

TITLE: Fraud Prevention and Detection Program

IDENTIFIER: S-FW-LD-1008

EFFECTIVE:

APPROVED: Executive Cabinet 09/07/10

 Acute Care:ENC: 09/10GH: 09/10

ORIGINAL FORMULATION: 11/03

LJ: 09/10MER: 09/10

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 SHAS:09/10 SMF:SC: 09/10SCMC: 09/10CSC: 09/10**KEYWORDS: Financial Irregularity, Fraudulent, Misappropriation, False, Misleading, Fictitious, Kickback, Overstate****I. PURPOSE**

The Scripps Fraud Prevention and Detection Program was formalized to recognize the need for and to establish mechanisms for prevention, detection, and investigation of fraudulent activities at Scripps Health. This policy, as a component of the overall Scripps Fraud Prevention and Detection Program, establishes the key requirements necessary to monitor for fraud, identify and report incidents of fraud, and investigate fraudulent activities. A formalized and implemented process results in prompt, thorough investigations and action plans to resolve potential fraudulent activity and financial irregularities.

II. DEFINITION

Fraud: Fraud is any intentional deception that results or could result in the loss or devaluation of an asset or something of value to Scripps Health. There are many types of fraud, but they all share the act of intent as opposed to something that occurs due to an error. Some frauds are perpetrated through misrepresenting or falsifying documents, often called false accounting or financial irregularity, while others are perpetrated through the taking of goods or services or loss of assets. These frauds are typically perpetrated against an organization by one of its own employees, vendors, or contractors for their own direct benefit. Insurance and billing fraud is a type of fraud that may be perpetrated by individual(s) against an outside organization for their own direct or indirect benefit. Fraud is often times referred to in conjunction with the term "white collar crime". Embezzlement is also a common term used and is a type of fraud. See Attachment A for specific examples, types and further definition of fraud.

Fraud Incident Team (FIT): Standing committee comprised of the Corporate VP - Chief Audit, Compliance & Information Security Executive, a designated Legal Office representative, and a designated Human Resources Director. These three individuals will convene an incident specific oversight group that will also include the Business Unit Administrator (or their designee) responsible for the employee or area under review and the HR Director for the impacted business unit. For situations where the subject of the inquiry is a member of the Medical Staff, the Chief Medical Officer and responsible Chief of Staff will be included in the incident response team.

III. POLICY

- A. The Fraud Prevention and Detection Program provides comprehensive organizational direction for the prevention, detection and investigation of activities that may be considered fraud against Scripps Health and establishes the following:
 - 1. Serves as a guide for Audit & Compliance Services to identify and establish specific antifraud-related internal controls and methodologies for continuous auditing and monitoring of business activities.
 - 2. Implementation is intended to achieve unbiased and independent investigations, maintain confidentiality, expedite the investigation process by trained personnel, and address corrective actions with consistency across all business units.
 - 3. Compliance with the program and associated requirements per this policy is an expectation of all individuals providing service for or on behalf of Scripps.
- B. It is Scripps policy that all significant fraudulent activities will be reported to outside law enforcement agencies and that Scripps will cooperate in the prosecution of those who commit fraudulent acts against the organization and to pursue civil restitution where applicable. Audit & Compliance Services in consultation with Legal department will determine whether and when a reported incident will be referred to outside law enforcement agencies.
- C. All parties must handle reporting and investigation of an alleged fraud or financial irregularity in a confidential manner until determination of the relevant facts and final Scripps Health action. After this determination, Scripps Health reserves the right to make disclosures as necessary.

IV. RESPONSIBILITIES

- A. **Members of the Scripps Health community:** Including employees, medical staff, volunteers, vendors, and contracted parties have a responsibility to immediately report known or suspected fraudulent activities to the Director of Internal Audit, or to the Scripps Compliance Alertline at 1-888-424-2387. Incidents or items that should be immediately reported include, but not limited to the following:
 - 1. Known fraudulent activities regardless of the value of the loss.
 - 2. Cash, check or credit card discrepancy or questionable transaction of \$500 or greater.
 - 3. Missing fixed assets or supplies with a value of \$5,000 or greater.
 - 4. Any questionable transaction or issue involving a supervisor-level employee or higher.
- B. **Directors, Managers and Supervisors:** Maintain an adequate system of internal controls by:
 - 1. Properly segregating job duties.
 - 2. Limiting and controlling access to enterprise and departmental information systems.
 - 3. Continuously monitoring business processes for unusual items or activities and reporting known or suspected frauds and financial irregularities or loss of assets.

4. Reporting discovered or suspected fraudulent activity to Internal Audit and not initiating investigations on their own.

C. Audit & Compliance Services:

1. Maintain the Scripps Fraud Prevention and Detection Program which includes (a) the Fraud Incident Response Team process and procedures; (b) education and awareness of antifraud safeguards; (c) continuous antifraud auditing; (d) periodic fraud risk assessments; (e) periodic reports to senior management and the Audit Committee of the Board on the activities of the Scripps Fraud Prevention and Detection program; and (f) annual plan review and update.
2. Conduct ongoing auditing and fraud detection reviews: Audit & Compliance Services conducts routine fraud detection and continuous auditing reviews within key business areas where there exists the potential for financial loss due to fraud, financial irregularity, processing errors, or control deficiencies. At a minimum, the following business areas will be subject to routine fraud detection and continuous auditing with follow-up performed accordingly:
 - a. Procurement & Acquisition of Goods & Services
 - b. Accounts Payable & Cash Disbursements
 - c. Payroll & Employee Benefits
 - d. Patient Accounting & Billing
 - e. Financial Reporting
 - f. Information System Security & Privacy Security Events and Logs
3. Notify applicable internal Scripps departments of any required remediation identified as a result of an investigation or review.

V. PROCEDURES

- A. **Monitoring Department Activities:** Business unit and department level management must:
 1. Review various weekly and monthly cost center revenue, expenditure and labor reports.
 2. Validate and understand reasons for unusual variances.
 3. Perform periodic accounting for assigned assets.
- B. **Reporting Fraud or Financial Irregularity:** Notify Internal Audit immediately to evaluate instances of suspected or documented fraudulent activity as soon as the manager / supervisor discovers that an incident or suspected irregularity exists. Reference the criteria in Section IV. A as guidance for evaluating reportable occurrences.
 1. Any incident involving theft or loss of information (data), electronic or paper, computer or biomedical equipment (i.e. laptops, medical equipment, etc.) must be reported to the IS Helpdesk (858-678-7500) immediately upon awareness of such incidents. The IS Helpdesk will notify Internal Audit of the incident.
 2. A person who discovers the alleged fraud or irregularity may choose to report the issue to Audit & Compliance Services directly or through the Scripps Compliance & Patient Safety Alertline (1-888-424-2387) if they are not

comfortable reporting an issue to their management or wish to remain anonymous.

3. Once an activity is reported to Internal Audit, recognize that all further investigation activities will be conducted and coordinated by Audit & Compliance Services.

C. Investigation of Suspected Fraud

1. Supervisors, Managers, Directors, and authorized HR personnel are limited to determining whether the situation has risen to the level of an incident that should be reported to Internal Audit according to this policy and must not investigate on their own.
2. Audit & Compliance Services will determine if the reported issue is significant enough to warrant convening the Fraud Incident Response Team or, if minor in nature, initiating an investigation or requesting the business unit management to review the matter and report back results.

D. Notifications and Written Reports

1. If there is sufficient evidence (established through documentation and interviews) of impropriety, the preliminary findings will be immediately communicated to the Fraud Incident Team and Business Unit Administrator. If the nature or magnitude of the issue warrants, the Corporate Executive VP, Chief Financial Officer; the Corporate Senior VP, Innovation, Human Resources & Performance Management; Corporate Senior VP, General Counsel; and the Corporate Senior VP, Chief Medical Officer (where appropriate) will also be notified.
2. Once the investigation is complete, findings will be reported to the Fraud Incident Team, convened for purposes of the specific investigation to confirm whether the scope of the investigation was sufficient and to determine appropriate corrective actions.
3. Audit & Compliance Services is responsible for communicating investigation outcomes to Corporate Risk Management, other department(s) or the Board of Trustees, as appropriate given the specifics of each investigation.

E. Internal Disciplinary Action: The Business Unit Chief Executive, in concert with Human Resources, is responsible for disciplinary action, if such action is warranted, in accordance with Scripps policy. The Fraud Incident Response Team has responsibility for concurring that any planned disciplinary action is appropriate and consistent with similar previous incidents, given the circumstances.

F. External Referral

1. General Counsel and the Corporate Vice President - Chief Audit, Compliance & Information Security Executive will determine whether an external referral of an incident is warranted such that Scripps should refer the matter to the District Attorney or responsible regulatory agency.
2. When a decision is made to refer a matter to external authorities or agencies, this referral must be done by the General Counsel's Office or the Corporate Vice President - Chief Audit, Compliance & Information Security Executive, as appropriate.

VI. RELATED POLICIES

- A. Scripps Compliance Program; S-FW-LD-1003
- B. Information Security Incident Reporting and Response; S-FW-IM-3005

VII. RELATED POLICIES

- A. [Scripps Standards of Conduct](#); Form Number: 100-8631-105,
[Scripps Standards of Conduct \(e-Guide\)](#)

VIII. ATTACHMENTS

Attachment A: Definitions

IX. SUPERCEDED

Formerly titled: "Antifraud Program: Incident Identification, Reporting & Investigation";
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Financial Irregularity: The purpose of a financial irregularity is to present the financial results and dealings of an organization in a better light than the reality. This is often done by overstating assets or understating liabilities or misrepresenting departmental budgets to reflect a financially stronger department, business unit, or overall organization. It includes any intentional misstatement, inclusion, or omission of information related to financial transactions or internal or external reporting that is inconsistent with applicable Scripps policies, laws and regulations or is otherwise detrimental to the interests of Scripps Health.

Loss of Assets: Loss of assets involves the theft or misappropriation of anything of value to an organization. Misappropriation of assets can be accomplished in a variety of ways including direct theft of cash or realizable assets, making false expense report claims, falsification of time card reporting, diverting payments or creating fictitious payroll employees or causing an organization to pay for goods and services not received. Loss or misappropriation of assets is often accompanied by false or misleading records or documents in order to conceal the fact that the assets are missing, and may indirectly cause accounting errors or irregularities in the financial statements. Loss of assets may be the result of collusion among individuals, which can result in receiving kickbacks or commissions from suppliers, or intimidation from third parties to disclose information or process inappropriate transactions.

Insurance and Billing fraud in healthcare and related industries will include a number of areas and varies widely in its nature. It includes, but is not limited to: overstated claims, multiple claims, and claims where service is never provided. It also includes obtaining coverage for assets on favorable terms on the basis of false information, destruction of assets to claim on insurance and deliberately under-insuring to reduce premiums, and false claims for losses that never occurred.

Statement on Auditing Standards No. 99 (SAS 99): The financial statements of Scripps Health are required to be audited each year by an outside independent accounting firm. These outside accounting firms rely on Statements on Auditing Standards as one basis to perform their audits and form an opinion on Scripps financial statements. SAS 99, Consideration of Fraud in a Financial Statement Audit, is a standard that places additional obligations on organizations to account for their processes and activities and their external auditors to look for fraud throughout the entire external audit process.

The standard defines fraud as an intentional act that results in a material misstatement in financial statements. There are two types of fraud considered: (1) misstatements arising from fraudulent financial reporting (e.g., falsification of accounting records) and (2) misstatements arising from misappropriation of assets (e.g., theft of assets or fraudulent expenditures). The standard describes the fraud in terms of a fraud “triangle” or three conditions which are generally present when fraud occurs. These three conditions are as follows:

1. Incentive or pressure that provides a reason to commit fraud;
2. An opportunity for fraud to be perpetrated (e.g., absence of controls, ineffective controls, or the ability of management to override controls.); and
3. Individuals committing the fraud possess an attitude that enables them to rationalize the fraud (motivation).