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Testimony

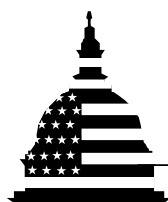
Before the Subcommittee on Government Management,
Information and Technology, Committee on Government
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HEALTH CARE FRAUD

Schemes to Defraud Medicare, Medicaid, and Private Health Care Insurers

Statement of Robert H. Hast, Assistant Comptroller
General for Special Investigations
Office of Special Investigations



G A O

Accountability * Integrity * Reliability

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss various schemes used to defraud the Medicare and Medicaid programs and private insurance companies and how the proposed legislation contained in H.R. 3461 and S. 1231 could strengthen federal and state health care programs. More specifically, I would like to focus on the schemes characterized as rent-a-patient, pill mill, drop box, and third-party billing that we have identified through our past investigations.

As you are keenly aware, health care fraud is a serious financial drain on our health care system. Large numbers of cases have been investigated and prosecuted, resulting in the recovery of large dollar amounts. We have designated health care fraud as a high-risk area. The Department of Health and Human Services' Office of Inspector General has reported that \$13.5 billion of processed Medicare fee-for-service claim payments for fiscal year 1999 may have been improperly paid for reasons that ranged from inadvertent error to outright fraud and abuse.

Our previous investigations¹ have provided evidence that, in addition to some legitimate health care and health care-related providers, career criminal and organized criminal groups have become involved in health care fraud across the country. Indeed, the emergence of an organized class of criminals who specialize in defrauding and abusing Medicare and Medicaid has increased program vulnerabilities for the Health Care Financing Administration (HCFA). In general, career criminals and organized criminal groups have little or no medical or health care education, training, or experience. Many group members have prior criminal histories for criminal activity unrelated to health care fraud—such as securities fraud, narcotics and weapons violations, grand theft auto, and forgery—indicating that the individuals have moved from one field of criminal activity to another.

To counter many of the fraudulent schemes used by such individuals, H.R. 3461 and S. 1231, both entitled “Medicare Fraud Prevention and Enforcement Act of 1999,” were introduced to amend title XVIII of the Social Security Act. Both bills are designed to establish additional provisions to combat fraud, waste, and abuse within the Medicare

¹ See *Medicare: Improper Third-Party Billing of Medicare by Behavioral Medical Systems, Inc.* (GAO/OSI-00-5R, Mar. 30, 2000); *Health Care: Fraud Schemes Committed by Career Criminals and Organized Criminal Groups and Impact on Consumers and Legitimate Health Care Providers* (GAO/OSI-00-1R, Oct. 5, 1999); and *Medicaid Drug Fraud: Federal Leadership Needed to Reduce Program Vulnerabilities* (GAO/HRD-93-118, Aug. 2, 1993).

program and for other purposes by strengthening the Medicare enrollment process, expanding certain standards of participation, and reducing erroneous payments.

Results in Brief

In the rent-a-patient scheme, organizations pay for—or “rent”—individuals to go to clinics for unnecessary diagnostic tests and cursory examinations. Licensed physicians sometimes participate in the rent-a-patient scheme. Medicare, Medicaid, and other insurers are billed for those services and often for other services or medical equipment never provided. In a variation of this scheme, perpetrators merely buy individual health care insurance identification numbers for cash. Implementing the proposed legislation will make the purchase, sale, and distribution of two or more Medicare or Medicaid beneficiary identification numbers a felony and will establish universal product numbers (UPN) for identifying the specific type of medical equipment or supply provided.

Similarly, in the pill mill scheme, separate health care individuals and entities—usually including a pharmacy—collude to generate a flood of fraudulent claims that Medicaid pays. After a prescription is filled, the beneficiary² sells the medication to pill buyers on the street who then sell the drugs back to the pharmacy. Making the trafficking in Medicare and Medicaid numbers a felony would also likely help reduce the number of fraudulent claims submitted to insurance systems as part of pill mill schemes.

The drop box scheme uses a private mailbox facility as the fraudulent health care entity’s address, with the entity’s “suite” number actually being its mailbox number. The fraudulent health care entity then uses the address to submit fraudulent Medicare, Medicaid, and other insurance claims and to receive insurance checks. For example, while the insurer sends payments to “Suite 478” at a certain address, payments are actually going to “Box 478” at a privately owned mailbox facility. The perpetrator then retrieves the checks and deposits them into a commercial bank account that he/she has set up. Requiring on-site inspections of the entity’s address and mandating background checks of the owners, as the legislation proposes, should reduce the number of criminals involved in the drop box scheme.

The third-party billing scheme revolves around a third-party biller—who may or may not be part of the scheme—who prepares and remits claims to

² Medicare-covered patients are most often referred to as “beneficiaries;” Medicaid-covered patients are referred to as “recipients;” and private insurance-covered patients are referred to as “insureds.” For simplicity, we refer to all insured individuals, or patients, as beneficiaries.

Medicare or Medicaid (electronically or by paper) for health care providers. It is possible, however, for a third-party biller to defraud Medicare, Medicaid, and others by adding claims without the providers' knowledge and keeping the remittances or by allowing fraudulent claims to be billed to Medicare or Medicaid through its service. The proposed legislation will require unique HCFA billing numbers to reduce fraudulent claims filed by third-party billers.

The bills also give the Department of Health and Human Services' Office of Inspector General additional enforcement tools to pursue health care swindlers.

Rent-a-Patient Scheme

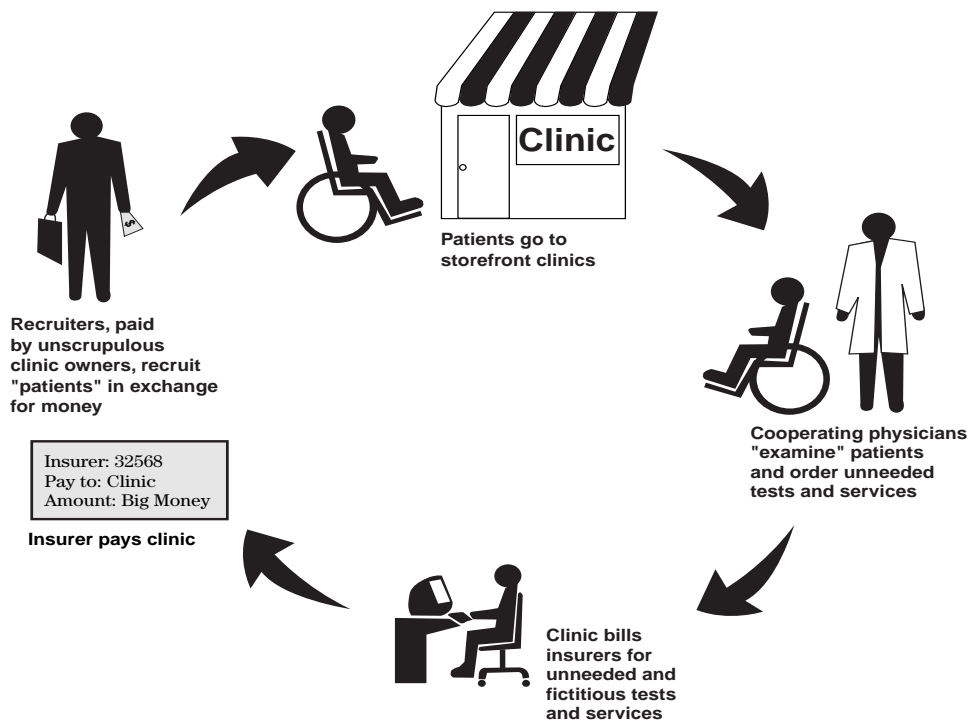
Under the rent-a-patient scheme, criminals pay "recruiters" to organize and recruit beneficiaries to visit clinics owned or operated by the criminals. (See fig. 1.) In other words, for a fee, recruiters "rent," or "broker," the beneficiaries to the criminals. Recruiters often enlist beneficiaries at low-income housing projects and retirement communities and drive them to area clinics. There the beneficiaries receive cursory examinations and testing, treatment, or durable medical equipment (DME) referrals. Recruiters generally receive \$100 or more for each beneficiary they bring to a clinic. In turn, recruiters often pay a portion of their fee to each cooperating beneficiary. Cooperating beneficiaries participate to "make a few bucks" and understand that if they need "a real doctor," they are to go elsewhere. Medicare, Medicaid, or other insurance companies are later billed for the services that were provided and for other services or equipment that was not provided.

Even a few licensed medical doctors and medical school graduates—including physician assistants—collaborate with rent-a-patient clinics in exchange for money. Medical school graduates perform actual procedures on the beneficiaries, including noninvasive medical tests, and fill out medical charts. Licensed physicians are generally paid \$50 or more per medical chart to periodically sign the chart for services they neither perform nor supervise or to provide certificates of medical necessity for medical equipment that is not needed.

Under the proposed legislation, Medicare claim forms will require a UPN for medical equipment and supplies instead of a billing code that covers a wide variety of items. Using the UPN, HCFA would be able to track the specific type of equipment that was allegedly provided to ensure that a lower-cost product had not been substituted. This provision may aid in reducing the number of claims submitted for medical equipment that is not provided as billed. Use of a UPN could also help investigators determine if a supplier had purchased sufficient stock of a particular item it supposedly supplied to beneficiaries.

In other instances, only beneficiary and/or identifying information is rented or brokered to the criminals. For example, some recruited beneficiaries provide only their insurance identification number in exchange for cash. Clinic owners nonetheless send blood samples—fraudulently labeled as being from the beneficiary—to labs for testing and the labs bill for the tests. The labs then kick back some of the payment they receive to the clinic owners. According to law enforcement officials, cooperating beneficiaries sometimes go to a private apartment to have x-rays taken with a portable x-ray unit or to have blood drawn. The beneficiaries receive cash or unneeded prescriptions, which they later fill and sell on the street. Their insurance plans are billed for x-rays, blood tests, or other unnecessary services or equipment. Under the proposed legislation, the purchase, sale, or distribution of two or more Medicare or Medicaid beneficiary identification numbers will be a felony.

Figure 1: Rent-a-Patient Scheme



Pill Mill Scheme

The pill mill scheme, a variation of the rent-a-patient scheme, is characterized by collusion between two or more entities—sometimes a network of clinics, pharmacies, physicians, laboratories, patient brokers, and middlemen distributors—to fraudulently divert prescription drugs and

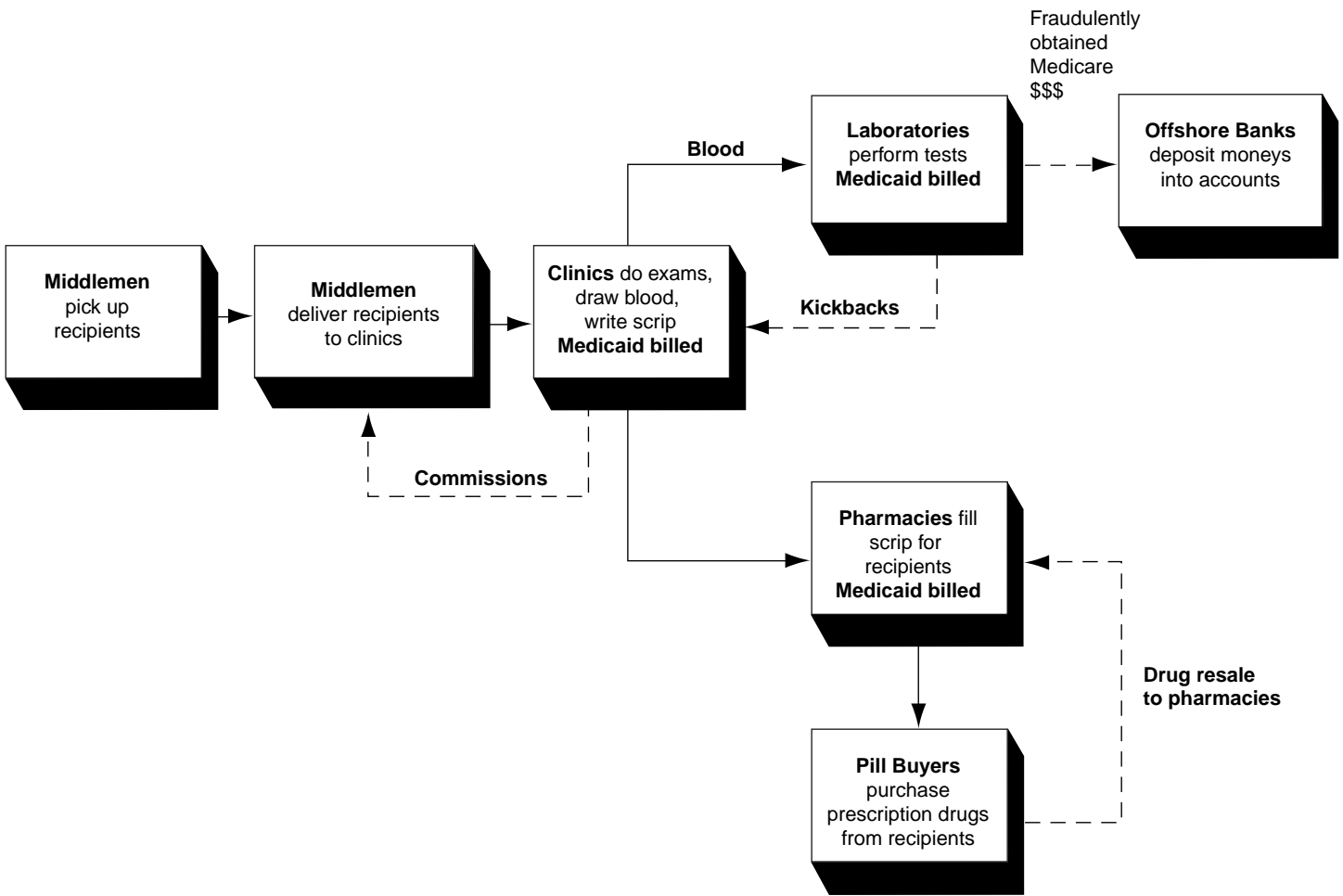
obtain unlawful reimbursement from insurers. Joint or related ownership of clinics, laboratories, and pharmacies is common. Beneficiaries often participate knowingly in this scheme, allowing their insurance identification numbers to be used for billing purposes in exchange for cash, drugs, or other inducements. Incentive for all parties to abuse an insurer's health benefit is considerable. Some medications have a substantial monetary value and profiteers can divert drugs for resale through illicit channels. (See fig. 2 for the overall structure of such a network.)

In general, the scheme works as follows. As in the rent-a-patient scheme, brokers locate beneficiaries who are often homeless or indigent individuals or drug addicts and take the beneficiaries to clinics for unnecessary examinations, blood tests, and prescriptions. Clinics and, subsequently, laboratories bill the insurer who pays the claims. In like manner, pharmacists involved in the scheme bill the insurer for the prescriptions they fill for the beneficiaries, and the beneficiaries sell the prescribed drugs to middlemen (pill buyers) in exchange for cash or illicit drugs. The middlemen, on behalf of the colluding parties, resell the drugs back to the pharmacies. Funds obtained through fraudulent billings are often moved to offshore banks to avoid recovery by law enforcement entities.

Then the cycle is repeated, with the diverted drugs being collected and resold at lower-than-wholesale prices to pharmacies. There they are repeatedly dispensed and billed to the insurer and may eventually be dispersed to legitimate patients, who could be subjected to potential harm through drugs that were not handled or stored properly or whose potency may have altered or expired.

The proposed legislation will make it a felony for a person to knowingly, intentionally, and with the intent to defraud, purchase, sell, or distribute two or more Medicare or Medicaid beneficiary identification numbers. This may aid in reducing the distribution of beneficiary identification numbers between clinics, laboratories, and other providers with the intention of defrauding insurance systems, as in the pill mill scheme.

Figure 2: Pill Mill Scheme



Drop Box Scheme

Another popular scheme is the drop box or mail drop scheme in which criminals or other unscrupulous individuals rent private mailboxes, or drop boxes, at privately owned commercial mail receiving agencies (CMRA). (See fig. 3.) In the drop box scheme, perpetrators set up medical-oriented corporations, using CMRA addresses as the providers' "official" addresses with the CMRA box numbers showing up as the providers' suite

numbers in the corporations' mailing addresses.³ If the proposed legislation becomes law, site inspections would verify whether there is actual business going on at a given address and whether the entity meets participation standards. Background checks should help eliminate those with a criminal background from getting a provider number.

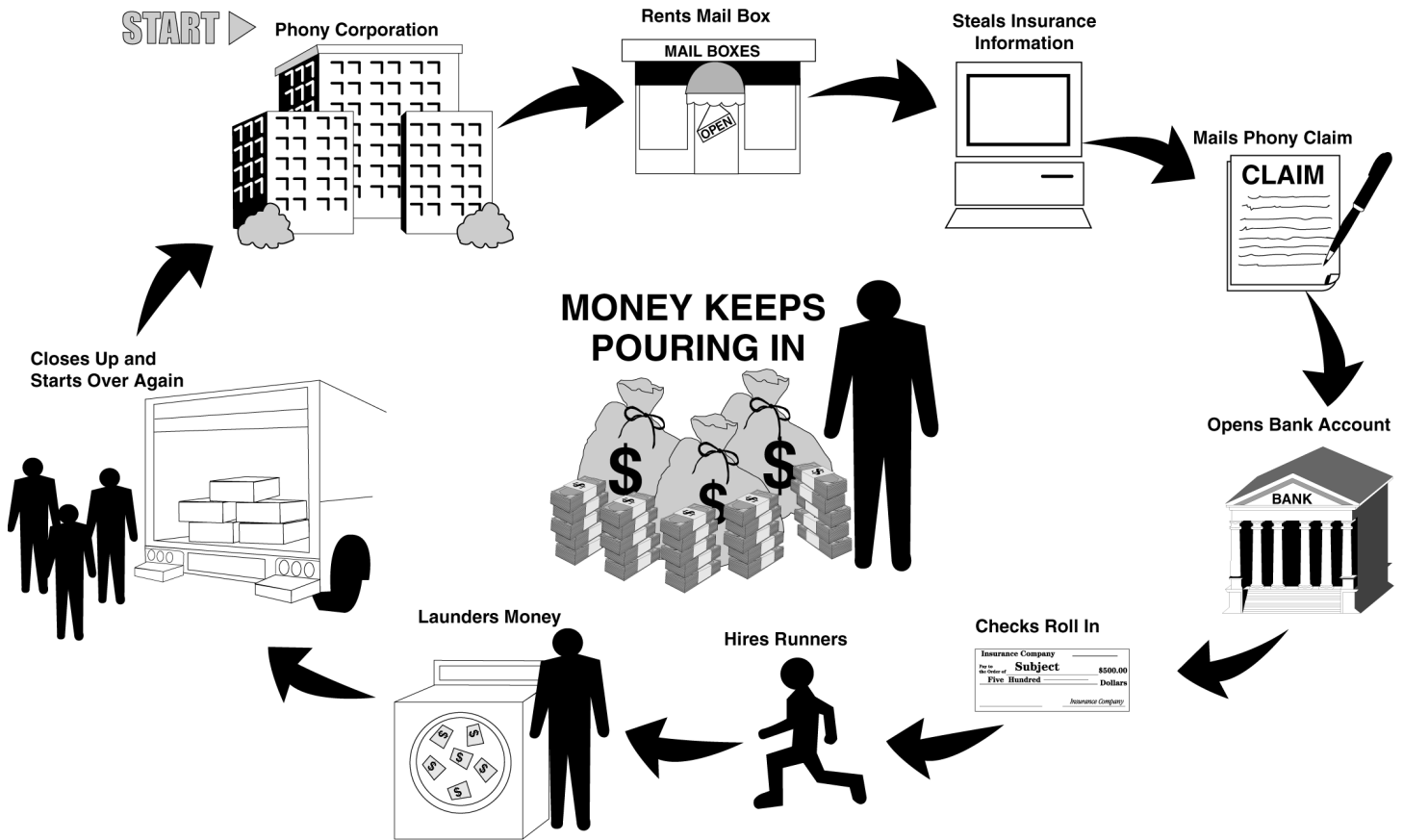
In furtherance of the drop box scheme, criminals also open corporate bank accounts to deposit insurance payments for the fraudulent health care claims they submit. They then steal, purchase, or otherwise obtain beneficiary and provider information and bill insurance plans for medical services and equipment that was not provided. A member of the group retrieves insurance payment checks from the drop boxes and deposits them in controlled bank accounts. Once deposited, proceeds are quickly converted to cash or transferred to other accounts and moved out of the reach of authorities.

While some drop boxes are set up using the name of a group leader or names of co-conspirators, others are set up with phony identification cards containing fictitious names or assumed identities together with the criminals' photographs. In another variation, criminals use the basic elements of a drop box scheme but receive the medical payments electronically in their bank accounts rather than through a private mailbox.

The proposed legislation will make the purchase, sale, or distribution of a Medicare or Medicaid provider number or two or more beneficiary identification numbers a felony. This proposal addresses the growing trend of the purchase, sale, and distribution of Medicare and Medicaid provider numbers and beneficiary identification numbers for the purpose of defrauding health insurance systems.

³ A new CMRA regulation adopted by the U.S. Postal Service on Apr. 26, 1999, required that all mail delivered to CMRAs be identified on its face as a private mailbox, or PMB (39 C.F.R part 111 and *Domestic Mail Manual DO42.2.6*). This regulation is meant to keep criminals from using CMRA addresses for credit card fraud and other scams. All CMRA customers were required to be in compliance by Apr. 26, 2000. This deadline was extended until Aug. 26, 2000. Responding to concerns of small business and privacy advocates, the U.S. Postal Service also announced its plan to propose additional modifications to the CMRA regulations. They include the option for using "PMB" or the "#" sign in customer addresses and prohibiting the use of the terms "suite," "apartment," or any other designation that implies something other than a box.

Figure 3: Drop Box Scheme



Source: Florida Department of Insurance, Division of Insurance Fraud

Third-Party Billing Scheme

Perpetrators sometimes use third-party billing companies to file fraudulent claims and receive payment. For example, criminals generate fraudulent, computerized Medicare claims by using the names and biographical data of recruited beneficiaries. The information is downloaded to tapes and delivered to a third-party billing company that may or may not be aware that the claims are fraudulent. The third-party biller enters the information into its own computer and electronically forwards the data to Medicare. Medicare then sends the payment to the perpetrator's bank account. Third-party billers in collusion with providers may benefit from this scenario by receiving kickbacks from the provider or simply by virtue of the sheer volume of such billings, particularly when the third-party biller receives a percentage of all Medicare payments to the provider.

A variation of this scheme involves a company that represents itself as a health care provider but also functions as a broker of medical services. In other words, the company submits health insurance claims on behalf of contracted physicians through a legitimate third-party biller and adds claims for services not provided. The legitimate biller submits billings to the insurer. The insurer then sends claim payments and the explanation of benefits to the company owner who is acting as a broker. Since the physicians receive no explanation of benefits, they are unaware that the broker is adding fraudulent claims to services provided and keeping the additional money.

The proposed legislation requires that all billing entities be registered and have a unique HCFA billing number. This number will allow HCFA to identify the specific billing entities and make them more responsible for claims they file. This should act to reduce the number of upcoded,⁴ unbundled,⁵ and fictitious claims filed through billing agencies.

Finally, with the enactment of the legislation, criminal investigators in the Department of Health and Human Services' Office of Inspector General will have full law enforcement authority to conduct investigations; obtain and execute warrants; and, under certain circumstances, make arrests without warrant.

Mr. Chairman, that concludes my prepared statement. I would be happy to answer any questions that you or Members of the Subcommittee may have.

Contacts and Acknowledgements

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

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⁴ Upcoded refers to billing for more expensive services at a higher service fee than was actually provided.

⁵ Unbundled refers to billing separately for services that should be included in a single service fee.

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