United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Oversight and Investigations, Committee on Commerce House of Representatives

For Release on Delivery
Expected at
10:00 a.m. EDT
Thursday,
April 6, 2000

MEDICARE

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

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Summary

Today's testimony concerns the results of GAO's investigation into the operations of Behavioral Medical Systems, Inc. (BMS) of Sugarland, Texas. BMS represented itself to Medicare as a healthcare provider but functioned as a broker of medical services and contracted with a third-party biller that, in turn, prepared and remitted claims to Medicare on behalf of providers contracted to BMS. While doing so, BMS billed Medicare improperly and violated the U.S. Code.

BMS contracted with nursing homes to provide psychiatric and related services to their residents. BMS also contracted with psychiatrists and psychotherapists—as independent contractors, not BMS employees—to provide those services. BMS then consistently caused improper Medicare claims, involving services by six psychiatrists contracted to it, to be submitted to its fiscal carrier. Of the approximately 4,900 claims that BMS filed in the 20-month period investigated, 87 percent—or almost 4,300 claims—were for medical services reportedly not provided. These Medicare claims for fictional services totaled $1.3 million. In addition, we believe that BMS violated the general statutory principle that Medicare payments should be made directly to the beneficiary or the assigned physician who provided the medical service. Neither of these situations fit BMS.

As a result of this investigation, the Medicare carrier temporarily suspended BMS in July 1999. At this time, BMS remains suspended. The matters have also been referred to the Inspector General of the Department of Health and Human Services and to the Department of Justice. However, the founder of BMS is currently submitting Medicare claims under an old provider number—unrelated to BMS—issued to her in 1993. We have not investigated these claims to determine if they are improper.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the results of our recent investigation of the operations of Behavioral Medical Systems, Inc. (BMS) of Sugarland, Texas, which functioned as a broker of medical services and contracted with a third-party biller for submitting claims to Medicare. Third-party billers prepare and remit (electronically or by paper) claims to Medicare contractors on behalf of health care providers.

You had asked that we undertake the investigation because of your concern about fraud and abuse within the Medicare program. Such activities could be involved in a recent estimate, reported by the Office of Inspector General (OIG), Department of Health and Human Services (HHS), that $12.6 billion of fiscal year 1998 Medicare payments for fee-for-service claims did not comply with Medicare rules. My testimony today is based on our recent report of our investigation, which you are releasing today.[1] More specifically, my remarks concern (1) BMS and how it conducted business, (2) its improper billing of Medicare, and (3) our belief that BMS violated the U.S. Code.

In brief, we determined that although BMS represented itself to Medicare as a health-care provider, in fact it functioned as a broker of medical services and, according to its contracted psychiatrists, a third-party biller. Further, through the services of the third-party biller with which it had contracted, BMS consistently caused improper Medicare claims to be submitted for services by six psychiatrists contracted to it. Indeed, of the approximately 4,900 Medicare claims that BMS filed in the 20-month period we investigated, 87 percent—or almost 4,300 claims—were for services that reportedly were not provided. Those improper Medicare claims totaled $1.3 million. As another matter, we believe that BMS violated the general statutory principle[2] that Medicare payments should be made directly to the beneficiary or the assigned physician who provided the medical service. Neither of these situations pertained to BMS.

On the basis of our investigation, the Medicare carrier temporarily suspended BMS from Medicare program participation on July 9, 1999. At

[1] See *Medicare: Improper Third-Party Billing of Medicare by Behavioral Medical Systems, Inc.* (GAO/OSI-00-5R, Mar. 30, 2000).

[2] 42 U.S.C. section 1395u(b)(6).

this time, BMS remains suspended. Further, we referred the matter to the HHS OIG, and it has been referred to the Department of Justice. However, we recently learned that the founder of BMS—Sandra J. Hunter, Ph.D., a licensed social worker—is currently submitting Medicare claims under an old provider number issued to her in 1993. That provider number is not related to BMS. We have not conducted an investigation to determine if these claims are improper.

BMS and Its Operations

In February 1995, Dr. Hunter applied to a Texas Medicare Part B carrier for a Medicare billing (provider) number for BMS. Dr. Hunter subsequently received a group provider number that allowed her to bill for Medicare services rendered. In the application, Dr. Hunter represented the location of BMS as a suite at a particular address in Sugarland, Texas. This gave the impression that BMS was located in a business environment and that medical services would be provided there. Instead, the stated suite number and business address consisted of a mailbox number at a local Mail Box Express.

In addition, on her application, Dr. Hunter represented BMS as a group practice specializing in psychiatry. We determined, however, that BMS did not directly employ psychiatrists and was thus not a group practice. Instead, in its business, BMS contracted with nursing homes to provide psychiatric and related services to their residents. BMS also contracted with psychiatrists and psychotherapists—as independent contractors, not BMS employees—to provide those services and, according to the psychiatrists, use BMS as their third-party biller.

Then, as was the BMS process, (1) the psychiatrists and psychotherapists prepared monthly activity reports providing necessary Medicare billing information; (2) the reports were forwarded to Dr. Hunter for processing; and (3) Dr. Hunter forwarded them to her contracted third-party biller for it to submit billings, following her direction, to Medicare on behalf of BMS. Medicare sent the claims payments to Dr. Hunter, who paid the contracted psychiatrists and psychotherapists. Medicare also sent the Explanations of Benefits, detailing the payments for the services, to BMS and not to the psychiatrists.[3] These psychiatrists stated that they were thus unaware of the additional claims made on their behalf.

[3] 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 Billed Medicare for Reportedly Fictional Visits to Patients

We compared the service dates that the psychiatrists submitted to Dr. Hunter in their activity reports and the claims that the BMS contractor submitted for reimbursement to Medicare, under Dr. Hunter's direction. Most—87 percent—of the claims that we analyzed from the period September 1997 through April 1999 (the period that we investigated) were for services that the psychiatrists had not rendered to their patients. For example, Medicare paid BMS for 90 visits by one psychiatrist to a patient between September 1, 1997, and February 28, 1998. However, according to his records, the psychiatrist had not visited the patient at all during that period. In addition, the same psychiatrist saw a second patient six times between May 23, 1998, and February 16, 1999. Yet carrier records show that BMS, through its contractor, billed Medicare for 70 additional visits by the psychiatrist during that time frame. According to another psychiatrist, he made five visits to one patient. Yet carrier claims records show that BMS billed Medicare for another 41 visits by that psychiatrist.

We analyzed the 4,922 claims that the BMS contractor submitted to Medicare on behalf of the 6 contract psychiatrists for the September 1997–April 1999 time frame. Of these claims, 4,291—or 87 percent—were reportedly fictitious. According to the 6 psychiatrists and fiscal carrier records, these claims represented 9,854 patient visits that never occurred. Also according to carrier records, the improper claims totaled $1.3 million for unrendered services. We determined that BMS had received over $362,000 in Medicare payments for the fictional visits and services. The difference of approximately $951,000 is attributable to claims that were disallowed/disputed, co-payments, deductibles, or claims that exceeded allowable Medicare reimbursable amounts.

BMS Violated the U.S. Code Concerning Direct Medicare Payments

BMS should not have billed Medicare because it neither (1) directly employed the psychiatrists and psychotherapists who provided the services to the Medicare patients nor (2) provided a facility in which the services were rendered. Based on statute[4] and HCFA's implementing regulations,[5] BMS was not entitled to bill Medicare directly for the services

[4] 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…."

[5] 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.

that the psychiatrists and psychotherapists provided for patients in the nursing homes.

We believe that the statutory language is clear that BMS could not bill Medicare because it was neither the beneficiary nor the provider of the services to the Medicare patients. The subject statute establishes the general principle that Medicare payments are to be made to the beneficiary or, under assignment, to the medical provider who rendered the service. Legislative history indicates that the Congress was concerned about third-party direct billing because, among other points, "[s]uch reassignments have been a source of incorrect and inflated claims for services." (H.R. No. 92-231, at 104 (1971)) Through the subject statute, the Congress sought to eliminate a third party's incentive to submit claims for unprovided services or to engage in abusive billing practices.

Mr. Chairman, this concludes my prepared remarks. We would be pleased to respond to any questions that you or other members of the Committee have.

GAO Contacts and Acknowledgements

For further information regarding this testimony, please contact Robert H. Hast at (202) 512-7455 or Steve Iannucci at (202) 512-6722. Robert Gettings and Harvey Gold made key contributions to this testimony.

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