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MEDICARE

One Scheme Illustrates Vulnerabilities To Fraud

GAO

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Human Resources Division

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The Honorable Fortney H. (Pete) Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

The Honorable Bill Gradison
Ranking Minority Member
Subcommittee on Health
Committee on Ways and Means
House of Representatives

Health care fraud and abuse add billions to our nation's annual cost of medical care. This report examines one insurance fraud scheme initially rooted in the Medicare program that investigators believe to be the largest case of health care fraud ever identified. Since the early 1980s, the scheme grew to involve hundreds of physicians and numerous medical laboratories and an estimated $1 billion in fraudulent claims to public and private insurers.

Referred to as the "rolling labs" scheme, it initially involved providers who used vans to transport medical equipment to provide noninvasive physiological tests, such as blood flow analysis, ultrasounds of the abdominal cavity, and other vascular studies, to groups of elderly persons in locations such as nursing homes. Eventually, the scheme progressed from vans stationed at health clubs and church parking lots to multiple free-standing clinics, all offering the same battery of tests to all comers. Patients would be solicited by mail and telephone to undergo physicals at no charge to them; often the "pitch" would be accompanied by dire statistics about the number of people who die annually from diseases of which they are unaware.

Typically, these tests were of questionable medical necessity and the providers induced individuals to obtain services by waiving copayments. To justify the tests and obtain Medicare payment, the operators retained physicians who certified the diagnoses or nonmedical administrative staff would simply make up fictitious diagnoses. The rolling labs' management also solicited kickbacks or "referral fees" from other laboratories for referring patient specimens to them for additional testing. To mask their scheme, the rolling labs operated under many different corporate names, splitting claims between them to avoid detection.

The practices allegedly used by the rolling labs—billing for unnecessary services, falsifying claims, routinely waiving copayments, and paying kickbacks—are illegal under Medicare. In 1987, several key persons involved in the operation were successfully prosecuted for Medicare violations. In 1991, U.S. Attorneys indicted scheme operators for defrauding other insurers. Appendix I contains additional details on the scheme's operation, detection, prosecution, and its transition from Medicare to other health insurers.

At your request, we reviewed Medicare's involvement in the rolling labs operation. Specifically, we assessed the extent of false claims paid by the Medicare program, the success of Medicare's efforts to recover these monies, and the program's vulnerability to similar fraudulent activities.

Results in Brief

The rolling labs case highlights several key Medicare vulnerabilities to health insurance fraud and abuse. These include difficulties recovering financial losses resulting from fraudulent schemes and the ease with which providers—whose Medicare history may evidence fraudulent or abusive activity—can bill the program with little prospect of being identified. Although Medicare uncovered the rolling labs operation and successfully prosecuted certain individuals associated with it, the program was unable to recover over $5 million in identified overpayments to providers involved in the scheme.

The highly publicized rolling labs case is thought to have spawned other schemes patterned after it. Detecting these schemes and preventing financial losses will continue to be difficult, and correcting some of the current weaknesses will take time and further analysis. But there are strategies Medicare can and should adopt to minimize its losses. For example, the Health Care Financing Administration (HCFA) should develop guidance for Medicare carriers on the use of available information to (1) monitor abnormal referral patterns between physicians and laboratories or suppliers and (2) identify and track the practices and affiliations of providers involved in past fraudulent or abusive activity. In addition, HCFA should establish standards for the assignment of provider billing numbers to laboratories.

HCFA recently requested increased funding for program safeguard activities and required carriers to establish independent fraud investigation branches. Coupled with recent legislative and regulatory changes, these

steps should help address vulnerabilities to schemes such as the rolling labs.

Background

Medicare insures about 35 million people aged 65 and over and certain individuals under 65 who are disabled. It provides coverage under two parts: part A, primarily hospital insurance, and part B, supplementary insurance. The latter covers physician services, outpatient hospitals, and such other health services as physiological laboratory tests.

HCFA, an agency within the Department of Health and Human Services (HHS), establishes Medicare policies, develops operating guidelines, and monitors compliance with legislation. The agency contracts with insurance companies, called intermediaries for part A and carriers for part B, to process, review, and pay claims for covered services.

Medicare part B carriers play an essential role in detecting fraud and abuse committed by physicians and other health care providers.[1] To identify cases of potential fraud or abuse, obtain additional information to develop them, and refer suspected cases to the OIG for further investigation, each carrier is required to maintain a program integrity unit. Investigations may result in such civil actions as fines or exclusion from the Medicare and Medicaid programs, or in criminal prosecution. In addition to acting on complaints, tips, or reports received from beneficiaries, government agencies, or other sources, the program integrity unit detects unusual billing patterns through postpayment and other reviews. Carriers also initiate overpayment collection actions and refer uncollectibles to HCFA.

Scope and Methodology

To respond to your request, we performed work at the two Medicare part B carriers in California, Transamerica in Los Angeles and Blue Shield in San Francisco, and HCFA's regional office in San Francisco. During the visits, we

- obtained information on the extent of Medicare payments made to physicians and laboratories involved in the operation,
- determined what efforts were made to recover overpayments resulting from false claims,
- determined what payment safeguards were in place, and

[1]Both fraud and abuse involve actions resulting in inappropriate program costs. They differ in that fraud generally is characterized by actions knowingly and willingly committed with the intent of cheating the program.

- assessed the Medicare program's vulnerability to similar fraudulent activities.

In addition, we discussed the rolling labs case with officials from the Department of Justice, the Defense Criminal Investigative Service, HHS's Office of the Inspector General (OIG), the Postal Service, the Internal Revenue Service, California's Department of Insurance's Fraudulent Claims Bureau and Medicaid fraud control unit, and private insurers in California.

Our work was conducted between August 1991 and April 1992 in accordance with generally accepted government auditing standards.

Medicare Unable To Recover Payments to Rolling Labs

Medicare's success in identifying and prosecuting the rolling labs' operators did not translate into successful recovery of payments for fraudulent or abusive claims. The rolling labs scheme resulted in millions of dollars of inappropriate Medicare expenditures—the exact amount is unknown. However, contractors were able to identify over $5 million that was overpaid to at least 56 physicians and laboratories affiliated with the operation. Of this amount, very little was recovered.[2] These providers used legal loopholes to avoid carrier and HCFA collection efforts—illustrating that considerable obstacles exist to recovering Medicare overpayments even after fraudulent or abusive activities have been detected.[3]

How Physicians and Laboratories Avoided Repayments

Once overpayments are established, Medicare's collection process requires that carriers send two notices to providers requesting payment. If these fail, carriers refer the matter to the HCFA regional office, from which a third notice requesting payment is sent. After sending the first letter, carriers are also authorized to recover overpayments by offsetting the amounts owed against a physician's or laboratory's current claims.[4]

Many physicians and laboratories involved with the rolling labs scheme avoided their liability for repaying Medicare overpayments and, in some cases, continued billing the program. The providers involved with the rolling labs did not respond to HCFA and carrier collection letters. Using

[2]One carrier collected a small percentage of the overpayments before they were referred to HCFA.

[3]An ongoing GAO review is assessing the adequacy of Medicare overpayment recovery efforts and how these efforts can be enhanced.

[4]HCFA policy permits contractors to begin the offset process 40 days after notifying the provider of their intended action.

several methods, they avoided offsets. Some stopped operating under their corporate identities, formed new corporate identities, or affiliated with another company or physician group practice. Further, liability for overpayments for laboratory tests can be difficult to establish because such tests are always requested by physicians.

Same Laboratory, New Identity

HCFA and carrier officials stated they were unable to recover overpayments to many physicians and laboratories involved in the rolling labs scheme. This was because the providers could not be located and had stopped operating under the corporate identity associated with the overpayment. Some unscrupulous providers use these tactics to avoid paying their Medicare debts. For example, in November 1986 a Medicare carrier advised a laboratory of an overpayment of over $101,000. In December 1986, the laboratory withdrew from the Medicare program and Medicare discontinued its collection efforts. Subsequently, carrier officials discovered that a second laboratory, formed around the time of dissolution of the first, was essentially the old laboratory operating under a new name and Medicare provider number. In such situations, where the legal identity of the second laboratory differs from that of the debtor laboratory, recovery action is unlikely to be successful, HCFA officials said.[5]

Repayment Evaded Through Group Practice Billing

Additionally, a change in provider billing identity can impede overpayment collection when a physician stops using his or her individual Medicare provider number and begins billing through a group provider number. According to HCFA's regional counsel and a carrier official, neither HCFA nor the carriers have the authority to offset the physician group's Medicare billings to recover the physician's overpayments. This is so even when the services billed were provided directly by the physician with the Medicare overpayment.

Several physicians and laboratories with large overpayments involved in the rolling labs scheme avoided Medicare offsets by changing the way they billed the program. For example, after a carrier notified several physicians that action to recover overpayments was imminent, they stopped submitting claims with their individual provider numbers. In one such case, Medicare did not offset a physician's $32,145 overpayment against his group practice's Medicare charges, which in 1990 exceeded $1.6 million.

[5]As a purely legal matter, it may not be unduly difficult to "pierce the corporate veil" and thereby reach the responsible individuals behind these sham corporations. But as with other obstacles to recovery, there may be limited resources with which to counter it.

Establishing Liability for Referral Services Difficult

Collecting overpayments is also difficult when they result from physicians ordering unnecessary laboratory tests or services. Generally, a physician will not be held financially liable for unnecessarily referring patients for tests unless it can be proved that he or she participated in a scheme to defraud the program, for example, by receiving kickbacks from a laboratory. Moreover, to recover from laboratories, a carrier must prove that they knowingly provided medically unnecessary tests or services—a difficult task. In practice, this means that even when Medicare can clearly establish that laboratory tests were unnecessary, often no one is held liable for the resulting overpayments.

The difficulty of recovering payments for unnecessary laboratory tests is illustrated by a case involving a laboratory affiliated with the rolling labs operation. The carrier determined that this laboratory was overpaid $122,931 for routine screening tests requested by several physicians. However, an administrative law judge found the laboratory to be without fault for the overpayment. Reasoning that laboratories act on physician orders, the judge ruled that the laboratory, given only a patient's diagnosis and the referring physician's name, could not have detected the physician's illicit referral patterns and should not be held liable for the cost of performing the requested tests. Consequently, Medicare recovered none of the money it paid for the unnecessary tests.

Pursuit of Fraud Cases Limited

When collection letters and offset actions do not result in recovery of overpayments, HCFA can begin civil procedures, including such action as referring these cases to the Department of the Treasury to reduce any tax refund owed to the providers. Medicare policy requires that HCFA involve the Department of Justice or GAO when the amount in question exceeds $20,000.

Many of the overpayments established for providers affiliated with the rolling labs scheme exceeded this $20,000 threshold. HCFA officials, however, have not pursued civil recovery or referred the cases to Justice or GAO. HCFA's regional officials explained they could not pursue recovery of the overpayments because HCFA's files had been provided to a federal task force to assist other prosecution actions against the rolling labs' operators. Subsequently, these files were never recovered. Justice Department officials, however, disagreed that HCFA had provided such files. It is unclear what happened to the files.

Program Remains Vulnerable to Similar Schemes

Fraudulent and abusive activities such as those associated with the rolling labs operation are inherently difficult to detect because they involve the collusive activities of a multitude of medical practitioners.[6] Carrier officials believe improved edits now in place can help identify certain activities, such as duplicate claims submitted by different entities, that occurred during the operation. The carriers, however, are not using nor required to use, available information that could help detect kickback arrangements for patient referrals.

Further, entities that choose to pattern themselves after the rolling labs can easily obtain multiple Medicare provider numbers to bill the program. Multiple provider numbers greatly complicate carriers' efforts to detect billings for suspiciously high volumes of tests. In recent years, Medicare's declining budgets for payment safeguard activities have adversely affected carrier efforts to correct the problems.

Current Reviews Inadequate To Detect Referral Fraud

As a result of their experience with the rolling labs, the two California carriers we visited have improved their computerized claims edits to correct several payment system weaknesses. The rolling labs operation sometimes billed more than once for the same or similar services. To avoid detection, it submitted the duplicate bills under different provider names. To mask the high volume of billing, the laboratories also fragmented their bills; instead of submitting a single large bill, they billed for the services separately and submitted the bills at different times.

To better detect such strategies for defrauding Medicare, both carriers developed computerized claims edits to automatically suspend claims payment if

- different providers bill, for the same beneficiary, similar procedures that were performed within a few days of each other or
- a provider submits several bills for related services performed for a beneficiary on the same day.

In addition, one carrier monitors the claims of physiological laboratories for unusual billing volumes.

Neither carrier, however, uses available information that could help them detect unusual referral patterns by physicians. An inordinately high

[6]Problems facing public and private payers in detecting and pursuing fraud and abuse are addressed in our report, Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (GAO/HRD-92-69, May 7, 1992).

volume of referrals, such as those of some physicians involved in the rolling labs scheme, can alert carriers to possible problems. These include kickbacks or other financial arrangements between the physician and the provider of the services that indicate a potential need to investigate in more detail. Although HCFA requires carriers to monitor physicians' claims experience, it does not require them to monitor physicians' referral patterns. Thus, at the two carriers we visited, physicians who directly perform a large number of tests for their patients can be detected by routine, computerized monitoring programs, but physicians who refer patients for a large number of tests are not subject to such routine monitoring.

HCFA has implemented the Universal Provider Identification Number (UPIN) system, which provides information carriers can use to monitor referral patterns of physicians (and certain other practitioners). Currently, claims submitted by laboratories and other diagnostic facilities are required to include the UPIN of the referring physician. The two carriers we reviewed believe systematic approaches to using this information might be developed, but HCFA does not provide guidance on the use of this information nor require that carriers develop such systems.

Ease of Obtaining Provider Numbers Reduces Detection

To avoid detection, rolling labs' operators relocated, changed names, and used a multitude of provider numbers. The U.S. Attorney concluded that, from 1981 to 1987, the rolling labs' owners operated under at least 30 different corporate names and Medicare provider numbers. The owners used these different corporate names to obtain multiple provider numbers. They then used the multiple numbers to increase payment by splitting claims for tests performed on a beneficiary into several claims.

The ease with which laboratories obtain Medicare provider numbers and the absence of medical requirements for licensing make it relatively easy for providers to obtain multiple provider numbers. Their use greatly complicates carrier safeguard activities and thus enhances abusive providers' ability to avoid having their unusual billing patterns detected. The ability to easily obtain new numbers also helps abusive providers avoid Medicare's efforts to recover overpayments.

To begin billing Medicare, physicians and laboratories must obtain provider numbers from carriers. Physicians must demonstrate they have a license to practice medicine. Physiological laboratories are not, however, required to meet medical or financial certification requirements for

operating under Medicare. Nor is there a standard form or policy as to what information must be provided to obtain a provider number. In practice, any entity that wishes to provide laboratory services can obtain a provider number and submit bills to Medicare. In addition, the independent physiological laboratories, the nucleus of the rolling labs operation, are essentially unregulated unless the state imposes medical quality assurance requirements through its licensing and inspection process. But only three states require licensing of independent physiological laboratories.[7]

Ownership Information Available but Not Effectively Used

Medicare law requires that entities supplying Medicare services and accepting assignment of Medicare part B claims must provide ownership information to HCFA. In June 1992, HCFA requested comments on a final rule requiring that all Medicare suppliers, including physiological laboratories, disclose the identities of all persons with ownership or control interests and of managing employees.[8] According to HCFA officials, this information must include the UPIN of any involved physician. This could be used to identify individuals with prior fraudulent or abusive behavior when they apply for new provider numbers. The requirements became effective August 17, 1992.

At the time of the rolling labs' involvement with Medicare, one of the two California carriers said it required physiological laboratories to submit information identifying the owners before assigning a provider number. Currently, officials at both carriers stated, ownership information must be collected, but the data need not be compared with the owners' past history or used to focus claims reviews.

The regulations specify that HCFA will not approve a provider number application and will terminate any existing agreements with an entity that fails to comply with the ownership disclosure requirements. However, according to carrier officials, unless the applicant was previously excluded from the program, there are no provisions to revoke a provider number or deny an application for such, so long as the information is provided. This is true even if it is revealed that a company or laboratory owner owes Medicare monies or has violated Medicare policies.

[7]We recently reported on the limited efforts by states to improve licensing, inspection, and enforcement activities concerning freestanding facilities. Health Care: Limited State Efforts To Assure Quality of Care Outside Hospitals (GAO/HRD-90-53, Jan. 1990).

[8]Clinical laboratories previously provided ownership information; however, at the carriers we visited there was no formal mechanism for using this information to identify potentially fraudulent or abusive operations.

Limited Resources Constrain Investigation and Prosecution of Fraud Cases

Reduced funding for carrier payment safeguards units may adversely affect reviews and investigations of potential fraud and abuse cases. From 1984 through 1990, claims volume increased by 66 percent (an annual rate of about 11 percent), while Medicare funds to process and pay claims in accordance with Medicare requirements were reduced on a cost per claim basis by about 33 percent.[9] Between fiscal years 1990 and 1992, Medicare payment safeguard funds in particular were cut from $345 million to an estimated $324 million.

The two California carriers' quality assurance units, which include program integrity staff, were cut substantially in fiscal year 1992—one by over 25 percent and the other by over 35 percent. The cuts will force carriers to either reduce the staff-hours on each investigation or avoid particularly complex cases, carrier officials said. In addition, one carrier official described past budget reductions as disrupting payment safeguard review operations and as a principle reason that safeguard units have problems retaining experienced staff.

In February 1992, HCFA required carriers to establish fraud investigation branches responsible for fraud detection procedures and investigations. They are to be separated from other payment safeguard functions. If approved, the President's fiscal year 1993 budget would increase payment safeguard funding and establish a separate budget line item for fraud and abuse within HCFA to monitor carrier efforts in detecting and investigating program fraud and abuse. Still, it may require several years of stable funding levels to develop and retain safeguard review continuity and staffing expertise.

Resources constrain Department of Justice officials in their ability to investigate and prosecute potential fraud cases, they reported. Because health fraud is resource-intensive and has had lower priority than other white collar fraud areas such as banking and defense contracting, U.S. Attorneys told us they may be unable to prosecute cases where health insurance fraud was detected.

In February 1992, the FBI announced that health care units would be established in 12 cities where fraud is most acute. To reinforce this initiative, the Department of Justice assigned 10 attorneys to criminal and civil health care fraud matters. However, the U.S. Attorney handling the rolling labs case said there are currently far more cases in the health area than can be meaningfully addressed. This attorney believes the

[9]Medicare: Further Changes Needed to Reduce Medicare Costs (GAO/HRD-91-67, May 1991).

identification of health care fraud as a national priority must be accompanied by a substantial dedication of resources before a significant impact will be realized.

Limited resources also have impaired California state investigators' ability to pursue other cases that "copycat" the rolling labs scheme in Southern California. State investigative officials were aware of at least six ongoing California operations having characteristics similar to that scheme. Because of the resources it is using on the original rolling labs operation, the California Department of Insurance has been unable to prosecute these other cases, one of its fraud investigators told us.

Conclusions

The rolling labs case highlights Medicare vulnerabilities in detecting and deterring fraudulent providers. Recent HCFA actions to increase funding for payment safeguards, if successful, and to strengthen fraud investigation activities should help address some of these problems. However, such vulnerabilities as legal loopholes allowing fraudulent providers to establish new corporate identities or affiliate with and bill through group practices will require further analysis of alternative remedies. For the present, Medicare can and should make better use of available information on ownership of facilities and referrals to detect potentially fraudulent operations.

The complex ownership and collusive provider arrangements used by the rolling labs' operators are difficult to detect systematically. Medicare carriers have improved methods of detecting duplicate claims and recently were required to obtain information on facility ownership and physician referrals that could help identify similar schemes. But ownership information is not compared with historical records that identify a laboratory owner's prior fraudulent or abusive Medicare activity, nor is referral information used to target claims review activities. Because there are no qualifying medical or financial criteria for physiological laboratories, virtually anyone can bill Medicare for physiological laboratory services. Furthermore, these laboratories can easily obtain and use multiple provider numbers to avoid detection.

Recently, HHS requested increased funding for payment safeguards and required that carriers maintain independent fraud investigation branches. These actions, along with recent regulatory changes, could enhance fraud detection and deterrence and reduce the likelihood of such schemes as the rolling labs causing substantial financial losses.

Recommendations to the Secretary of Health and Human Services

We recommend that the Secretary of HHS direct the Administrator of HCFA to develop procedures and provide policy guidance to Medicare contractors concerning the use of available information on

- referrals, to identify and review providers who prescribe abnormal amounts of diagnostic tests or medical supplies or whose referrals to specific laboratories or suppliers are unusually high, and
- ownership, to identify and review instances of individuals who were involved in past fraudulent or abusive activity or have an individual ownership interest in entities to which they refer patients.

Also, the Administrator should be directed to strengthen controls over who can bill the program by establishing standards for the assignment of provider numbers to laboratories.

Agency Comments and Our Evaluation

Given a draft of this report, HHS provided comments, which we considered in finalizing it (see app. II). HHS generally agreed with our findings and recommendations. It stated that the report identifies areas in which legislative action could enhance HHS's ability to recoup debts from fraudulent or abusive providers.

Because the trial judge expressed concern with pretrial press coverage and with parties discussing case merits in the media, officials from the Department of Justice suggested that we delay issuance of this report until the rolling labs trial commenced. Also, to avoid publicizing ways of circumventing Medicare program safeguards, these officials stated that report dissemination should be limited to those with a "need to know." We considered these concerns. However, our report uses information from publicly available records—without commenting on the merits of the case. Our emphasis is on whether Medicare is susceptible to the types of abuses alledgedly practiced by the operators of the rolling labs. The health insurance abuses described in our report have been discussed previously by GAO and others at hearings and in published reports, as well as in the news media.

As arranged with the subcommittee staff, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time, we will send copies to other congressional committees, the Secretary of Health and Human Services, and other interested parties. Copies will be made available to others upon request. The report was prepared under the direction of Janet L. Shikles,

Director of Health Financing and Policy Issues. If you have any questions regarding it, she can be reached at (202) 512-7119. Other major contributors are listed in appendix III.

Lawrence H. Thompson

Lawrence H. Thompson
Assistant Comptroller General

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Abbreviations

HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
OIG	Office of the Inspector General
UPIN	Unique Provider Identification Number

The Rolling Labs Scheme

The rolling labs scheme began in 1981 when the owners of physiological laboratories specializing in noninvasive tests, such as blood flow analysis and other vascular studies, began offering "free" services to Medicare and Medicaid patients. Over nearly 10 years, the rolling labs operated under more than 500 organizational names. One of several ways the scheme operated was to take mobile testing equipment to locations with large populations of Medicare beneficiaries, such as nursing homes, and advise the residents of the benefits of available tests they could get free of charge. Scheme operators also secured patients through large-scale telemarketing operations. Laboratory assistants then administered a costly and often unnecessary battery of tests, usually waiving the patient's copayment.

To obtain payment from the carriers processing the Medicare claims, laboratories enlisted physicians to certify diagnoses justifying the tests. In return, the physicians received either a fixed salary or were allowed to bill for the exams and tests. Rolling labs' operators also referred beneficiaries to clinical laboratories for such services as blood testing. In turn, the clinical laboratories paid kickbacks or provided a share of their billings to the rolling labs' operators.

Medicare Billing Patterns Revealed Kickbacks

These activities were detected in 1983 when, as part of a special study involving billings for noninvasive tests, a carrier found one physician billed for tests that were also billed by another physician and a laboratory. A subsequent carrier review revealed a dramatic change in the first physician's practice pattern—his Medicare charges jumped from $18,953 during the first quarter of 1983 to $188,241 during the second. After also gathering information on the second physician and the laboratory that performed the tests, the carrier referred the case to HHS's Office of the Inspector General. As a result of its investigation, the OIG concluded that the laboratory owners paid kickbacks to physicians for referrals of Medicare patients and performed medically unnecessary tests. In addition, the OIG found that the physiological laboratory owners had solicited kickbacks from a clinical laboratory that performed blood testing, in return for referring Medicare patients to them.

Private Insurers Also Victimized

In approximately 1986, after one owner was arrested as a result of the OIG's investigation, the rolling labs are believed to have ceased treating Medicare and Medicaid beneficiaries and only treated patients with other types of health insurance. Mobile units moved from nursing homes to health clubs offering free testing to individuals with private health

insurance.[1] Also in 1986, three insurance companies sued the owners of the rolling labs, alleging that physicians affiliated with them had falsified patients' diagnoses to justify claims for costly and medically unnecessary tests. In civil court, the insurers won a default judgment of $18 million after the owners reportedly fled the country. To date, the insurance companies have collected less than $3,000 of this judgment.

Conviction, Further Indictments Obtained

Medicare's case against one of the rolling labs' owners and three co-conspirators was prosecuted successfully in 1987 by the U.S. Attorney's office. These individuals were convicted on multiple counts of soliciting and receiving kickbacks for referring Medicare patients. In addition to being fined $50,000, one rolling labs' owner was sentenced to three concurrent prison terms of 3 years, suspended from participating in Medicare-Medicaid for 25 years, and prohibited from engaging in any business whose income is derived from federal funds. The co-conspirators were fined from $50 to $50,000; one also was sentenced to 3 years in prison.

Even though one owner of the rolling labs was in prison from approximately May 1987 through May 1988, the laboratories' operations continued, handling only non-Medicare insurees. In July 1991, the rolling labs' owners and several others (including two physicians) were indicted by U.S. Department of Justice attorneys in federal court. The indictments, charging mail fraud, wire fraud, bankruptcy fraud, conspiracy to defraud the United States, and violations of 13 other federal statutes, were filed by the U.S. Attorney for the Central District of California. Allegedly, the owners and their accomplices used extensive telephone marketing to entice insured persons to undergo unnecessary medical tests for which the patient had no financial obligation to pay. To obtain payment for these tests from insurers, the indicted physicians allegedly falsified patient diagnoses.

[1]Because health maintenance organizations channel enrollees to certain providers with cost-effective practice patterns, the rolling labs did not seek out these enrollees.

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General

Washington, D.C. 20201

JUN 23 199

Ms. Janet L. Shikles
Director, Health Financing
and Policy Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Shikles:

Enclosed are the Department's comments on your draft report, "Medicare: One Scheme Illustrates Vulnerabilities To Fraud," GAO/HRD-92-76, dated May 1992. The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

For Richard P. Kusserow
Inspector General

Enclosure

Comments of the Department of Health and Human Services on the General Accounting Office Draft Report, "Medicare: One Scheme Illustrates Vulnerabilities to Fraud"

General Comments

We agree with many of GAO's findings with regard to the difficulties that Medicare faces in identifying and addressing fraudulent schemes such as the "rolling-labs" scheme.

We believe this report identifies areas where legislative action could enhance our ability to take prompt action to recoup debts from providers which engage in fraudulent and abusive practices. Legislation that would prevent or hinder providers from hiding fraudulently-obtained assets through various "legal" schemes is clearly needed. We also need Congressional support for the President's Fiscal Year (FY) 1993 budget request for a substantial increase in funding for Medicare contractor fraud and abuse activities.

GAO Recommendation

We recommend that the Secretary of HHS direct the Administrator of the Health Care Financing Administration (HCFA) to develop procedures and provide policy guidance to Medicare contractors on the:

-- use of the available information on referrals to identify and review providers who prescribe abnormal amounts of diagnostic tests or medical supplies or whose referrals to specific laboratories or suppliers are unusually high;

Department Comment

In the past few months, we have implemented new requirements for inclusion of information regarding the referring physician on claims for diagnostic tests, radiological services, clinical laboratory services, and medical equipment.

We and the carriers will be devoting substantial resources in 1993 towards the profiling and analysis of physician referral patterns, using the above-mentioned information. Through statistical analysis, carriers will identify physicians that frequently refer patients for unnecessary services; carriers will use this information to enhance their educational efforts with physicians and to target their medical review activities. The Medicare program integrity units will also be expected to use this kind of analysis to identify possible fraud schemes.

GAO Recommendation

-- use of available ownership data to identify and review individuals who were involved in fraudulent or abusive activity in the past and to identify where an individual has an ownership interest in entities to which they refer patients.

Department Comment

Our new regulations (proposed at 56 FR 56612) provide for the collection and use of ownership information from suppliers. Four regional carriers will be responsible for establishing supplier billing numbers through use of a standard application form. The form will request information that will enable the carriers to identify each unique entity, its ownership, related entities, and sanctions. This information will be retained in a clearinghouse and will be available to each of the regional carriers.

This information will allow the regional carriers to identify suppliers with owners or managers that have been, or currently are, involved with other businesses which may be suspected of fraudulent or abusive practices or which have failed to repay overpayments. We will expect the carriers to use such information to focus their pre-payment review activities and possibly prevent further fraud or overpayments.

However, we would like to point out that HCFA is limited in the action that it can take against these individuals when they are identified. HCFA can instruct carriers to intensify their review of claims submitted by the identified individuals or entities. However, as noted in the GAO report, the entity cannot be excluded from the program unless one of the owners, office directors, agents, or managing employees was previously convicted of fraud, had received a civil monetary penalty, or had been previously excluded from the program. This authority is stipulated in section 1128(b)(8) of the Social Security Act.

There are other situations where, although exclusion may be warranted, exclusion is not authorized under current law:

(1) A health care entity cannot be excluded from the program if one of the owners was previously the owner of another entity where the entity, but not the owner, was convicted, sanctioned, or excluded from the program.

(2) A health care entity cannot be excluded from the program if an owner was previously the owner of another entity that was assessed an overpayment under Medicare but did not pay. In addition, HCFA may not collect the overpayment from either the new entity or the individual owner previously associated with the old entity.

These limitations make it difficult to take affirmative action against health care providers that are owned by individuals who previously were associated with fraudulent companies. As noted in the GAO report, it is relatively easy for health care providers to suspend their operation and simply begin operating under a different corporate identity.

HCFA is currently in the process of evaluating options for proposing a legislative change that would broaden the authority to exclude providers in the types of situations identified above. We hope to be able to complete our analysis within the next few months.

GAO Recommendation

Also, the Administrator should be directed to strengthen controls over who can bill the program by establishing standards for the assignment of provider numbers to laboratories.

Department Comment

HCFA is currently revising its Disclosure of Ownership and Control Interest Statement (HCFA-1513). The revised form will effectively capture the information necessary to assist Medicare contractors in implementing this recommendation. The ownership data will be maintained in an electronic database that can identify providers engaged in fraudulent activity.

Technical Comment

Now on p. 3, text revised

The background section on page 4 contains one error. The first sentence in this section states that, "Medicare insures about 33 million people aged 65 and over and certain individuals under 65 who are disabled." HCFA estimates current enrollment is about 35 million beneficiaries in FY 1992. The number of unduplicated Medicare beneficiaries in FY 1991 was approximately 34.6 million.

Major Contributors to This Report

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