AN ALERT FROM THE BDO CENTER FOR HEALTHCARE EXCELLENCE & INNOVATION

# BDO KNOWS: HEALTHCARE

# DOJ RAMPS UP ACTION AGAINST FRAUD IN HEALTHCARE

## Why ASC 606 Elevates Industry's Risk

**The Department of Justice (DOJ) has sent a message: It's not backing away from efforts to eradicate and penalize fraud in the healthcare industry anytime soon.**

On July 13, Attorney General Jeff Sessions and Department of Health and Human Services (HHS) Secretary Tom Price announced the "largest ever healthcare fraud enforcement action." The Medicare Fraud Strike Force charged more than 412 people for about $1.3 billion in false billings, including those for the prescription and distribution of opioids. This comes just over a year after the June 2016 healthcare fraud takedown that resulted in charges against more than 300 individuals to the tune of $900 million.

Underscoring its intentions to ramp up action against fraud, in early August, Sessions debuted a new pilot program within the DOJ focused on opioid fraud and abuse detection. Sessions said the unit will work in conjunction with the Federal Bureau of Investigation (FBI), Drug Enforcement Agency (DEA), HHS, and other state and local partners to identify and prosecute providers engaged in opioid-related healthcare fraud.

### WHO WAS CHARGED, AND HOW WAS THE FRAUD DETECTED?

The 412 individuals charged in July included, according to the *Washington Post*, 115 doctors, nurses and other licensed medical professionals. The operation spanned at least 30 states and involved more than 1,000 law enforcement agents. Among the 412 individuals charged, more than 120 were charged with opioid-related crimes, including one clinic exchanging prescriptions for cash and a Florida drug rehabilitation clinic that billed the government for more than $58 million in fraudulent tests and treatments. HHS also initiated suspensions against 295 providers. Sessions said the investigation was spurred by "computer programs that identify outliers" as well as tips from affected communities.

While this case is notable in its reach and severity, providers can find themselves subject to new fraud risks under value-based reimbursement, whether intentional or not, as FASB Accounting Standard Update (ASU) 2014-09, or *ASC 606, Revenue from Contracts with Customers*, takes hold and the DOJ simultaneously puts more resources behind detecting and prosecuting healthcare fraud.

### HOW DO I GET MORE INFORMATION?

For more information about how healthcare organizations can mitigate fraud risk, contact:

**STEVEN SHILL**
Assurance Partner and National Co-Leader, The BDO Center for Healthcare Excellence & Innovation
714-668-7370 / sshill@bdo.com

**VENSON WALLIN**
Managing Director, The BDO Center for Healthcare Excellence & Innovation
804-614-1188 / vwallin@bdo.com

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## WHERE ASC 606 COMES IN

As we've discussed on our blog before, compliance with the new revenue recognition literature (ASC 606) could be particularly challenging for healthcare organizations, as it takes effect at the same time that value-based reimbursement initiatives under Medicare take hold. There's also a layer of added compliance scrutiny of how healthcare organizations operate.

Healthcare organizations already struggle to use comparable revenue measures across a variety of provider types and structures. When trying to represent such diverse revenue streams in financial statements, healthcare organizations will need to be careful to include appropriate supplemental disclosures and discussions to avoid inadvertently presenting misleading information.

Inappropriate reporting could result in retroactivity, which in turn results in recovery of funds from federal or state programs that the provider was not entitled to receive. It could, in fact, hide situations where retroactive reconciliation could call for the repayment of funds to federal or state programs. The underlying complexity of ASC 606 may make fraud and abuse or pure financial fraudulent reporting situations more difficult to detect, or even cover them up entirely.

Revealing fraudulent financial reporting may, in some cases, reveal fraud and abuse situations in turn. In many cases, fraud and abuse situations are discovered by chance by external auditors examining a contract who discover inappropriate financial reporting. For example, inappropriate revenue recognition or deferral can sometimes be used to cover up the existence of kickbacks for referrals or inappropriate payments to vendors. Such situations only become evident when auditors break apart the revenue streams and evaluate the contacts under financial accounting rules in accordance with Generally Accepted Accounting Principles (GAAP). This sometimes goes down to the granular level of tracing debits and credits through the general ledger.

## ADDED DUE DILIGENCE NEEDED DURING M&A

Fraud discoveries can also be made during mergers and acquisitions during the adjustment phase. For example, consider a scenario in which an acquirer discovers financial algorithms written by the acquired company that excluded certain transactions, resulting in overpayment from the federal government under Medicare. In addition to fraudulent reporting, there's also a question of liability for the acquirer, in accordance with existing reps and warranties pursuant to the purchase agreement.

Particularly on the minds of regulators are non-GAAP reporting measures used by publicly traded healthcare entities. Non-GAAP measures are growing more common: Just under 6 percent of companies in the S&P 500 closed their books in 2015 using only GAAP measures. While non-GAAP measures like EBITDA can be helpful in presenting a financial picture that sustains investor interest and confidence, when such measures stray toward potentially misleading information, they can put organizations at risk of violating anti-fraud provisions of securities laws.

For publicly traded healthcare entities, misleading reporting could include practices like presenting a non-GAAP measure inconsistently between reporting periods, providing undue prominence to non-GAAP measures or selectively editing data. For healthcare, the risk is arguably greater, as organizations must take care of how they report relative to the rules of the relevant Medicare or Medicaid program for which they seek reimbursement.

The increased scrutiny on financial measurement brought on by changing revenue recognition standards coupled with a doubling-down of fraud enforcement by the Department of Justice necessitate extreme caution for healthcare. Healthcare entities should use non-GAAP measures cautiously and ensure consistency with SEC guidance and rules.

*Read more about the implementation of ASC 606 **here**.*

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