Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Carrier Fraud Units

JUNE GIBBS BROWN
Inspector General

NOVEMBER 1996
OEI-05-94-00470

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EXECUTIVE SUMMARY

PURPOSE:

To evaluate carrier fraud units and identify factors that contribute to and work against successful program integrity operations.

BACKGROUND:

In 1994, Medicare carriers processed over 615 million claims. That same year, carriers received about 118,000 complaints alleging fraud or abuse. The Health Care Financing Administration (HCFA) has charged their contractors with the responsibility of detecting and deterring program fraud, waste and abuse. Both carriers and intermediaries have set up fraud and abuse units as one element of HCFA's overall benefit integrity program. To help defray the cost of investigating complaints, HCFA provided the carriers with nearly $23 million to fund their fraud units.

We obtained information from 37 carrier fraud units. We examined selected case files and obtained documentation relating to program integrity operations. We interviewed 292 employees and visited 6 carrier units to carry out in-person discussions. Based on the information we obtained, we compared carrier performance using the following five criteria:

- Accuracy of complaint disposition
- Assessing financial damage
- Case documentation
- Internal proactive safeguards
- External proactive safeguards

FINDINGS:

Very few carriers were successful in meeting all of our outcome criteria.

Only two carriers consistently ranked high when we analyzed fraud unit performance using the five criteria mentioned above. We found that few carrier fraud units follow case development procedures. Overpayment information is often inaccurate and information concerning frequency and nature of past problems with providers is often missing. Despite claims of being proactive in their approach to combating fraud and abuse, only 14 carriers could provide evidence that they took steps to correct vulnerabilities they identified in their claims processing systems, policies and procedures.

The most effective program integrity efforts are found in corporations that accord a high priority and adequate management attention to the fraud units.

Resources and Organization. Strategic organizational placement of most, if not all, postpayment functions within the jurisdiction of the fraud units appears to be key to

better performance. Effective fraud units are part of a corporate culture that supports them in hiring and keeping highly motivated and qualified persons. They invested more in competitive salaries, technology and ongoing staff training.

Staffing. Successful fraud units integrate persons with law enforcement backgrounds with personnel who have knowledge of claims processes and policies. Analysts, auditors and statisticians are hired to meet special needs. No one discipline dominates the successful fraud unit. Less successful fraud units employed staff with backgrounds primarily from a single prepayment discipline such as provider relations or claims processing.

Training. Staff at better units receive ongoing training from internal and external sources. In other fraud units, at least 2 out of every 3 people have had no HCFA, Office of Inspector General or other outside training on fraud and abuse since HCFA began funding fraud units in the fall of 1992.

RECOMMENDATIONS:

Concerns regarding the effectiveness of Medicare carrier fraud units are similar to those discussed in our report entitled *"Surveillance and Utilization Review Subsystems' Case Referrals to Medicaid Fraud Control Units," OEI-07-95-00030.* As a result, we believe that a concerted effort addressing both Medicare and Medicaid fraud units is called for. We are proposing a uniform team approach. We recommend that HCFA, in consultation with the Office of Inspector General should:

Convene a Medicare and Medicaid fraud and abuse task force to plan and implement improvements in fraud unit operations. This would include:

- Clarifying goals and objectives for program integrity efforts.
- Establishing guidelines for developing suspected fraud cases.
- Developing a universal protocol for appropriately referring fraud and abuse cases.
- Coordinating data systems to ensure that data are reliable and consistent across all entities in the fraud and abuse fighting network.
- Developing a training program designed to educate program integrity personnel on procedures, case referrals and best practices.

Continue to provide support and technical assistance to carriers so they can emulate those carriers operating successful programs. This can include:

- Encouraging carrier commitments that result in increased resources to combat fraud and abuse such as investments in technology and people.
- Suggesting ways of organizing a successful program integrity effort.
- Limiting the role of medical review units in program integrity to those cases involving issues of abuse, policy, coverage and medical necessity.
- Rewarding carriers for identifying policy, procedure and systems vulnerabilities and implementing corrective safeguards.
- Separating the budget for postpayment activity from the budget for claims processing and other front-end operations such as provider enrollment and provider relations.

AGENCY COMMENTS

We appreciate all the positive steps that HCFA has taken thus far to safeguard the Medicare program and we recognize the accomplishments of the Program Integrity Group. We are pleased that HCFA has concurred with our recommendations and we look forward to working with HCFA in their implementation.

We believe that the best approach would be a collaborative one involving HCFA and OIG, with consultation from high performing State Surveillance and Utilization Review Subsystem Units (S/URS) and carriers. We suggest that this effort focus on:

- Developing and implementing model practices.
- Revising current contractor performance measures that reward carriers for overpayment recovery but not for fraud and abuse referrals or efforts to improve claims processing safeguards.
- Identifying the most effective practices which carrier and State personnel use to eliminate claims processing vulnerabilities that enable providers to defraud health programs.

We believe that achieving the goals both HCFA and the OIG have established for improving program integrity functions at the carriers and in the States can best be accomplished by these kinds of collaborative efforts. We look forward to working with HCFA to bring about further measurable change.

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INTRODUCTION

PURPOSE

To evaluate carrier fraud units and identify factors that contribute to and work against successful program integrity operations.

SCOPE

The Health Care Financing Administration (HCFA) contracts with insurance companies to process medical claims incurred by Medicare beneficiaries. Fiscal intermediaries process hospital insurance (Part A) claims which cover hospital inpatient, skilled nursing facility and home health agency services. Supplemental Medical Insurance (Part B) claims are processed by carriers. Part B covered services encompass: doctors' services, diagnostic laboratory tests, outpatient hospital services, outpatient physical therapy, outpatient speech therapy, outpatient speech pathology, home health care and many other health services and supplies not covered by hospital insurance.

The HCFA has charged their contractors with the responsibility of detecting and deterring program fraud, waste and abuse. Both carriers and intermediaries have set up fraud and abuse units as one element of HCFA's overall benefit integrity program.

During this study, we contacted 37 of HCFA's 42 carriers responsible for processing Medicare Part B claims. This number includes the four Durable Medical Equipment Regional Carriers that process providers' claims for medical supplies and durable medical equipment.

BACKGROUND

Medicare losses due to fraud and abuse concern Congress, HCFA, the Office of Inspector General (OIG) and others. The HCFA and their carriers work together to detect and deter fraud and abuse through various means. Carriers refer their fraud and abuse cases to the OIG for development and evaluation and possible referral to the Department of Justice. The OIG, in turn, works with the Department of Justice to prosecute these cases.

Medicare carriers process about 615 million claims each year. In 1994, approximately 118,000 complaints alleging fraud or abuse were received. These complaints were assigned to about 400 carrier employees for screening and investigation. According to OIG records for 1994, carrier investigations produced approximately 400 cases involving 1,300 subjects that were subsequently referred to OIG for in depth investigation.

Since the inception of the Medicare program, HCFA has supported carrier efforts at safeguarding Medicare payments. Despite these efforts, the General Accounting Office (GAO) in 1992 reported that the Medicare program was vulnerable to fraud, waste, abuse and mismanagement. The GAO estimates that nearly $2 million is lost to fraud and abuse each hour. The GAO report and other recent events have encouraged HCFA to pursue regulatory and administrative changes aimed at correcting flawed payment policies, weak controls and deficient program management. Most visible of HCFA's efforts was its financial commitment to supporting carrier fraud and abuse units. In fiscal year 1994, HCFA provided approximately $23 million to carriers in benefit integrity funding.

In addition to financial support, HCFA has undertaken a number of other initiatives in recent years to correct flawed payment policies and improve program management. For the first time since the Medicare program began, HCFA established national and regional positions to focus the Agency's fraud and abuse efforts and to provide guidance to the carriers.

One element of HCFA's revitalized effort to guide carriers to improve their performance was a change in the way HCFA evaluated carrier performance. Prior to 1994, HCFA evaluated carrier performance by comparing carriers and providing a numerical score intended to represent how a particular carrier fared against its peers. In 1994, HCFA took steps to change and improve the process for evaluating carrier performance. Numerical scores for comparing carrier performance were abandoned in favor of a new system emphasizing continuous improvement.

The OIG issued a report in 1995 that reviewed HCFA's new system for monitoring carrier fraud and abuse unit performance. The report concluded that HCFA's ability to assess carrier performance had improved but that HCFA had failed to make full use of the information gathered during the review process to improve carrier ability to safeguard Medicare payments.[1] This current study was undertaken to further contribute to the improvement of carrier program integrity efforts.

METHODOLOGY

Data and information presented in this report was derived from: (1) a survey of carrier fraud and abuse staff, (2) carrier data and other documents, and (3) actual cases developed by carrier staff involving allegations of fraud and abuse.

Thirty-one carriers were contacted by telephone or mail. We visited six carriers and talked to fraud and abuse management and staff. Overall, we identified 351 employees whose duties involved the screening of complaints and/or the development of potential fraud and abuse cases. Of the 351 employees, 292 (83.2%) completed our written survey. The survey was designed to obtain information about employee work

1 Office of Inspector General, *Monitoring Medicare Contractor Performance: A New Approach*, DHHS/OIG Office of Evaluation and Inspections, OEI-01-93-00160, August 1995.

experience, the organization of the carrier, its program integrity operations and procedures. In addition to the written survey responses, we held discussions about carrier operations and procedures with more than 80 carrier employees.

Survey responses were supplemented with information obtained from managers during the initial telephone contact and, in some cases, during subsequent telephone contacts. In addition to our employee surveys, we requested each carrier to provide data and documentation. We asked for documentation of fraud and abuse unit procedures and information on the unit's workload and accomplishments. Other information was obtained from HCFA and the OIG, Office of Investigations headquarters and regional staff. In addition to interviews with HCFA personnel, we also obtained and analyzed HCFA carrier performance evaluations.

We asked our survey respondents what criteria they felt should be used to evaluate their fraud unit's performance. Of the 19 criteria suggested by respondents, we selected the following 5 criteria to judge each carrier's performance:

(1) Accuracy of complaint disposition.
(2) Adherence to procedures for developing and projecting overpayments.
(3) Adherence to procedures for documenting frequency of complaints in referrals to OIG.
(4) Number of internal proactive measures initiated by the fraud unit that result in carrier payment safeguards.
(5) Number of external proactive measures initiated by the fraud unit that increase awareness of schemes to defraud government programs.

We considered two additional performance measures: return on investment and overpayment recoveries. Although final action to obtain convictions, assess fines and return overpayments rests with entities other than the fraud units, we thought these measures were important as a reflection of the units' contributions to final disposition of cases and outcomes. We collected data on these measures from the units. However, after consultation with HCFA, we determined that the data reported might be unreliable and invalid. Since no uniform reporting requirements for these data exist, it is reasonable to assume that carrier units might not have the systems in place to verify and validate the data. As a result, we have included no information on these measures or the data reported to us in this report.

We used the above criteria and ranked each carrier's performance using information each carrier provided. When all of the information had been analyzed, we combined the results in a single table to determine if any carrier(s) had consistently scored better in each of our five criteria.

We focused on outcomes that had resulted from each carrier's program integrity efforts. For example, when carriers claimed to be aggressive in preventing fraud through systems' safeguards, we looked for identifiable accomplishments they had initiated that would decrease Medicare vulnerabilities to fraud and abuse. Whenever

possible, we validated carrier responses by examining other information and data available to us from the carrier, OIG and HCFA.

We looked for attributes that may have contributed to good performance and then ascertained the presence or absence of these traits at all the carriers. We looked for consistency in what carriers told us they did and what they actually did in the more than 120 case files we reviewed. Whenever possible we have used examples to illustrate the types of problems we repeatedly observed in our review of carrier case development. Given limited space, we are unable to provide extensive examples of problems. The examples used in this report were those that we felt best illustrate the problems.

FINDINGS

OUTCOME CRITERIA. Few carriers were successful in meeting all of our outcome criteria.

Criteria 1: Accuracy of Complaint Disposition.

The cases we reviewed show that carriers differ significantly in their ability to properly identify potential fraudulent activity. Of the cases we reviewed, we found that 2 out of 3 cases referred to the OIG were inadequately developed or did not involve a violation of criminal or civil statute. We also found that 58 percent of the reviewed cases resolved by carriers administratively were incorrectly handled. Cases handled administratively were frequently inadequately developed. Cases that we felt showed strong evidence of fraud or abuse were not referred or discussed with the OIG. Carriers routinely sought to resolve complaints by contacting providers.

Our case reviews show that carrier procedures for notifying providers of a potential overpayment need to be examined so as to avoid the loss of millions of dollars in potential overpayments. Particularly troublesome were significant overpayment recovery cases that were not discussed with OIG before the carrier initiated recovery action and which appeared to involve fraud. For example, consider the following case:

> *The case file showed extensive documentation of contacts with beneficiaries, their relatives, the vast majority of whom claimed not to have received the service billed and not to have any of the conditions indicated on claims submitted to Medicare. Contact with the beneficiaries' attending physicians also indicated that the beneficiaries had none of the conditions stated on the claims. Further development by the carrier revealed that none of the physicians whose names appeared on the certificates of medical necessity had heard of the patient, or the provider. All denied having signed the certificates of medical necessity. The carrier's development also disclosed "unverifiable" information on the provider's application for a billing number.*
>
> *The case was never discussed with the OIG, instead the carrier sent a letter requesting the provider refund the calculated overpayment. The letter was sent to the provider's out-of-state post office box articulating the information mentioned above as the bases for the carrier's overpayment decision. A second notice regarding the overpayment was sent several weeks later. When the second notice was returned indicating the addressee had moved and left no forwarding address, the case was then referred to the OIG. The premature alert of the provider makes it extremely difficult for the OIG, or any law enforcement agency, to pursue this case.*

The above case illustrates a problem we encountered repeatedly during our case file reviews. The case development clearly shows false statements, billing for services not rendered and other criminal statute violations. Carriers are to refer cases involving potential fraud to the OIG for possible criminal action if the case meets OIG referral criteria. Carriers should contact the OIG and discuss all cases involving fraud issues <u>before</u> initiating recovery action.

Criteria 2: Assessing Financial Damages.

Carriers did not consistently develop payment information. One fourth of the cases we reviewed contained no information about the total payments made to the provider. In nearly half of the cases, carrier staff did not accurately determine the amount overpaid. The data suggests that carriers may not be doing expanded reviews and projecting overpayments accurately when an allegation is substantiated. The cases we reviewed provided further evidence that expanded sampling was not always done when an allegation of fraud or abuse was substantiated.

Of the cases we reviewed, only 1 out of every 3 cases referred to the OIG contained accurate overpayment information. One out of every 5 cases either over or under stated the actual overpayment, and 1 of 5 cases did not provide any information about the potential dollars lost by the program or dollars paid to a provider in a specified time period. In one case the carrier reported total dollars paid to a provider as the potential overpayment. At issue in the case were specific procedure codes, not the entire practice. If the carrier had properly determined the potential overpayment for the procedure codes in dispute, the amount reported would have been considerably less than stated on the referral to the OIG and the case would not have met OIG regional office criteria for referral.

Two out of 5 reviewed cases developed for overpayment recovery and not referred to the OIG were incorrectly handled. During our review we noted that the overpayment on these cases was frequently understated because the carrier did not conduct a sample upon which to project additional payments, or did not develop for additional overpayments when the provider was the member of a group or had multiple provider numbers.

Failure to provide accurate payment and overpayment information can waste limited carrier and law enforcement resources. With current emphasis on presenting cases to the Justice Department early to determine interest in a case, one can readily see the consequences of inaccurate payment and overpayment information on resources. Likewise carrier failure to adequately audit all related billing numbers and failure to utilize adequate sampling methodologies results in inappropriate overpayment recovery actions that should have been referred to law enforcement agencies.

During our discussions with OIG special agents, we were told of carriers pursuing overpayments on cases that had not been discussed with the OIG and that they believed had significant prosecutive merit. The cases we reviewed support what we heard from OIG special agents. In many of the cases, the OIG was not consulted before overpayment actions were initiated.

Criteria 3: Case Documentation.

Of the 37 carriers participating in this study, only 5 consistently indicated information about frequency of problems with a specific provider. Documentation on the number

of complaints alleging fraud or abuse is required by HCFA. Furthermore, 9 out of 10 survey respondents indicated that this information was readily apparent when a case was assigned to them.

Despite written procedures and claims that documentation on the number of complaints against a provider is readily available, such information is not surfacing in cases being developed by carriers. The absence of this information may affect law enforcement agency decisions on whether to pursue a full scale investigation of a provider. Furthermore, failure to mention previous problems may prove detrimental to an investigation or prosecution if the existence of other carrier files surface at a later date and are found to contain information that compromises the case. We were told by OIG, Office of Investigations respondents that this has happened on more than one occasion. Not only is this embarrassing to law enforcement agencies, it damages relations with Assistant United States Attorneys and the relationship between the carrier and law enforcement agencies.

We frequently found contradictory statements in the files we reviewed concerning frequency of complaints. To illustrate, consider the following statements found in one carrier's case development file: "This is our first problem with Doctor X." Among the other information in the file we came across this statement: "Doctor X and problems with his patterns of practice are well known to us." On the other end of the spectrum are cases where the frequency is stated but no information is provided about the issues involved and their resolution.

Criteria 4: Internal Proactive Safeguards

Our fourth criteria compared carriers by the number of internal proactive measures initiated by their fraud units. We considered an action by the fraud unit to be proactive if:

- it identified a specific policy, system function or procedure vulnerable to fraud or abuse, and

- made specific recommendations on how to eliminate or reduce the identified vulnerability.

Our analysis of internal proactive measures indicates that less than half of the 37 carriers (42%) that participated in this study had identified vulnerabilities and initiated changes in their claims processing and other operations. Since October 1992, there have been less than 100 such changes recommended by 14 of the 37 carrier fraud units in this study. As Table A shows, the majority of the recommendations designed to make it harder to defraud government programs were initiated by one carrier. While many carriers claim to have initiated steps designed to reduce the likelihood that their systems will be defrauded, only 14 could provide evidence of an identifiable action designed to curb a specific vulnerability in their system.

Of the 37 carriers in this study, only 3 had initiated more than 3 corrective actions. Five fraud units mentioned strengthening the process for assigning provider numbers to independent physiological laboratories. Four reported implementing prepayment edits upon discovering how a provider, or providers, were circumventing their system safeguards.

Table A

Carrier	# Of Internal Proactive Safeguards Initiated By The Fraud Unit
FF	50
HH	8
CC	5
Y	3
L	3

Our case review indicates that procedure, policy and system shortcomings are often identified by fraud unit staff during case development. We documented 19 such vulnerabilities, including payments to non certified laboratories and duplicate payments that were not addressed. We are unsure as to why these vulnerabilities are not being addressed.

Criteria 5: External Proactive Safeguards

Our final criteria measured the number of fraud alerts that had been generated by each carrier. We chose to measure fraud alerts because they were a quantifiable, proactive product containing information helpful to other carriers in safeguarding program funds.[2]

Table B

Carrier	# of External Proactive Safeguards Initiated By The Fraud Unit
FF	12
HH	10
AA	8
BB	4
L	4

Of the 37 carriers in this study, 19 reported to us that they had submitted at least one fraud alert to their HCFA regional office for consideration. Our review of carrier files and other information collected during this inspection found that many of the cases involved issues and problems that we felt should have been, but were not, brought to the attention of the regional HCFA office and other carriers.

As with other criteria we evaluated, more successful fraud units also are more prolific producers of fraud alerts. These units not only identify internal weaknesses but also actively seek to disseminate information about their findings to HCFA and other carriers.

We were told by a number of respondents that the current process for submitting and getting a fraud alert issued is so cumbersome and lengthy that it discouraged them from initiating such efforts. Respondents indicated that a less formal vehicle is needed so that carriers can communicate information quicker about problems they are experiencing.

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2 Our evaluation of proactive measures did not take into consideration beneficiary, provider and employee education programs being conducted by all carriers. The HCFA requires carriers to conduct education programs; therefore, we considered them to be the baseline on which proactive measures designed to prevent fraud and abuse should be built.

Summary of the Five Criteria Used to Measure Performance.

The five outcome criteria we used to compare carrier performance are summarized in Table C. The table shows that some carrier program integrity efforts are consistently better than their peers. More importantly, the table shows that only a few carriers have well rounded and successful program integrity efforts. We compared these carriers with others and analyzed information available to us in an effort to determine why their performance is better. Tables showing how all of the carriers in this study ranked can be found in Appendix A.

Table C

TOP CARRIER FRAUD AND ABUSE UNITS		
OIG SELECTED OUTCOME CRITERIA		
CRITERIA 1	CRITERIA 2	CRITERIA 3
Carriers Who Accurately Disposed Complaints	Carriers Who Consistently Assessed Accurate Overpayments	Carriers Who Consistently Documented The Number Of Previous Complaints In Cases Referred To OIG
K	I	K
FF	K	S
HH	S	Z
A	X	FF
M	AA	HH
X	FF	
	II	

CRITERIA 4		CRITERIA 5	
Carrier	Number Of Internal Proactive Safeguards Initiated By The Fraud Unit	Carrier	Number Of External Proactive Safeguards Initiated By The Fraud Unit
FF	50	FF	12
HH	8	HH	10
CC	5	AA	8
Y	3	BB	4
L	3	L	4

RESOURCES & ORGANIZATION. The most effective program integrity efforts are found in corporations that provide adequate resources and strategic organizational placement.

Increased Resources

Successful fraud units have access to corporate resources. These resources include the support of the highest levels of management from all sectors of the carrier's business. Corporate support enables successful units to obtain adequate financial support which appears essential to establishing a stable and effective program integrity effort.

Adequate program integrity budgets enable fraud and abuse managers to create higher paid positions that help attract and keep highly motivated and qualified staff in the unit. As one of our survey respondents commented: "Well-trained analysts will be less likely to leave this position for a better paying job if more attention is given to maintaining salaries at a level equal to the importance of this job." More successful fraud and abuse units operate in an environment where each person working in program integrity can advance their careers and salary potential without leaving the unit.

Effective fraud units occupy a distinct and secure space within carrier operations that serves, not only as a constant reminder to all employees of the carrier's corporate commitment to fraud and abuse, but also protects the confidentiality of sensitive work. Clearly defined, distinct and secure space also serves to differentiate postpayment/program integrity activities from front-end, customer oriented claims processing areas.

Among the resources available to successful fraud units is state-of-the-art technology that enables them to do their job efficiently and effectively. They have access to on-line services, beepers and cellular telephones. They have their own facsimile machines and reproduction equipment. Each fraud unit and program integrity employee has their own personal computer. In addition to personal computers, successful fraud units have invested in mainframe hardware and powerful user-friendly software that enables them to analyze large data sets quickly and easily. Coupled with on-line access to claims processing information and their own historical claims processing data on storage media, successful fraud units have the capacity to run their own data for analysis.

At some less successful carriers, fraud unit staff share telephones and/or personal computers. Some fraud units send and receive sensitive facsimile information and reproduce documents at a central mail room. Sharing these resources with other carrier operations may result in the loss of essential information or compromise evidence chain of custody. Furthermore, the ability to analyze data at many carriers is limited not only by the lack of hardware and user-friendly software, but also by the lack of access to the raw data.

Strategic Organizational Placement

Carrier operations can be viewed as falling into two distinct groups: prepayment and postpayment operations. Prepayment operations have a customer service orientation with functions geared to assist patients and providers. Postpayment operations, on the other hand, consist of investigations, audits and other program integrity initiatives designed to protect the Medicare trust funds. Inquiries and audits designed to ensure that proper payments are made generally are not well received by providers.

The most successful fraud units operate in an environment where most, if not all, postpayment functions have been consolidated into the carrier's overall program integrity efforts. The fraud unit, through the fraud unit manager, has the primary responsibility for overseeing and directing all carrier postpayment and program integrity efforts, including all staff responsible for:

- conducting routine or mandated audits of providers;
- identifying, analyzing and resolving systems' vulnerabilities that enable providers to circumvent payment safeguards;
- the analysis of claims data aimed at detecting potentially aberrant providers; and,
- receiving, controlling and resolving allegations of fraud and abuse.

Successful fraud units report directly to the highest levels of corporate management. Recognized experts in health care fraud, and many of the people we spoke to during this inspection, believe that this arrangement provides for a more objective assessment of the needs and recommendations of postpayment/program integrity. It recognizes the dichotomy that exists between program integrity goals and front-end claims processing goals. It provides the highest levels of management with information that can be used to improve day-to-day operations from the divergently different perspectives of front-end operations and postpayment operations.

More effective fraud units have established a clearinghouse or other specialized unit responsible for controlling and for triaging all postpayment activity. Clearinghouses, under the control and guidance of the fraud unit, determine whether referrals to the program integrity unit are appropriate. Inappropriate referrals are returned to the originators for resolution (i.e., beneficiary/customer service). Case controls and files are established for appropriate referrals and an initial analysis is conducted to determine whether the issues involved are fraud, abuse or both. Allegations involving only medical necessity are referred to medical review for development. Allegations involving fraud and abuse are developed to determine whether or not the allegation can be substantiated. Substantiated allegations involving providers with whom the carrier has had previous problems are referred to investigators if they meet frequency, monetary and other guidelines.

Effective program integrity programs use their fraud unit investigators to develop or direct the development of cases involving issues of fraud or abuse. Case development conducted outside the fraud unit is done at the discretion and under the direction of the fraud unit. Control over the sensitive information developed during carrier investigations, and the proper conduct of all carrier employees involved in developing such information, is critical to prosecution and overpayment recovery. At one successful carrier, employees outside the fraud unit who are asked to assist in evaluating or developing a case with potential for referral to the OIG must sign a statement that the information they gain will not be discussed or otherwise divulged to anyone.

Fraud units that do not control case development and the role played by other carrier operating components in developing potential fraud and abuse cases, run a high risk of having these cases compromised. During our case review, inappropriate development of cases with potential prosecutive merit occurred frequently when prepayment and claims processing components became involved in the development of complaints alleging fraud. Medical review units in particular appeared to routinely make contact with potential subjects and readily accept provider explanations. Medical review units often initiated recoupment action before the case was discussed with, or declined by, the OIG. The following case summary illustrates a common problem:

> *This case was assigned to the fraud unit and involved an ophthalmologist misrepresenting services and billing for services not rendered. The fraud unit developed information on 37 claims and determined a potential overpayment of $17,000.00. Following internal procedures, the case was sent to medical review for medical necessity development.*
>
> *The medical review unit report states that this ophthalmologist has a history of misrepresenting services and undocumented services dating back to 1988. The exact number of prior problems is not stated in the file nor is there any information about any prior educational contacts.*
>
> *The medical review unit informed the fraud unit that they should not pursue the fraud issues because they know the ophthalmologist and when problems have surfaced in the past they have always been clerical errors for which the provider has always willingly made restitution. The medical review unit undertook no additional development. The OIG was not consulted about potential fraud issues. The case was resolved with a request for repayment of the overpayment determined by the fraud unit.*

The involvement of medical review staff sometimes changed the complexion of the case from the initial allegations of fraud to issues involving medical necessity. Fraudulent activity was not addressed, inadequately addressed or subverted by raising immaterial abuse, medical necessity or overutilization issues that overshadowed or obscured the more serious fraudulent activity. Effective fraud units prevent this from happening by controlling and directing development of all cases alleging fraud or abuse.

STAFFING. Successful fraud units have an effective mix of investigators, auditors, statisticians and analysts.

Successful fraud unit staff bring diverse backgrounds and skills to the job. They have a good mix of disciplines. Successful fraud units and program integrity efforts integrate persons with law enforcement backgrounds with personnel who have knowledge of claims processes and policies. They also add analysts, accountants and statisticians to compliment their staff. No one discipline dominates the program integrity or fraud unit. Personnel recruited from carrier front-end operations such as claims processing are selected not only for their knowledge of front-end operations and polices, but for their commitment to aggressively combat fraud and abuse.

Program integrity units that can keep employees perform better than units with constant turnover. Turnovers, according to people we interviewed, have severely hampered fraud and abuse efforts. We heard complaints about the replacement of persons considered to have a grasp of the job and with good working relationships with OIG and other law enforcement agencies. It is alleged that some carriers perpetually reorganize staff, thereby, never developing a cadre of individuals proficient at the job. At one carrier, five different people have headed up the fraud unit in the past 12 months.

Fraud unit staffing turnovers adversely affect the quality of case development. Carriers have been required to dedicate some staff to combat fraud and abuse virtually from the inception of the Medicare program nearly 30 years ago. Given how long carriers have played a program integrity role in the Medicare program, the current fraud unit staff at many carriers appears to lack investigative experience.

Our analysis indicates that half of the fraud unit staff have less than 2 years experience in the unit. A third of the staff have less than 1 year's experience and nearly 1 in 5 employees has less than 6 months experience. The average fraud unit employee has been employed by the carrier for about 9 years.

The number of people working in the fraud units varies by carrier, ranging from 1 employee to over 50 employees. Nine units have two or less employees and a third of the units have five or less employees. We found little or no relationship between the size of the fraud unit and claims processed, dollars paid or operating budget.

The variance in fraud unit size reflects a number of factors including the carrier's organizational structure and the number of program integrity related functions being carried out by, or under the direction of, the fraud unit. The number of employees and the placement of postpayment activities in the carrier's organizational structure appears to have an effect on the quality of a carrier's program integrity efforts. Successful prevention, detection, deterrence and prosecution efforts clearly require adequate staff.

Nine out of 10 people working in the fraud units came to the unit from the carrier's front-end operations. At some less successful fraud units, all of the employees come from front-end operations. Sixty percent came to the fraud unit with only beneficiary service and/or provider relations experience. Less than a third of the fraud unit employees have experience in the fraud and abuse unit's predecessor called program integrity or in Federal, State or local law enforcement.

The inability of fraud units to attract and keep staff may affect the quality of their referrals. We have heard that positions in the fraud unit and other postpayment areas are among some of the lowest paying jobs at some carriers. One carrier employee told us that a position in the fraud unit is a "dead end job." Another remarked that "you get what you pay for." And still another commented that "Well-trained analysts will be less likely to leave this position for a better paying job if more attention is given to maintaining salaries at a level equal to the importance of this job."

More successful fraud units have stable management and have policies designed to keep staff long enough to become proficient at their job. One carrier requires new fraud unit employees to sign an agreement that they will remain with the unit for at least 3 years.

Constant staff and management turnover also appears to hamper training initiatives. Some people responsible for training carrier fraud unit managers and staff expressed frustration at the frequency of staff turnovers. They felt that the time and effort they had spent in preparing for training was lost when staff were re-assigned shortly after attending the training course.

TRAINING. Successful fraud units provide their staff with adequate and ongoing training.

Our survey respondents had, on average, 9 years of experience working for the carrier, however, half have less than 2 years experience working in the fraud unit and a third have less than 1 years experience. Though knowledgeable about Medicare coverage, billing and reimbursement criteria, and carrier operations, they may lack training and experience in investigative techniques. Their short time on the job deprives them of the experiences and the insights investigators develop through years of working myriad fraud and abuse situations.

Better fraud and abuse units not only have more stable staff but better trained staff. Staff at better units receive more training each year than their peers at other carriers. They often have formal training plans that document past training and identify individual training needs. Forty percent of our survey respondents have had less than 8 hours of training since January 1, 1994. That equates to less than 1 hour of training a month. Only 1 out of every 4 persons working in the carrier fraud units has had more than 40 hours of training since January 1994.

More than half of the employees who responded to our survey believe that their training needs have not been adequately met. Two out of every 3 people working in the carrier fraud and abuse units have had no HCFA, OIG or other outside training on fraud and abuse since HCFA began funding fraud units in October of 1992. This is a marked difference from responses we received from employees of more successful fraud units.

Staff turnover may explain why 25 percent of the fraud unit employees have had no training. Staff at better units receive training from internal and external sources while, at least 2 out of 3 employees at other units have no training from outside sources. Our survey responses indicate that 75 percent did receive in-house training. At some carriers this training is conducted by medical review, provider relations and other operating component staff.

Better performing fraud units ensure that all of their employees receive direct training from inside and outside sources. Staff are required to participate in a fixed number of hours of training each year. Whenever possible staff are sent to outside training and conferences designed to provide information on how others have: prevented abuse of their systems, educated providers, detected fraudulent and abusive providers within their system, and successfully prosecuted providers. Better fraud units encourage hands on experience, conference attendance, peer training and participation in meetings with OIG investigators and other law enforcement personnel.

Analysis of survey responses shows that half of the people currently working in the fraud units expressed no interest in training related to skills needed to combat fraud and abuse. Of the half who did express an interest in training related to fraud and abuse skills, they indicated a desire for training in the following areas: (1) investigative knowledge and techniques (i.e., rules of criminal evidence, analysis techniques), (2) interviewing techniques, and, (3) State and Federal laws and regulations (i.e., the Stark bills and Safe Harbor regulations involving joint ventures). About 10 percent of our survey respondents indicated they had not received training and that they had no desire to take such training.

RECOMMENDATIONS

Efforts by the OIG and HCFA to identify and combat Medicare and Medicaid fraud and abuse have intensified over the past several years. As part of these efforts, the Department is piloting a demonstration program entitled Operation Restore Trust (ORT). Under ORT the OIG, in partnership with HCFA, emphasizes interdisciplinary teamwork with other State and Federal agencies as an important component for enhancing fraud and abuse activities.

Concerns regarding the effectiveness of Medicare carrier fraud units are similar to those discussed in our report entitled ***"Surveillance and Utilization Review Subsystems' Case Referrals to Medicaid Fraud Control Units," OEI-07-95-00030.*** As a result, we believe that a concerted effort addressing both Medicare and Medicaid fraud units is called for. We are proposing a uniform team approach. We recommend that HCFA, in consultation with the Office of Inspector General should:

Convene a Medicare and Medicaid fraud and abuse task force to plan and implement improvements in fraud unit operations. This would include:

- Clarifying goals and objectives for program integrity efforts.
- Establishing guidelines for developing suspected fraud cases.
- Developing a universal protocol for appropriately referring fraud and abuse cases.
- Coordinating data systems to ensure that data are reliable and consistent across all entities in the fraud and abuse fighting network.
- Developing a training program designed to educate program integrity personnel on procedures, case referrals and best practices.

Continue to provide support and technical assistance to carriers so they can emulate those carriers operating successful programs. This can include:

- Encouraging carrier commitments that result in increased resources to combat fraud and abuse such as investments in technology and people.

  Provide sufficient resources to support program integrity efforts including secured space, facsimile and photocopy equipment, computer hardware and software and other technologies.

  Pay persons working in program integrity salaries comparable to those in other areas of carrier operations.

- Suggesting ways of organizing a successful program integrity effort.

  Develop an independent program integrity organization within their operations that reports directly to a sufficiently high level of corporate management.

  Consolidate all postpayment functions under the control of the fraud unit manager.

  Triage all allegations of fraud and abuse through a centralized clearinghouse, properly trained to identify fraud and abuse and under the control of the fraud unit.

- Limiting the role of medical review units in program integrity to those cases involving issues of abuse, policy, coverage and medical necessity.

  Medical review units should not be involved in cases alleging fraud unless they are requested to assist in the development of a fraud case by the fraud unit. In no fraud case should the medical review unit be responsible for settling or determining the closing action.

- Rewarding carriers for identifying policy, procedure and systems vulnerabilities and implementing corrective safeguards.

- Separating the budget for postpayment activity from the budget for claims processing and other front-end operations such as provider enrollment and provider relations.

AGENCY COMMENTS

We appreciate all the positive steps that HCFA has taken thus far to safeguard the Medicare program and we recognize the accomplishments of the Program Integrity Group. We are pleased that HCFA has concurred with our recommendations and we look forward to working with HCFA in their implementation.

We believe that the best approach would be a collaborative one involving HCFA and OIG, with consultation from high performing State Surveillance and Utilization Review Subsystem Units (S/URS) and carriers, to improve program integrity activities at the carrier and State level. We suggest that this effort focus on:

- Developing and implementing model practices to help carriers and S/URS decide which cases should be developed for medical review and overpayment recovery or for referral for fraud. In addition, existing protocols should be implemented for referral of fraud cases to appropriate investigative entities (the OIG for Medicare cases and Medicaid Fraud Control Units for Medicaid cases). We believe that together we can increase overpayment recovery amounts and increase the number of successful prosecutions by law enforcement agencies.

- Revising current contractor performance measures that reward carriers for overpayment recovery but not for fraud and abuse referrals or efforts to improve claims processing safeguards.

- Identifying the most effective practices which carrier and State personnel use to eliminate claims processing vulnerabilities that enable providers to defraud health programs.

We believe that achieving the goals both HCFA and the OIG have established for improving program integrity functions at the carriers and in the States can best be accomplished by these kinds of collaborative efforts. We look forward to working with HCFA to bring about further measurable change.

The full text of HCFA's comments is contained in Appendix B.

APPENDIX A

Tables
Comparing Carriers

CRITERIA 1: COMPLAINT DISPOSITION		
Carrier	**Accurate**	**Problematic**
A	X	
B		X
C		X
D		X
E		X
F		X
G		X
H		X
I		X
J		X
K	X	
L		X
M	X	
N		X
O		X
P		X
Q		X
R		X
S		X
T		X
U		X
V		X
W		X
X	X	
Y		X
Z		X
AA		X
BB		X
CC		X
DD		X
EE	Carrier did not provide data	
FF	X	
GG		X
HH	X	
II		X
JJ		X
KK		X

CRITERIA 2: CASE FILE DOCUMENTATION ACCURATELY STATES OVERPAYMENT AMOUNT			
Carrier	Always	Sometimes	Never
A		X	
B		X	
C		X	
D	No cases analyzed		
E		X	
F		X	
G			X
H		X	
I	X		
J		X	
K	X		
L		X	
M		X	
N		X	
O			X
P			X
Q		X	
R			X
S	X		
T			X
U		X	
V			X
W		X	
X	X		
Y		X	
Z			X
AA	X		
BB			X
CC		X	
DD		X	
EE			X
FF	X		
GG			X
HH		X	
II	X		
JJ		X	
KK	No cases analyzed		

CRITERIA 3: CASE FILE DOCUMENTATION AS TO THE NUMBER OF PREVIOUS COMPLAINTS IN CASES REFERRED TO OIG			
Carrier	Always	Sometimes	Never
A			X
B		X	
C			X
D			X
E		X	
F			X
G			X
H			X
I			X
J			X
K	X		
L			X
M		X	
N			X
O			X
P			X
Q			X
R			X
S	X		
T			X
U			X
V			X
W			X
X		X	
Y			X
Z	X		
AA			X
BB			X
CC			X
DD			X
EE			X
FF	X		
GG		X	
HH	X		
II			X
JJ			X
KK			X

CRITERIA 4: NUMBER OF INTERNAL PROACTIVE SAFEGUARDS INITIATED BY THE FRAUD UNIT	
Carrier	**Number of Safeguards**
FF	50
HH	8
CC	5
Y	3
L	3
X	2
GG	2
G	1
J	1
M	1
R	1
S	1
BB	1
KK	1
The remaining carrier fraud units initiated no internal proactive safeguards.	

CRITERIA 5: NUMBER OF EXTERNAL PROACTIVE SAFEGUARDS INITIATED BY THE FRAUD UNIT	
Carrier	**Number of Safeguards**
FF	**12**
HH	**10**
AA	**8**
L	**4**
BB	**4**
P	**3**
N	**2**
A	**2**
R	**2**
D	**2**
I	**1**
G	**1**
Y	**1**
V	**1**
M	**1**
Q	**1**
DD	**1**
X	**1**
CC	**1**
The remaining carrier fraud units initiated no external proactive safeguards.	

APPENDIX B

Health Care Financing Administration
Response to Report

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: SEP 26 1996

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Carrier Fraud Units" (OEI-05-94-00470)

We reviewed the above-referenced report concerning Medicare/Medicaid losses due to fraud and abuse. The report identifies specific factors which contribute to and work against successful program integrity operations.

Our detailed comments are attached for your consideration. Thank you for the opportunity to review and comment on this report. Please contact us if you would like to discuss our comments.

Attachment

Health Care Financing Administration (HCFA) Comments on
Office of Inspector General (OIG)Draft Report Entitled: "Carrier Fraud Units,"
OEI-05-94-00470)

OIG Recommendation

HCFA should convene a Medicare and Medicaid fraud and abuse task force to plan and implement improvements in fraud unit operations. This would include:

- o Clarifying goals and objectives for program integrity efforts.
- o Establishing guidelines for developing suspected fraud cases.
- o Developing a universal protocol for appropriately referring fraud and abuse cases.
- o Coordinating data systems to ensure that data are reliable and consistent across all entities in the fraud and abuse fighting network.
- o Developing a training program designed to educate program integrity personnel on procedures, case referrals and best practices.

HCFA Response

We concur. HCFA established the Program Integrity Group (PIG) to address fraud and abuse issues within the Medicaid/Medicare programs. The goals of this group are consistent with the report recommendations. The group's overall responsibilities include completing and monitoring the activities of short and long term projects, such as, changing the conditions of participation for home health agencies, developing a strategic plan with our law enforcement partners, clarifying program integrity language contracts, and determining how to better use data to reduce waste, fraud, and abuse. In addition, HCFA is working to address issues common to both programs. For example, Medicaid Surveillance and Utilization Review Subsystems Units are (or are planned to be) users of the recently developed Fraud Investigation database. The database ensures that information on cases developed by Medicare carriers is shared across a number of program and law enforcement organizations. Inputting fraud cases developed by the Medicaid program would allow tracking both Medicare/Medicaid fraud cases on the same system. The OIG suggests that there is a need to develop standard guidelines for the development and referral of fraud cases; however, the OIG has already developed such guidelines. HCFA has provided these guidelines for case development and referral to the

carrier fraud units and contractors. We encourage the use of these OIG guidelines by the states.

OIG Recommendation

HCFA should continue to provide support and technical assistance to carriers so they can emulate those carriers operating successful programs. This can include:

- Encouraging carrier commitments that result in increased resources to combat fraud and abuse such as investments in technology and people.
- Suggesting ways of organizing a successful program integrity effort.
- Limiting the role of medical review units in program integrity to those cases involving issues of abuse, policy, coverage, and medical necessity.
- Rewarding carriers for identifying policy, procedure and systems vulnerabilities and implementing corrective safeguards.
- Separating the budget for postpayment activity from the budget for claims processing and other front-end operations such as provider enrollment and provider relations.

HCFA Response

We concur. HCFA actively encourages carriers with effective fraud units to operate and share best practices with other carrier fraud units and will continue to do so. Additionally, each region has a Medicare Fraud Information Coordinator to coordinate information about fraud cases, alerts, etc., to ensure the sharing of information between regional office, central office, and other interested parties. Further, the OIG suggests that the budgets for program safeguard activities be separated from that of other contractor activities. This modification is a feature of pending legislation and HCFA supports it. This legislation, if enacted, would, over the next several years, significantly increase the resources devoted to these activities.

Technical Comments

- On page 8, the report states that a number of respondents complained that the current process for submitting and getting a fraud alert issued is so cumbersome and lengthy that it discourages them from initiating such efforts. The report indicated that a less formal vehicle is needed to allow them to communicate information quicker about problems they are experiencing. Formal procedures are also important to ensure that alerts are not disseminated to inappropriate parties or that inaccurate or misleading information is not distributed, making later prosecution efforts difficult or impossible.

  HCFA already has a less formal procedure in place to allow carriers and intermediaries to quickly communicate information about potential fraud and abuse situations. In April of 1995, we implemented a process which allows carriers and intermediaries to prepare "Significant Investigation Reports" which are forwarded to HCFA Regional Offices for immediate distribution to all carriers and intermediaries and other appropriate parties.

- On page 10, the report states that "effective fraud units occupy a distinct and secure space within carrier operations" and notes the importance of protecting the confidentiality of sensitive work. This is a very important element of fraud unit operations and, for this reason, we included specific security procedures in the most recent revisions to the fraud sections of the carrier and intermediary manuals. These are identified in section 14032 of the Medicare Carriers Manual (MCM) and include sections related to the privacy of fraud operations, appropriate handling of sensitive information, and other security guidelines that carriers are expected to follow to the greatest degree possible.

- On page 12, the report points out the importance of maintaining control over sensitive information. It notes that one successful carrier utilizes employees outside the fraud unit to assist in fraud development and requires these employees to sign a statement that the information they gain will not be discussed or otherwise divulged to anyone. Again, we fully support this type of requirement and have included instructions to address this in our contractor manuals. Specifically, section 14032 E of the MCM states that persons hired to work in the fraud unit should be required to fill out a conflict of interest declaration as well as a confidentiality statement.