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United States General Accounting Office
Washington, DC 20548

Office of Special Investigations

B-283471

March 30, 2000

The Honorable Tom Bliley
Chairman
Committee on Commerce
House of Representatives

Subject: Medicare: Improper Third-Party Billing of Medicare by Behavioral Medical Systems, Inc.

Dear Mr. Chairman:

The \$200-billion Medicare program, which is responsible for financing health services delivered by hundreds of thousands of providers to about 39 million elderly and disabled Americans, is vulnerable to fraud, waste, and abuse. A recent report by the Office of the Inspector General, Department of Health and Human Services, estimated that in fiscal year 1998, \$12.6 billion of Medicare's \$176.1 billion in fee-for-service payments was for claims that did not comply with Medicare rules. In connection with your concerns about fraud and abuse within the Medicare program, including the roles of third-party-billing entities¹ in such activities, you asked that we investigate the operations of Behavioral Medical Systems, Inc. (BMS). To develop this information, we reviewed BMS claims history data and applicable laws and regulations pertaining to Medicare's third-party billing program. Further, we interviewed psychiatrists and psychotherapists who were under contract to BMS and a contractor that submitted electronic billings to Medicare on behalf of BMS. We conducted our investigation from July 12, 1999, through October 21, 1999.

In summary, we determined that while BMS represented itself to Medicare as a provider, in fact it functioned as a broker and a third-party biller. We found a

¹ In June 1999, GAO reported on (1) the Health Care Financing Administration's (HCFA) method for identifying claims through third-party billing companies that prepare and remit claims on behalf of health care providers to Medicare contractors (electronically or by paper) and (2) how HCFA and its contractors monitored third-party billing companies. GAO determined that HCFA was unable to identify claims associated with problem third-party billers. *Medicare: Identifying Third-Party Billing Companies Submitting Claims* (GAO/HEHS-99-127R, June 2, 1999).

consistent pattern by which BMS caused improper Medicare claims to be submitted for services not provided by six psychiatrists. Of the Medicare claims filed by BMS during a 20-month period, 87 percent were for provider services that reportedly were not rendered. These Medicare claims totaled \$1.3 million, of which BMS received over \$362,000. We have referred the matter to the Office of the Inspector General, Department of Health and Human Services, for its consideration. Further, in functioning as a broker and a third-party biller, BMS violated 42 U.S.C. section 1395u(b)(6), which establishes the general principle that Medicare program payments should be made directly to the beneficiary or, under an assignment, to the physician who provides the medical service. The following sections describe how BMS operated, directed the billing for services not provided, and violated the statute.

BMS Operations

Sandra J. Hunter, Ph.D., a licensed social worker, is president and chief executive officer of BMS. Dr. Hunter established BMS in January 1995 and submitted an application in the following month to the Medicare Part B carrier (Blue Cross and Blue Shield of Texas) for a Medicare billing (provider) number.² The application referenced BMS as a group practice specializing in psychiatry with a business address of 4646 Highway 6 South, Suite 217, Sugarland, Texas.³ Dr. Hunter subsequently received a group provider number that allowed her to bill Medicare for services rendered.

BMS, representing itself as a group provider, entered into contracts with various nursing homes in Houston, Beaumont, Corpus Christi, and San Antonio, Texas, whereby BMS would provide psychiatric and related services to nursing home residents. BMS also contracted with psychiatrists and psychotherapists to provide these services to the nursing homes. Based on interviews with Dr. Hunter⁴ and the psychiatrists and psychotherapists who contracted with BMS, as well as a review of two of the contracts, we confirmed that the psychiatrists and psychotherapists were independent contractors and not employees of BMS.

We were informed that, in accordance with the BMS process, these psychiatrists and psychotherapists prepared monthly activity reports in which the attending psychiatrist/psychotherapist identified necessary Medicare billing information, including the procedural code and date of service provided for each patient. The completed activity reports were then forwarded by mail or facsimile to Dr. Hunter for processing. Dr. Hunter told us that she forwarded the monthly activity reports to

² HCFA officials advised us that after 1994, Part B carriers were empowered to issue provider numbers to nonmedical personnel, such as social workers, upon request.

³ Dr. Hunter secured mailbox number 217 at Mail Box Express located at 4646 Highway 6 South, Sugarland, Texas 77478. By having the mailbox number appear on BMS correspondence as an office suite number, Dr. Hunter made it appear that the location was an office building.

⁴ OSI initially interviewed Dr. Hunter for the purpose of obtaining background information on BMS and its professional relationship with psychiatrists operating in the Corpus Christi area. Subsequent to the interview, Dr. Hunter secured legal counsel who prohibited further contact with their client.

another contractor for the submission of electronic billings to Medicare on behalf of BMS. According to this contractor and our review of relevant documents, the billing information was submitted to Medicare as directed by Dr. Hunter. Dr. Hunter told us that she received payments from Medicare that she deposited into her personal bank account and subsequently paid the contracted psychiatrists and psychotherapists from this account.

Medicare's Explanations of Benefits that detail the payments for patient services were transmitted directly to BMS and not the psychiatrists or psychotherapists because the claims for services were submitted under the BMS group provider number. The psychiatrists stated that they were thus unaware of the additional claims made on their behalf. Additionally, the psychiatrists we interviewed acknowledged that they had failed to reconcile payments received from Dr. Hunter for the services they performed on behalf of BMS.

Billing Medicare for Reportedly Fictional Visits to Patients

We compared the service dates that the psychiatrists⁵ reported to BMS and the claims that the contractor submitted, as directed by Dr. Hunter, to Medicare for reimbursement. That analysis disclosed numerous improper claims for services not rendered to the psychiatrists' patients. For example, according to one psychiatrist, the psychiatrist had not visited a certain patient from September 1, 1997, to February 28, 1999. However, fiscal carrier claims records provided to us by Blue Cross and Blue Shield of Texas showed that Medicare had paid BMS on the psychiatrist's behalf for 90 visits to the patient during this time frame. Further, this same psychiatrist had seen a second patient six times between May 23, 1998, and February 16, 1999. Yet, carrier records showed that BMS's contractor had billed Medicare, on this psychiatrist's behalf, for 70 additional visits to the patient for the same period. According to another psychiatrist, he had made 5 visits to a patient in the nursing home; but according to carrier claims records, the BMS contractor billed Medicare for an additional 41 visits by the psychiatrist.

Medicare carrier records for September 1997 through April 1999 (the period that we investigated) identified six psychiatrists who were under contract to BMS and on whose behalf the BMS contractor submitted Medicare claims. We analyzed the 4,922 claims that the BMS contractor had submitted on behalf of the 6 BMS psychiatrists for the 20-month period in question. Of these claims, 4,291 (87 percent of the total Medicare claims that BMS had billed) were improper. According to the 6 psychiatrists and Medicare records, these claims to Medicare represented 9,854 patient visits that had not occurred. Further, according to Medicare records, the claims totaled \$1.3 million for services that were not rendered. We determined that

⁵ Our analysis did not include a review of psychotherapists because their rate of reimbursement was based on an hourly rate for individual services rendered.

BMS had received over \$362,000 in Medicare payments for the fictional visits and services.⁶

On the basis of our investigation, the Medicare carrier temporarily suspended BMS on July 9, 1999, from participation in the Medicare program. We also referred the matter to the Office of the Inspector General, Department of Health and Human Services, for its consideration of possible violations of 18 U.S.C. 1001 (False Statements); 18 U.S.C. 1035 (False Statements Relating to Health Care Matters); and 18 U.S.C. 287 (False, Fictitious or Fraudulent Claims).

Violation of Title 42 of the U.S. Code by BMS

BMS could not bill Medicare because it neither directly employed the physicians who provided the services to the Medicare recipients nor provided a facility in which the services were provided to Medicare recipients. Rather, BMS entered into a contract with nursing homes to provide services at the nursing facilities and then hired psychiatrists and psychotherapists as independent contractors to provide the services at the nursing homes.

Title 42 U.S.C. section 1395u(b)(6)⁷ establishes the general principle that Medicare payments are to be made to the beneficiary or under an assignment to the medical provider who provides the service. According to the legislative history, the Congress was concerned about third-party direct billing because “[s]uch reassignments have been a source of incorrect and inflated claims for services and have created administrative problems with respect to determinations of reasonable charges and recovery of overpayments.” (H.R. No. 92-231, at 104 (1971)) In passing section 1395u(b)(6), the Congress sought to destroy a third party’s incentive to engage in abusive billing practices or to submit claims for services that were not provided.

We believe that the statutory language is clear that BMS could not bill Medicare since it was neither the beneficiary nor the provider of the services to the Medicare recipients. We note that the Administrator of the Health Care Financing Administration (HCFA) reached a similar conclusion in an analogous situation involving Coastal Physician Services, Inc.’s disagreement with HCFA over its interpretation of HCFA’s regulation implementing 42 U.S.C. 1395u(b)(6). Coastal had contracted with a hospital to provide the physicians to staff the hospital’s emergency

⁶ The resulting difference of approximately \$951,000 is attributable to either claims that were disallowed/disputed, co-payments, deductibles, or claims that exceeded allowable Medicare reimbursable amounts.

⁷ Title 42 U.S.C. section 1395u(b)(6) states in pertinent part, “No payment under that part [B] for a service provided to any individual shall be made to anyone other than such individual or[,] pursuant to an assignment[,] . . . [to] the physician or other person who provided the service, except that (A) payment may be made (i) to the employer of such physician or other person . . . [or] (ii) (where the service was provided in a hospital, rural primary care hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such services”

room. The company then contracted with physicians, as independent contractors, to staff the emergency room and provide all necessary medical services. In a letter decision dated March 26, 1997, HCFA's Administrator concluded that direct payments to Coastal for the services of contract physicians in hospital emergency rooms violated 42 U.S.C. section 1395u(b)(6) and HCFA's regulations at 42 C.F.R. section 424.73(a).⁸

In the letter decision, the Administrator recognized that exceptions in the statute and HCFA's regulations permitted payment to a supplier's employer and the facility that provides the service in certain circumstances.⁹ However, the Administrator concluded that the physicians did not meet the first exception since they were independent contractors and that the second exception would have allowed the Medicare payment to go to the hospital if certain conditions were not met rather than directly to Coastal. Finally, the Administrator noted that while the statute and HCFA regulations allowed direct payments to a "healthcare delivery system," Coastal had not established that it was such a system.

We can discern no difference between BMS and Coastal insofar as application of 42 U.S.C. section 1395u(b)(6) and HCFA's implementing regulations are concerned. Accordingly, BMS or its agent was not entitled to bill Medicare directly for the services actually provided by the psychiatrists and psychotherapists in the nursing homes.

As agreed with your office, unless you disclose the contents of this letter earlier, we plan no further distribution of this letter until 30 days after the letter's date. At that time, we will send copies of the letter to interested congressional committees. We

⁸ HCFA regulations at 42 C.F.R. section 424.73(a) implement the congressional intent by limiting the extent to which Medicare pays individuals or entities that do not directly provide medical care.

⁹ Pursuant to statute and HCFA's regulations, Medicare may pay the supplier's employer if the supplier is required, as a condition of employment, to turn over to the employee the fees for his or her services. Under 42 U.S.C. section 1395u(b)(6)(A)(I) and 42 C.F.R. section 424.80(b), Medicare may also pay the facility in which the services were furnished if there is a contractual arrangement between the facility and the supplier under which the facility bills for the supplier's services. (42 U.S.C. section 1395u(b)(6)(A)(ii), and 42 C.F.R. section 424.80(c))

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will also make copies available to others on request. If you have any questions or need additional information, please contact Assistant Director Steve Iannucci at (202) 512-6722. Robert Gettings and Harvey Gold were key contributors to this case.

Sincerely yours,

A handwritten signature in black ink, appearing to read "Robert H. Hast". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Robert H. Hast
Acting Assistant Comptroller General
for Special Investigations

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