

GAO

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MEDICARE

Adapting Private Sector Techniques Could Curb Losses to Fraud and Abuse

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SUMMARY

Medicare could save billions of dollars by curbing fraud, waste, and abuse. These losses occur largely because of inappropriate pricing and inadequate scrutiny of claims for payment and because abusive or poorly qualified providers of medical services and supplies are allowed to participate in the program.

These problems are not unique to Medicare--they can be found elsewhere in both the public and private sectors. However, private payers have been able in many instances to react quickly, through a variety of management approaches, whereas Medicare's pricing methods and controls over utilization, which were consistent with health care financing and delivery when the program started, have not been adapted to today's environment. For example:

- Unlike most successful private payers, Medicare pays higher--than-market rates for many services and lacks the capability for fast price adjustment. In one case, it took 3 years to reduce payments for home blood glucose monitors from an average \$186 to \$59 each, although drug stores sold them for less than \$50 or gave them away as a marketing ploy.
- Claims processing systems can fail to detect gross overpayments--\$23,000 was paid in one instance, when the appropriate payment was \$1,650. Sophisticated new software exists to detect many such aberrancies, but the Health Care Financing Administration (HCFA) is only now evaluating their potential utility.
- We have identified instances of providers obtaining authorization to bill Medicare and being paid for their claims who were not legitimate business entities and in some cases had no space or employees. HCFA is exploring ways to tighten participation requirements, but is concerned about the reporting burden on honest providers.

Faced with similar problems, private sector payers use modern management techniques, such as competitive bidding, advanced software programs, and preferred provider networks. Meanwhile, HCFA is generally unable to negotiate with providers for discounts; promptly change prices to match those available in the market; or provide incentives to encourage beneficiaries to use providers meeting utilization, price, and quality standards. If Medicare were able to apply appropriate private sector techniques, its weaknesses could be significantly remedied.



Mr. Chairman and Members:

We are pleased to be here today as this Subcommittee explores the problems of waste, fraud, and abuse in the Medicare program. As we testified before you in a joint hearing last May and have documented in numerous reports and other congressional testimony, billions of dollars could be saved by curbing questionable, abusive, and exploitative billing.

You asked that we examine ways in which Medicare is particularly vulnerable to abuse, why any response to these problems is slow even after they surface, and what could be done to remedy program weaknesses. My comments today are based on our extensive work in these areas in the past year. (See app. II for a list of related GAO products.)

In summary, our work has shown that Medicare's continuing vulnerability stems from a combination of circumstances:

- an environment ripe for abuse because of higher-than-market rates for certain services, inadequate checks for detecting fraud and abuse, and inadequate criteria for confirming the authenticity of providers billing the program and
- lengthy delays and inadequacies in corrective actions even after problems are identified.

In contrast, private payers have adopted various management approaches to alleviate the problems of overcharging, inadequate claims scrutiny, and abusive or poorly qualified providers. Medicare's pricing methods and controls over utilization, while consistent with health care financing and delivery 30 years ago, are not well aligned with today's major financing and delivery changes. To some extent, the predicament inherent in public programs--the uncertain line between adequate managerial control and excessive government intervention--helps explain the dissimilarity in the ways Medicare and private health insurers administer their respective "plans."

We believe that a viable strategy for remedying the program's weaknesses would be to adapt the health care management approach of private payers to Medicare's role as public payer. Such a strategy would focus on pre-enforcement efforts. It would entail (1) more competitively developed payment rates, (2) enhanced fraud and abuse detection efforts through modernized information systems, and (3) more rigorous criteria for granting authorization to bill the program.

BACKGROUND

Medicare is the nation's largest single payer of health care costs. In 1994, it spent \$162 billion, or 14 percent of the federal budget, on behalf of about 37 million elderly and disabled people. Approximately 90 percent of Medicare beneficiaries obtained services on an unrestricted fee-for-service basis; that is, patients chose their own physicians or other health care providers, with charges sent to the program for payment. This setup mirrored the nation's private health insurance indemnity plans, which prevailed until the 1980s.

Since then, revolutionary changes have taken place in the financing and delivery of health care. Greater competition among hospitals and other providers has enabled health care buyers to be more cost-conscious. Private payers, including large employers, use an aggressive management approach to control health care costs. The Health Care Financing Administration (HCFA), within the Department of Health and Human Services (HHS), is Medicare's health care buyer. HCFA's pricing of services and controls over utilization have been carefully prescribed by statute, regulation, or agency policy.

HCFA contracts with about 77 private companies--such as Blue Cross and Aetna--to handle claims screening and processing and to audit providers. Each of these commercial contractors works with its local medical community to set coverage policies and payment controls. As a result, billing problems involving waste, fraud, and abuse are handled, for the most part, at the contractor level. This arrangement was prompted when the program was established in the mid-1960s by concerns that the federal government, which lacked extensive claims processing expertise and experience, would prove incapable of providing service comparable to that of private insurers.

PROGRAM VULNERABILITIES MAKE MEDICARE AN APPEALING TARGET FOR ABUSE

Most observers agree that the vast majority of Medicare providers seek to abide by program rules and strive to meet beneficiaries' needs. But certain characteristics of the program and the way it is administered create a climate ripe for abuse by some providers. For many supplies and services, Medicare reimbursement far exceeds market rates. Scrutiny of incoming claims is often inadequate to reveal overpricing or oversupply. And providers are allowed to participate in the program without sufficient examination of their qualifications and their business and professional practices.

Above-Market Rates for Many
Services Encourage Oversupply

Unlike the most successful private payers, Medicare pays substantially higher-than-market rates for many services. For example:

- The HHS Office of Inspector General (OIG) reported in 1992 that Medicare paid \$144 to \$211 each for home blood glucose monitors when drug stores across the country sold them for less than \$50 (or offered them free as a marketing ploy).¹ HCFA took nearly 3 years to reduce the price to \$59.
- Medicare was billed \$8,415 for therapy to one nursing home resident, of which over half--\$4,580--was for charges added by the billing service for submitting the claim. Such practices escape notice because for institutional providers Medicare allows almost any patient-related costs that can be documented.
- Anesthesia payments, unlike payments to other physicians, are based on units of time, thus providing a financial incentive to prolong anesthesia service delivery. Our studies have shown that reported times for the same anesthesia service vary widely for no apparent reason and that basing fees on a procedure's median anesthesia time could reduce Medicare payments by over \$50 million a year.

HCFA contacts told us that resources are not available to routinely check market prices for items covered by Medicare. Yet such excessive payment rates can encourage an oversupply of services and thus foster a climate ripe for abuse. Further, our work has shown that HCFA's inability to systematically review payment rates as technologies mature and become more widely used, and as providers' costs per service decline, can support the proliferation of costly technology. Magnetic resonance imaging (MRI) equipment is a case in point, as we reported in 1992.² In the absence of systematic adjustment, the Congress has had to act several times, specifically reducing rates for various procedures and services, such as overpriced surgeries, selected durable medical equipment items, intraocular lenses, MRIs, and CT scans.

¹Home blood glucose monitors enable individuals to determine the adequacy of their blood glucose levels. The manufacturers have an incentive to promote the sale of their brand of monitor to ensure future sale of related test strips. According to HCFA, the income generated in 1 month by the sale of test strips can exceed the total income generated from the sale of the monitors.

²Medicare: Excessive Payments Support the Proliferation of Costly Technology (GAO/HRD-92-59, May 27, 1992).

Medicare Underutilizes Advanced Technology to Check Claims

Medicare's claims processing contractors employ a number of automated controls to prevent or remedy inappropriate payments.³ Although these measures are effective in some instances, abusive claims costing billions of dollars escape detection.

Our work shows that improbable charges or unlikely payments often escape the controls and go unquestioned. For example, in March 1994, Medicare's surgical dressing benefit was greatly expanded to include various types and sizes of gauze pads not previously covered and to extend the duration of coverage to whatever is considered medically necessary. Yet none of the contractors who process claims for medical equipment and supplies automatically reviews high-dollar claims for these newly covered surgical dressings. In consequence, one such contractor paid \$23,000 when the appropriate payment was \$1,650.

As we told you in our earlier testimony, we recently compared what Medicare actually paid providers against what would have been paid by four commercial firms that market computerized systems to detect errors or deliberate abuse involving miscoded claims. We invited each firm to reprocess 200,000 statistically selected claims that Medicare paid in 1993. On the basis of this sample, we estimated that if Medicare had used this commercial software the government would have saved \$3 billion over 5 years by detecting these billing abuses.⁴

Medicare Does Not Adequately Screen Providers for Credibility

Our studies and those of the HHS Inspector General have found that for some providers there are so few requirements that must be met in order to obtain authorization to bill Medicare that their credibility cannot be assumed. The result is that, too often, Medicare loses large sums to providers and suppliers that never should have been authorized to serve program beneficiaries. This problem has become more acute as providers

³Some controls are designed to stop processing when claims do not meet certain conditions for payment. For example, one control flags claims that exceed the allowed threshold of 12 chiropractic manipulations a year per beneficiary. Another kind of control, postpayment review of data, is intended to enable Medicare to spot patterns and trends of unusually high spending.

⁴See Medicare Claims Billing Abuse: Commercial Software Could Save Hundreds of Millions Annually (GAO/T-AIMD-95-133) and Medicare Claims: Commercial Technology Could Save Billions Lost to Billing Abuse (GAO/AIMD-95-135), both issued May 5, 1995.

that are less scrutinized or more transient than doctors and hospitals use elaborate, multilayered corporations to bill Medicare.

The following examples show instances in which such providers obtained Medicare provider numbers and billed the program extensively over the past several years:

- Five clinical labs (that Medicare paid over \$15 million in 1992) have been under investigation since early 1993 for the alleged submission of false claims. The labs' mode of operation was to bill Medicare large sums over 6 to 9 months; whenever a lab received inquiries from Medicare, it went out of business.
- A therapy company added \$170,000 to its Medicare reimbursements over a 6-month period, while providing no additional services, by creating a "paper organization" with no space or employees. The company simply reorganized its nursing home and therapy businesses to allocate a large portion of its total administrative costs to Medicare.
- A medical supply company serving nursing facility patients obtained more than 20 different Medicare provider numbers for companies that it controlled. The companies, all in the same state, were nothing more than shells that allowed the supplier to spread its billings over numerous provider numbers to avoid detection of its overbillings.

HCFA's Program Integrity Group is currently examining ways of limiting participation of suppliers and providers to those that appear to be legitimate business entities. The group is concerned, however, about the reporting burden and costs that new requirements may pose for honest providers.

RESPONSE IS TARDY EVEN AFTER PROBLEMS SURFACE

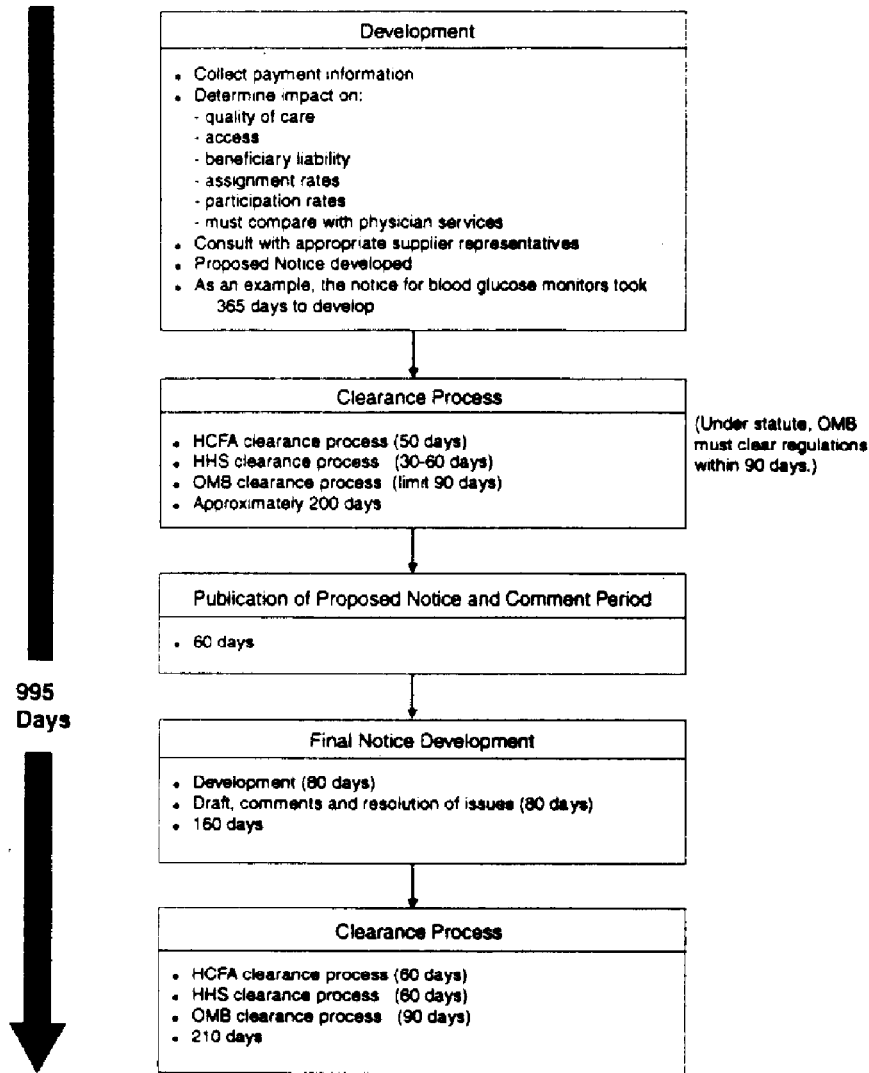
Whether because of strict constraints imposed by statute or because of its own burdensome regulatory and administrative procedures, we have found that HCFA is slow to address problems involving overpricing, inadequate payment checks, or abusive providers.

Pricing Changes Slow or Impossible

The OIG cited home glucose monitors as an overpriced item in 1992. HCFA reported in January of this year that the process (under its "inherent reasonableness" authority) required to lower the reimbursement for these monitors took about 3 years (see fig. 1). The final notice establishing the special payment limits was issued in the Federal Register on January 17, 1995. Industry

sources claimed that this "speedy" response was possible only because few suppliers commented on the proposed rule, thus allowing it to become final without changes.

Figure 1: HCFA's Process for Using Inherent Reasonableness Authority

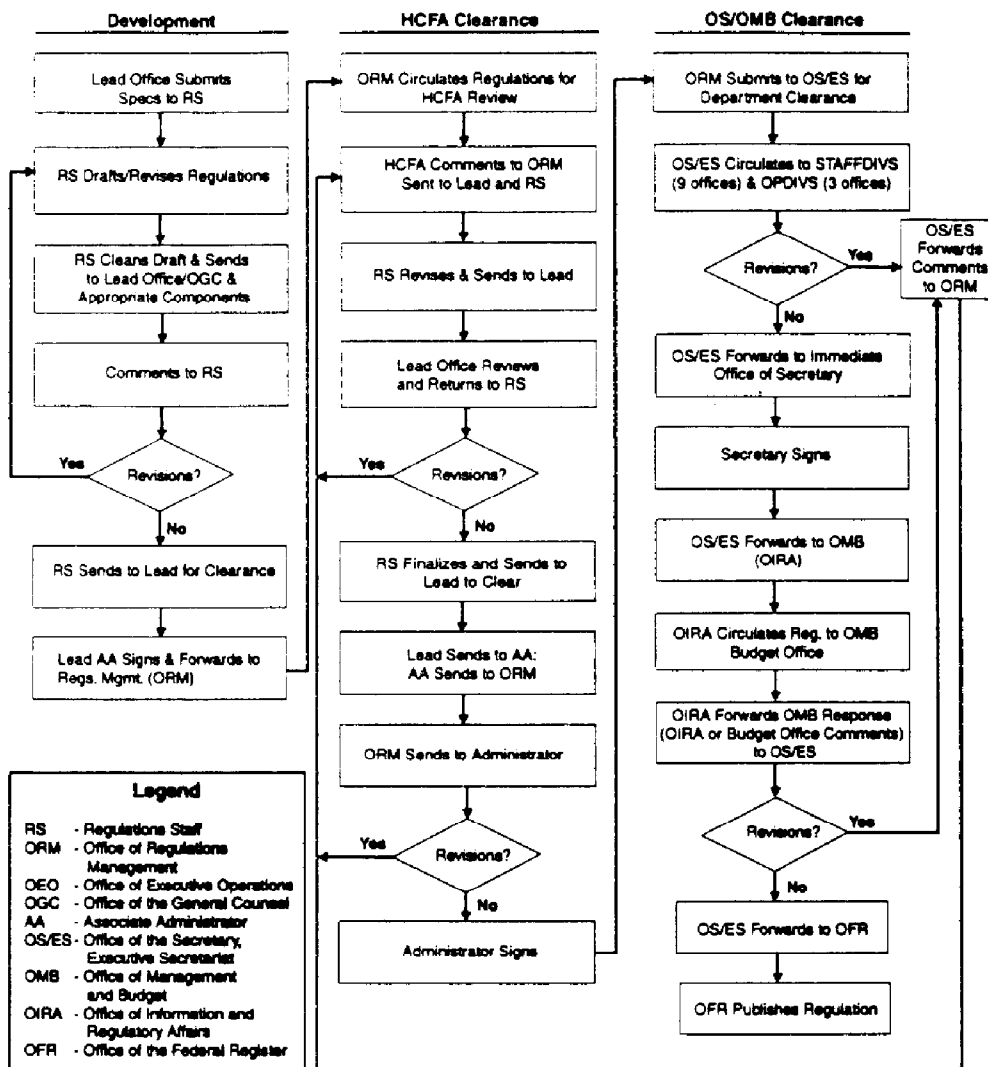


Source: HCFA Bureau of Policy Development

Investigation into a second overpriced item, oxygen equipment, was initiated in November 1994. A HCFA official told us that HCFA lacked resources to deal with questions of reasonable pricing for more than one item at a time, though it would like to compare prices for about 80 of the supplies and services that are most costly overall.

In December 1994, the Secretary of HHS announced an initiative to "dramatically shorten" the time it takes to issue final regulations to 24 months. The current regulatory process within HHS is shown in figure 2. HCFA has not yet developed its implementation plan under this initiative.

Figure 2: HCFA's Regulatory Process



Source: HCFA Bureau of Policy Development

No Immediate Prospect of Enhancing Payment Controls

Enhancement of payment controls is problematic in the current fiscal environment. Contractor resources are a major factor here. Individual claims for reimbursement may be singled out for review in the course of automated checks and are subject to denial before payment if found to be inappropriate for any reason. Payments may be delayed while claims undergo further review or to recover previous overpayments. Postpayment analyses are also conducted to detect aberrant patterns of billing. But all these activities demand the investment of time by qualified professionals.

However, contractor funding on a per claim basis has declined in recent years, as shown in table 1. As a consequence, we have found instances where automated screens have been turned off for lack of staff to follow up.

Table 1: Medicare's Contractor Funding Per Claim for Selected Activities

Activity	1989 budget	1995 budget	Percent decrease	
			Not adjusted for inflation	Adjusted for inflation
Medical review of claim	\$0.32	\$0.15	54.4	60.7
All payment safeguards	\$0.74	\$0.50	32.7	43.3
Total contractor budget	\$2.74	\$2.05	25.1	37.3

As regards adopting enhanced commercial systems to detect billing abuses, inappropriate coding, and other aberrancies in claims submitted for payment, HCFA is currently evaluating available off-the-shelf software packages to determine their potential utility for the Medicare program. HCFA officials said that they have to resolve three key issues: whether commercial system rules match or can be modified to match Medicare payment policies; to what extent commercial firms would be willing to disclose information about their systems in order to allow physicians and other interested parties to comment on Medicare policies; and what would be the cost and technical feasibility of installing the commercial software on existing carrier claims processing systems.

In the general area of advanced technology, improvements lie ahead in the form of the Medicare Transaction System (MTS), intended to replace the 10 existing automated systems used by 77 contractors at 56 sites to process and pay claims. HCFA hopes thus to improve administrative efficiency, enhance its ability to manage contractors, and place greater emphasis on safeguarding program dollars. According to the HCFA Administrator, the single integrated system will track all claims for each beneficiary and be able to identify any suspicious activities. However, HCFA says that full implementation of MTS--currently scheduled for September, 1999--is already 9 months behind schedule.

Penalties for Wrongdoing Unduly Delayed

Currently, providers who defraud or otherwise abuse health care payers have little chance of being prosecuted or having to repay fraudulently obtained money. Few cases are pursued as fraud. Even when they are, many are settled without conviction, penalties are often light, and providers frequently continue in business. These are characteristics of health care fraud (and of white-collar crime in general) and are not confined to Medicare. They are variously blamed on the complexity of cases, lack of resources, necessity for interagency coordination, and uncertainty of outcome. In recent testimony, the Special Counsel for Health Care Fraud at the Department of Justice noted that health care fraud cases are extremely resource-intensive and are among the most document-intensive of all white-collar crime.⁵

Various entities are involved in the identification and pursuit of potentially fraudulent activities, including not only Medicare contractors and HHS but also law enforcement agencies at all levels. The lack of resources hampers investigations for each group, and leads to extended delays in case resolution. Our recent investigation of inappropriate therapy billings for Medicare beneficiaries in nursing homes traced one case from the initial beneficiary complaint through its close-out by the OIG. This case took more than 3 years, and the resolution was inconclusive. (See app. I for further details.)

The first line of defense against fraud, waste, and abuse in Medicare is the contractor. The primary check on abusive or fraudulent practices consists of beneficiary complaints made directly to the contractor or referred there by HCFA. Fraud units at each contractor site investigate leads and in turn refer persuasive cases to regional offices of the HHS OIG, who make

⁵Statement of Gerald M. Stern, Special Counsel, Health Care Fraud, Department of Justice, before the Subcommittee on Human Resources and Intergovernmental Affairs, Committee on Government Reform and Oversight, House of Representatives, concerning Medicare and Medicaid fraud and abuse, June 15, 1995.

recommendations regarding OIG involvement. OIG headquarters decides whether to seek civil or administrative sanctions.⁶ In California, we were told the OIG seeks civil monetary penalties only in those cases with significant potential for financial recovery in terms of both amount of fraud and collectibility. In 10 to 20 percent of cases a year, the provider declares bankruptcy or has no identifiable assets. The OIG does not--and cannot afford to--pursue those cases. We were told "this is a cash-based industry, and it is very hard to recover assets."

Many fraud cases are negotiated among the various parties involved before conviction to explore possible plea bargains. While the cases are developed at local OIG offices, which are also empowered to negotiate lower-dollar cases (those with settlement values of less than \$100,000), they must still be reviewed and approved by headquarters, which has only three qualified and available negotiators for the entire country. Where cases are settled through such negotiation, it is usually a means for the provider to avoid exclusion.⁷ Ninety percent of cases judged by the OIG to have merit are settled through negotiation.

Even in some of the most egregious cases of Medicare fraud, corporate providers are allowed to continue their program participation. In one of the more significant federal health care fraud prosecutions to date, National Health Laboratories acknowledged over \$100 million in fraud committed against Medicare, Medicaid, and CHAMPUS⁸ over a 4-year period. The lab

⁶The OIG has no authority to pursue criminal action--this is the province of the Department of Justice, which can also initiate civil actions in federal court. In Medicare cases, the OIG investigators provide the information on which the Department of Justice bases its decision. The OIG may also refer cases to local or state law enforcement agencies if they are declined by the Department of Justice.

⁷The Secretary of HHS has the authority to exclude health care providers from Medicare for a number of reasons, and has delegated these authorities to the OIG. Program exclusion is mandatory following convictions for Medicare or Medicaid program-related crimes or for patient abuse and neglect. Under other conditions, the OIG can exercise judgment as to whether exclusion is appropriate.

⁸CHAMPUS--the Civilian Health and Medical Program of the Uniformed Services--is a federal medical program for military dependents and retirees that pays for care received from civilian hospitals, physicians, and other providers.

was allowed to negotiate a civil settlement including language that specifically permitted its continued participation in all three programs.

In fiscal year 1994, there were 1,265 exclusions, of which 471 were mandatory and 794 permissive. However, almost one-half (566) of the exclusions were for failure to repay student loans; only 289 were for program-related convictions.

The OIG is working with HCFA to seek a nationwide uniform provider agreement that would not allow excluded individuals to be paid. They are also seeking expanded authority to act against culpable owners of excluded companies. Currently, the owner of such a company is free to reincorporate or start another business without fear of exclusion.

PRIVATE SECTOR MANAGEMENT TECHNIQUES
SUGGEST WAYS TO REMEDY PROGRAM WEAKNESSES

Private sector payers have confronted similar problems of high prices, inadequate claims scrutiny, and abusive or poor-quality providers. Their response has been to shift their role from that of passive payers to that of more prudent managers of health care costs, providers, and services. Specifically:

- Employers purchase health care by assessing the market options; for example, Walt Disney World in Orlando, Proctor and Gamble in Cincinnati, and LTV Steel in Cleveland have organized health care coalitions to help them make better purchasing decisions. They collect information on provider costs and performance to obtain the best value for their health care dollars.
- Insurers use state-of-the-art computer software to detect coding manipulation and computerized systems to monitor utilization; almost 200 private insurers now use commercial systems to detect code manipulation, including 13 of the 20 largest.
- Health plans use preferred provider networks and other contractual arrangements to help select providers that perform favorably in terms of quality and use of services. Even such managed indemnity plans as Blue Cross and Blue Shield use provider networks.

Medicare's pricing methods and utilization controls, on the other hand, are not well-aligned with the revolutionary changes in today's health care market. Instead, Medicare's day-to-day operations have been shaped by three principles on which the program was founded in 1965: the government should not interfere in medical practice; patients should be free to choose their own health care providers; and attempts to alter public programs

require public comment and discussion. Although these are sensible principles with wide appeal, they have not been adapted to the contemporary health care marketplace and today's demands for fiscal discipline in public programs.

As a result, HCFA is generally unable to negotiate with providers for discounts; promptly change prices to match those available in the market; or competitively bid prices for widely used items such as pacemakers, intraocular lenses, and wheelchairs. This has resulted in Medicare paying higher prices than other large payers.⁹ Similarly, HCFA cannot differentiate between providers who meet utilization, price, and quality standards and those who do not, nor can it provide incentives to encourage beneficiaries to use providers meeting any such standards.

CONCLUSIONS

Medicare's vulnerability to exploitation can be summarized as follows:

- Despite the current competitive health care market, Medicare often pays more than the market price for medical services and supplies.
- Although payment of claims for services provided constitutes the program's chief administrative function, Medicare does not use available state-of-the-art technology to screen claims for overcharging or overutilization.
- Despite the increase in nonmedical providers billing for services and supplies, Medicare does little to scrutinize the qualifications of such providers.
- Although delays allow program losses to escalate, Medicare does not respond in timely and effective fashion to address identified problems or to punish those who abuse the program.

The problems facing Medicare confront private insurers as well, but they are armed with a larger and more versatile arsenal of health care management techniques than HCFA currently has. These techniques may not be wholly applicable to Medicare, but in general they offer a menu of options for devising ways to make Medicare more cost effective. Commercial contractors, which play a key role in administering Medicare, routinely employ management-of-care techniques and use state-of-the-art technology

⁹For further discussion of competitive bidding and negotiation strategies, see Medicare Managed Care: Program Growth Highlights Need to Fix HMO Payment Problems (GAO/T-HEHS-95-174, May 24, 1995).

in their capacity as private insurers. If they were able to apply these techniques to Medicare, the program's weaknesses could be significantly remedied.

Given the current emphasis on fiscal discipline, the "pay and chase" approach targeting abusive providers will continue to fall behind the demands placed upon it. Increased emphasis on pre-enforcement efforts is needed. Such an approach would adopt the following three strategies:

1. Allow Medicare to price services and procedures more competitively. This could include streamlining processes required to revise excessive payment rates and allow competitive bidding for and negotiation of prices.
2. Enhance Medicare's antifraud and abuse efforts. This could include completing the modernization of Medicare's claims processing and information systems and expanding the use of state-of-the-art computerized controls.
3. Require providers to demonstrate their suitability as Medicare vendors before being given unrestricted billing rights. This could include HCFA's establishment of preferred provider networks, development of more rigorous criteria for authorization to bill the program, and use of private entities to provide accreditation or certification.

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Mr. Chairman, this concludes my statement. I will be pleased to answer any questions.

For more information on this testimony, please call Edwin P. Stropko, Assistant Director, at (202) 512-7108. Other major contributors include Audrey Clayton, Hannah Fein, Pete Oswald, and Don Walthall.

INVESTIGATION OF OUT-OF-STATE SERVICES

A report by HHS' Office of Inspector General in Atlanta reveals a combination of dubious--if not demonstrably fraudulent--billing practices involving one large rehabilitation company. Complaints were made regarding billing for services not medically indicated; billing for services not delivered; billing through a provider who could not exercise supervision;¹⁰ and failing to notify beneficiaries or their representatives, as required, of claims submitted on their behalf and of copayments due.

One resident of a Kansas nursing home was comatose. His daughter discovered accidentally¹¹ that Medicare had been billed \$8,610 for speech therapy for this patient by a nursing home in Florida. The family considered such treatment inappropriate, in view of his comatose condition, and questionable, in view of his location. The Medicare contractor's investigation found inconsistencies in the medical records regarding the patient's residence and that the physician's signature on the orders for treatment did not match the name of the attending or referring physician.

The family of a Georgia nursing home resident received a statement from Medicare (Explanation of Medicare Benefits, or EOMB) that over \$7,644 had been billed for speech therapy treatments on his behalf (46 treatments, at an average cost of \$166). Again, the family claimed the patient--who had advanced Parkinson's disease--could not benefit from such treatments, which they had not approved,¹² and could not have received so many treatments without the family's knowledge because of their frequent presence. Again, the claim was submitted by a nursing home in Florida.

The regional OIG investigated the two Florida nursing homes named in these complaints. It found that both used the same

¹⁰Before August, 1989, regulations required the provider (that is, the biller) of rehabilitative services to take an active role in the monitoring, treatment, and record-keeping associated with such services. While some requirements for supervision are retained in the current version, they are much less specific.

¹¹Providers are prohibited from waiving copayments except in specified circumstances. Even then, attempts to collect must be made. No copayments were requested in this instance.

¹²Family approval is not mandatory, but the family--where available--is supposed to be involved in treatment decisions.

rehabilitation company to provide the therapy services.¹³ The nursing homes also shared the same management company, which prepared all bills for them. Together, the two homes billed Medicare \$3.2 million for part B therapy in 1 year, amid numerous complaints of treatments that were not delivered, inappropriate, or both.

An investigation by the Medicare contractor of a sample of therapy claims submitted by one of these two nursing homes found that fewer than 5 percent had the correct beneficiary address. For more than 95 percent, the address given was that of the therapy company. This meant that the EOMBs went to the company, not the beneficiary or his or her representative--who would thus have no way of knowing what services were being billed, what they cost, and whether they were delivered as claimed. Therapy bills for this nursing home jumped from zero one year to \$1.4 million the next. The OIG's investigation sampled claims for 25 beneficiaries and found that 23 of them (92 percent) resided in Kansas, not Florida. The nursing home's claims for one month for just 10 of these patients exceeded \$26,500. Their medical records were kept in Florida, but verifying their accuracy would require a Kansas investigation. In at least one of these cases, it proved impossible to determine where the beneficiary lived; the only address cited was that of the therapy company in Georgia.

In addition, for both of these Florida nursing homes, it appeared that the therapists were the ones initiating patient contact and diagnosing the need for therapy, although the therapy company was able to produce doctors' certification upon request.¹⁴ Apparently, its therapists examined each resident in these and other nursing homes and found that the majority needed physical therapy, speech therapy, or both. It is difficult to imagine circumstances under which this could happen unless the therapists illegally obtained access to the records of all residents of a specific facility or facilities.¹⁵

¹³This company had its own Medicare provider number and could have billed directly, instead of through the nursing homes. In fact, it did bill directly for physical therapy services to the patient with Parkinson's disease.

¹⁴Medicare generally holds the attending physician responsible for developing a plan of care in consultation with family members.

¹⁵Federal regulations require that nursing facilities safeguard clinical record information against unauthorized use; all information contained in the patients' records must be kept

Three years after the initial complaint was lodged, the OIG sent a warning letter to the rehabilitation company but closed the investigation, stating that there were too many conflicting regulatory issues and problems with uniform policies across the country for the case to have any prosecutorial potential.

confidential except when release is required by (1) transfer to another health care institution, (2) law, (3) third-party payment contract, or (4) the resident.

RELATED GAO PRODUCTS

Medicare: Rapid Spending Growth Calls for More Prudent Purchasing (GAO/T-HEHS-95-193, June 28, 1995).

Medicare: Modern Management Strategies Needed to Curb Program Exploitation (GAO/T-HEHS-95-183, June 15, 1995).

Medicare Managed Care: Program Growth Highlights Need to Fix HMO Payment Problems (GAO/T-HEHS-95-174, May 24, 1995).

Medicare: Reducing Fraud and Abuse Can Save Billions (GAO/T-HEHS-95-157, May 16, 1995).

Medicare Claims Billing Abuse: Commercial Software Could Save Hundreds of Millions Annually (GAO/T-AIMD-95-133, May 5, 1995).

Medicare Claims: Commercial Technology Could Save Billions Lost to Billing Abuse (GAO/AIMD-95-135, May 5, 1995).

Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes (GAO/HEHS-95-23, Mar. 30, 1995).

Medicare and Medicaid: Opportunities to Save Program Dollars by Reducing Fraud and Abuse (GAO/T-HEHS-95-110, Mar. 22, 1995).

Medicare's Secondary Payer Program: Actions Needed to Realize Savings (GAO/T-HEHS-95-92, Feb. 23, 1995).

Medicare: High Spending Growth Calls for Aggressive Action (GAO/T-HEHS-95-75, Feb. 6, 1995).

High-Risk Series: Medicare Claims (GAO/HR-95-8, Feb. 1995).

Medicare: Inadequate Review of Claims Payments Limits Ability to Control Spending (GAO/HEHS-94-42, Apr. 28, 1994).

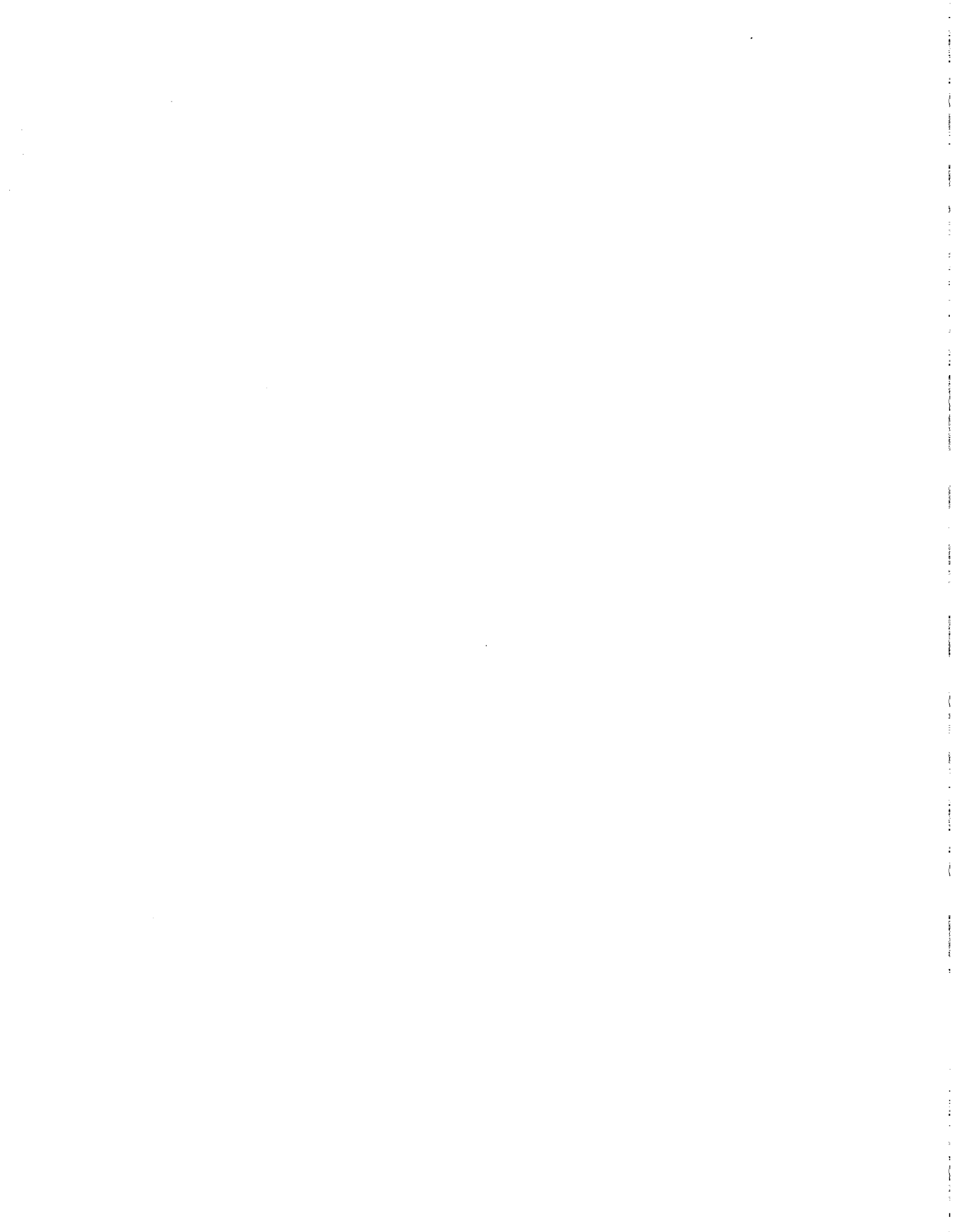
Health Care Reform: How Proposals Address Fraud and Abuse (GAO/T-HEHS-94-124, Mar. 17, 1994).

Medicare: Greater Investment in Claims Review Would Save Millions (GAO/HEHS-94-35, Mar. 2, 1994).

Medicare: New Claims Processing System Benefits and Acquisition Risks (GAO/HEHS/AIMD-94-79, Jan. 25, 1994).

Medicare: Adequate Funding and Better Oversight Needed to Protect Benefit Dollars (GAO/T-HRD-94-59, Nov. 12, 1993).

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