UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES DIVISION

January 30, 1984

B-214207

The Honorable Howard M. Metzenbaum
United States Senate

Dear Senator Metzenbaum:

Subject: Information on Medicare's Administrative Sanction Process as it Relates to a Practitioner (GAO/HRD-84-30)

You asked us to review the medical and billing practices of Dr. Alan Weiner, Family Foot Care Associates, Incorporated, and Americare. Specifically, you asked five questions dealing with Dr. Weiner and his associations with the two podiatrist groups.

We found that extensive reviews of the billing practices of Dr. Weiner and his associates had been done beginning in 1969 or were ongoing in January 1984, by (1) the Department of Health and Human Services' (HHS') Health Care Financing Administration (HCFA), Chicago Region; (2) HHS' Office of Inspector General, Chicago Region; (3) Federal Bureau of Investigation (FBI), Cleveland Office; and (4) Nationwide Mutual Insurance Company, the Medicare Part B claims processing agent for Ohio. We did not independently review Medicare claims submitted by Dr. Weiner and his associates because of these other investigations. Rather, we reviewed the results of those investigations. Based on the information we obtained, it appears that Dr. Weiner is no longer involved with the Medicare program.

Each of your questions is addressed below.

QUESTION 1

"Is Dr. Alan Weiner, either directly or indirectly, receiving any Medicare funds through the billings of other podiatrists at the Family Foot Care Center or Americare?"

Dr. Weiner has not received Medicare payments directly since he was excluded from the Medicare program in 1981. Dr. Weiner had been under continual investigation since 1969 for his Medicare billing practices, and on October 2, 1981, he was excluded from participating in the program for 15 years. He was excluded for providing services that substantially exceeded his patients' needs and professionally recognized standards of health care.

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According to the records of Nationwide Mutual Insurance Company, the last payment to Dr. Weiner by Medicare was for services provided on November 6, 1981. The claim for this service was submitted by the patient who was paid $152 on May 5, 1982.[1] In total Dr. Weiner's patients were paid $368 in 1982 for services he provided in 1981 and no direct payments were made to him in 1982.

Because Dr. Weiner sold Family Foot Care Center and does not appear to be connected with Americare, he should not be receiving any Medicare funds through either of these entities. (See the response to Question 2.)

QUESTION 2

> "Does Dr. Weiner continue to practice podiatry at Family Foot Care Associates, Inc. or Americare and what, if any, financial interests does he hold in either corporation?"

At the time of his exclusion from the Medicare program, Dr. Weiner was the sole owner of Family Foot Care Associates, Incorporated. After his exclusion, Dr. Weiner sold his podiatry practice. According to the FBI investigation, negotiations for the sale began about January 1982. The negotiations ended in a sales agreement dated April 30, 1982, to become effective July 1, 1982. The sales agreement was amended several times and on April 15, 1983, was amended for the last time changing the consideration to a lump sum payment. The purchaser informed the FBI that, since July 1982, Dr. Weiner has had nothing to do with the management of Family Foot Care Associates, has not treated any patients at these clinics, and, as far as the new owner was aware, was not practicing podiatry.

The information we obtained, primarily from the Office of the Ohio Secretary of State, on the ownership of Americare Foot Care Centers, Incorporated showed no evidence that Dr. Weiner held a financial interest in it. According to the Ohio Secretary of State's Office, Americare was formed by another podiatrist on December 21, 1981.

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[1]Medicare regulations permit one payment to be made to a patient of an excluded doctor after the exclusion date. When this payment is made, the patient is notified of the exclusion and no payments are made for services provided more than 15 days after the notification.

QUESTION 3

"Are the goals of the Medicare exclusion provisions being carried out when one member of a medical group practice is excluded from participation in the Medicare program, but other providers in the same association continue to receive reimbursement, especially if the excluded practitioner continues to have some type of financial interest in the group practice?"

Under current law, an excluded doctor can hold a financial interest in a group practice that provides services to Medicare patients without affecting the eligibility of the group to participate in Medicare. HHS only has the authority to refuse to pay for services directly provided by the excluded doctor. However, HHS is authorized to refuse to enter into a Medicare participation agreement or renew such an agreement with any institutional provider[2] that has 5 percent or more ownership by a person who has been convicted of a criminal act related to Medicare or Medicaid.

A bill (Health Care for Unemployed Workers (S. 951)), as reported by the Senate Committee on Finance, would extend HHS' sanction authority to allow HHS to exclude from participation in the Medicare program any entity or supplier of services in which a significant ownership or controlling interest is held by a person convicted of a criminal offense against Medicare or Medicaid. This expansion of sanction authority would permit HHS to exclude a group practice if it is owned or controlled by a person convicted of a crime against Medicare or Medicaid. However, it would not permit exclusion of a group practice where the owner was excluded from Medicare for overutilization and quality of care issues, as was the case for Dr. Weiner.

QUESTION 4

"Is the present administrative process of Medicare exclusion and termination too cumbersome and, if so, in what ways might the process be streamlined to better achieve the goals of the program?"

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[2]The law defines a provider as a hospital, skilled nursing facility, home health agency, comprehensive outpatient rehabilitation facility, or hospice. Under the law a doctor of podiatry is considered a physician, not a provider.

In a report to the Congress entitled "Improving Medicare and Medicaid Systems To Control Payments for Unnecessary Physician's Services" (GAO/HRD-83-16, Feb. 8, 1983), we pointed out the need to improve and speed up the exclusion process. For example, the Medicare fraud referral and investigation process included overlaps and involved the claims processing agents, HCFA, and HHS' Office of Inspector General. This had resulted in delays in completing investigations. Also, we pointed out that HHS' HCFA required Medicare claims processing agents to (1) refer cases of suspected fraud to a HCFA regional office and (2) not attempt to collect overpayments until after the fraud investigation was completed. Most of the potential Medicare fraud cases were eventually dropped and returned to the claims processing agents for overpayment collection action as overutilization cases. As a result, several years could pass after the overutilization was initially detected before collection efforts were begun.

Carrier personnel told us that as a result of the passage of time, recovery of overpayments related to fraud investigation cases became more difficult and less productive. This was because (1) passage of time increases the likelihood of records being lost or destroyed, (2) beneficiaries or providers die, and (3) beneficiaries (often elderly) can forget what services were provided to them.

In cases not suspected of fraud, we pointed out that one of the reasons overutilizers were not being excluded from the program was the apparent confusion about who should perform peer review of suspected overutilizers. The claims processing agents relied on their in-house medical review groups and/or made agreements with state or private peer review groups to review the claims of a practitioner to determine if accepted professional standards were being followed in providing and billing for services. However, HCFA procedures required that its medical review contractors, the Professional Standards Review Organizations, be used to perform peer reviews and exclusion actions were not taken unless a review by one of these organizations was performed.

We made the following recommendations to the Secretary of HHS to improve the exclusion process.

--Exclude providers, in accordance with due process requirements, who remain on prepayment review for over a specified time period because they refuse to correct their abusive billing practices.

--Make it clear to carriers which peer review mechanisms, besides Professional Standards Review Organizations, are acceptable for initiating exclusion procedures.

HHS, in concurring with our recommendations, stated that an effort had begun to identify practitioners who had historically been overusers and should be sanctioned. In addition, conferences with Medicare claims processing agents were being held on how to develop sanction cases. Also, an expansion of the instructions to claims paying agents on referring cases to HCFA regional offices for potential administrative sanctions is in process. During January 1983, the responsibility for administering the Medicare sanction program was transferred from HCFA to HHS' Office of Inspector General.

These actions should help alleviate some of the problems with the administrative sanctions process; however, the tangible results of such actions measured in terms of the number of habitual overutilizers actually excluded, will depend on the Office of Inspector General's followup action on referrals from claims processing agents. Such action appears to have begun. In fiscal year 1983, 230 administrative sanctions were imposed on providers and practitioners as compared to 91 in fiscal year 1982.

QUESTION 5

> "Are the other podiatrists at Family Foot Care Associates, Inc. and Americare engaged in any fraudulent or abusive medical or billing practice that might warrant their exclusion from the Medicare program?"

The billing practices of some of Dr. Weiner's former associates, who continue to practice with Family Foot Care, were, as of January 1984, being reviewed. The following chronological listing of events, most of which took place before our 1983 report, illustrates why we made our recommendations regarding the need for improving the process and taking more aggressive action.

--In September 1981, the HCFA Chicago Regional Office requested sample cases from Nationwide on one of Dr. Weiner's associates.

--In October 1981, Dr. Weiner was excluded from participation in the program for 15 years. The exclusion was the result of his providing services that substantially exceeded his patients' needs and which were of a quality that failed to meet professionally recognized standards of health care.

--In October 1981, a review of sample cases of two of Dr. Weiner's associates by a Nationwide consultant showed, in the consultant's opinion, severe overutilization and excessive charges. He recommended that the formal peer review process bypass these two podiatrists and that they be removed from the program as quickly as possible.

--In March 1982, HCFA Chicago Regional Office personnel visited Cleveland and interviewed patients concerning the services they had received from Dr. Weiner's associates. Affidavits were obtained from some of these patients.

--In May 1982, the HCFA Chicago Regional Office directed Nationwide to place seven podiatrists that were associated with Dr. Weiner on prepayment review for all claims. Under the prepayment procedures all claims are manually reviewed prior to payment. These reviews resulted in about 90 percent of the amounts billed in 1982 being denied for payment.

--In September 1982, the HCFA Chicago Regional Office's files on Dr. Weiner and his associates were turned over to the FBI for criminal investigation.

--In February 1983, after reviewing the material submitted by the HCFA Chicago Regional Office for 20 Medicare beneficiaries, the FBI concluded that only one case was indicative of fraud on the podiatrist's part. The others were not considered good cases for prosecution for a number of reasons, including the advanced age of the beneficiary and confusion over the services that were actually provided.

--From March through July 1983, the FBI investigated the financial holdings of Dr. Weiner and the possible violation of his exclusion from Medicare participation.

--In August 1983, the U.S. Attorney's Cleveland Office was advised of the FBI's investigative results. The U.S. Attorney determined that there was neither sufficient credible evidence nor enough reliable witnesses to pursue criminal prosecution. However, he decided civil litigation should be pursued with the aid of HHS' Office of Inspector General.

In May 1983, HHS' Office of Inspector General opened an investigation of Family Foot Care Associates, Incorporated. However, this investigation was suspended in July at the request of

Medical Mutual of Northeast Ohio (a private insurance company) which was concerned that a government investigation might interfere with an investigation it was performing concerning private insurance claims submitted by Dr. Weiner's former associates. The Office of Inspector General investigation was reactivated in November 1983 in conjunction with the U.S. Attorney to pursue civil litigation. The estimated completion date for this investigation is during the first quarter of 1984.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objective of our review was to obtain answers to your questions. We discussed them with HCFA's and Office of Inspector General's headquarters, and their Chicago Regional Offices; the FBI, Cleveland Office; the Ohio Secretary of State; and the Nationwide Mutual Insurance Company officials. We also reviewed our prior work concerning this subject. We completed our work in December 1983. Our work was done in accordance with generally accepted government audit standards.

We discussed the information in this report with HHS' Office of Inspector General officials and considered their comments in preparing the report. We believe that when the recommendations in our February 1983 report are fully implemented, the exclusion process should be substantially improved. Therefore, we are not making additional recommendations at this time.

Unless you publicly announce its contents earlier, no further distribution of this report will be made for 30 days. At that time, we will send copies to the Secretary of HHS and other interested parties and make copies available to others upon request.

Sincerely yours,

Richard L. Fogel
Director