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# Strategies to Prevent Medicare Claims Fraud Committed by Speech Pathologists

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This is to certify that the doctoral study by

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## Abstract

Fraudulent business activities have the potential for adverse business outcomes. Speech pathology business owners who lack a robust fraud prevention strategy may subject their practices to severe civil and criminal penalties. Grounded in Wilhelm's eight-stage fraud management lifecycle theory, the purpose of this qualitative multiple case study was to explore strategies speech pathologist business owners used to prevent Medicare claims fraud. The participants were five speech pathologist business owners from three practices in a western U.S. state who successfully implemented fraud prevention strategies. Data were collected using semistructured interviews and reviewing organization policies and procedures manuals. Three themes emerged using Yin's five-step data analysis process: ethics policies, fraud prevention training, and techniques. One key recommendation is for speech pathologist business owners to ensure billing codes are cross-referenced with therapy notes to ensure the correct billing codes match the services rendered. The implications for positive social change include the potential to increase access to needed care for the Medicare population and reduce potential physical harm to patients.

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# Dedication

I dedicate this doctoral study to my wife and my two kids, Jolie and Mateo. I also dedicate this work to all my teachers and professors that have provided me with the guidance and support to complete my academic journey. In addition, I dedicate this paper to all the hard-working speech pathologists working in the field to improve people's lives.

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# Section 1: Foundation of the Study

In 1965, U.S. President Johnson signed into law a federal health insurance program called Medicare, which is for all Americans over the age of 65. In 1972, the government grew the program to include people under the age of 65 who have specific permanent disabilities (Clemente et al., 2018). Before 1965, many Americans were unable to obtain health insurance due to their age, preexisting conditions, or their inability to afford the premiums (Shepard et al., 2020). The Medicare program is paid for by American taxpayers through payroll taxes (Butler, 2018). Americans spend roughly 3 trillion dollars a year on health care services, and the Medicare program accounts for approximately 550 billion dollars of those costs (McGee et al., 2018). It is undeniable that a portion of those costs is the result of fraudulent claims (Meyers, 2017), which impact the safety and integrity of the U.S. health care system.

## Background of the Problem

Medicare fraud, waste, and abuse costs the American taxpayers approximately 60 billion dollars a year and continues to grow (McGee et al., 2018). To mitigate the losses from fraud, U.S. lawmakers have passed legislation to punish fraudsters, grifters, and the corrupt (Kennedy, 2019). U.S. lawmakers have also passed legislation to encourage and reward individuals for reporting incidents of Medicare fraud and abuse. For example, in 2017, U.S. government officials recovered over 2 billion dollars from fraudulent activities due to confidential informant information. These confidential informants (whistle-blowers) can receive up to 30% of the money recovered by government officials (Grubman, 2018). Regardless of the legislative efforts by the U.S. government,

America's health care leaders must continue to identify ways to discourage the ease of overtreatment, excessive waste, and corrupt activities (Buck, 2018). To effectively combat Medicare fraud, health care leaders must immerse themselves in understanding the deceptions and a perpetrator's motivation to commit fraud (Ekin et al., 2018). Consequently, health care leaders must explore and implement adequate training strategies to prevent Medicare fraud and abuse.

## Problem and Purpose

Fraud constitutes approximately 10% of the taxpayer's dollars spent on health care services for Medicare recipients (Clemente et al., 2018). The estimated losses due to Medicare fraud are about 50 billion dollars a year (Herland et al., 2018). The general business problem is that some speech pathologist business owners may not be aware of the resources available to prevent claims fraud. The specific business problem is that some speech pathologist business owners lack adequate training strategies to prevent Medicare claims fraud.

The purpose of this qualitative multiple case study was to explore adequate training strategies some speech pathologist business owners use to prevent Medicare claims fraud. The target population consists of five speech pathologist business owners from three speech therapy clinics in California with successful experience in preventing Medicare claims fraud. Speech pathologist business owners can use the outcomes from this study to develop strategies to potentially mitigate Medicare fraud. The implications for positive social change include reducing financial waste, fraud, and abuse, which could

result in giving patients access to necessary treatments and reducing physical harm, such as overtreating patients with unnecessary procedures.

## Population and Sampling

The target population for this study consisted of five licensed speech pathologists who own a private practice or is a principal or partner in a private practice located in California. Participants were found from past conventions, meetings, or networking events and no prior personal relationship existed. The study participants had the role or responsibility of implementing fraud mitigation training techniques. The choice for this population was based on the increased number of licensed speech pathologists entering the field. I initially contacted study participants via telephone and informed them about the study. After the initial telephone call, I sent each prospective participant an email with the consent form attached. I used purposeful sampling to recruit participants who have the appropriate experience and knowledge of the phenomenon. One of the biggest challenges in conducting research is finding people who are willing to participate (McSweeney et al., 2019). I used multiple sources (e.g., interviews and corporate fraud policy and procedures documents) to strengthen the validity of my study.

## Nature of the Study

The three research methods are qualitative, quantitative, and mixed (Baškarada & Koronios, 2018). Using the qualitative method, researchers attempt to answer the *what, why*, and *how* of a phenomenon (Williams & Moser, 2019). I used the qualitative

research method to answer the what, why, and how of the phenomenon under investigation, which is Medicare claims fraud. Quantitative researchers examine concise research questions, hypotheses, and the relationships among variables to analyze the data (Bansal et al., 2018; Yin, 2018). I did not select the quantitative method because I did not examine relationships among variables using statistical analyses through hypotheses testing. The mixed method is a synergistic combination of qualitative and quantitative methods (Khanna, et al., 2021). I did not select the mixed method because I did not use statistical analysis to test statistical hypotheses. I therefore used the qualitative methodology.

For my qualitative study, I had the option of choosing among ethnographic, phenomenological, narrative, or case study designs. The ethnographic design is an exploration of a culture or social group where behaviors and customs are observed to understand the group's norms in their environment (Bartholomew & Brown, 2019), but the focus of this study was not the participants' behaviors and customs in their environment. Phenomenological researchers seek to explore the personal meanings of participants' lived experiences with a phenomenon (Adams & van Manen, 2017), which was also not the focus of the study. Finally, I did not choose the narrative design because researchers use it to explore the account of participants' experiences through personal life stories (George & Selimos, 2018). Case study design is a verifiable and in-depth exploration of the *what*, *why*, and *how* of a phenomenon (Alpi & Evans, 2019). I chose the multiple case study design because the focus was Medicare fraud. Evidence gathered

from a multiple case study is considered stronger and more vigorous than that from single case designs, which is the reason I chose a multiple case study design (Yin, 2014).

## Research Question

What adequate training strategies do some speech pathologist business owners use to prevent Medicare claims fraud?

## Interview Questions

1. In your fraud prevention success, what specific fraud activities did you identify or define as being Medicare fraud?
2. In your strategy to prevent Medicare claims fraud, what specific suspected fraudulent activities did you investigate?
3. As a result of your investigative findings, what were the specific components and schedules of your training program's items to help prevent Medicare fraud committed by speech pathologists?
4. What were the key types of resistance or problems you encountered while investigating or implementing your fraud detection program?
5. How did your organization address the key types of resistance or problems you encountered during your investigations?
6. What specific actions and measures did you implement to detect, identify, and locate fraud before, during, or after the fraud was committed?
7. What types of analysis did you use to measure the effectiveness of your fraud prevention strategies?

8. What specific policies did you implement to address termination and prosecution for Medicare fraud violations committed by speech pathologists?
9. What additional information about Medicare fraud education and training would you like to share with me?

## Conceptual Framework

The rapidly changing regulatory structure and legal environment of the health care system have made it difficult for health care businesses to adapt to the constant changes (Stowell et al., 2018). The fundamental framework for this study is the fraud management lifecycle theory (FMLT). Wilhelm (2004) created the FMLT to detail the flow of the eight stages of fraud management activities for business managers. Wilhelm identified deterrence, prevention, detection, mitigation, analysis, policy, investigation, and prosecution as the eight interconnecting nodes in the fraud management network. Speech pathologist managers effectively implementing and managing the FMLT may reduce the losses due to fraud. I used the FMLT as a lens to evaluate the dynamics and specifics of training strategies that speech pathologists successfully use to mitigate and prevent fraud.

## Operational Definitions

*Medicare fraud:* Medicare fraud is knowingly present or cause to be presented a fraudulent claim for payment to the federal government (Tovino, 2019).

*Protected health information:* Protected health information is any information taken from a medical record that can be used to identify a patient and was created while receiving medical treatment (Bowman & Maxwell, 2019).

*Upcoding*: Upcoding is fraudulent billing for services that are never rendered, using the incorrect code, or diagnosing a patient with a more complex and more expensive diagnosis (McGee et al., 2018).

## Assumptions, Limitations, and Delimitations

### Assumptions

Researchers often view assumptions as facts or truths (Waldkirch, 2020). I assumed that all the answers given to me by my interviewees were factual, truthful, and free from bias. I encouraged my participants to be open and honest during the interview process. I assumed that any documents provided to me by the participants factually represented their company's policies and procedures regarding Medicare fraud prevention strategies. I assumed that all the participants are aware of the Medicare program and have a general knowledge of the rules and regulations of the program. I also assumed that my research could provide a roadmap for speech pathologist business owners to develop strategies to prevent Medicare fraud.

### Limitations

Limitations refer to the potential weaknesses of a study that are out of the researcher's control (Theofanidis & Fountouki, 2018). Speech therapy clinics located in California might not represent the entire speech therapy industry because fraud risks may differ from region to region. The findings from this study may not apply to all speech therapy clinics because some clinics may not see Medicare patients and only accept private insurance patients. Furthermore, the findings from this study may not transfer across groups, such as privately funded health insurance programs.

### Delimitations

Delimitations refer to the boundaries or scope set by the researcher to reach the study's objectives (Theofanidis & Fountouki, 2018). The scope of this research is limited to speech therapy clinics in California that may have experience in preventing Medicare fraud. Furthermore, the data collection process included semistructured interviews with speech therapy business owners and a review of their company's policies and procedures. I rejected observation as a data collection method because it was unlikely for me to witness the phenomenon as it occurs.

## Significance of the Study

### Contribution to Business Practice

The results from this study might be valuable to speech pathologist business owners who may lack adequate antifraud strategies. The findings from this study could contribute to the development of effective training strategies to avoid Medicare fraud and increase business profitability by reducing the loss of revenue. The results from the study could provide speech pathologist business owners with effective strategies to prevent Medicare fraud and thereby improve treatment appropriateness, which could improve process efficiencies and reduce costs.

### Implications for Social Change

Findings from this study might contribute to positive social change by (a) improving access to needed care and (b) reducing potential physical harms, such as ordering too many tests that can lead to harmful courses of treatment. With a reduction in Medicare fraud, the U.S. government officials may have more economic resources

needed to improve access to necessary treatments and allocate funds to other areas of health care that can benefit society. Health care providers significantly affect daily lives; when they abuse that power, they can reduce the quality of our lives dramatically (Ikono et al., 2019).

## A Review of the Professional and Academic Literature

The purpose of this literature review is to provide a critical analysis and synthesis of the literature relating to the potential themes of this study, which was focused on training strategies some speech pathologist business owners use to prevent Medicare claims fraud. The goal is to provide evidence to support the conceptual framework of the research question: What adequate training strategies do some speech pathologist business owners use to prevent Medicare claims fraud? In this section, I will discuss the conceptual framework of this study, which is the FMLT, fraud theories, fraud training strategies, and a brief overview of how Medicare fraud impacts the health care industry.

The strategy for searching the literature in this review was to represent in detail the major themes of my study. I researched peer-reviewed articles between 2013 and 2021 by using the Walden University Library's online multi-database search function. The online databases included ABI/INFORM Collection, ProQuest Central, Sage Journals, etc., contain full-text resources, including peer-reviewed journals, trade publications, business news, reports, and working papers. I used search engines such as Google Scholar and government websites, such as Medicare.gov, to obtain relevant information about the topic. The words and phrases I searched include *Medicare*, *Medicare claims fraud*, *Medicare law and regulation*, *fraud training, Medicare fraud*

*investigation, Medicare fraud prosecution,* and *fraud education.* The total number of references for this study was 232, of which 93% (216) of the references were peer-reviewed journal articles and 86% (200) were published within 5 years of 2022.

**Application to the Applied Business Problem**

The purpose of this qualitative multiple case study was to explore the adequate training strategies some speech pathologist business owners use to prevent Medicare claims fraud. The fundamental framework for this study is the FMLT. Wilhelm (2004) developed the FMLT so fraud management professionals can have a standard definition of each stage in the fraud management lifecycle. Wilhelm suggested that fraud prevention and fraud detection techniques are the bedrock policies managers should use when building fraud mitigation strategies. To have a successful fraud management strategy, managers must understand the FMLT and train employees to manage fraud risk. An adequate training program is an essential element in fraud management (Drogalas et al., 2017). Fraud impacts every business, and a shared understanding of the theories and definitions of fraud would lead to effective communication among managers and organizational leaders to their employees (Wilhelm, 2004). Each stage of the FMLT is independent of the other, but they can occur sequentially and can be linked. The FMLT is made up of eight stages: deterrence, prevention, detection, mitigation, analysis, policy, investigation, and prosecution. Managers must have a thorough understanding of fraud before they can implement a successful training program within their organization.

**Stage 1: Deterrence**

Deterrence occurs when people avoid committing fraudulent acts because the consequences or costs of those acts are too high (Bhattacherjee & Shrivastava, 2018). For example, in criminology, the perception of severity, certainty, and swiftness of punishment plays a crucial role in deterrence (Gonzalez, & Hoffman, 2018). Managers should establish policies and procedures that will deter fraudulent acts in the workplace (Gonzalez, & Hoffman, 2018). Policies and procedures should include the severity of possible violations. The only way to deter crime is with a two-step process (Hurwitz, 2019). First, there should be a minimum sentence for all fraud-related cases. Second, government officials should prioritize prison sentences to individuals that commit or direct acts of fraud. The goal should be to deter individuals from committing fraudulent acts.

Wilhelm (2004) expanded the definition of deterrence to include the element of difficulty. For example, Gonzalez and Hoffman (2018) studied continuous auditing notifications as a fraud deterrence tool. Adding continuous auditing notifications becomes the deterrent because the fraudster must work harder to finish the crime. However, for internal auditing to be effective, auditors must be continuously trained at a very high level (Drogalas et al., 2017). Auditors specifically trained on fraud are more likely to detect fraud versus being trained on general auditing principles (Drogalas et al., 2017).

Further, low self-control increases the likelihood that an individual will commit fraud (Bobbio et al., 2019). Individuals who lack self-control tend to seek risky behaviors

with immediate rewards and do not consider the consequences (Bobbioet al., 2019). For deterrence to work, fraudsters must be aware of the laws and the penalties that are coupled with the crime. If fraudsters perceive that consequences will be swift and severe, fraud rates will go down (Schneiderstarr, 2019). Further, knowledge of punishment risk could be increased if the increased risk is better communicated to the public (Nixon & Barnes, 2019). For deterrence to be effective, policymakers and business managers must include punishment announcements or other punishment related bulletins to deter criminal behavior.

**Stage 2: Prevention**

Fraud prevention refers to the measures an organization's leaders take to stop or prevent an act of fraud from occurring (N'Guilla et al., 2018). Wilhem (2004) described prevention as hindering, checking, or stopping fraud. Business leaders can utilize prevention stage measures to prevent fraud from occurring. N'Guilla et al. (2018) addressed the effectiveness of the following fraud prevention measures: consistent action, positive work environment, internal audit, internal controls, management attention to fraud risk, enforce regulation, fraud awareness training, whistle-blowing, employee background checks, code of conduct, fraud risk assessment, ethical tone at the top, and account verification by professionals. The authors revealed that every manager (126) agreed that the existence of effective preventive measures could make their organizations more profitable and reduce their exposure to fraud. Fraud prevention is relevant within fraud management because it is more cost effective to prevent fraud versus reacting to fraud. However, the researchers discovered a significant gap in the implementation of the

standards. One possible explanation for the discrepancy in implementing preventative policies can be the negligence by owners and managers to enforce policies related to fraud prevention. But managers are not the only employees who should be involved in fraud prevention programs. Employees should also be required to attend fraud prevention courses for consistent refreshers and reminders about fraud (Gunasegaran et al., 2018).

One proactive measure an employer can take to prevent fraud is by conducting background checks on their prospective and current employees. Speech pathologists and speech pathology assistants must obtain a license from their respective states before they can provide treatment to a patient. Applicants must submit a history of any criminal arrests or any criminal convictions (Starr, 2017). In most cases, license renewal dates may require licensed providers to update their background check status at each renewal period. In 2018, more than 31 million American job applicants were required to submit a background check (Denver, 2020). A background check could consist of a criminal records check, professional and personal reference check, employment history, drug history, and education verification. Even if the prospective employer meets all the requirements for the position, there may still be an ethical concern about their character, and managers cannot rely on the results of background checks when they make hiring decisions (Denver, 2020). Ten percent of background checks result in the discovery of a felony or misdemeanor conviction (Sarode & Deore, 2017). However, ex-convicts are likely to re-offend (Holloway & Wiener, 2020). If an employer considers a clean background as a critical element of their fraud prevention effort, a background check on all prospective employees may be necessary.

Regardless of internal controls or training, technological innovations are playing a pivotal role in fraud prevention strategies. Technological tools and equipment can monitor transactions and automating controls as they occur. For example, automation methods can prevent abnormal transactions from occurring in real time. Automated reports or alerts can be useful to managers and employees to prevent fraud in real-time. Technological controls also give managers the ability to restrict individual employees from accessing specific data (Gunasegaran et al., 2018). As a result of technological advancements and the sophistication of fraud, managers must be continuously trained to implement fraud prevention strategies (Gunasegaran et al., 2018).

Employees must also be trained on using government resources to prevent fraud. For example, On June 30, 2016, former President Barack Obama signed the Fraud Reduction and Data Analytics Act (Fambrough, 2019). The purpose of the Fraud Reduction and Data Analytics Act is to provide government agencies with a framework to implement fraud control activities. One control strategy is the implementation of the fraud, waste, and abuse hotline. The hotline provides individuals the opportunity to quickly notify the authorities of any suspected fraud, waste, and abuse. If the information given to the authorities merits an investigation, the material is forwarded to the proper authorities (Fambrough, 2019). The hotline may be used by managers to prevent fraud from occurring (Fambrough, 2019). In addition to the hotline, the framework utilizes data analytics technology to detect abnormal activities using cost-effective, state-of-the-art computer technology. Sophisticated and more aggressive fraud schemes are becoming harder to distinguish. The use of data gives auditors the ability to examine a more

extensive and more diverse set of information versus the tradition of gathering information from managers. By gathering real-life data, investigators can gather more reliable information versus chasing leads from a hotline (Tang & Karim, 2019).

**Stage 3: Detection**

Wilhelm (2004) defined detection as the measures used to identify and locate fraud before, during, or after the fraud has taken place. Detection plays a key role in the fraud management lifecycle because the longer the fraud existence, the less profitable the organization becomes. The three closely related activities in the fraud detection arena are fraud testing, fraud attempts, and fraud success. The purpose of the tests is to reveal any vulnerabilities in detection activities and policies. Using big data processing and machine learning are viable fraud detection mechanisms, helping to discover new information from data sets (Herland et al., 2018; Zandian & Keyvanpour, 2017). Another viable fraud detection method is to examine annual reports through linguistics and natural language models (Chen et al., 2017).

Whistle-blowing is also a vital tool for preventing and detecting fraud (Foxley, 2019; Ugaddan & Park, 2019). Whistle-blowing is an effective way to protect corporations and the public when internal reviews are insufficient (Kenny et al., 2019). Whistle-blowing is the disclosure of fraud, corruption, or abuse by reporting a suspected incident beyond the normal scope of reporting guidelines (Kyu et al., 2018). An example of whistle-blowing is an employee reporting accounting fraud to a media reporter or a law enforcement official. In 2018, the U.S. House of Representatives impeached President Donald Trump after a whistle-blower came forward and reported suspected

wrongdoing by the President in Ukraine. The Senate cleared the President after a brief trial in 2019 (Allin, 2020). However, the American public saw the importance and power of whistle-blowing.

Government programs such as the Sarbanes-Oxley Act encourage whistle-blowers to come forward to detect fraud as the most effective form of deterrence (Labriola, 2017). Under the Sarbanes-Oxley Act, all employers are required to protect whistle-blowers from retaliation. Employers are encouraged to implement anonymous reporting channels, so a whistle-blower's identity will be unknown. However, there is no legal requirement for organizations to protect whistle-blowers (Labriola, 2017). Even with whistle-blower protection, 17% to 38% of whistle-blowers suffered retaliation for coming forward, suggesting that organizations need to do more to protect whistle-blowers (Kyu et al., 2018). For example, in 2004, the United Nations passed regulations to protect whistle-blowers from retaliation (Nwoke, 2019).

**Stage 4: Mitigation**

Mitigation begins when fraud is detected, or suspicious activity is being committed and stopped by the organization (Wilhelm, 2004). There are many health care fraud mitigation programs in place. For example, in 2010, the Affordable Care Act (ACA) received additional funding to implement state-of-the-art predictive modeling technology to advance Medicare fraud strike teams (Clemente et al., 2018). Predictive modeling allows business leaders to use an algorithm made up of several algorithms that score an event on a scale from high to low. Medicare officials send all claims through predictive software to identify claims before they are paid (Clemente et al., 2018).

Mitigation is a key component in the fraud management cycle and managers can use mitigation techniques to limit fraudulent activity and resultant consequences.

The use of enterprise resource planning (ERP) software from vendors like SAP, Oracle, and Microsoft to improve operations through continuous auditing is a fraud mitigation strategy (Messabia et al., 2020). ERP tools such as using internal controls, and accounting reporting measures enable business leaders to implement effective auditing and fraud prevention (Messabia et al., 2020). Management can utilize ERP to increase transparency and add the ability to monitor fraud proactively. Managers can set user controls to influence data, purchases, costs, and capital expenditures throughout the organization.

The problem with ERP software is that it may be expensive and may require expert technical knowledge to work effectively in the workplace. Small health care organizations may not be able to purchase expensive ERP software. Internal controls and fraud prevention programs, as processes created by management, are the first line of defense in preventing and detecting fraud (Kamaliah et al., 2018). Managers are also responsible for putting effective practices in place to stop fraud. It is the responsibility of top management to design, implement, and maintain effective internal control policies (Chen et al., 2018). Organizations must train their employees on fraud mitigation programs and outline the organization's attitude and commitment to prevent and detect fraud. Internal controls establish the roles and responsibilities within the organization and communicate to staff that fraud will not be tolerated, creating a culture that is dedicated to mitigating fraud (Kamaliah, et al., 2018).

**Stage 5: Analysis**

In the analysis stage, managers seek to identify the extent of fraudulent activities despite implementing the first four stages (Wilhlem, 2004). Managers can use the analysis stage to determine the effectiveness of the other steps of the company and customers. The analysis stage allows managers to gather feedback on the performance of the different four stages. The purpose of this stage is to enable managers to interpret data (Wilhelm, 2004). The analysis is a key component of the FMLT because it allows managers to reexamine the effectiveness of their policies and procedures.

The idea of fraud analysis derives from the need to examine the vulnerabilities that result from fraudulent behavior (Eshghi & Kargari, 2018). For example, Liu et al. (2016) analyzed Medicare fraud by using data mining techniques. The researchers concluded that their analysis could be used to enhance the performance of future evaluations and initiate audits and investigations. Managers can use the analytical data derived from the analysis to make informed and rational decisions (Wilhelm, 2004). managers must be able to identify the fraudulent activity as soon as possible and in real-time to maximize the fraud analysis system (Carminati et al., 2018). Fraud detection is a time-consuming activity; managers must balance a manageable level of fraud detecting activities. Fraud analysis means that fraudulent activities must be discovered within milliseconds of the activity (Morar et al., 2019).

**Stage 6: Policy**

Managers use policy as a guideline to create the activities and resources necessary to combat fraud (Wilhelm, 2004). The responsibility to prevent, investigate, and establish

the necessary resources to combat fraud is the responsibility of the organization's leadership (Doig, 2018). In a study conducted by Doig (2018), the author suggested that an appropriate antifraud framework must include clear strategies, a controlled environment, and the ability to measure and evaluate performance. Doig's (2018) research indicated that an organization must fully embrace risk management, internal audit, information governance, and ethical standards to create an antifraud culture.

However, Jalil (2018) concluded that internal controls alone do not affect fraud prevention. Jalil recommended that fraud prevention must have specific steps: First, top management must maintain structured internal controls. Second, executives should review internal controls daily. Third, top executives should be committed to evaluating the performance of employees consistently. Finally, executives should encourage antifraudulent behavior by rewarding employees. Jalil (2018) believed that as well as internal controls, antifraud awareness, and fraud risk assessment are two viable concepts in preventing fraud. Antifraud awareness means that the leaders of the organizations emphasize the importance of fraud prevention to all parties. Fraud awareness has the potential to minimize fraud committed by the manager and employees. The goal of the organization is to protect its employees and its assets (Jalil, 2018).

Employees must do more than follow internal control and participate in fraud prevention activities (Dewi & Ariandi, 2017). In a study conducted by Dewi and Ariandi (2017), the authors suggested that rewarding employees for contributing to fraud detecting behavior could encourage an antifraud culture. Dewi and Ariandi (2017)

believed that organizations must create a culture of honesty and integrity, consistently evaluate antifraud controls, and develop effective fraud control processes.

**Stage 7: Investigation**

Investigation activities involve gathering evidence and information to stop fraud, recovering and restoring assets, and providing material information to prosecute fraudsters (Wilhelm, 2004). These steps give managers the power to properly investigate fraudulent activity. The purpose of a fraud investigation is to give managers the ability to determine if fraud occurred and to pursue the fraudster (McNeal, 2017). To have a successful investigation program, executives must be vigilant, monitor all activities in the organization, and hold fraudsters accountable (Drogalas et al., 2017). Health care related laws passed by U.S. Government officials include the ability to investigate and prosecute individuals for committing health care fraud. For example, in 2007, government officials at the Office of the Inspector General created the Medicare Fraud Strike Force. The program was established to use data analytics to identify and combat health care fraud (Clark & George, 2017). Fraud investigations are a key part of the conceptual framework because investigators must be able to recognize and investigate suspicious activity.

The goal of a fraud investigation is to uncover the facts and reconstruct the past to discover the truth of an event (Gottschalk, 2019). Gottschalk (2019) proposed that utilizing internal or private fraud investigators can prevent fraud from occurring or prevent it from happening again. The primary purpose of a fraud investigation should be to complete a thorough and systematic investigation. The goal should be to discover the possible white-collar crime, any other criminal activity within the organization, and any

vulnerability for future fraud. However, Gottschalk and Tcherni-Buzzeo (2017) contended that white-collar crime, when discovered, is not being reported to law enforcement. Gottschalk and Tcherni-Buzzeo (2017) found that nonreporting of fraud incidents can be as high as 96%.

**Stage 8: Prosecution**

The goal of the prosecution stage is to provide managers with the ability to punish fraudsters, deter future fraudsters, and recover damages (Wilhelm, 2004). The U.S. Government must give the appropriate authorities the powers and abilities to prosecute fraud (Frohock & Jimenez, 2020). In 2007, U.S. Government officials intensified their fight against fraud by creating the Medicare Strike Force. The Medicare Strike Force was initially tasked with targeting fraud hotspots like Miami, Detroit, and Chicago (Crawford, 2017). In May 2009, fraud prevention was designated as a top priority by government officials (Clemente et al., 2018). Government officials created the Health Care Fraud Prevention and Enforcement Action Team to prosecute Medicare fraud. As a result, more than 1400 defendants have been charged with falsely billing Medicare for over $4.1 billion. Additionally, the ACA of 2010 contains stricter rules and harsher sentences for fraud (Clemente et al., 2018). Part of Health Care Fraud Prevention and Enforcement Action Team's mandate was to increase collaboration between the DOJ and HHS to prosecute health care fraud.

Medicare fraud and abuse is a severe problem that can unnecessarily cost taxpayers millions of dollars and puts the recipients' well-being at risk. According to the Government Accountability Office (2017), in 2016, Centers for Medicare and Medicaid

Services (CMS) made improper payments totaling 95 million dollars due to their vulnerability to fraud, waste, and abuse. Griffith (2019) described fraud as acting dishonestly with the intent of making a gain or causing a loss to another person. Unlike private insurance providers, Medicare generally pays all claims and only investigates fraud after it has been uncovered (Pande & Maas, 2013). In 2010, President Barrack Obama passed the ACA, and the legislation contained some antifraud tools.

Medicare fraud prosecution is a problem for lawmakers because it limits tax revenue collections and the effectiveness of laws and regulations (Goel & Saunoris, 2017). According to Gerald Wilson, the Chief of the FBI's Health Care Fraud Unit, upcoding is the most common form of fraud (Miller, 2013). Medicare fraud schemes include billing schemes (upcoding), kickback schemes, and medical identity theft.

**Upcoding**

Upcoding is fraudulent billing for services that are never rendered, using the incorrect code, or diagnosing a patient with a more complex and more expensive diagnosis (McGee et al., 2018). According to CMS (2013), in 2012, upcoding payments exceeded $965 million. A contributing factor to the increase in upcoding is providers picking patients with more profitable health conditions. Specific diagnoses are considered more profitable, and hospitals respond by encouraging certain admissions and treatment plans (Coustasse, 2021). The punishment for committing fraudulent billing includes the revocation of a medical license, fines, or imprisonment (Flasher & Lamboy-Ruiz, 2019).

**Kickbacks**

Kickbacks are another type of fraud that has encouraged legislators to pass numerous laws. Kickbacks consist of receiving gifts, money, or any other form of incentive for patient referrals (McGee et al., 2018). For example, providing potential referral sources free office supplies with unique identifying practice information in exchange for patient referrals. According to the U.S. Department of Health and Human Services (2002), remuneration may be any offer of valuable goods and services as part of a marketing or promotional activity regardless of whether the marketing or promotional activity is active or passive. For example, in 2014 in Kentucky, King's Daughter Medical Center paid $40.9 million for an illegal kickback scheme that involved the hospital and referring cardiologists (Clemente et al., 2018).

**Medical Identity Theft**

Medical identity theft occurs when a patient uses another person's health insurance to receive medical treatment. According to the Federal Trade Commission, over 8 million people have been victims of medical identity theft. In 2008, the Federal Trade Commission required hospital and institution leaders to implement programs to prevent medical identity theft. However, in 2010, Congress exempted many health care providers from the regulation. As a result of the legislative changes, many health care providers have failed to implement identity theft policies or train their staff to recognize identity theft (Sharma & Baweja, 2017).

Medicare fraud cases are complex and successful prosecutions may be difficult. Levy (2018) found that alternatives to traditional prosecutions can lower the incidences

of crime. Levy (2018) discovered that criminal behavior dropped when the prosecution of high profile criminals was used as the model. Levy believed that not every crime should be pursued.

**Fraud Theories**

This section includes a critical analysis of fraud theories and concepts that are common in fraud research that support and contrast with the FMLT. Fraud has become the biggest threat to the global economy, it has penetrated the public and private sector, and no country is protected from fraudsters (Abdullahi & Mansor, 2018). Cases such as Ken Lay from Enron and Bernie Madoff highlight the devastating effects fraud has on organizations and individuals. Political pressure and media coverage of fraudulent acts are motivating individuals to focus more on fraud prevention. It is more cost effective to prevent fraud from occurring than detecting fraud after it has happened (Poquioma et al., 2020). In the case of Bernie Madoff, by the time the authorities discovered the fraudulent acts, the opportunity to recover the victim's funds was gone. To fight fraud effectively, business leaders must understand the motivating factors that can lead to a fraudulent act. Fraud is widely diverse and usually recognized when it is too late. Fraud is a dynamic process that is continuously changing. Fraudsters are becoming more sophisticated and incredibly good at penetrating through multiple layers of corporate procedures. Due to their ability to remain undetected, fraudsters are not easily caught with simple rules or supervision (Eshghi & Kargari, 2019). Combating fraud is a long and expensive process that requires a deep understanding of the acts (Vousinas, 2019). Before managers can reduce incidents of fraud, they must understand and identify the factors that lead to

fraudulent behavior (Said et al., 2017). A fraudster is a person that understands and is capable of exploiting loopholes, regulations, and weaknesses. Intelligent and creative people like Bernie Madoff understand vulnerabilities and can use those vulnerabilities for financial gain.

In 2014, the U.S. spent more money on health care than any other country in the world (McGee et al., 2018). Due to Medicare's size, complexity, and national reach, there are plenty of opportunities for fraud (Krause, 2017). The increases in fraud have prompted government officials to form various task forces and conduct investigative research. Fraud has become a challenge for health care providers, and no organization is entirely resistant to fraud (Azam, 2018). Various fraud theories and social learning concepts in the prevention of fraud include white-collar crime, differential association theory, the theory of planned behavior, FT, fraud diamond theory, and fraud scale theory. The synthesis of each theory plays a key role in implementing training strategies to prevent fraud.

**Fraud Triangle Theory**

Fraud triangle theory (FT) was developed by Cressey in 1953. Cressey studied 250 criminals over five months to determine why people commit a crime (as cited in Abdullahi & Mansor, 2018). Cressey was inspired by Sutherland and built the FT based on Sutherland's work (as cited in Lokanan, 2018). The FT consists of perceived pressure, perceived opportunity, and perceived rationalization (Huber, 2017). An employee working under perceived pressure, regardless of a monetary incentive being present, would likely commit fraud (Huang et al., 2017). Pressure, due to a personal event, is the

motivator or incentive that drives a fraudster to commit fraud (Machado & Gartner, 2018). It is essential to point out that perception is a vital part of the element because the pressure to commit fraud may not be real. It may only be perceived as real to the fraudster (Abdullahi & Mansor, 2018). Perceived opportunity to commit fraud occurs when there are weak internal controls, and a situation for fraud occurrence exists (Azam, 2018). An opportunity arises when there is a low risk of being caught, and the fraudster rationalizes the behavior (Muhtar et al., 2018). Managers and employees with a longer tenure could use their extensive knowledge of an organization to exploit opportunities to commit fraud (Fathi et al., 2017). Abdullahi and Mansor (2018) described opportunity as the weaknesses in the system where the perpetrator has the ability and power to commit the fraudulent act. Organizations need to maintain strong internal controls to stop fraudulent activity from being concealed. Perceived rationalization is a way to legitimize a concept that is typically contrary to a personal belief. The fraudster believes that the act being carried out is, in fact, not illegal. For example, an employee may feel underpaid and justify embezzling money from an employer to make things right. It is impossible to understand why a fraudster rationalizes their behavior unless they are caught and confess to the act. Even with its shortcomings, the FT has become an establishment in auditing standards, academic works, and professional handbooks in the field of fraud prevention (Muhtar et al., 2018).

Muhtar et al. (2018) suggested that FT is a suitable framework for organizational leaders to reveal corruption because FT can expose corruption at an institutional and individual level. The researchers believed that pressure could come from financial, non-

financial, and social-political burdens. Financial pressure may come from high levels of debt, such as student loan debt. Non-financial pressure may come from the desire to promote within an organization. Social-political pressure can come from the desire to be viewed by others as wealthy. Lokanan (2018) described pressure as the incentive that ultimately leads to rationalization procedures used to commit fraud. Said et al. (2018), believed that rationalization is the most significant contributor to fraud. For example, rationalizing the need to pay bribes or give gifts to win contracts. An individual may justify that similar organizations or individuals are paying bribes and must do the same to remain competitive or be successful. Fraudsters know the behavior is illegal or wrong but will convince themselves that it is not. Zuberi and Mzenzi (2019) asserted that fraud could not be committed without the element of opportunity. Opportunity includes the environment that surrounds a fraudster. For example, weak internal controls, company culture, executives with unlimited power, the lack of adequate rules and regulations, and the lack of punishment.

However, FT has been subject to criticism from researchers. Huber (2017) criticized the FT because the FT does not include a section on the cause of fraud. Huber (2017) believed that the FT fails to consider other factors like social and organizational influences. Iffah et al. (2017) asserted that religion is a contributing factor that shapes behavior and influences conduct in the workplace. Iffah et al. (2017) believed that religion is a tool that is used to shape human behavior and impacts human lives. Hauser (2019) concluded that FT's framework fails to address employees that observe fraud or employees that are pressured by other employees to engage in corrupt behavior. FT also

fails to consider cases where fraud controls do not exist, and no fraud is committed. Even though the FT has its weakness and critics, the FT remains the primary foundation for fraud literature (Zuberi & Mzenzi, 2019).

**Fraud Diamond Theory**

The fraud diamond theory by Wolfe and Hermanson consists of four elements underlining the existence of fraud: pressure, opportunity, rationalization, and capability (Avortri & Agbanyo, 2020). Fraud diamond theory is like the FT theory with the additional element of capability. Umar et al. (2017), proposed that pressure is the motivator that drives a fraudster to commit an act of fraud. Pressure creates a situation where an employee must choose to behave rationally or irrationally. Pressure can arise from work problems, personal problems, or financial problems. It is at this point in the fraud diamond theory that the fraudster recognizes the opportunity to commit fraud. An opportunity occurs when people realize that internal controls and monitoring are insufficient, and the act will go undetected. Kumar et al. (2018), suggested that if an employer fails to remove an opportunity to commit fraud, an employee may rationalize the opportunity as an invitation to commit fraud. Capability acts as the catalyst that turns opportunity into reality (Azam, 2018). Hierarchical position, job function, or key position is a contributing trait to an individual's capability to commit fraud, for example, an employee's function in the organization as a cash handler (Avortri & Agbanyo, 2020). Capability means that an individual or organization has the skill coupled with the ability to commit a fraudulent act. Capability is the point in the act where the perpetrator

recognizes the opportunity and acts to commit the fraud. A fraudulent opportunity may be preset for many individuals or organizations.

**Fraud Scale Theory**

In addition to the FT and fraud diamond theory, there is another fraud theory called the fraud scale theory. The fraud scale theory consists of 3 elements that are common to fraud: situational pressures, opportunity to commit fraud, and personal integrity (Abdullahi & Mansor, 2018). Situational pressure is an element of fraud that is caused by an outside force on the person committing the fraud. Situational pressure can come in the form of money or coercion and can happen at the personal level or the professional level (Abdullahi & Mansor, 2018). A CEO may overstate the financial success of the company due to pressure from Wall Street. Fraud perpetrators must also believe there is an opportunity to commit fraud without the fear of being caught. Albrecht et al. (2018) concluded that factors that contribute to the perceived opportunity to commit fraud include weak internal controls and a lack of oversight. Personal integrity is the ethical value we use to determine what we perceive as being right or wrong. A fraudster is a morally corrupt individual with low moral values and does not see anything wrong with breaking the law. Abdullahi and Mansor (2018) suggested that the fraud scale is used to measure the degree of fraud risk. For example, when personal integrity is low and perceived opportunities are high, fraud is more likely to occur

**Differential Association Theory**

In the differential association theory by Sutherland (1939), the researcher proposed that individuals' choices to engage in crime are based on their socialization

within specific groups and the prospect that the benefits of the crime will outweigh the consequences (as cited in Lokanan, 2018). For example, members of street gangs interacting with their criminal peers will perceive criminal behavior as positive and view those behaviors as norms. The theory has two main assumptions: the way criminal behavior is learned, and the information the criminal learned from the process (Lokanan, 2018). Lokanan (2018) believed that the longer an individual is exposed to negative behavior, the more likely the individual will commit the negative act. Exposure to negative behavior can be in the form of direct or indirect contact, for example, mass media (Rahaim & Matusitz, 2020). Lokanan (2018) concluded that individuals either learn positive or negative behavior depending on the behavior to which they are exposed). Rahaim & Matusitz (2020) contended that the DAT may explain how and why people choose criminal behavior. DAT fits in the Medicare fraud category because health care providers that view Medicare fraud as acceptable will infect other health care providers. Their peers will eventually move toward criminal behavior (Lokanan, 2018).

**Convenience Theory**

Gottschalk (2018) believed that convenience is a significant driver of criminal behavior. Convenience causes an offender to think that committing a white-collar crime is more attractive than the alternative when the ability to commit a crime is present (Nolasco & Vaughn, 2019). Convenience can be described in three perspectives: economic, organizational, and behavioral. The economic perspective includes the motive for exploiting the possibilities. Greed is not always a motivating factor. Zabyelina (2017) concluded that motivation is a necessary element, but there must also be an opportunity

to commit a crime. Gottschalk (2018) suggested that the organizational perspective presents the opportunity for an offender to commit a crime. The offender is given access to the resources needed to commit the crime by the organization. The behavioral perspective describes the offender's actions or techniques used to commit the indiscretions.

Menting (2018) believed that criminals are more likely to commit crimes in areas that they are familiar with and provide an opportunity to carry out a successful offense. Area awareness occurs when an employee, including offenders, develops a routine over time. Offenders will spend a significant amount of time in each space. Over time, offenders will gain the ability to search for a suitable target because they have extensive knowledge of the area and the people that come and go from the area. Menting (2018) agreed that knowledge of the area will influence an offender's perception of an opportunity to commit a crime. Opportunities occur when the offender can commit a crime with the confidence that they will not get caught and avoid punishment (Gottschalk, 2018).

**Money, Ideology, Coercion, and Ego**

Money, ideology, coercion, and ego fraud theory contrasts with traditional fraud theories such as the FMLT and FT. Money, ideology, coercion, and ego fraud theory expands beyond pressure and opportunity and includes characteristics like social status, ego, and a culture of competition that drives fraud (Desai, 2020). Wu et al. (2019), found that individuals with high egos are more likely to exhibit dishonest behavior.

Said et al. (2018) suggested that a key piece missing from the FMLT and FT is religiosity. The researchers believed that the desire for worldly needs and adherence to religion controls human behavior. Ward and King (2018) found that religious individuals believe they are committed to prosocial behavior because of religion. Laeheem (2020), concluded that all aspects of religious activity influence ethical behavior.

One major alternative to the FMLT is white-collar crime. The phrase *white-collar crime* was introduced in 1939 by Sutherland. Sutherland described white-collar crime as crimes that are committed by powerful individuals that have high status within their fields (as cited in Crawford, 2017). The term white-collar crime generally includes crimes that are non-violent and are committed for financial gain. Punishments for white-collar crimes, like health care fraud, can be like punishments for violent crimes. Perpetrators can face fines, incarceration, community service, restitution, and paying for the cost of the prosecution. Health care fraud, government fraud, and insurance fraud are among the most common forms of white-collar offenses. The Federal Bureau of Investigations, the U.S. Postal Service, and OIG are all responsible for investigating health care fraud. In 1997, federal prosecutors only filed fraud charges in 28 health care fraud cases. However, by 2014 that number rose to 496 cases. The number of health care fraud convictions is also on the rise. In 1997, prosecutors scored 363 convictions. By 2014, that number rose to 734 (Crawford, 2017).

White-collar crime is a convenient means for privileged individuals to acquire more money (Gottschalk, 2017). As put forward by Gottschalk (2017), white-collar crime is based on the concept that the opportunity to commit fraud is convenient and easily

exploitable for the fraudster. Because the opportunity to commit fraud is timely, the act becomes attractive and available to the fraudster. Convenience allows the fraudster to enrich themselves easily because they are comfortable with the process if they do not get caught. Gottschalk (2017) believed that committing white-collar crimes meant that the fraudster could save time and money by committing fraud versus working hard.

Alalehto (2018) described the concept of white-collar crime as divided into occupational crime versus corporate crime. Occupational crime is described as a crime committed by individuals in their work setting against employers, employees, clients, etc. Corporate crime is described as a crime committed by corporate officials in the interest of their organization or against other organizations. Alalehto (2018) believed that a corporation has a body, a physical location, policies, and procedures, and therefore each employee acts as a member of the corporation. Individualism is replaced by "group think" because corporate policies and procedures from the top shape the culture of the organization.

White-collar crime and contrasting theories were not explored for this study because the alternate theories do not explore fraud mitigation. Thus, the strategy for managers should be to provide adequate procedures to prevent employees from committing fraudulent acts. Crawford (2017) defined white-collar crime as a specific type of crime committed by specific individuals in an organization. Wilhelm's FMLT examined the steps that occur when an individual commits a fraudulent act, and mitigation techniques at each step.

## Fraud Training Strategies

This section contains an overview of training strategies and relevant Medicare laws and regulations in place to mitigate Medicare fraud. Managers may use the FMLT and fraud training strategies as their foundation to mitigate fraudulent activity. Fraud has become the greatest threat to the global economy, and fraud continues to grow and get worse (Abdullahi & Mansor, 2018). In 2017, Medicare lost between $21 billion to $70 billion due to fraud (Herland et al., 2019). One of the most effective ways to prevent fraud is to hire trusted individuals that can be trained in fraud prevention and implement fraud prevention measures (Drogalas et al., 2017). In a study conducted by Drogalas et al. (2017), the researchers concluded that an essential business practice that needs to improve is fraud training.

### Fraud Awareness Training

The desired result is to create a controlled environment where the prevention or hindering of fraudulent activities occurs (Wilhelm, 2004). Further, Wilhelm (2004) believed that visible government regulation leads to fraud mitigation. Prevention is the second stage and mitigation is the fourth stage of the FMLT. To prevent fraud effectively, companies must continuously train staff on fraud prevention. An organization's managers can identify fraud by implementing a variety of fraud prevention strategies (Drogalas et al., 2017). Similarly, Peltier-Rivest (2018) discovered that companies with regular antifraud training could incur 36% less fraud than organizations without antifraud programs. Wilhelm (2004) concluded that one of the most prevalent fraud prevention activities is fraud awareness training. A comprehensive fraud training program should

include antifraud tools such as individual and group fraud prevention meetings, flyers, posters, video messages, emails, newsletters, webcasts, etc. (Peltier-Rivest, 2018). Peltier-Rivest (2018) recognized that fraud training is a complex task, and it takes time to achieve a positive work environment and ethical corporate governance.

Managers must have an in-depth knowledge of their business operations to prevent fraud. Fraud risk is unique to each organization, and techniques to identify fraud are specific to each organization (Treadwell, 2021). Antifraud training provides managers with the ability to teach employees how to recognize signs of fraudulent behavior and the steps that should occur once fraudulent behavior begins. An organization must transition from a reactive approach to a proactive approach. Many times, lower level employees or those employees that are unfamiliar with the business may not have in-depth knowledge of the company and may not be able to identify fraudulent activities. Training lower-level employees in their industry will encourage them to report suspicious activity. Additionally, organizational knowledge leads to early detection. Fraudsters rarely stop a successful scheme. Fraud detection may prevent costly disruptions and reputational damage (Treadwell, 2021).

One way managers could streamline the complexities of fraud training is to follow the guidelines provided online from CMS or insurance providers like Aetna (Boerner, 2015). CMS training modules are available on the CMS (www.cms.gov) website for free. Training modules on each component of Medicare are available for use as a side-by-side comparison with any compliance program. The PowerPoint presentations are the same

resources used by health care providers that have met fraud training requirements (Boerner, 2015).

However, Hauser (2019) recognized that there are gaps in the research of effectiveness on training and antifraud activities. In a study conducted by Hauser (2019), the researcher discovered that there is a strong connection between fraudulent activity and emotional decision making. When the opportunity to commit an act arises, the fraudster may decide to refrain from committing the action due to the negative emotions associated with spending time in prison or choose to engage in the fraudulent activity without concern for the consequences, regardless of receiving antifraud training. Under these circumstances, neutralization techniques involving changing the way employees feel about fraud could be an effective deterrent. The author discovered that some individuals might not see any value in fraud training. However, the employee that fears prosecution or fears losing their job may need more than just antifraud training.

Drogalas et al. (2017) pointed out that fraud training alone is ineffective if employees are not highly trained and do not have expert experience detecting fraud. Part of an effective training strategy should be to run fraud simulations to observe any response from employees. Sandhu (2020) added that concealment is a primary activity of fraudulent activities. Therefore, managers should focus on employee behavior and observe clues that could lead to early fraud detection.

**Medicare Regulations Training**

Employees must understand and follow Medicare laws (Sieck et al., 2017). Medicare laws strengthen the need for health care organizations to continuously improve

the delivery of health care services (Jaffe, 2019). Wilhelm (2004) pointed out that the fear of consequences acts as a deterrent to fraudulent activities. Deterrence is the first stage of the FMLT. A lack of understanding or lack of attention to guidelines by health care workers can lead to severe consequences for patients and providers. Protecting patients ensures a patient's trust in their health care provider and encourages patients to seek medical treatment (Yaraghi & Gopal, 2018).

In 1996, the ACA expanded Medicare laws and regulations to include protected health information (PHI). PHI is any information that is taken from a medical record that can be used to identify a patient and was created while receiving medical treatment (Bowman & Maxwell, 2019). Some of the Medicare laws and regulations currently in place include the Health Insurance Portability and Accountability Act of 1996, the False Claims Act, Civil Monetary Penalties Law, Stark Law, Antikickback Statute, and the ACA. Each regulation includes the criminal or civil penalties the government can impose on individuals or entities that violate the law by making them liable for knowingly committing fraud (Hill et al., 2014). Medicare regulations are constantly changing, and employees must possess a basic understanding of the regulations (Sieck et al., 2017).

**The Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

The purpose of HIPAA is to provide a national standard and provisions on safeguarding protected PHI (Boyd, 2020). The regulations are covered in the *Privacy and Security Rule.* The regulations are meant to protect PHI while medical information flows from provider to provider to ensure the quality of care and to protect the public. The Privacy Rule is a national set of standards that are designed to protect PHI. Examples of

PHI include name, social security number, phone number, address, or any other unique identifying characteristics that can be used to identify an individual (Burnett, 2019). The Security Rule is a national set of standards that are designed to protect PHI that is stored electronically, including hard drivers and moveable storage devices, or transmitted over the internet or intranet (Craig, 2017). Researchers Cohen and Mello (2018) described HIPAA as awkward at its inception because of the program's complex security algorithms and narrow scope. However, Cohen and Mello (2018) concluded that improvements in the program have led to its success. For example, the Health Information Technology for Economic and Clinical Health Act was passed in 2009 in anticipation of the electronic exchange of PHI. The Health Information Technology for Economic and Clinical Health Act includes regulations that increase the fines for violating HIPAA and expands privacy and security protections (Cohen, & Mello, 2018). However, in a study conducted by Yaraghi and Gopal (2018), the authors discovered that sophisticated ransomware attacks continue to pose a threat to patient privacy.

**False Claims Act (FCA)**

The FCA is the government's most powerful weapon for fighting fraud because it may revoke the rights of providers to participate in the Medicare program (Goldin, 2017). Federal penalties for violating the FCA range from $5,000 to $11,000, plus three times the number of damages the government sustains (Parrish, 2018). In 1987, the FCA instituted the qui tam "whistle-blower" provision to help combat fraud. The whistle-blower provision encourages individuals to come forward and report incidents of fraud. The regulation has resulted in billions of dollars in recovered funds and millions of

dollars paid to whistle-blowers. For example, Cheryl Eckard was rewarded $96 million for reporting GlaxoSmithKline for fraud (Parrish, 2018). Unfortunately, it is still very difficult for law enforcement to prosecute or discover repeat offenders (Kennedy, 2019). Kenny (2019) discovered that in some circumstances the cost of prosecuting offenders is more than law enforcement can expect to recover.

**Antikickback Statute**

The purpose of the antikickback statute (AKS) is to criminalize providers for soliciting, offering, paying, or receiving anything of value in return for a referral for services covered by Medicare (Stowell et al., 2018). The purpose of the AKS is to minimize overutilization, lower medical costs, prevent anticompetitive behavior and maintain patients' rights to choose their health care (Stowell et al., 2018). The penalties for violating the law include civil or criminal liability. For example, in October 2015, Warner Chilcot PLC agreed to pay $125 million and pleaded guilty to a felony charge of fraud for violating the AKS (Patel & Sherer, 2016). However, not all indictments lead to a conviction. For example, a pharmaceutical company manager was found not guilty after being arrested for violating the AKS. The manager was accused of providing free meals and speaker fees to high prescribing doctors. When the doctors stopped writing their products, the meals and speaker programs were stopped. (Patel & Sherer, 2016).

**Civil Monetary Penalties Law**

The Civil Monetary Penalties Law authorizes officials at the Department of Health and Human Services Office of the Inspector General (HHS-OIG) to enforce civil penalties for committing fraud against Medicare. The maximum penalty for committing

fraudulent claims is $100,000 depending on the offense (Gobena & Marberg, 2018). The HHS-OIG enforces the penalties, and the conduct of the provider determines the severity of the penalties and the amount of the fines. According to Gobena and Marberg (2018), a provider may incur a penalty by committing the following:

- Presenting claims to a federal health care program that the provider knows were not provided.
- Violating the AKS by paying or receiving remunerations by requesting or receiving referrals.
- Submitting claims for services that are not eligible for repayment under Stark Law.

**Stark Law**

The Stark Law or the physician self-referral law became law in 1989, and it was designed to limit the overutilization of the health care system due to providers' financial interests (Zigrang & Bailey-Wheaton, 2020). The law is intended to prohibit providers with a financial interest within a designated health care business from referring Medicare patients to that business (Schmitz & Moodie, 2018).

A provider does need to know that they violated the law for a violation to occur. Initially, the Stark Law only applied to clinical laboratories. In 1993, Stark Law was extended to include ten very broadly defined *designated health services* (Schmitz & Moodie, 2018). Self-referral arrangements could create opportunities for a provider to place their financial interest over the interest of the patient (Collins et al., 2018).

**Exclusion Statute**

The Exclusion Statute defines the circumstances in which individuals or health care entities can be excluded from participating in the Medicare program. For example, if an individual is convicted of fraudulent billing, he/she could be added to the exclusion list. The exclusion list is maintained by the HHS-OIG, and when an individual is added to the list, they can no longer participate in the Medicare program. In addition, the individual may not be associated with any bill submitted to the Medicare program from any organization that provides health care services. Providers on the list may also have a difficult time acquiring contracts with private insurance plans. The purpose of the statute is to limit a health care provider from earning potential revenue after being added to the list, acting as a deterrent to fraudulent behavior (Flasher & Lamboy-Ruiz, 2019).

Kim (2017) believed that a lack of regulation training could lead to fraud and the unauthorized disclosure of patient information, financial harm to the organization and individual employees, and the risk of repeat offenses and breaches. Every employee in an organization makes decisions that can impact an organization's data; for example, opening an email with a virus, clicking on malicious links on a website, or giving individuals direct access to data may lead to harmful consequences. Any breach of patient data may put patient safety at risk. Kim (2017) suggested that untrained employees are the weakest component of any organization because they are unaware of potential risks. Kim (2017) described a thorough training program that includes regular training on good practices, simulated attacks to gauge the effectiveness of the current training program, and retraining of employees based on the results of simulated attacks. A vital component

of any training program should include the ability to report any suspicious or unusual behavior within the organization. Any delays in reporting incidents may result in harm to patients or the organization. However, Vanderpool (2019) argued that no number of resources could prevent open violations of patient privacy. A vital component of the HIPAA law is the requirement that all members of a health care organization be trained on the policies and procedures of PHI.

Medicare laws and regulations are constantly changing making it difficult for organizations to conform and stay aware of the current laws and regulations (Clemente et al., 2018). For example, the FCA, AKS, and the Stark Law have all been modified since their inception. The government has added stricter consequences to the laws to increase the consequences for any violations. Even though severe consequences are in place for violators, health care fraud is going to increase (Clemente et al., 2018).

**Policy Training**

Wilhelm (2004) believed that policies are created to communicate and deploy fraud mitigation strategies. Policy development should come from the organization's leadership because leaders must be able to consider the needs of the whole organization. Policy is the sixth stage of the FMLT. A corporation's executives can be held criminally and civilly liable for the actions of their employees (Liu et al., 2019). Therefore, every fraud mitigation action should be clearly defined, and every employee should not doubt what is expected from them and what they will get in return from the organization. Policies should be implemented across the whole organization at the same time to improve the consistency of practices (Hewko et al., 2018).

Contrary to Wilhem (2004), van Assen (2021), asserted that policy implementation only improves when employees are involved with the training process. Employees that are involved in the process will seek out ways to solve complex problems and improve work processes. Subramanian and Zimmermann (2020) concluded that employees' personal development improves when they can contribute to the plan.

**Staff Ethics Training**

The existence of unethical behavior continues to distress the business community. According to The Ethics Resource Center, 45% of U.S. employees witnessed unethical behavior at work, and 63% of managers are behaving unethically (Weber, 2015). Ethics training is different from compliance training because compliance training is focused on following the law; for example, Stark Law. Ethics training emphasizes incorporating ethical values and helping employees make the right decisions. Wilhelm (2004) does not explicitly identify ethics as part of the FMLT. However, Wilhelm (2004) believed that each stage is influenced by internal and external factors and an equilibrium must be achieved. External factors come from outside the organization, such as Stark Law. Ethics training comes from internal factors, such as the organization's fraud mitigation philosophy. Regular ethics training for staff is an essential tool for deterring illegal and unethical behavior (Hauser, 2020). Wilhelm (2004) believed an effective fraud mitigation strategy contains aggressive and proactive mitigation measures that may increase deterrence. Mitigation and deterrence are common themes presented throughout the FMLT.

The goal of ethics training is to teach others to do the right thing (El-Mallakh & Potter, 2019). Self et al. (2017) listed looking at oneself, promoting the development of ethic related activities in a clinical setting, and promoting ethic related leadership roles as a model for ethics training. Leaders must make difficult decisions, and there is usually little time to reflect on the consequences of their actions (Asencio et al., 2017). Asencio et al. (2017) described an efficient and capable ethics training program as one where leaders discuss ethics with their employees, set clear standards, hold people accountable for ethics violations, and lead by example. The researchers concluded that an adequately developed ethical culture would encourage members to ask questions about what is right and wrong, admit when violations occur and seek advice when determining what the correct decisions are to make. Furthermore, internal checks and balances are necessary to create regular oversight.

Conversely, Chiaravutthi (2019), suggested that ethics is not something that is taught. Chiaravutthi (2019) described ethics as the standards that guide us to make decisions that we believe are right or wrong. Self et al. (2017), stated that health care professionals must be able to recognize and navigate ethical challenges independently and without supervision. Hauser (2020) believed ethics training is ineffective because there are five significant barriers to conducting practical ethics training in the workplace: the legitimacy of the source, time, relevance, consistency, and impact. First, the legitimacy of the source is the key to the effectiveness of the training. External sources may have expertise in ethics topics; however, they may lack credibility with the staff. Internal trainers may have credibility with the team, but they may not be experts in the

field of ethics. Next, executives and employees may believe that ethics training is a waste of time. Employees may think they can benefit from learning more relevant skills versus attending ethics training. Additionally, most employees believe ethics training is hypocritical because ethics training and real-life scenarios are inconsistent. For example, an ethics trainer may encourage employees to report every suspected unethical behavior. However, pressure from managers and executives may discourage them from applying what they have learned in ethics training. Finally, the impact of ethics training is usually measured by the number of training and the number of attendees, not the effect of the training. Because of low impact training, the effectiveness of ethics training is not easy to see (Hauser, 2020).

**The Medicare Program**

Medicare coverage has become the backbone of health care for adults over the age of 65 and individuals with certain disabilities. On July 30, 1965, President Lyndon B. Johnson signed Medicare into law (Clemente et al., 2018). Before 1965, only a fraction of the elderly population had health care coverage (Shepard et al., 2020). Johnson signed Medicare into law because the elderly population could not get medical coverage due to their age or preexisting medical conditions. In 1972, Medicare coverage included individuals with disabilities and end-stage renal disease (Clemente et al., 2018).

Medicare consists of four separate parts, Part A, Part B, Part C, and Part D. Part A covers inpatient hospital care, Part B covers outpatient care, Part C covers the combination of private insurance plans and Medicare plans. Part D is delivered by private insurance plans that contract with Medicare to provide prescription drug coverage (Socal

et al., 2021). Medicare is paid for with payroll taxes, beneficiary premiums, state payments, social security taxes, and interest (Masaba, 2015). Medicare pays for about 70% of the health care delivered by medical providers such as doctors and hospital personnel on a fee-for-service basis (Moon, 2015). The Medicare budget consists of over 15 percent of the entire federal budget (McGee et al., 2018). The primary revenue source for Part A is through employee and employer taxes (Moon, 2015). State and local taxes fund Medicare Part B and Part D.

The U.S. government officials spend more money annually per capita on health care compared to other developed nations (Hill et al., 2014). Preserving the financial integrity of the Medicare program has been a focus of policymakers since the program's inception in 1965 (Santo, 2014). The CMS, which is part of the Department of Health and Human Services, is responsible for the administration of the Medicare program. Within CMS is the Center for Program Integrity which is responsible for detecting and combating fraud, waste, and abuse of the Medicare program. The U.S. Government Accountability Office is an independent, nonpartisan agency that works for Congress and investigates how the federal government spends taxpayer dollars (Anders, 2013). The U.S. Government Accountability Office advises Congress and the heads of executive agencies about ways to make government more efficient, effective, ethical, equitable, and responsive.

## Conclusion

If fraud continues to go unchecked, taxpayers will be paying $100 million annually to fight fraud (Clemente et al., 2018). Clemente et al. (2018) argued that

increasing provider liability and holding providers accountable for not maintaining ethics training could reduce fraud or unintentional overbilling. In 2012, the Obama administration created the Healthcare Fraud Prevention Partnership. The Healthcare Fraud Prevention Partnership formed a data sharing partnership between public and private insurance entities to help identify fraudulent schemes and prevention measures.

A complex regulatory and business environment makes it difficult for health care providers to operate a business. To reduce fraud, the HHS-OIG maintains and continuously updates its website to assist providers in staying current on investigations, audits, administrative enforcement, and other economic efficiencies (Demske et al., 2018). Demske et al. (2018) described the HHS-OIG's efforts as an educational tool for providers to stay in compliance with health care regulations and how to deal with compliance issues appropriately. The researchers concluded that providers should use the HHS-OIG's guidance to create best practices to alleviate compliance and fraud related matters.

Training must be directly connected with the goals and mission objectives of the organization. Rawashdeh and Tamimi (2020) believed that the significant effects on employees' performance through proper training are lower cost, reduced risks, and increase production and profitability. According to Esteban-Lloret et al. (2018), employee training provides organizations and their employees with the tools needed to deal with various environmental changes. Estaban-Lloret et al. (2018) suggested that traditional training focuses primarily on competing for the best economic results for the organization. Esteban-Lloret et al. (2018) concluded that effective training starts with the

organization's managers. Managers must know why they are training their employees and must know what they are hoping to achieve with each training session. Health care providers who fail to train their employees can risk being held liable for violating the law. The purpose of a comprehensive fraud training program is to ensure that each employee, manager, executive, contractor, or any other individual that functions on behalf of the organization can do their job in compliance with all the rules and regulations (Brown, 2018).

## Transition

Section 1 of this qualitative case study provided a thorough description of the Medicare program, and the financial impact fraud has on the program. I provided a comprehensive and critical analysis of the existing body of knowledge regarding fraud theories and conceptual models as they relate to adequate training strategies to prevent Medicare fraud. The training topics included in this section were HIPAA, Medicare laws, and ethics training. This section also provided employee risk mitigation techniques such as employee background checks and whistle-blower provisions.

In section 2 of this study, I described the purpose of this study, the researcher's role, the participants, and data collection techniques. I also addressed the importance of mitigating my personal views in the research by using interview protocols, member checking, reaching data saturation, and using other bias mitigation strategies. Section 2 concluded with details of the key concepts that I used to validate the research.

Key findings and themes are presented in Section 3 of this study. I also presented the significance of the study, application to professional practice, implications for social

change, recommendations for actions, recommendations for future research, and reflection of the Doctoral Study process in Section 3.

# Section 2: The Project

This section includes a discussion on the role of the researcher as well as the importance of ethical research, the study participants, and participant safety. I also describe the research method and design, data collection, data analysis, and data organization techniques for this study. Finally, I discuss the importance of reliability and validity as it relates to reducing bias in the research.

## Purpose Statement

The purpose of this qualitative multiple case study was to explore adequate training strategies some speech pathologist business owners use to prevent Medicare claims fraud. The target population consisted of at least five speech pathologist business owners from three speech therapy clinics in California with successful experience in preventing Medicare claims fraud. Speech pathologist business owners can use any positive outcomes from this study to develop strategies to prevent Medicare fraud. The implications for positive social change include reducing waste, fraud, and abuse, which could result in giving patients access to necessary treatments and reducing physical harm, such as overtreating patients with unnecessary procedures.

## Role of the Researcher

My role as the researcher included selecting, screening, and interviewing research participants. By conducting interviews, researchers gain a new view and deep insight into the phenomenon (Konecki, 2019). My role was to gather, analyze, and present data clearly and concisely. The purpose of qualitative research is to synthesize data to discern patterns and gain insight (Bansal et al., 2018). As a researcher, I have a nonprofessional

connection with the participants. My wife is currently a speech pathologist, and her employment as a speech therapist motivated me to select her profession as the basis for my study. Through networking, I have become professionally acquainted with several speech pathologists and speech pathologist business owners in California. I have no experience creating education or training strategies to prevent Medicare fraud. But as a pharmaceutical sales representative, I have received extensive training on the Medicare program and Medicare fraud prevention.

On September 30, 1978, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research issued *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research* (National Commission for the Protection of Human Subjects and Biomedical and Behavioral Research, 1979). The three core principles that guided my research were respect for persons, beneficence, and justice. The commission's report provides a framework to assist researchers in the resolution of any ethical problems that may arise from studies involving human subjects (Adashi et al., 2018). Four of the main points of the commission's report include defining the limits between research and practice, determining if the research is worth the risk to the participant, creating suitable guidelines for participant selection, and providing the standard for establishing informed consent (Friesen et al., 2017). In my role as a researcher, I followed the guidelines as they are established in the *Belmont Report*. I also completed the online Collaborative Institutional Training Initiative Program modules (Certificate number 45060616). Furthermore, I

gained informed consent from all participants, protected all participants from harm, and selected all participants in an equal manner.

The role of the researcher is also to create an arena for individuals to share their experiences and remove or minimize any biases that may influence the outcome of the study such as question bias, sampling bias, and anticipated outcomes bias (Wadams & Park, 2018). First, the researcher should not use questions that can guide or lead the participants (Roulston & Shelton, 2015). Second, the sample should reflect the experience of the study participants to reduce any outside bias (Wadams & Park, 2018). Third, the researcher should not anticipate the results of the study. If an outcome is already expected, a researcher may lean toward that result (Wadams & Park, 2018). To mitigate bias and avoid viewing data through a biased lens, I conducted interviews without asking leading questions, ensured the sample population was focused on the experience, and I did not anticipate the results of the study.

Researchers have found that interview protocols (see Appendix A) are structured around central components: establishing rapport, setting up the rules of the interview, discussing the phenomenon, and closing the interview (Navarro et al., 2019). The purpose of the interview protocol is to ensure the questions reflect the actual line of inquiry. The protocol provides the framework for presenting questions in a consistent manner that does not permit the researcher to bias the data collected. It ensures data collection is consistent and encourages a fair inquiry (Yin, 2018). Open-ended questions provide the most accurate and detailed answers (Hamilton et al., 2015). Interview protocols and procedures should be designed to maximize the quality of the data (van de Wiel, 2017). I

used semistructured interviews and my interview protocol so my interviewees could provide their most accurate and detailed answers.

## Participants

Qualitative research involves studying the views and perspectives of participants' lives in real world conditions. Study participants must have experience in the phenomenon being studied (Yin, 2018). A description of the participants should be included in the study to give the reader a description of the participants (Rashid et al., 2019). The eligibility criteria for participants of this study were to be a licensed speech pathologist who owns a private practice, is a principal or partner of a private practice, or is an independent contractor. The study participants must also have the role or responsibilities for training employees on Medicare fraud mitigation and fraud policy enforcement. Case study participants provide the most critical evidence in research (Yin, 2018).

To gain access to the selected participants of my study, I emailed each prospective participant with the intent of my research. Participants were found through my extensive professional network of speech pathologist business owners across California. The email included a description of my role as a student-researcher and the eligibility criteria I used for selecting participants. The email included instructions on how to decline participation and instructions to sign the consent form if they chose to participate in the study. After the participant agreed to participate, I followed up with a phone call or email to establish the appropriate time to conduct the face-to-face or virtual audio/video interview.

To establish a working relationship with the participants, I emphasized the objectives of my research and how the results of the study might improve process efficiencies and reduce costs. The interaction between the researcher and the participant is also a social process (Korstjens & Moser, 2017). Interviews should be conducted in a friendly setting so participants can be free to express their experiences and views (Jobin & Turale, 2019). To build trust, researchers should establish a working relationship with the study participants (Cross, 2020). Study participants must trust that the researcher is going to be consistent and transparent throughout the study (Cross, 2020). When trust is established, study participants will give genuine answers (Cross, 2020).

Researchers should be guided by the belief of doing no harm to the participants or their professional practices (Favaretto et al., 2020). Researchers should ensure proper ethical protections of research participants' rights by withholding any personal identifying information. Nonessential occupational data like the location of a workplace should be removed from the study (Flanagin et al., 2020). Consent by a research participant must be for a specifically designed project; research studies must not be overly broad (Thaldar et al., 2020). Research participants should also have the right to withdraw at any time during the study (Favaretto et al., 2020). I used open-ended questions (see Appendix B) during the interview to allow participants to respond freely. Open-ended questions are useful in interviews because open-ended questions enable the participant to support an opinion or evaluate ideas (Ciftci, 2019). I listened attentively to each answer to build trust with the participant by using effective listening techniques,

such as smiling and nodding in agreement. My goal was to establish trust with the interviewee, so the interviewees provide genuine answers (see Barnham, 2015).

## Research Method and Design

### Research Method

The three research methods are qualitative, quantitative, and mixed (Baškarada & Koronios, 2018). Using the qualitative method, researchers attempt to answer the *what, why,* and *how* of a phenomenon (Williams & Moser, 2019). I used the qualitative research method to answer the what, why, and how of the phenomenon under investigation, which is Medicare claims fraud. Quantitative researchers examine concise research questions, hypotheses, and the relationships among variables to analyze the data (Bansal et al., 2018; Yin, 2018). I did not select the quantitative method for the study because I did not examine relationships among variables using statistical analyses through hypotheses testing. The mixed method is a synergistic combination of qualitative and quantitative methods (Khanna et al., 2021). I therefore used qualitative methodology.

Qualitative research is not about transforming answered questions into numerical data. Qualitative research is about discovering the nature of the phenomenon, not the quantity (Mykhalovskiy et al., 2018). The development of procedures, techniques, research methods, and data analyses makes qualitative studies more precise (Koneck, 2019). Furthermore, creativity and openness extend the capability of researchers to link the cause and effects of social phenomena. Qualitative data includes words and visuals that can be delivered either statically or dynamically. Qualitative data can be counted;

however, it must be interpreted first to recognize patterns and a deep understanding of the phenomenon (Bansal et al., 2018).

**Research Design**

For my qualitative study, I had the option of choosing among ethnographic, phenomenological, narrative, or case study designs. The ethnographic design is an exploration of a culture or social group where behaviors and customs are observed to understand the group's norms in their environment (Bartholomew & Brown, 2019). Ethnographic research seeks to understand everyday practices through participant observation (Walshe, 2020). I did not choose the ethnographic design because the focus of the proposed study is not the participants' behaviors and customs in their environment.

Phenomenological researchers seek to explore the personal meanings of participants' lived experiences with a phenomenon (Adams & van Manen, 2017). Researchers using phenomenological design typically look for a single and uniform sample of participants (Larkin et al., 2019). I did not choose the phenomenological design for my study because the focus of the proposed research is not the personal meanings of participants' lived experiences.

Researchers use the narrative design to explore the account of participants' experiences through personal life stories (George & Selimos, 2018). Narrative design is focused on the content of what is written and said (Ghodrati & Gharbi, 2019). I did not choose the narrative design because the focus of the proposed study is not the participants' personal life stories.

The case study design is a verifiable and in-depth exploration of the *what*, *why*, and *how* of a phenomenon (Alpi & Evans, 2019). The case study design allows researchers to gather in-depth data through interviews (Amu & Nyarko, 2019). The case study design offers a pluralistic understanding of participants by permitting the flexible collection and analysis of data from a variety of views (Erickson, 2019). I chose the case study design because the focus of the study was to explore Medicare fraud. A rationale for using a single case study design is to explore an unusual or extreme case (Yin, 2014). In my study, I did not investigate a rare or extreme case. Evidence gathered from a multiple case study is considered more robust and more vigorous than that from single case designs (Yin, 2014), which is the reason I chose a multiple case study design.

Data saturation occurs when observing more data does not lead to the discovery of new information (Lowe et al., 2018). Saturation is the point where nothing further information can be added (Nelson, 2017). Data saturation is the point where coding is no longer achievable, and there is enough information to replicate the study (Fusch & Ness, 2015; Korstjens & Moser, 2017). Failing to reach data saturation could harm the validity of the research. I continued to interview research participants until reoccurring themes emerge from my research. For this study, member checking was used to ensure data saturation. Member checking refers to providing participants with the opportunity to review the data and verify the accuracy of the content (Madill & Sullivan, 2018).

## Population and Sampling

The target population for this study consisted of at least five licensed speech pathologists who own a private practice or is a principal or partner in a private practice.

The study participants had the role or responsibility of implementing fraud mitigation training techniques. The choice for this population was based on the increased number of licensed speech pathologists entering the field. I initially contacted study participants via telephone and informed them about the study. After the initial telephone call, I sent each prospective participant an email with the consent form attached. McSweeney et al. (2019) pointed out that one of the biggest challenges in conducting research is finding people that are willing to participate. I used purposeful sampling to recruit participants that had the appropriate experience and knowledge of the phenomenon. Bungay et al. (2016) suggested that purposeful sampling recruits should provide rich information about their experiences on a phenomenon being studied. Purposeful sampling allows researchers to synthesize the evidence and reach a rich representation of the concepts. Further, researchers will have the flexibility to confirm or disconfirm the findings in the future (Benoot et al., 2016).

Researchers select a sample size based on the ability to gain fruitful and relevant information about an event (Vasileiou et al., 2018). I chose five speech pathologist business owners who were responsible for implementing fraud mitigating strategies. My choice for this sample size and population was based on the subjects' experiences with the phenomenon I explored. Sample sizes in qualitative research can be small so that the researcher can derive rich information (Vasileiou et al., 2018). The purpose of qualitative inquiries is to uncover a thorough description of a phenomenon being studied (Tran et al., 2017). I used member checking to ensure data saturation. Member checking involves providing the research participants with the raw data to read and provide feedback. This

method ensures that raw data is accurate and consistent (Brear, 2019). I started with five participants and checked for data saturation. Data saturation was achieved, so I did not include any more participants. If data saturation was not achieved, I would have added more participants until no new information emerged.

Qualitative interviews are vital to gaining the information needed to provide a meaningful understanding of a phenomenon (Connelly & Peltzer, 2016). I used face-to-face interviews with each participant and followed the interview protocol. Researchers should select a distraction-free location and allow plenty of time to conduct the interviews (Luizzo, 2019). The participants in this study were able to choose the time, location, and setting for the interviews. I gave each participant enough time to answer each question. The duration of the interviews was between 10 – 20 minutes.

## Ethical Research

One of the primary principles of ethical research is seeking informed consent from the participants (Beattie et al., 2019). Participants received an informed consent form via e-mail to review and sign. The informed consent form contained the details regarding the intent and purpose of the study. Before the interview was scheduled, all participants signed and returned the consent form. I reviewed the consent form with each participant before I started the interviews to ensure each participant understood the content of the form. Participants did not receive any form of compensation for their participation as stated on the consent form. Participants were informed that they may withdraw from the study via e-mail or phone at any time. Participants were notified via email that they can refuse to answer any question at any time. I reminded participants at

the beginning of the interview that they may withdraw from the interview at any point, refuse to answer any questions, and that no harm or negative consequence will result in their refusal to participate. Researchers must ensure that participants do not experience any negative consequences for declining to participate (Dalkin et al., 2019).

Institutional review boards (IRB) are important for the development of safe and ethical research involving human subjects (Lapid et al., 2019). I complied with Walden University's IRB process to ensure my research met all the ethical standards and completed web-based training on the ethical protections of humans. I did not collect any data for my study until I received full IRB approval (Walden IRB approval no. 11-09-21-0563671). Special ethical protections are needed to protect human subjects participating in research (Yin, 2014). To ensure the participants' privacy, each participant was assigned an alphanumeric code beginning with *A* followed by sequential numbers from *1* to *10* (A1, A2, A3). Further, no identifying information such as age, gender, race, place of employment, or any other descriptions was used to identify a participant. All data collected will be securely stored in a locked container for at least 5 years to protect the confidentiality of the participants and any electronic data will be stored on a password-protected thumb drive for at least 5 years.

## Data Collection Instruments

I served as the data collection instrument. The qualitative researcher is the primary collection instrument used to gain the participants' insight for data analysis (Clark & Vealé, 2018). I conducted semistructured interviews and reviewed participants' policies and procedures manuals to collect the data. The semistructured interview

questions were open-ended. The interviews were an open discussion versus a rigid answer and question format. Open-ended questions allow the participant to provide a detailed description of a situation and provide different and differing paths (Sarwanto et al., 2021). Baines et al. (2018) believed that semistructured interview questions work well with qualitative data collection techniques because discussions allow researchers to gain a comprehensive understanding of a topic. Semistructured interviews allow researchers to capture the contributing factors of a phenomenon (Naghavi et al., 2019). Creating a fruitful dialogue through the right questions during the data collection phase is the desired result of qualitative inquiries (Yin, 2014).

I used an interview protocol as a guide to follow in every step of the interviews. I followed the interview protocol in detail to ensure a consistent, fair, and unbiased inquiry. Following interview protocols may increase the reliability of the research (Yin, 2018). Researchers use interview protocols to guide them through a detailed step-by-step interview process (Hamilton et al., 2017). I used member checking during the interview process to enhance the reliability and validity of the data collection process. First, I digitally transcribed the interview responses. Second, I shared the responses with the participants to ensure my synthesis was accurate. Finally, I summarized the information provided to me by the participants and then summarized it back to them to ensure accuracy. Madill and Sullivan (2018) suggested that member checking is appropriate to use in qualitative research because the researcher and participant can mutually agree on the accounts of the data collected.

## Data Collection Technique

Using the interview protocol as my guide, I conducted semistructured face-to-face interviews with the participants to collect the data. In qualitative research, the researcher's role is defined as being participatory (Clark & Vealé, 2018). An advantage to using interviews is the participants can share their personal experiences of a phenomenon. Using semistructured interviews allows the researcher and the participants to clarify and ask further questions if necessary (Barr et al., 2017). Using interviews to collect data allows researchers to accurately capture the accounts and experiences of the participants (Lanka et al., 2021). However, gathering information from interviews can be a disadvantage because the topic of the questions can cause participants to become embarrassed and withhold information (Schober, 2018). Additionally, face-to-face interviews can be time consuming for the participants if interviews are too long. The data collection process began with a brief introduction of me and a review of the consent form. After the introduction, I notified the participants that I will be audio recording the interview and then began the interview. During the interview, I summarized and clarified the answers with the participants to ensure accuracy in the study. When the interviews were complete, I thanked the participants for their time and reminded them of the follow-up interview to review my interview synthesis.

I recorded the interviews on my phone using an application called Otter (otter.ai) so I could have a more accurate rendition of the meeting. I used the web-based application on otter.ai to convert the audio files to text. I used the transcribed text to summarize my interviews for member checking. Member checking is an established

approach for validating research findings (Brear, 2019). Member checking assures that the accounts between the researcher and the participants are mutually acceptable (Caretta, & Pérez, 2019).

## Data Organization Technique

For this study, I maintained all data on a data log in Microsoft Excel on a password-protected computer and transferred all the data to a password-protected thumb drive. A case study database should be an orderly compilation of all the data. Word processing tools like Microsoft Word or Excel can be used to arrange the data (Yin, 2014). The data log contains (a) the contact information and alphanumeric identifier for each participant, (b) the date and time when the original informed consent form was emailed to the prospective participants, (c) the date and time of consent form retrieval from participants, (d) the date and time of collection of all scanned documents, and (e) the time and location of the interviews. The purpose of the interview log is to make the materials readily available for review (Yin, 2014). I downloaded all the audio files from the recorded interviews to a folder on my password-protected computer and transferred them to a password-protected thumb drive. The thumb drive also contains the audio-to-text file conversions. I stored the Excel spreadsheet, sound files, and audio-to-text conversion files in the same folder on my password-protected thumb drive. I will securely store all the raw data, corporate documents, and scanned files on a password protected thumb drive for 5 years.

## Data Analysis

Yin (2014) described data analysis as *playing* with your data until patterns, insights, and concepts emerge. I used multiple sources (e.g., interviews and corporate fraud policy and procedures documents) to strengthen the validity of my study. I chose methodological triangulation to validate the data I used to answer my research question. Battaglio and Hall (2018) concluded that triangulation is necessary to provide a robust understanding of a phenomenon. Collins and O'Riordan (2022) noted that triangulation provides more valid and reliable results. Joslin and Müller (2016) believed that triangulation when analyzing two or more data sources could assist researchers in overcoming bias and weaknesses in their study. Additionally, as my second data source I reviewed each company's policies and procedures on fraud mitigation strategies and reviewed the American Speech–Language–Hearing Association (ASHA) and the Speech-Language Pathology & Audiology & Hearing Aid Dispensary Board's policies on ethics and fraud training. Mackieson et al. (2019) believed that using documentary data sources can increase vigor and transparency in qualitative analysis.

I followed Yin's five-step data analysis process to compile, dissemble, reassemble, interpret, and provide a conclusion based on the data (Yin, 2011). For this study, I (a) compiled the data by conducting and audio recording face-to-face interviews and collected any applicable documents, (b) separated the data into themes, (c) reassembled the data into common themes, (d) translated the themes, and (e) created a conclusion of the data.

To explore the qualitative data, I created individual interviewee reports after the interviews were completed. I put the reports on a database using Microsoft Notepad. Each report consists of interviewee responses and interview notes. The reports were organized based on the interviewees' responses to the interview questions. The database also includes any documents or internal controls that speech pathologist business owners use to prevent Medicare claims fraud. I categorized the interviewees' responses by common words and phrases. I also categorized common words and phrases from any documents I received from the participants.

The next step was to tabulate the data into identifiable themes. I used QRS NVivo software to assist me in coding the data and extracting any themes. Yin (2018) noted that software tools could help researchers in coding and categorizing data. QRS NVivo software allows researchers to easily move through their data and find similarities and differences across the different data files (Swygart-Hobaugh, 2019). I used the software by downloading my documents, exploring the data, coding, and finding themes, gathering, and reviewing the material, and providing an account of my discoveries. I focused on extracting themes that assisted me in answering the research question and identify themes related to training strategies used to mitigate Medicare fraud. The function of NVivo software is to gather material so themes and patterns can be identified (Dalkin et al., 2021).

The next step was to recombine the data for interpretation and provide a conclusion based on the data. Grammes and Açikalin (2016) noted that an accurate end should include the evidence for the conclusion and explain the process behind the

conclusion. Researchers should be genuine in the way they present their findings and conclusions (Bansal et al., 2018). Yin (2014) concluded that evidence should not be presented in a biased manner; readers should be able to reach an independent decision. To focus on key themes, I correlated the participants' responses with the eight stages of Wilhelm's (2004) FMLT to establish common phrases and connected the data. Furthermore, I utilized the NVivo software to identify common phrases and patterns to perform a deeper analysis of the data. I also used key themes within the literature review to correlate the data.

## Reliability and Validity

### Reliability

Lindhult (2019) defined research reliability as a robust and consistent process of inquiry that leads to expected outcomes with limited risk of negative consequences. The process should include a trail of documentation to ensure that findings are consistent with the data. One way to ensure accuracy and consistency is by maintaining a journal (Lindhult, 2019). Moser and Korstjens (2018) described research dependability as a process by which the researcher provides a complete set of notes or a journal to ensure accuracy and fairness. Yin (2014) described reliability as being able to conduct a study over again and coming to the same result. To ensure reliability and dependability, I used a journal throughout the study to document my work. The purpose of the journal was to document the procedures that I followed in case the study is repeated in the future. Yin (2018) believed that using a journal may assist another researcher in conducting the same case over again to achieve similar results.

Another key component of reliability is member checking (Birt et al., 2016). I used member checking to ensure that my interviewees' answers were accurate. I verified my interpretation of the interviews with my interviewees to ensure the reliability of the study. Yin (2014) believed that member checking can corroborate study findings or produce new evidence that may not have been initially discovered.

**Validity**

Researchers enhance study validity through the process of credibility, transferability, confirmability, truthfulness, data saturation, and methodological triangulation to validate their findings (Fitzpatrick, 2019). One of the most critical aspects of research validity is to precisely represent the experiences of the study participants (Vishnevsky & Beanlands, 2004). Vishnevsky and Beanlands (2004) concluded that truthfulness in research is measured by credibility and comprehensiveness, referring to how accurate the participants' experiences have been recorded. To ensure truthfulness and validity, I used member checking so the participants can confirm that my interpretations were credible and comprehensive.

**Credibility**

Credibility refers to the accuracy of the participant's views from the researcher's perspective (Belcher et al., 2019). I provided all my research participants with my data and interpretations to confirm credibility through member checking. Fitzpatricks (2019) believed that a crucial part of validation is allowing participants to interpret their transcripts and provide feedback. Shufutinsky (2020), concluded that enhanced credibility in research may reduce researcher bias.

## Transferability

Joram et al. (2020) put forward that transferability is the process of applying the results of a qualitative study to a population or idea that is different from the original research. To address transferability in my research, I provided rich, thick, and transparent descriptions of the settings, sample population, and data collection and data analysis. By providing a thick and rich description a reader can evaluate the conclusions and how they may be transferable to other settings (Hadi & Closs, 2016).

## Confirmability

Confirmability is the extent to which the researcher can show that the data is a representation of the participants' responses and not the researcher's biases (Korstjens & Moser, 2018). Some of the methods that researchers can use to ensure confirmability are the maintenance of logs, detailed notes, an audit trail, or member checking (Connelly, 2016). To ensure confirmability in my research, I used member checking so the research participants can confirm the accuracy of the data.

## Data Saturation

Lowe et al. (2018) posited that a critical aspect of qualitative data is reaching data saturation. Data saturation occurs when no new information or themes can be pulled from the data (Tran et al., 2016). To ensure data saturation, I continued to interview research participants until reoccurring themes emerged from my research.

I used more than one method to collect my data. I applied methodological triangulation to cross-verify my semistructured interview data and corporate documents data. Nwanna-Nzewunwa et al. (2019) believed that researchers can use methodological

triangulation to overcome biases associated with single-observation studies. Natow (2020) noted that each source of data provides researchers with a slightly different view of the phenomenon that can be combined for a more extensive review. Yin (2018) believed that case study conclusions may be more accurate if it is based on several different sources of information.

## Transition and Summary

In Section 2 of this study, I presented the purpose of the research and the target population of the study. I described the role of the researcher, the participants, the research method and design, and population and sampling. This section includes a discussion on the importance of ethical research and how to ensure the safety and anonymity of the research participants. I provided an overview of how the data will be collected, organized, and analyzed. Finally, I discussed the reliability and validity techniques that I will use to minimize researcher bias.

In Section 3 of this study, I will present the findings of my research and how those findings can be applied to business practices, and the implications for social change. Section 3 will include a recommendation for action based on the participants' description of the strategies they use to prevent Medicare fraud. I will provide recommendations for further research related to fraud training strategies and address limitations, identified in Section 1, in future research. Finally, I will summarize the study by reflecting on the doctoral study process and conclude the investigation with my final thoughts on adequate training strategies some speech pathologist business owners can use to prevent Medicare claims fraud.

Section 3: Application to Professional Practice and Implications for Change

## Introduction

The purpose of this qualitative multiple case study was to explore adequate training strategies some speech pathologist business owners use to prevent Medicare claims fraud. Because of fraud, health care resources are being drained and reducing the quality of health care services. Higher health care costs are also driven by fraud, waste, and abuse (Herland et al., 2020). Health care costs must remain reasonably low so that the elderly population and young people with certain diseases can receive the health care they deserve.

Findings from this study indicated that speech pathologist owners can do more to mitigate Medicare fraud by considering every aspect of their practice as vulnerable to fraudulent activities. Findings from this study include three key themes: (a) ethics policies, (b) fraud prevention training, and (c) fraud prevention techniques. Participants expressed that the complicated and rapidly changing Medicare regulatory environment makes it difficult to navigate the nuances of Medicare fraud and appropriate business practices. One participant (A5) was completely unaware of how a speech pathologist business owner could treat Medicare patients in their practice.

## Presentation of the Findings

Five licensed speech pathologist business owners from California participated in the research to address the research question: What adequate training strategies do some speech pathologist business owners use to prevent Medicare claims fraud? Utilizing transcribed interview data and NVivo software to code themes, three themes

materialized. The themes were (a) ethics policies, (b) fraud prevention training, and (c) fraud prevention techniques.

**Theme 1: Ethics Policies**

The first identified theme was ethics policies. Business ethics is the business norms and values a business owner follows that conforms to societal norms (Bağış & Ardıç, 2021). An adequately developed ethical culture can encourage members to ask questions about what is right and wrong, admit when violations occur, and seek advice when determining what the correct decisions are to make (Asencio et al., 2017). Three out of five (60%) of the participants (A2, A3, and A4) indicated that they utilize some form of ethics training or require employees to sign an agreement stating that they will behave ethically. Organizational structures are put in place so employees may conform to their roles (Mejia, 2022). Two study participants (A2 and A4) noted that speech pathologists are bound by their governing body ASHA and are required to follow their code of ethics. All speech pathologist business owners in the state of California must be licensed by ASHA to provide speech services in California. Additionally, the Speech-Language Pathology and Audiology Board of California requires 1 hour of ethics training annually. The training includes a section on coding and billing.

Policies should also be used to create the activities and resources necessary to combat fraud (Wilhelm, 2004). Three out of five (60%) of the participants (A2, A3, and A4) indicated that they have company policies in place to address fraud. As indicated by one participant about committing fraud,

> If an SLP [speech-language pathologist] or someone in the billing department committed fraud, they would be terminated. That violates both our company policy, as well as the ASHA code of ethics that we are bound by and our state license. (Participant A2).

Study participants (A2, A3, and A4) believed that running a successful speech therapy practice was reliant on ethical business practices. The participants' views on ethics are in line with stage six (policy) of Wilhelm's FMLT. Wilhelm (2004) believed that business owners are responsible for creating an ethical work environment. One of the key elements for an effective ethics program is a commitment from the key players at the top (Furlotti & Mazza, 2020). However, internal controls, fraud awareness, and fraud risk assessments may not be enough to mitigate fraudulent activities (Jalil, 2018).

Ethics policies is the framework a speech pathologist business owner may use in their practice. Specific ethic policies may address billing and reimbursement protocols, treatment, continuing education guidelines, etc. Specific policies could state:

- Employees must perform all billing and coding activity with integrity and dignity.
- Employees must maintain patient and client confidentiality.
- Employees must follow all state, federal, and local laws.

Clinicians may strengthen their ethics policy programs through consistent education, training, and experience. Guidelines for dealing with ethics in a private practice may be incorporated into code of conduct policies, speech pathologist-patient relationships, confidentiality, and data security (Kaplan, 2022).

### *Theoretical Framework and Theme 1*

In this study, the FMLT was used as the theoretical foundation. Stage 6 of the FMLT is policy. Wilhem (2004) suggested that policies are the activities managers create to construct ethical business practices. An appropriate antifraud framework must include clear policies and the ability to evaluate performance (Doig, 2018). Responses from the study participants align with stage six of the FMLT. Participant A2 expressed that every employee gets a training handbook that includes the company's policies and procedures on activities like ethics and workplace behavior. Organizations must fully embrace ethics policies to create an antifraud culture (Doig, 2018).

### Theme 2: Fraud Prevention Training

The second identified theme deals with fraud prevention training. Treadwell (2021) argued that fraud training can assist business owners with detecting and deterring fraud. Wilhelm (2004) believed that a key component of fraud mitigation is creating measures to prevent fraud before it takes place. In line with Wilhelm's view, four out of five (80%) of the study participants (A1, A2, A3, and A4) expressed that training or education is a key component of their mitigation techniques. Two study participants (A2 and A3) expressed that fraud training should occur at initial hiring, periodically, or annually depending on the rapidly changing Medicare billing environment.

Three out of the five participants (60%) believed that training their staff was an essential component of their prevention training. Participant A2 emphasized that every insurance carrier has a unique set of codes and billing requirements; therefore, each employee must be trained on each carrier to understand their billing requirements.

Participant A4 expressed that a training manual should be provided to all employees and supervisors as a resource to ensure proper billing. Participant A4 believed that the training manual should provide step-by-step instructions on billing correctly so employees and supervisors can reference correct billing producers. Participant A3 believed that fraud training was an essential component of maintaining a viable business.

There are multiple ways for a perpetrator to act in a fraudulent or malicious manner and there is a direct correlation between fraud training and the reduction of fraudulent acts (Balfour et al., 2021). Fraud training may provide business owners with the skills needed to master fraud related activities. To create an effective fraud training program, business owners can:

- Train employees to spot suspicious activity.
- Establish transaction check points to verify information.
- Ensure employees know how to report a fraudulent act.
- Help employees understand why a person may commit a fraudulent act.
- Use real examples of fraud and how it impacted the business and the perpetrator.

One of the most effective ways to prevent fraud is with regular fraud training (Hauser, 2019).

Moyes et al. (2019) research found that fraud mitigation measures should include training. Three of the participants (A1, A2, and A3) expressed that a key component to fraud training is consistent emails and communication with new information regularly. Fraud prevention meetings, emails, video messaging, and flyers are key elements of fraud

mitigation techniques (Peltier-Rivest, 2018). One participant (A1) expressed that educating staff on the appropriate billing codes and what qualifies under each code would be the best way to avoid fraud. Peltier-Rivest (2018) agreed that an effective prevention model includes regular anti-fraud training. However, Gunasegaran et al. (2018) concluded that training alone is ineffective because companies may not have the resources to commit to consistent fraud training.

### *Theoretical Framework and Theme 2*

A key component of the FMLT is training. Wilhelm (2004) believed that the successful application of the FMLT involves training participants at each stage. Peltier-Rivest (2018) posited that a comprehensive training program includes fraud prevention training. Responses from the participants suggested that fraud prevention training was the key to their antifraud success. Participant A3 expressed that a successful and viable business model must include fraud prevention training. Participant A2 noted that fraud training is conducted at new hire training, annually, or when changes to the billing process occur. The development of a comprehensive fraud prevention training program may be used by business owners to reduce fraud.

### Theme 3: Fraud Prevention Techniques

The third identified theme was fraud prevention techniques. Stage two of Wilhelm's FMLT is prevention. Wilhelm (2004) described fraud prevention as the steps an organization takes to prevent a fraudulent act before it occurs. Consistent with the FMLT, four out of five (80%) of the participants (A1, A2, A3, and A4) expressed that the action they took before the fraud was committed was to audit billing codes or therapy

notes that were submitted by employees. Participant A1 expressed that every Medicare claim should be thoroughly reviewed by a supervisor. Participant A2 believed that a patient's diagnosis code and treatment protocol are always investigated to ensure that they match before billing can proceed. Participant A3 mentioned that monitoring therapy dates to ensure that billing did not occur on dates where services were never rendered. Participant A4 expressed that supervisors were required to review a clinician's therapy notes with the codes submitted before billing could process a claim. Four out of five (80%) of the participants (A1, A2, A3, and A4) expressed that they cross-referenced billing codes with therapy notes to ensure that the correct billing codes matched the services that were rendered. Providing false or unnecessary procedures cost more than $100 billion annually (Drabiak & Wolfson, 2020). Peiris and Aruppala (2021) believed that proactive attention to fraud is vital because employees rely on the inability of managers to monitor employee activities.

Business owners and executive leaders are responsible for implementing mechanisms to prevent fraud. Wilhelm (2004) believed that managers must be able to prevent fraud by using prosecution or termination as a tool against fraudsters. However, it is extremely difficult for small businesses to fight fraud because larger organizations can deploy audit teams, training staff, and other fraud mitigation techniques. Study participants were solely responsible for implementing and enforcing their fraud prevention programs. One participant (A1) stated that they didn't have any specific policies regarding the enforcement of detected fraudulent activity within their organization. Business owners should not be the only people involved in fraud

prevention; employees should also play a key role in anti-fraud strategies (Gunasegaran et al., 2018). Further, one participant (A5) did not have any form of Medicare fraud prevention strategy or Medicare fraud training within their organization.

Speech pathologist business owners can implement internal controls as part of their fraud prevention strategy. Internal controls are the plans that are utilized to protect assets and deter fraud (Baugh et al., 2021). Internal controls could include segregation of duties and verification of documentation. Kim et al. (2020) described segregation of duties as assigning different people to various steps in the process. One challenge small business owners may face is their inability to assign multiple people to a task due to the lack of resources and staffing issues. In the verification of documentation process organizations may use an individual or a team of people to examine documents for accuracy. Speech pathology business owners can establish a process to ensure that fake or fraudulent claims are not being sent to Medicare for fraudulent reimbursement. In a study conducted by Denman (2019), the author discovered that weak internal control has a significant impact on gross margins.

***Theoretical Framework and Theme 3***

Stage two of the FMLT is prevention. Wilhelm (2004) described prevention as the steps an organization takes to hinder, check, or stop fraud. Responses from the study participants were consistent with stage two of the FMLT. For example, participants A1, A2, A3, and A4 expressed that all billing activities were audited for inconsistencies before being submitted to Medicare. The Medicare industry as whole can utilize prevention techniques to prevent fraud from occurring.

## Applications to Professional Practice

Medicare is one of the largest health care programs in the US and accounts for about 15% of total US federal spending (Bauder & Khoshgoftaar, 2020). The data from this study could be valuable to speech pathologist business owners who may lack the resources and training needed to implement a robust fraud prevention strategy. The results from this study may contribute to the creation of effective fraud prevention techniques and increase business survival rates. Effective strategies to prevent Medicare fraud include (a) ethics policies, (b) fraud training, and (c) fraud prevention techniques.

Medicare fraud has an adverse effect on health care costs and the quality of services (Bauder & Khoshgoftaar, 2020). The findings of this study suggest that implementing robust fraud prevention strategies may be difficult for speech pathologist business owners because Medicare is complex and resource dependent. However, the long-term benefits may encourage speech pathologist business owners to prioritize fraud prevention strategies. The findings from this study may prompt speech pathologist business owners to recognize the importance of implementing a vigorous fraud prevention program in their organizations. A vigorous fraud prevention program may increase the longevity of their organization and improve the quality of treatment for their clients.

## Implications for Social Change

In the United States, over $2 trillion is spent on health care. Medicare fraud costs U.S. taxpayers over $60 billion a year (Coustasse, 2021). Findings from this study might contribute to positive social change by improving access to needed care for the Medicare

population and reducing potential physical harm to patients. A reduction in Medicare fraud may provide government officials with the ability to direct resources to much needed areas of the economy. Many acts of Medicare fraud threaten the health and safety of patients. For example, providers may sell Medicare-reimbursed prescription drugs for illegal use. Perpetrators may target specific patient subgroups and fraudulent treatments may make their conditions worse (Nicholas et al., 2019). Findings from the study may also contribute to the development of interventions that protect Medicare patients.

## Recommendations for Action

Based on the strategies described by the participants, speech pathologist business owners are not adequately trained to prevent Medicare fraud effectively. I recommend that every speech pathologist business owner in California be required to take Medicare fraud training courses and be certified annually. Furthermore, I would recommend that every speech pathologist business owner be required to provide ethics training to every employee on an annual basis. Even though speech pathologists may be required to have ethical training, their employees do not have a similar requirement. Furthermore, in line with Wilhelm's FMLT, I recommend that the State of California pass legislation requiring speech pathologist business owners to complete fraud training and provide fraud training to employees. Wilhelm (2004) believed that visible government regulation leads to fraud mitigation. In place of legislation, college curriculum could include mandatory fraud prevention strategy courses and ethics courses as part of graduation requirements.

I will provide the participants with a summary of my findings and ask them to share the findings with their peers via literature review, training, etc. Speech pathologist business owners may utilize the findings from this study to create their strategies to prevent Medicare fraud. I do not plan to present these findings at professional association meetings or write a professional paper based on my research for publication in a journal.

## Recommendations for Further Research

One limitation of this study was the geographical boundaries. Speech pathologist business owners in California may not represent the entire speech pathology market because fraud prevention strategies may differ in different geographical regions. Another limitation to this study is that not all speech therapy clinics treat Medicare patients. Some speech therapy clinics may only treat private insurance patients or cash only patients. Furthermore, the findings from this study may not transfer across groups, such as privately funded health insurance programs. Privately funded health insurance programs may have successful fraud prevention procedures that can be explored and utilized by speech pathologist business owners. Another limitation to this study is the subject of fraud. Some participants may get nervous about discussing the issue of fraud with researchers. One recommendation for further research includes exploring how states other than California legislate fraud prevention activities. Researchers could explore fraud prevention strategy effectiveness in states where prevention measures are mandated by law.

## Reflections

The DBA Doctoral Study process was one of the most fulfilling experiences of my life. It allowed me to explore a phenomenon through the lens of my study participants and other researchers. I have worked in the health care industry for over 15 years, and I developed my preconceived ideas regarding Medicare fraud over those years. The study made me realize that not everyone looks at fraud through the same lens. In addition, the literature review was a real eye-opening experience. It directed me to different topics and opinions that I never imagined were out there. I am looking forward to taking my research skills and applying them to my professional work.

## Conclusion

The purpose of this qualitative multiple case study was to explore strategies to prevent Medicare claims fraud committed by speech pathologist business owners. The conceptual framework for this study was the FMLT created in 2004 by Wilhelm. Wilhelm believed that fraud prevention and fraud detection techniques are the bedrock policies managers should use when building fraud mitigation strategies. I gathered data by analyzing peer reviewed journal articles, interviewed five participants, and reviewed the participants' policies and procedures manuals.

Findings from this study revealed that speech pathologist business owners who incorporate ethical behavior, fraud training, and fraud prevention techniques might reduce the financial and physical burdens fraud places on Medicare patients. The study participants affirmed Wilhelm's (2004) belief that fraud prevention and fraud detection techniques are key to mitigating Medicare fraud, protecting the public, and business

longevity. Medicare fraud does not only impact patients, but it also puts a tremendous amount of pressure on taxpayers, the economy, and employment opportunities. Additionally, educating the public on the harmful outcomes of Medicare fraud may significantly reduce fraud risks across a wider spectrum of the economy in general.

# References

Abdullahi, R., & Mansor, N. (2018). Fraud prevention initiatives in the Nigerian public sector. *Journal of Financial Crime*, *25*(2), 527–544. https://doi.org/10.1108/JFC-02-2015-0008

Adams, C., & van Manen, M. A. (2017). Teaching phenomenological research and writing. *Qualitative Health Research*, *27*, 780–791. https://doi.org/10.1177/1049732317698960

Adashi, E. Y., Walters, L. B., & Menikoff, J. A. (2018). The Belmont Report at 40: Reckoning with time. *American Journal of Public Health*, *108*, 1345–1348. https://doi.org/10.2105/AJPH.2018.304580

Alalehto, T. (2018). The logic of agency or the logic of structure in the concept of white collar crime: a review. *Crime, Law & Social Change*, *69*(3), 385–399. https://doi.org/10.1007/s10611-017-9744-9

Albrecht, W. S., Albrecht, C., & Albrec2ht, C. C. (2018). Current trends in fraud and its detection. *Information Security Journal: A Global Perspective*, *17*, 2–12. https://doi.org/10.1080/19393550801934331

Allin, D. H. (2020). Impeachment, Trump and US foreign policy. *Survival*, *62*, 221–232. https://doi.org/10.1080/00396338.2020.1715089

Alpi, K. M., & Evans, J. J. (2019). Distinguishing case study as a research method from case reports as a publication type. *Journal of the Medical Library Association*, *107*, 1–5. https://doi.org/10.5195/jmla.2019.615

Amu, H., & Nyarko, S. H. (2019). Satisfaction with maternal healthcare services in the Ketu South Municipality, Ghana: A qualitative case study. *Biomed Research International*, *2019*, 1–6. https://doi.org/10.1155/2019/2516469

Anders, S. B. (2013). Website of the month: U.S. government accountability office. *CPA Journal*, *83*(8), 72–73.

Asencio, H., Byrne, T., & Mujkic, E. (2017). Ethics training for U.S. military leaders: Challenging the conventional approach. *Public Integrity*, *19*(5), 415–428. https://doi.org/10.1080/10999922.2016.1272153

Avortri, C., & Agbanyo, R. (2020). Determinants of management fraud in the banking sector of Ghana: The perspective of the diamond fraud theory. *Journal of Financial Crime*, *28*, 142–155. https://doi.org/10.1108/JFC-06-2020-0102

Azam, M. R. (2018). Theory application: Why people commit fraud. *International Journal of Management, Accounting & Economics*, *5*, 54–65.

Bağış, M., & Ardıç, K. (2021). Changes in the intellectual structure of business ethics: A review on journal of business ethics, 2000-2020. *Turkish Journal of Business Ethics*, *14*(2), 296–328. https://doi.org/10.12711/tjbe.2021.14.2.2059

Baines, L. S., Dulku, H., Jindal, R. M., & Papalois, V. (2018). Risk taking and decision making in kidney paired donation: A qualitative study by semistructured interviews. *Transplantation Proceedings*, *50*(5), 1227–1235. https://doi.org/10.1016/j.transproceed.2018.02.079

Balfour, W., Sullivan, G., Self, S., & Byers, R. (2021). Detecting and deterring not-for-profit organization accounting fraud. *Journal of Accounting & Finance (2158-3625)*, *21*(4), 50–74.

Bansal, P., Smith, W. K., & Vaara, E. (2018). New ways of seeing through qualitative research. *Academy of Management Journal*, *61*, 1189–1195. https://doi.org/10.5465/amj.2018.4004

Barnham, C. (2015). Quantitative and qualitative research. *International Journal of Market Research*, *57*(6), 837–854. https://doi.org/10.2501/IJMR-2015-070

Barr, A. L., Knight, L., Franca-Junior, I., Allen, E., Naker, D., & Devries, K. M. (2017). Methods to increase reporting of childhood sexual abuse in surveys: The sensitivity and specificity of face-to-face interviews versus a sealed envelope method in Ugandan primary school children. *Bmc International Health and Human Rights, 17*, 1–11. https://doi.org/10.1186/s12914-016-0110-2

Bartholomew, T. T., & Brown, J. R. (2019). Entering the ethnographic mind: A grounded theory of using ethnography in psychological research. *Qualitative Research in Psychology*, *16*(3), 1–31. https://doi.org/10.1080/14780887.2019.1604927

Baškarada, S., & Koronios, A. (2018). A philosophical discussion of qualitative, quantitative, and mixed methods research in social science. *Qualitative Research Journal*, *18*, 2–21. https://doi.org/10.1108/QRJ-D-17-00042

Battaglio, R. P., & Hall, J. L. (2018). Trinity is still my name: Renewed appreciation for triangulation and methodological diversity in public administration. *Public Administration Review*, *78*(6), 825–827. https://doi.org/10.1111/puar.13010

Bauder, R. A., & Khoshgoftaar, T. M. (2020). A study on rare fraud predictions with big Medicare claims fraud data. *Intelligent Data Analysis*, *24*, 141–161. https://doi.org/10.3233/IDA-184415

Baugh, M., Ege, M. S., & Yust, C. G. (2021). Internal control quality and bank risk-taking and performance. *Auditing: A Journal of Practice & Theory*, *40*(2), 49–84. https://doi.org/10.2308/AJPT-19-037

Beattie, E., O'Reilly, M., Fetherstonhaugh, D., McMaster, M., Moyle, W., & Fielding, E. (2019). Supporting autonomy of nursing home residents with dementia in the informed consent process. *Dementia: The International Journal of Social Research and Practice*, *18*, 2821–2835. https://doi.org/10.1177/1471301218761240

Belcher, B. M., Ramirez, L. F., Davel, R., & Claus, R. (2019). A response to Hansson and Polk (2018) "Assessing the impact of transdisciplinary research: The usefulness of relevance, credibility, and legitimacy for understanding the link between process and impact." *Research Evaluation*, *28*(2), 196–201. https://doi.org/10.1093/reseval/rvy037

Benoot, C., Hannes, K., & Bilsen, J. (2016). The use of purposeful sampling in a qualitative evidence synthesis: A worked example on sexual adjustment to a cancer trajectory. *BMC Medical Research Methodology*, *16*, 1–12. https://doi.org/10.1186/s12874-016-0114-6

Bhattacherjee, A., & Shrivastava, U. (2018). The effects of ICT use and ICT laws on corruption: A general deterrence theory perspective. *Government Information Quarterly*, *35*, 703–712.

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking. *Qualitative Health Research*, *26*(13), 1802–1811. https://doi.org/10.1177/1049732316654870

Bobbio, A., Arbach, K., & Vazsonyi, A. T. (2019). Self-control and deviance: A test of the general theory of crime in Argentina. *Victims & Offenders*, *14*, 119–142. https://doi.org/10.1080/15564886.2018.1552222

Boerner, C. M. (2015). Do you call it "fraud, waste, and abuse (FWA)" training? *Journal of Health Care Compliance*, *17*(3), 31–60.

Bowman, M. A., & Maxwell, R. A. (2019). A beginner's guide to avoiding protected health information (PHI) issues in clinical research - with how-to's in REDCap data management software. *Journal of Biomedical Informatics, 85*, 49–55. https://doi.org/10.1016/j.jbi.2018.07.008

Boyd, B. L. (2020). HIPAA guidelines for the dental office. *Dental Assistant*, *89*(6), 8–11.

Brear, M. (2019). Process and outcomes of a recursive, dialogic member checking approach: A project ethnography. *Qualitative Health Research*, *29*(7), 944–957. https://doi.org/10.1177/1049732318812448

Brown, J. (2018). No time like the present for compliance annual training. *Journal of Health Care Compliance*, *20*, 39–40.

Buck, I. D. (2018). A farewell to falsity: Shifting standards in Medicare fraud enforcement. *Seton Hall Law Review*, *1,* 1.

Bungay, V., Oliffe, J., & Atchison, C. (2016). Addressing underrepresentation in sex work research: Reflections on designing a purposeful sampling strategy. *Qualitative Health Research*, *26*, 966–978. https://doi.org/10.1177/1049732315613042

Burnett, E. (2019). Solving the uncertainty: Why the HIPAA privacy rule fails to appropriately address disclosures of psychotherapy notes of deceased patients. *Health Matrix: Journal of Law-Medicine*, *29*, 401–427.

Caretta, M. A., & Pérez, M. A. (2019). When participants do not agree: Member checking and challenges to epistemic authority in participatory research. *Field Methods*, *31*(4), 359–374. https://doi.org/10.1177/1525822X19866578

Carminati, M., Polino, M., Continella, A., Lanzi, A., Maggi, F., & Zanero, S. (2018). Security evaluation of a banking fraud analysis system. *Acm Transactions on Privacy and Security*, *21*(3), 31. https://doi.org/10.1145/3178370

Collins, A., Clark, K., & George, A. (2018). A stark future for the Stark law? *Home Healthcare Now*, *36*(6), 393. https://doi.org/10.1097/NHH.0000000000000750

Chen, H., Hua S., & Sun, X. (2018). CEO age and the persistence of internal control deficiencies. *Journal of Accounting & Finance (2158-3625)*, *18*(7), 24–49. https://doi.org/10.33423/jaf.v18i7.459

Chen, Y.-J., Wu, C.-H., Chen, Y.-M., Li, H.-Y., & Chen, H.-K. (2017). Enhancement of fraud detection for narratives in annual reports. *International Journal of Accounting Information Systems*, *26*, 32–45. https://doi.org/10.1016/j.accinf.2017.06.004

Chiaravutthi, Y. (2019). Ethical orientation versus short-term ethics training: Effects on ethical behavior in the prisoner's dilemma game and dictator game experiments. *DLSU Business & Economics Review*, *29*, 58–71.

Ciftci, S. (2019). Metaphors on open-ended question and multiple-choice tests produced by pre-service classroom teachers. *International Electronic Journal of Elementary Education*, *11*, 361–369. https://doi.org/10.26822/iejee.2019450794

Clark, K., & George, A. (2017). Home healthcare and the Medicare fraud strike force. *Home Healthcare Now*, *35*, 549–553. https://doi.org/10.1097/NHH.0000000000000620

Clark, K. R., & Vealé, B. L. (2018). Strategies to enhance data collection and analysis in qualitative research. *Radiologic Technology*, *89*(5), 482–485. http://www.radiologictechnology.org/

Clemente, S., McGrady, R., Repass, R., P., III, D. P., & Coustasse, A. (2018). Medicare and the affordable care act: Fraud control efforts and results. *International Journal of Healthcare Management*, *11*(4), 356–362. https://doi.org/10.1080/20479700.2017.1401277

Cohen, I. G., & Mello, M. M. (2018). HIPAA and protecting health information in the 21st century. *JAMA*, *320*(3), 231–232. https://doi.org/10.1001/jama.2018.5630

Collins, C., & O'Riordan, R. (2022). Data triangulation confirms learning in the zoo environment. *Environmental Education Research*, *28*(2), 295–317. https://doi.org/10.1080/13504622.2021.197435

Connelly, L. M. (2016). Understanding research trustworthiness in qualitative research. *MEDSURG Nursing*, *25*(6), 435–436.

Connelly, L. M., & Peltzer, J. N. (2016). Underdeveloped themes in qualitative research relationship with interviews and analysis. *Clinical Nurse Specialist*, *30*, 51–57. https://doi.org/10.1097/NUR.0000000000000173

Coustasse, A. (2021). Upcoding Medicare: Is healthcare fraud and abuse increasing? *Perspectives in Health Information Management*, *18*(4), 1–14.

Craig, D. (2017). Ensuring compliance with the HIPAA security rule: Think twice when e-mailing protected health information. *Nurse Practitioner*, *42*(6), 12.

Crawford, K. (2017). Health care fraud sentencing. *Georgetown Law Journal*, *105*(4), 1079–1106.

Cross, Z. (2020). The working relationship and desistance: What constitutes a 'good quality' working relationship? *Salus Journal*, *8*(2), 77–99.

Dalkin, S., Forster, N., Hodgson, P., Lhussier, M., & Carr, S. M. (2021). Using computer assisted qualitative data analysis software (CAQDAS; NVivo) to assist in the complex process of realist theory generation, refinement and testing. *International Journal of Social Research Methodology*, *24*, 123–134. https://doi.org/10.1080/13645579.2020.1803528

Demske, G. E., Taylor, G., & Ortmann, J. (2018). Shared goals: How the HHS Office of Inspector General supports health care industry compliance efforts. *Mitchell Hamline Law Review*, *44*(4), 1145.

Denman, D. E. (2019). 2018 Report on occupational fraud: Results and how companies can protect their assets. *Journal of Accounting & Finance*, *19*(4), 97–112. https://doi.org/10.33423/jaf.v19i4.2175

Denver, M. (2020). Criminal records, positive credentials and recidivism: Incorporating evidence of rehabilitation into criminal background check employment decisions. *Crime & Delinquency*, *66*(2), 194–218. https://doi.org/10.1177/0011128719833358

Desai, N. (2020). Understanding the theoretical underpinnings of corporate fraud. *Vikalpa: Journal for Decision Makers*, *45*, 25–31. https://doi.org/10.1177/0256090920917789

Dewi, R., & Ariandi, I. (2017). The effect of internal control and anti-fraud awareness on fraud prevention. *Journal of Economics, Business & Accountancy*, *20*, 113–124. https://doi.org/ 10.14414/jebav.v20i1.751

Doig, A. (2018). Fraud: From national strategies to practice on the ground-a regional case study. *Public Money & Management*, *38*(2), 147.

Drabiak, K., & Wolfson, J. (2020). What should health care organizations do to reduce billing fraud and abuse? *AMA Journal of Ethics*, *22*(3), 221–231. http:// doi.org/10.1001/amajethics.2020.221

Drogalas, G., Pazarskis, M., Anagnostopoulou, E., & Papachristou, A. (2017). The effect of internal audit effectiveness, auditor responsibility and training in fraud detection. *Accounting & Management Information Systems, 16*, 434–454. https://doi.org/10.24818/jamis.2017.04001

Ekin, T., Ieva, F., Ruggeri, F., & Soyer, R. (2018). Statistical medical fraud assessment: Exposition to an emerging field. *International Statistical Review, 86*(3), 379–402. https://doi.org/10.1111/insr.12269

El-Mallakh, R., & Potter, N. (2019). Aims, methods, and resources for ethics training. *Philosophy, Psychiatry & Psychology*, *26*(3), 215–217. https://doi.org/10.1353/ppp.2019.0036

Erickson, J. D. (2019). Primary readers' perceptions of a camp guided reading intervention: A qualitative case study of motivation and engagement. *Reading & Writing Quarterly*, *35*, 354–373. https://doi.org/10.1080/10573569.2018.1548952

Eshghi, A., & Kargari, M. (2018). Detecting frauds using customer behavior trend analysis and known scenarios. *International Journal of Industrial Engineering and Production Research, 29,* 91–101. https://doi.org/10.22068/ijiepr.29.1.91

Eshghi, A., & Kargari, M. (2019). Introducing a new method for the fusion of fraud evidence in banking transactions with regards to uncertainty. *Expert Systems with Applications*, *121*, 382–392. https://doi.org/10.1016/j.eswa.2018.11.039

Esteban-Lloret, N. N., Aragón-Sánchez, A., & Carrasco-Hernández, A. (2018). Determinants of employee training: Impact on organizational legitimacy and organizational performance. *International Journal of Human Resource Management*, *29*(6), 1208–1229. https://doi.org/10.1080/09585192.2016.1256337

Fambrough, G. (2019). Introduction to the Fraud Reduction and Data Analytics Act of 2015. *Armed Forces Comptroller*, *64*, 45–46.

Fathi, W., Ghani, E., Said, J., & Puspitasari, E. (2017). Potential employee fraud scape in Islamic banks: The fraud triangle perspective. *Global Journal Al-Thaqafah*, *7*(2), 79–93. https://doi.org/10.7187/GJAT122017-3

Favaretto, M., De Clercq, E., Gaab, J., & Elger, B. S. (2020). First do no harm: An exploration of researchers' ethics of conduct in big data behavioral studies. *PLoS ONE*, *15*(11), 1–23. https://doi.org/10.1371/journal.pone.0241865

Fitzpatrick, B. (2019). Validity in qualitative health education research. *Currents in Pharmacy Teaching and Learning*, *11*(2), 211–217. https://doi.org/10.1016/j.cptl.2018.11.014

Flanagin, A., Bauchner, H., & Fontanarosa, P. B. (2020). Patient and study participant rights to privacy in journal publication. *JAMA: Journal of the American Medical Association*, *323*(21), 2147–2150. https://doi.org/10.1001/jama.2020.3590

Flasher, R., & Lamboy-Ruiz, M. A. (2019). Impact of enforcement on healthcare billing fraud: Evidence from the USA. *Journal of Business Ethics*, *157*, 217–229. https://doi.org/10.1007/s10551-017-3650-z

Foxley, I. (2019). Overcoming stigma: Whistle-blowers as “supranormal” members of society? *Ephemera: Theory & Politics in Organization*, *19*(4), 847–864.

Friesen, P., Kearns, L., Redman, B., & Caplan, A. L. (2017). Rethinking the Belmont Report? *American Journal of Bioethics*, *17*, 15–21. https://doi.org/10.1080/15265161.2017.1329482

Frohock, C. M., & Jimenez, M. D. (2020). Exactly what they asked for: Linking harm and intent in wire fraud prosecutions. *University of Miami Law Review*, *74*(4), 1037.

Furlotti, K., & Mazza, T. (2020). Code of ethics and workers’ communication policies: The role of corporate governance. *Corporate Social Responsibility & Environmental Management*, *27*(6), 3060–3072. https://doi.org/10.1002/csr.2024

Fusch, P. I., & Ness, L. R. (2015). Are we there yet? Data saturation in qualitative research. *Qualitative Report*, *20*, 1408–1416.

George, G., & Selimos, E. D. (2018). Using narrative research to explore the welcoming of newcomer immigrants: A methodological reflection on a community-based research project. *Forum: Qualitative Social Research*, *19*, 119–138. https://doi.org/10.17169/fqs-19.2.2907

Ghodrati, H., & Gharbi, M. (2019). The social construction of identity in the Golestan quarter of Sabzevar: Narrative research of challenges and identity of the Ghorbat community. *Romani Studies*, *29*, 85–110. https://doi.org/10.3828/rs.2019.04

Gobena, G., & Marberg, S. C. (2018). Health care program penalties rise with bipartisan budget act of 2018. *Journal of Health Care Compliance*, *20*(4), 41–67.

Goel, R., & Saunoris, J. (2017). The nexus of white-collar crimes: Shadow economy, corruption and uninsured motorists. *Applied Economics*, *49*, 3032–3044. https://doi.org/10.1080/00036846.2016.1251570

Goldin, N. J. (2017). Wrongly "identified": Why an actual knowledge standard should govern health care providers' False Claims Act obligations to report and return Medicare and Medicaid overpayments. *Washington University Law Review*, *94*(5), 1295.

Gottschalk, P. (2017). Entrepreneurs in white-collar crime: A convenience perspective. *International Journal of Entrepreneurial Knowledge*, *5*(2), 47–55. https://doi.org/10.1515/ijek-2017-0010

Gottschalk, P. (2018). Analysis of economic crime in religious institutions using convenience theory: What is so special about motive, opportunity and willingness? *Pakistan Journal of Criminology*, *10*, 1–15.

Gottschalk, P. (2019). Empirical evidence of convenience theory: Reports of investigations by fraud examiners. *Deviant Behavior*, *40*, 110–121. https://doi.org/10.1080/01639625.2017.1411045

Gottschalk, P., & Tcherni-Buzzeo, M. (2017). Reasons for gaps in crime reporting: The case of white-collar criminals investigated by private fraud examiners in Norway. *Deviant Behavior*, *38*(3), 267–281. https://doi.org/10.1080/01639625.2016.1196993

Gonzalez, G. C., & Hoffman, V. B. (2018). Continuous auditing's effectiveness as a fraud deterrent. *Auditing: A Journal of Practice & Theory*, *37*(2), 225–247. https://doi.org/10.1016/j.giq.2018.07.006

Grammes, T., & Açikalin, M. (2016). Qualitative data collection and interpretation: A Turkish social studies lesson. *Journal of Social Studies Education Research*, *7*, 1–40.

Griffith, R. (2019). Fraud in the NHS. *British Journal of Nursing*, *28*(19), 1168–1169. https://doi.org/10.12968/bjon.2019.28.19.1168

Grubman, S. R. (2018). Top government enforcement priorities in the health care space. *Journal of Health Care Compliance*, *20*(4), 5–13.

Gunasegaran, M., Basiruddin, R., Abdul Rasid, S. Z., & Mohd Rizal, A. (2018). The case studies of fraud prevention mechanisms in the Malaysian medium enterprises. *Journal of Financial Crime*, *25*, 1024–1038. https://doi.org/10.1108/JFC-05-2017-0034

Hadi, M. A., & Closs, S. (2016). Ensuring rigour and trustworthiness of qualitative research in clinical pharmacy. *International Journal of Clinical Pharmacy, 38*(3), 641–646. https://doi.org/10.1007/s11096-015-0237-6

Hamilton, G., Powell, M. B., & Brubacher, S. P. (2017). Professionals' perceptions regarding the suitability of investigative interview protocols with Aboriginal children. *Australian Psychologist*, *52*, 174–183. https://doi.org/10.1111/ap.12196

Hauser, C. (2019). Fighting against corruption: Does anti-corruption training make any difference? *Journal of Business Ethics*, *159*, 281–299. https://doi.org/10.1007/s10551-018-3808-3

Hauser, C. (2020). From preaching to behavioral change: Fostering ethics and compliance learning in the workplace. *Journal of Business Ethics*, *162*(4), 835–855. https://doi.org/10.1007/s10551-019-04364-9

Herland, M., Khoshgoftaar, T., & Bauder, R. (2018). Big data fraud detection using multiple Medicare data sources. *Journal of Big Data*, *5*, 1–21. https://doi.org/10.1186/s40537-018-0138-3

Herland, M., Khoshgoftaar, T., & Bauder, R. (2019). The effects of class rarity on the evaluation of supervised healthcare fraud detection models. *Journal of Big Data*, *1*, 1. https://doi.org/10.1186/s40537-019-0181-8.

Herland, M., Bauder, R. A., & Khoshgoftaar, T. M. (2020). Approaches for identifying U.S. Medicare fraud in provider claims data. *Health Care Management Science*, *23*, 2–19. https://doi.org/10.1007/s10729-018-9460-8

Hewko, S. J., Cummings, G. G., Pietrosanu, M., & Edwards, N. (2018). The impact of quality assurance initiatives and workplace policies and procedures on HIV/AIDS-related stigma experienced by patients and nurses in regions with high prevalence of HIV/AIDS. *AIDS and Behavior*, *22*(12), 3836–3846. https://doi.org/10.1007/s10461-018-2066-9

Hill, C., Hunter, A., Johnson, L., & Coustasse, A. (2014). Medicare fraud in the United States: Can it ever be stopped? *Health Care Manager*, *33*(3), 254–260. https://doi.org/10.1097/HCM.0000000000000019

Holloway, C. P., & Wiener, R. L. (2020). Criminal history, sex, and employment: Sex differences in ex-offender hiring Stigma. *Analyses of Social Issues & Public Policy*, *20*, 211–229. https://doi.org/10.1111/asap.12192

Huang, S., Lin, C.-C., Chiu, A.-A., & Yen, D. (2017). Fraud detection using fraud triangle risk factors. *Information Systems Frontiers*, *19*(6), 1343–1356. https://doi.org/10.1007/s10796-016-9647-9

Huber, W. D. (2017). Forensic accounting, fraud theory, and the end of the fraud triangle. *Journal of Theoretical Accounting Research*, *12*(2), 28–49.

Hurwitz, M. H. (2019). Focusing on deterrence to combat financial fraud and protect investors. *Business Lawyer*, *75*, 1519–1550.

Iffah, W., Fathi, W., Ghani, E., Said, J. & Puspitasari, E. (2017). Potential employee fraud scape in Islamic banks: The fraud triangle perspective. *Global Journal Al-Thaqafah*, *2*, 79. https://doi.org/10.7187/GJAT122017-3

Ikono, R., Iroju, O., Olaleke, J., & Oyegoke, T. (2019). A meta-analysis of fraud, waste and abuse detection methods in healthcare. *Nigerian Journal of Technology*, *38*, 490–502. https://doi.org/10.4314/njt.v38i2.28

Jaffe, S. (2019). Home health care providers struggle with state laws And Medicare rules as demand rises. *Health Affairs*, *38*(6), 981–986. https://doi.org/10.1377/hlthaff.2019.00529

Jalil, F. Y. (2018). Internal control, anti-fraud awareness, and prevention of fraud. *Etikonomi, 17*(2), 297–306. https://doi.org/10.15408/etk.v17i2.7473

Jobin, P., & Turale, S. (2019). Choosing the right qualitative approach: Is phenomenography a design for my study? *Pacific Rim International Journal of Nursing Research*, *23*, 314–319.

Joram, E., Gabriele, A. J., & Walton, K. (2020). What influences teachers' "buy-in" of research? Teachers' beliefs about the applicability of educational research to their practice. *Teaching and Teacher Education*, 88, 1–12. https://doi.org/10.1016/j.tate.2019.102980

Joslin, R., & Müller, R. (2016). Identifying interesting project phenomena using philosophical and methodological triangulation. *International Journal of Project Management*, *34*(6), 1043–1056. https://doi.org/10.1016/j.ijproman.2016.05.005

Kamaliah, K., Marjuni, N. S., Mohamed, N., Mohd-Sanusi, Z., & Anugerah, R. (2018). Effectiveness of monitoring mechanisms and mitigation of fraud incidents in the public sector. *Administration & Public Management Review*, *30*, 82–95. https://doi.org/10.24818/amp/2018.30-06

Kaplan, B. (2022). Ethics, guidelines, standards, and policy: Telemedicine, COVID-19, and broadening the ethical scope. *Cambridge Quarterly of Healthcare Ethics : CQ : The International Journal of Healthcare Ethics Committees*, *31*, 105–118. https://doi.org/10.1017/S0963180121000852

Kennedy, P. (2019). Lies and statistics: Statistical sampling in liability determinations under the False Claims Act. *Stanford Law Review*, *71*(5), 1353–1396.

Kenny, K., Fotaki, M., & Scriver, S. (2019). Mental health as a weapon: Whistle-blower retaliation and normative violence. *Journal of Business Ethics*, *160*(3), 801–815. https://doi.org/10.1007/s10551-018-3868-4

Khanna, T., Lakhani, K. R., Bhadada, S., Khan, N., Dave, S. K., Alam, R., & Hewett, M. (2021). Crowdsourcing memories: Mixed methods research by cultural insiders-epistemological outsiders. *Academy of Management Perspectives*, *35*(3), 384–399. https://doi.org/10.5465/amp.2018.0090

Kim, R., Gangolly, J., Ravi, S. S., & Rosenkrantz, D. J. (2020). Formal analysis of segregation of duties (SoD) in accounting: A computational approach. *Abacus*, *56*(2), 165–212. https://doi.org/10.1111/abac.12190

Kim, L. (2017). Cybersecurity awareness: Protecting data and patients. *Nursing Management*, *48*(4), 16–19. https://doi.org/10.1097/01.NUMA.0000514066.30572.f3

Konecki, K. T. (2019). Creative thinking in qualitative research and analysis. *Qualitative Sociology Review*, *15*, 6–25. https://doi.org/10.18778/1733-8077.15.3.01

Korstjens, I., & Moser, A. (2017). Series: Practical guidance to qualitative research. Part 2: Context, research questions and designs. *European Journal of General Practice*, *23*, 274–279. https://doi.org/10.1080/13814788.2017.1375090

Korstjens, I., & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice*, *24*, 120–124. https://doi.org/10.1080/13814788.2017.1375092

Krause, J. H. (2017). Teaching fraud and abuse law: Seeing both the forest and the trees. *Saint Louis University Law Journal*, *61*(3), 457.

Kumar, K., Bhattacharya, S., & Hicks, R. (2018). Employee perceptions of organization culture with respect to fraud – where to look and what to look for. *Pacific Accounting Review*, *30*(2), 187. https://doi.org/10.1108/PAR-05-2017-0033

Kyu, T., Fu, J., & Yang, K. (2018). Do good workplace relationships encourage employee whistle-blowing? *Public Performance & Management Review*, *41*(4), 768–789. https://doi.org/10.1080/15309576.2018.1464935

Labriola, L. (2017). Paying too dearly for a whistle: Properly protecting internal whistleblowers. *Fordham Law Review*, *85*(6), 2839–2878.

Laeheem, K. (2020). Causal relationships between religion factors influencing ethical behavior among youth in the three southern border provinces of Thailand. *Children & Youth Services Review*, *108,* 1–7. https://doi.org/10.1016/j.childyouth.2019.104641

Lapid, M. I., Clarke, B. L., & Wright, R. S. (2019). Institutional review boards: What clinician researchers need to know. *Mayo Clinic Proceedings*, *94*(3), 515–525. https://doi.org/10.1016/j.mayocp.2019.01.020

Lanka, E., Lanka, S., Rostron, A., & Singh, P. (2021). Why we need qualitative research in management studies. *RAC - Journal of Contemporary Administration*, *25*(2), 1–7. https://doi.org/10.1590/1982-7849rac2021200297.en

Larkin, M., Shaw, R., & Flowers, P. (2019). Multiperspectival designs and processes in interpretative phenomenological analysis research. *Qualitative Research in Psychology*, *16*, 182–198. https://doi.org/10.1080/14780887.2018.1540655

Levy, K. M. (2018). Note: Individually-focused deterrence: A proposed incentives-based non-prosecution strategy for second chances and its constitutional hurdles. *Rutgers University Law Review*, *71*, 509–536.

Lindhult, E. (2019). Scientific excellence in participatory and action research: Part II. Rethinking objectivity and reliability. *Technology Innovation Management Review*, *9*(5), 22. https://doi.org/10.22215/timreview/1238

Liu, J., Bier, E., Wilson, A., Guerra-Gomez, J. A., Honda, T., Sricharan, K., & Davies, D. (2016). Graph analysis for detecting fraud, waste, and abuse in health-care data. *AI Magazine*, *37*(2), 33–46.

Liu, N., Wing-Hung Lo, C., & Zhan, X. (2019). Regulatory ties and corporate compliance strategies. *Public Performance & Management Review*, *42*(3), 580–605. https://doi.org/10.1080/15309576.2018.1486214

Lokanan, M. (2018). Informing the fraud triangle: Insights from differential association theory. *Journal of Theoretical Accounting Research*, *14*, 55–98. ~~http://jtar.org/~~

Lowe, A., Norris, A. C., Farris, A. J., & Babbage, D. R. (2018). Quantifying thematic saturation in qualitative data analysis. *Field Methods*, *30*, 191–207. https://doi.org/10.1177/1525822X17749386

Luizzo, A. (2019). Effective interview techniques. *Journal of Healthcare Protection Management*, *35*, 110–117.

Machado, M. R., & Gartner, I. R. (2018). The Cressey hypothesis (1953) and an investigation into the occurrence of corporate fraud: An empirical analysis conducted in Brazilian banking institutions. *Accounting & Finance Magazine - USP*, *29*(76), 60–81. https://doi.org/10.1590/1808-057x201803270

Mackieson, P., Shlonsky, A., & Connolly, M. (2019). Increasing rigor and reducing bias in qualitative research: A document analysis of parliamentary debates using applied thematic analysis. *Qualitative Social Work*, *18*(6), 965–980. https://doi.org/10.1177/1473325018786996

Madill, A., & Sullivan, P. (2018). Mirrors, portraits, and member checking: Managing difficult moments of knowledge exchange in the social sciences. *Qualitative Psychology*, *5*(3), 321–339. https://doi.org/10.1037/qup0000089

Mejia, S. (2022). Socratic ignorance and business ethics. *Journal of Business Ethics*, *175*(3), 537–553. https://doi.org/10.1007/s10551-020-04650-x

Masaba, S. (2015). Diagnosed with time is money: Arbitrary Medicare provisions differentiating observation services from inpatient admissions violate beneficiaries' due process rights. *William & Mary Bill of Rights Journal*, *23*(4), 1185–1214.

McGee, J., Sandridge, L., Treadway, C., Vance, K., & Coustasse, A. (2018). Strategies for fighting Medicare fraud. *Health Care Manager*, *37*(2), 147. https://doi.org/10.1097/HCM.0000000000000204

McNeal, A. (2017). What's your fraud IQ? *Journal of Accountancy*, *224*(3), 32–35.

McSweeney, J. C., Boateng, B., James, L., McElfish, P. A., Robinson, D., Hatley, S. E., Christie, P., & Indelicato, N. (2019). Developing and launching a research participant registry. *Health Communication*, *34*(10), 1159–1165. https://doi.org/10.1080/10410236.2018.1465794

Menting, B. (2018). Awareness x opportunity: Testing interactions between activity nodes and criminal opportunity in predicting crime location choice. *British Journal of Criminology*, *58*(5), 1171–1192. https://doi.org/10.1093/bjc/azx049

Messabia, N., Elbekkali, A., Blanchette, M., & Xiaoling Xing. (2020). Using the audit risk model in an ERP environment: Evidence from Canada and China. *Journal of Applied Business & Economics*, *22*(9), 83–99. https://doi.org/10.33423/jabe.v22i9.3670

Miller, A. (2013). White coats and white-collar crime. *CMAJ: Canadian Medical Association Journal*, *185*, E19-E20. https://doi.org/10.1503/cmaj.109–4346

Miracle, V. A. (2016). The Belmont report: The triple crown of research ethics. *Dimensions of Critical Care Nursing*, *35*, 223–228. https://doi.org/10.1097/DCC.0000000000000186

Meyers, T. J. (2017). Examining the network components of a Medicare fraud scheme: The Mirzoyan-Terdjanian organization. *Crime Law and Social Change*, *68*(1–2), 251–279. https://doi.org/10.1007/s10611-017-9689-z

Moon, M. (2015). Improving Medicare financing: Are we up to the challenge? *Generations*, *39*(2), 164–171.

Morar, N., Baber, C., McCabe, F., Starke, S. D., Skarbovsky, I., Artikis, A., & Correai, I. (2019). Drilling into dashboards: Responding to computer recommendation in fraud analysis. *IEEE Transactions on Human-Machine Systems*, *49*(6), 633–641. https://doi.org/10.1109/THMS.2019.2925619

Moser, A., & Korstjens, I. (2018). Series: Practical guidance to qualitative research. Part 3: Sampling, data collection and analysis. *European Journal of General Practice*, *24*, 9–18. https://doi.org/10.1080/13814788.2017.1375091

Moyes, G. D., Anandarajan, A., & Arnold, A. G. (2019). Fraud-detecting effectiveness of management and employee red flags as perceived by three different groups of professionals. *Journal of Business & Accounting*, *12*, 133–147.

Muhtar, Sutaryo, & Sriyanto. (2018). Corruption in Indonesian local government: Study on triangle fraud theory. *International Journal of Business & Society*, *19*, 536–552.

Mykhalovskiy, E., Eakin, J., Beagan, B., Beausoleil, N., Gibson, E., Macdonald, E., & Rock, J. (2018). Beyond bare bones: Critical, theoretically engaged qualitative research in public health. *Canadian Journal of Public Health*, *109*, 613–621. https://doi.org/10.17269/s41997-018-0154-2

National Commission for the Protection of Human Subjects and Biomedical and Behavioral Research (1979). *The Belmont Report: Ethical principles and guidelines for the protection of human subjects of research*. Washington, DC: U.S. Department of Health and Human Services.

Naghavi, K. Z., Mortazavi, S. B., Asilian M., H., & Hajizadeh, E. (2019). Exploring the contributory factors of confined space accidents using accident investigation reports and semistructured interviews. *Safety and Health at Work*, *10*(3), 305–313. https://doi.org/10.1016/j.shaw.2019.06.007

Natow, R. S. (2020). The use of triangulation in qualitative studies employing elite interviews. *Qualitative Research*, *20*(2), 160–173. https://doi.org/10.1177/1468794119830077

Navarro, C., Knight, T., Sharman, S. J., & Powell, M. B. (2019). Challenges in translating interview protocols for alleged child victims of sexual abuse to different languages: A case study. *Child Abuse & Neglect*, *94*, 1–10. https://doi.org/10.1016/j.chiabu.2019.104033

Nicholas, H., Segal, J., Hanson, C., Zhang, K., & Eisenberg, M. D. (2019). Medicare beneficiaries' exposure to fraud and abuse perpetrators. *Health Affairs*, *38*(5), 788–793. https://doi.org/10.1377/hlthaff.2018.05149

Nelson, J. (2017). Using conceptual depth criteria: Addressing the challenge of reaching saturation in qualitative research. *Qualitative Research*, *17*, 554–570. https://doi.org/10.1177/1468794116679873

N'Guilla Sow, A., Basiruddin, R., Mohammad, J., & Abdul Rasid, S. Z. (2018). Fraud prevention in Malaysian small and medium enterprises (SMEs). *Journal of Financial Crime*, *25*(2), 499–517. https://doi.org/10.1108/JFC-05-2017-0049

Nixon, T., & Barnes, J. (2019). Calibrating student perceptions of punishment: A specific test of general deterrence. *American Journal of Criminal Justice, 44*(3), 430–456. https://doi.org/10.1007/s12103-018-9466-2

Nolasco, C., & Vaughn, M. S. (2019). Convenience theory of cryptocurrency crime: A content analysis of US Federal court decisions. *Deviant Behavior*. https://doi.org/10.1080/01639625.2019.1706706

Nwanna-Nzewunwa, O. C., Ajiko, M. M., Motwani, G., Kabagenyi, F., Carvalho, M., Feldhaus, I., Kirya, F., Epodoi, J., Dicker, R., & Juillard, C. (2019). Identifying information gaps in a surgical capacity assessment tool for developing countries: A methodological triangulation approach. *World Journal of Surgery*, *43*(5), 1185–1192. https://doi.org/10.1007/s00268-019-04911-5

Nwoke, U. (2019). Whistle-blowing as a corporate governance mechanism: South Africa and Nigeria in perspective. *Journal of Corporate Law Studies*, *19*(2), 421–450. https://doi.org/10.1080/14735970.2018.1561795

Pande, V., & Maas, W. (2013). Physician Medicare fraud: Characteristics and consequences. *International Journal of Pharmaceutical and Healthcare Marketing*, *7*, 8–33. https://doi.org/10.1108/17506121311315391

Parrish, H. (2018). The cost of qui tam suits: An empirical analysis of state false claims Acts. *Journal of the Legal Profession*, *42*(2), 277–290.

Patel, K., & Sherer, J. D. (2016). DOJ targets individuals for violations of false claims act and anti-kickback statute. *Journal of Health Care Compliance*, *18*(4), 53–56.

Peiris, G. K. H., & Aruppala, W. D. N. (2021). A study on fraud prevention and detection Methods in Sri Lanka. *Kelaniya Journal of Management*, *10*(2), 37–56. https://doi.org/10.4038/kjm.v10i2.7692

Peltier-Rivest, D. (2018). A model for preventing corruption. *Journal of Financial Crime*, *25*(2), 545. https://doi.org/10.1108/JFC-11-2014-0048

Poquioma T., Kashirskaya, L., Karabasheva, M., Khoruzhy, L., Marmilova, E., & Perepechkina, E. (2020). Diagnostics of corporate fraud and counteraction measures. *Journal of Security & Sustainability Issues*, *9*(4), 1511–1521. https://doi.org/10.9770/jssi.2020.9.3(32)

Rahaim, A., & Matusitz, J. (2020). Patty Hearst and the Symbionese Liberation Army (SLA): An examination through differential association theory. *Journal of Applied Security Research*, *15*(3), 408–422. https://doi.org/10.1080/19361610.2019.1710094

Rashid, Y., Rashid, A., Warraich, M., Sana, S., & Waseem, A. (2019). Case study method: A step-by-step guide for business researchers. *International Journal of Qualitative Methods*, *18,* 1–13. https://doi.org/10.1177/1609406919862424

Rawashdeh, A. M., & Tamimi, S. A. (2020). The impact of employee perceptions of training on organizational commitment and turnover intention: An empirical study of nurses in Jordanian hospitals. *European Journal of Training & Development*, *44*(2/3), 191–207. https://doi.org/10.1108/EJTD-07-2019-0112

Roulston, K., & Shelton, S. A. (2015). Reconceptualizing bias in teaching qualitative research methods. *Qualitative Inquiry*, *21*, 332–342. https://doi.org/10.1177/1077800414563803

Said, J., Alam, M.M., Ramli, M., & Rafidi., M. (2017). Integrating ethical values into fraud triangle theory in assessing employee fraud: Evidence from the Malaysian banking industry. *Journal of International Studies*, *10*(2), 1–20. https://doi.org/10.14254/2071-8330.2017/10-2/13

Said, J., Asry, S., Rafidi, M., Obaid, R., & Alam, M. (2018). Integrating religiosity into fraud triangle theory: Empirical findings from enforcement officers. *Global Journal Al-Thaqafah*, *1*, 131. https://doi.org/10.7187/GJATSI2018-09

Sandhu, N. (2020). Behavioral red flags of fraud: A gender-based ex post analysis. *Journal of Financial Crime*, *27*(4), 1307. https://doi.org/10.1108/JFC-04-2020-0048

Santo, C. (2014). Walking a tightrope: Regulating Medicare fraud and abuse and the transition to value-based payment. *Case Western Reserve Law Review*, *64*, 1377–1418.

Sarode, A. P., & Deore, S. S. (2017). Role of third-party employee verification and background checks in HR management: An overview. *Journal of Commerce & Management Thought*, *8*, 86.

Sarwanto, L. E., & Chumdari. (2021). Open-ended questions to assess critical-thinking skills in Indonesian elementary school. *International Journal of Instruction*, *14*, 615–630. https://doi.org/10.29333/iji.2021.14137a

Schmitz, K., & Moodie, B. (2018). A Stark reminder: Some common compliance pitfalls. *Journal of Health Care Compliance*, *20*(2), 5–11.

Schneider, A. (2019). Deterrence theory in Paraguay: Exploring fraud and violation of trust cases. *Social Sciences, 8*, 23. https://doi.org/10.3390/socsci8010023

Schober, M. (2018). The future of face-to-face interviewing. *Quality Assurance in Education*, *26*(2), 290. https://doi.org/10.1108/QAE-06-2017-0033.

Self, M. M., Wise, H., Beauvais, J., & Molinari, V. (2017). Ethics in training and training in ethics: Special considerations for postdoctoral fellowships in health service psychology. *Training and Education in Professional Psychology*, *12*(2), 105–112. https://doi.org/10.1037/tep0000178

Sharma, A., & Baweja, P. (2017). Medical identity theft: A case report. *Annals of Internal Medicine*, *166*(5), 380. https://doi.org/10.7326/L16-0360

Sieck, R., Lohman, H., Stupica, K., Minthorne-Brown, L., & Stoffer, K. (2017). Awareness of Medicare regulation changes: Occupational therapists' perceptions and implications for practice. *Physical & Occupational Therapy in Geriatrics*, *35*(2), 67–80. https://doi.org/10.1080/02703181.2017.1288672

Shepard, M., Baicker, K., & Skinner, J. (2020). Does one Medicare fit all? The economics of uniform health insurance benefits. *NBER/Tax Policy & the Economy (University of Chicago Press)*, *34*(1), 1–41. https://doi.org/10.1086/708168

Shufutinsky, A. (2020). Employing use of self for transparency, rigor, trustworthiness, and credibility in qualitative organizational research methods. *Organization Development Review*, *52*, 50–58.

Socal, M. P., Ezebilo, I., Bai, G., & Anderson, G. F. (2021). Biosimilar formulary placement in Medicare Part D prescription drug plans: A case study of infliximab. *American Journal of Health-System Pharmacy : AJHP : Official Journal of the American Society of Health-System Pharmacists*, *78*(3), 216–221. https://doi.org/10.1093/ajhp/zxaa376

Starr, K. T. (2017). Background checks: Do you have something to report? *Nursing*, *47*(10), 11–12. https://doi.org/10.1097/01.NURSE.0000524752.74764.17

Stowell, N. F., Schmidt, M., & Wadlinger, N. (2018). Healthcare fraud under the microscope: Improving its prevention. *Journal of Financial Crime*, *25*, 1039–1061. https://doi.org/10.1108/JFC-05-2017-0041

Subramanian, D., & Zimmermann, B. (2020). Voice in French corporate training: A critical issue in developing employee capability. *Economic & Industrial Democracy*, *41*(2), 296–322. https://doi.org/10.1177/0143831X17704311

Swygart-Hobaugh, M. (2019). Bringing method to the madness: An example of integrating social science qualitative research methods into NVivo data analysis software training. *IASSIST Quarterly*, *43*(2), 1–16. https://doi.org/10.29173/iq956

Tang, T., & Karim, K. (2019). Financial fraud detection and big data analytics – implications on auditors' use of fraud brainstorming session. *Managerial Auditing Journal*, *34*(3), 324. https://doi.org/10.1108/MAJ-01-2018-1767

Thaldar, D., Townsend, B., Staunton, C., Adams, R., Botes, M., Dove, E. S., … & de Vries, J. (2020). Privacy rights of human research participants in South Africa must be taken seriously. *SAMJ: South African Medical Journal*, *110*(3), 175. https://doi.org/10.7196/SAMJ.2020.v110i3.14450

Theofanidis, D., & Fountouki, A. (2018). Limitations and delimitations in the research process. *Perioperative Nursing*, *7*(3), 155–163. https://doi.org/10.5281/zenodo.2552022

Tovino, S. A. (2019). Fraud, abuse, and opioids. *University of Kansas Law Review*, *5*, 901.

Tran, V. T., Porcher, R., Falissard, B., & Ravaud, P. (2016). Point of data saturation was assessed using resampling methods in a survey with open-endedquestions. *Journal of Clinical Epidemiology*, *80*, 88–96. https://doi.org/10.1016/j.jclinepi.2016.07.014

Tran, T., Porcher, R., Tran, C., & Ravaud, P. (2017). Predicting data saturation in qualitative surveys with mathematical models from ecological research. *Journal of Clinical Epidemiology*, *82*, 71–78. https://doi.org/10.1016/j.jclinepi.2016.10.001

Treadwell, G. W. (2021). Preventing employee frauds in small businesses with low-cost methods. *Journal of Business & Accounting*, *14*, 3–15.

Ugaddan, R. G., & Park, S. M. (2019). Do trustful leadership, organizational justice, and motivation influence whistle-blowing intention? Evidence from federal employees. *Public Personnel Management*, *48*, 56–81. https://doi.org/10.1177/0091026018783009

Umar, M., Sitorus, S., Surya, R., Shauki, E., & Diyanti, E. (2017). Pressure, dysfunctional behavior, fraud detection and role of information technology in the audit process. *Australasian Accounting, Business and Finance Journal, 11*(4),102–115.

U.S. Department of Health and Human Services. (2013). Medicare fee-for-service 2013 improper payment rate report.

U.S. Government Accountability Office. (2017). CMS needs to fully align its antifraud efforts with the fraud risk framework (GAO Publication No. GAO-18-88).

van Assen, M. F. (2021). Training, employee involvement and continuous improvement – the moderating effect of a common improvement method. *Production Planning & Control*, *32*(2), 132–144. https://doi.org/10.1080/09537287.2020.1716405

Vanderpool, D. (2019). HIPAA compliance: A common sense approach. *Innovations in Clinical Neuroscience*, *16*, 38–41.

van de Wiel, M. W. J. (2017). Examining expertise using interviews and verbal protocols. *Frontline Learning Research*, *5*, 112–140. https://doi.org/10.1111/j.1365-2929.2005.02250.x

Vasileiou, K., Barnett, J., Thorpe, S., & Young, T. (2018). Characterising and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year period. *BMC Medical Research Methodology*, *18*, 1–18. https://doi.org/10.1186/s12874-018-0594-7

Vishnevsky, T., & Beanlands, H. (2004). Qualitative Research. *Nephrology Nursing Journal, 31(*2), 234–238.

Vousinas, G. L. (2019). Advancing theory of fraud: The S.C.O.R.E. model. *Journal of Financial Crime*, *26*, 372–381. https://doi.org/10.1108/JFC-12-2017-0128.

Wadams, M., & Park, T. (2018). Qualitative research in correctional settings: Researcher bias, western ideological influences, and social justice. *Journal of Forensic Nursing, 14*, 72–79. https://doi.org/10.1097/JFN.0000000000000199

Waldkirch, M. (2020). Non-family CEOs in family firms: Spotting gaps and challenging assumptions for a future research agenda. *Journal of Family Business Strategy*, *11*, 1–24. https://doi.org/10.1016/j.jfbs.2019.100305

Walshe, C. (2020). Aims, actions and advance care planning by district nurses providing palliative care: An ethnographic observational study. *British Journal of Community Nursing*, *25*(6), 276–286. https://doi.org/10.12968/bjcn.2020.25.6.276

Ward, S. J., & King, L. A. (2018). Religion and moral self-image: The contributions of prosocial behavior, socially desirable responding, and personality. *Personality & Individual Differences*, *131*, 222–231. https://doi.org/10.1016/j.paid.2018.04.028

Weber, J. (2015). Investigating and assessing the quality of employee ethics training programs among US-based global organization. *Journal of Business Ethics*, *129*, 27–42. https://doi.org/10.1007/s10551-014-2128-5

Wilhelm, W. K. (2004). The fraud management lifecycle theory: A holistic approach to fraud management. *Journal of Economic Crime Management*, *2*(2), 1–38. https://www.jecm.org

Williams, M., & Moser, T. (2019). The art of coding and thematic exploration in qualitative research. *International Management Review*, *15*, 45–55.

Wu, S., Peng, M., Mei, H., & Shang, X. (2019). Unwilling but not unable to control: Ego depletion increases effortful dishonesty with material rewards. *Scandinavian Journal of Psychology*, *60*(3), 189–194. https://doi.org/10.1111/sjop.12526

Yaraghi, N., & Gopal, R. D. (2018). The role of HIPAA Omnibus Rules in reducing the frequency of medical data breaches: Insights from an empirical study. *Milbank Quarterly*, *96*, 144–166. https://doi.org/10.1111/1468-0009.12314

Yin, R. K. (2011). *Qualitative research from start to finish.* The Guilford Press.

Yin, R. K. (2014). *Case study research: Design and methods.* (5th. ed.). Sage Publications.

Yin, R. K. (2018). *Case study research and Applications: Design and methods* (6th. ed.). Sage Publications.

Zabyelina, Y. G. (2017). Can criminals create opportunities for crime? Malvertising and illegal online medicine trade. *Global Crime*, *18*, 31–48. https://doi.org/10.1080/17440572.2016.1197124

Zandian, Z. K., & Keyvanpour, M. (2017). Systematic identification and analysis of different fraud detection approaches based on the strategy ahead. *International Journal of Knowledge Based Intelligent Engineering Systems*, *21*(2), 123–134. https://doi.org/10.3233/KES-170357

Zigrang, T. A., & Bailey-Wheaton, J. L. (2020). Healthcare valuation implications of the Stark Law proposed rule. *Value Examiner*, *Jan/Feb*, 27–32.

Zuberi, O., & Mzenzi, S. I. (2019). Analysis of employee and management fraud in Tanzania. *Journal of Financial Crime*, *26*(2), 412–431. https://doi.org/10.1108/JFC-01-2018-0012

# Appendix A: Interview Protocol

Interview Title: Training strategies some speech pathology managers use.

1. I will begin the interview process with a brief introduction of myself, build relationships through casual conversation, and thank each participant for their time and efforts.
2. I will review the informed consent letter each participant signed and provide a copy to them via email. I will review the contents of the letter and remind participants that they can quit the study or not answer any of the interview questions at any time.
3. I will discuss member checking with each participant and notify them that I will be scheduling a follow-up interview to ensure the accuracy of my summaries. I will inform them that they can add new information during the follow up interview if necessary.
4. I will inform the participant that we will be starting the interview and I will be turning on the audio recorder. I will state the date, time, and alphanumeric code of the participant, and start the interview.
5. Each participant will be given as much time as they need to answer each question and ask any follow-up questions.
6. After the last question, I will notify the participants that the interview has concluded and that I will be turning off the audio recorder. I will thank the participant for their time and schedule the follow-up interview.

## Appendix B: Interview Questions

1. In your fraud prevention success, what specific fraud activities did you identify or define as being Medicare Fraud?
2. In your strategy to prevent Medicare claims fraud, what specific suspected fraudulent activities do you investigate?
3. As a result of your investigative findings, what are the specific components and schedules of your training program's items to help prevent Medicare fraud committed by speech pathologists?
4. What were the key types of resistance or problems you encountered while investigating or implementing your fraud detection program?
5. How did your organization address the key types of resistance or problems you encountered during your investigations?
6. What specific actions and measures did you implement to detect, identify, and locate fraud before, during, or after the fraud was committed?
7. What types of analysis do you use to measure the effectiveness of your fraud prevention strategies?
8. What specific policies did you implement to address termination and prosecution for Medicare fraud violations committed by speech pathologists?
9. What additional information about Medicare fraud education and training would you like to share with me?