his Masters in Accountancy at the Loyola University Graduate School of Business. Questions and comments can be sent to nitin1217@gmail.com.

(Endnotes)

- ¹www.sec.gov/news/speech/2008/spch082708cc_ifrs.htm
- ² SEC Release NOS. 33-8982; 34-58960; File No. S7-27-08]. Roadmap for The Potential Use of Financial Statements Prepared in Accordance with International Financial Reporting Standards by US Issuers. Available at kpmgifs.institute.com.
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- ⁷ Landler, Mark, and Daniel Wakin. "The Rise and Fall of Parma's First Family." *New York Times* January 11, 2004: Section 3; Column 4
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The Unethical Entrepreneur

The makers of a prosthetic penis to help men cheat on drugs tests have pleaded guilty to two charges of conspiracy in a US federal court.

The two men, George Wills and Robert Catalano, had been selling the device - known as the Whizzinator - over the internet for three years.

The device was sold with a heating element and fake urine to help people test negative for illegal substances.

They could face up to eight years in prison and a \$500,000 fine.

The men ran an internet company known as Puck Technology, which between 2005 and 2008 sold the Whizzinator and a similar device, known as Number One.

"The Whizzinator is the ultimate solution for a drug testing device," says a statement on the website of the California-based company, which calls itself the "undisputed leader in synthetic urine."

"The prosthetic penis is very realistic and concealing is simple, while our quality production and materials assures you that the Whizzinator will let it flow again and again, anytime, anywhere you need it!"

Mr. Wills and Mr. Catalano appeared before a federal court in Pittsburgh, and are scheduled to be sentenced in February.

Source:

<http://news.bbc.co.uk/2/hi/americas/7747833.stm>

ACFE Greater Chicago Chapter Upcoming Events - 2008-2009

December 9
Tuesday
Chicago Chapter Annual Holiday Luncheon
Location: Maggiano's
Banquets- Chicago, IL
Presented by: Lawrence Oliver II,
The Boeing Company

February 13
Friday
Guest Speaker: TBD
Location: Robert Morris
College, Chicago

March 4-6
Wed-Fri
National Training
"Legal Elements of Fraud" &
"Professional Interviewing Skills"
Location: AMA Conference
Center, Chicago

The above events are tentative. For information, visit www.acfechicago.org or call the Chapter Administrator at 815-NO FRAUD

Patient Advocacy: Combating Fraud by Creating Conscientious Consumers

By A.R. Graham McNally

A year after Lind Weaver, a 56-year-old retired school teacher, found out she was a victim of medical identity theft, she was spending 40 hours per week trying to identify errors in her medical records and reverse the fraudulent hospital charges billed to her name. Weaver discovered that an identity thief used her name to obtain care and sent bills to her insurer. While 200,000 instances of medical identity theft were estimated in a 2003 federal report, many patients, unlike Weaver, probably never find out that they are victims of fraud – unless they receive a hospital bill or query from their insurer. Medical identity theft can cause victims to be exposed to a greater risk of injury or even death if doctors make treatment decisions based on bad information and can jeopardize careers and insurance coverage as health information is often used to make determinations on hiring, promotions and benefit decisions.¹

Medical identity theft is just one of the many serious issues facing our healthcare system today. Several attempts at healthcare reform since the turn of the 20th century have failed to assemble a suitable US healthcare system and fraud, waste, abuse and errors remains a significant concern in the marketplace. Many industry stakeholders agree that the key to managing, controlling and reducing the cost of healthcare lies in the hands of our patients. Similarly, patients can play a vital role in preventing medical fraud, waste, abuse and errors. But are our patients ready and equipped to help?

Analysts that promote “patient centric healthcare” opt to shift the responsibility of care to our patients, placing them in charge of their own well-being. Of course our patients are ready to adopt new technologies that will enable patients to become more engaged in their healthcare experience. People have been changing their behavior to adapt to new technologies (e.g. the wheel, the ATM, the Internet, the Smartphone) throughout the history of mankind. The question is whether our patients have the ability to derive benefit from our technological advances to protect their information and make better, more informed healthcare decisions.

That the provision of healthcare in our country is complex is an obvious understatement. One episode of healthcare can be affected by several market

participants (e.g. physicians, dentists, nurses, hospitals, pharmacies, benefit plan sponsors, insurance companies, third party administrators, pharmacy benefit administrators, durable medical equipment manufacturers, pharmaceutical manufacturers, ambulatory surgical centers, laboratories, nursing homes, lawyers, and, of course, patients, etc.) and each of the contractual relationships among them. Complicating matters is the fact that the flow of information between and among parties in our current health system infrastructure is fragmented. Fragmented information can lead to fraud, waste, abuse and errors – as well as delayed treatment, limited care options, denied care, substandard care, and poor health decisions.

We do not just throw our children in the pool and expect them to swim. To create conscientious consumers, our patients need to be taught to become informed healthcare consumers capable of making sound healthcare decisions and coached to recognize fraud, waste, abuse and errors. We need resources to help our patients access, understand and apply information relating to their care.

Access

We need to provide our patients with access to information about their healthcare. Fortunately, today’s technological advances have paved the way to virtually 24/7 access to information through a variety of mediums. Countless organizations have created websites containing comprehensive trustworthy clinical reference material to help patients find quality clinical healthcare information. Clinical information however only addresses one piece of the healthcare puzzle.

Let us not forget that providers cannot deliver care without financial and administrative services (and that financial and administrative considerations often affect patient treatment plans and options). If we want our patients to be conscientious consumers of healthcare, then not only will they need to understand the content of their treatment plan but they will also need to understand how it will be paid for and how it will be administered. Imagine “Joe the Mechanic” wants to buy a new car. Just because “Joe” knows how engines, steering, suspension and transmissions work does not mean that he can recognize the best price or lease option. Similarly, a patient who experiences hip failure and is fully informed of the clinical facets of hip operations does not necessarily know which treatment would be in

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his or her best interest due to financial and administrative complications.

It is also vital for our patients to have access to the financial and administrative information that relates to their care, such as bills and insurance policies and procedures. As we continue to develop and update clinically related healthcare information, we desperately need to invest in the development of informational repositories that unravel the complex business of healthcare finance and administration for our patients.

Unlike shopping for mass produced cars, the purchase of healthcare is a uniquely personal endeavor. While the right car often does depend upon personal preferences, the right care depends upon the patient's own body and his own insurance coverage. Therefore, although access to general healthcare information is important, access to *patient specific* healthcare information is critical for patients to recognize fraud, waste, abuse and errors as well as making sound healthcare decisions related to their care. Thanks to the world of information technology and emerging Personal Health Records (PHRs), patients can have comprehensive and secure access to their own healthcare information. The best of today's generation of PHRs enable patients to effectively manage and control their complete healthcare experience – clinical, financial and administrative.

Understanding and Application

Once our patients have the ability to access to the necessary healthcare information, then they will need to understand and apply this information. Medical schools are highly competitive educational institutions but let's face it; one does not need to attend the French Culinary Institute to bring the right pie home for Thanksgiving dinner and our patients certainly do not have to be doctors to recognize anomalies in their care and make informed healthcare decisions. To bring the right pie home for Thanksgiving dinner, one needs to understand the type of pie he (and his guests) wants, how he is going to pay for it and how he is going to get it from the bakery to his home. By way of analogy, our patients need to understand the type of procedure or service they want, how their care is going to be paid for and how it is going to be administered.

Understanding and applying healthcare information will undoubtedly be more challenging for some patients than others – depending on factors including

the complexity of care and any financial considerations or administrative stipulations. As we shift responsibility to our patients and place the responsibility of managing their own healthcare experience in their own hands, we must provide the necessary support to make our patients conscientious healthcare consumers. We must help them understand and apply relevant general and personal information to make effective healthcare decisions.

Patient advocacy is the vehicle that will lead our patients to recognize anomalies and make informed, sound healthcare decisions. Resources that help patients know where to look, what to ask and what to avoid will strengthen our patients' capacities to be a conscientious healthcare consumers.

Government agencies such as California's Office of the Patient Advocate (OPA) and Connecticut's Office of the Healthcare Advocate (OHA) that aim to empower patients with information and education about their rights and responsibilities as healthcare consumers are on the right track. OPA represents "the interests of health plan members" in California "to get the care they deserve" and promotes "transparency and quality health care." It primarily involves itself in consumer education about "first steps" and HMO/PPO complaints, public reporting and collaboration with patient assistance programs.² OHA protects "the interests of covered persons under managed care organizations health plans in Connecticut, educates "consumers about their rights and how to advocate on their own behalf," and assists "consumers in understanding and exercising their rights."³

Organizations devoted to consumer education and advocacy that can help resolve patient concerns (as well as help identify concerns patients should recognize) are necessary for a successful patient centric healthcare system. We need organizations with dedicated patient advocates to listen to concerns, respond to complaints, explain policies and procedures, and to provide information to resolve conflicts. A competent patient advocate would need to understand different types of benefit plans, read and apply information contained in medical records, and have proficient interpersonal, communication and computer skills.

The complexities of healthcare have created an environment in which it has become too easy for patients to become susceptible to fraud, waste, abuse and errors or simply overwhelmed by our

healthcare system. To create conscientious healthcare consumers, our patients not only need access to general and personal clinical, financial and administrative healthcare information but also access to patient advocate resources that will help them understand and apply this information effectively. With the right resources, medical identity victims like Weaver will be able to detect, mitigate and even prevent fraud, waste, abuse and errors and our patients will learn to become their own best advocates.

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(Footnotes)

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wishes you and your family a joyous holiday season.*