

**GAO**

United States General Accounting Office

Report to the Chairman, Subcommittee  
on Human Resources and  
Governmental Relations, Committee  
on Government Operations, House  
of Representatives

**WARRANTY PAYERS  
Vulnerable Payers  
Lose Millions to  
Fraud and Abuse**



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**United States  
General Accounting Office  
Washington, D.C. 20548**

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**Human Resources Division**

B-246412

May 7, 1992

The Honorable Ted Weiss  
Chairman, Subcommittee on Human Resources  
and Intergovernmental Relations  
Committee on Government Operations  
House of Representatives

Dear Mr. Chairman:

The size of the health care sector and sheer volume of money involved make it an attractive and relatively easy target for fraudulent and abusive providers. Expected to total nearly \$700 billion in 1991, health care spending will consume over 12 percent of our gross national product; by 1995 expenditures are expected to exceed \$1 trillion, representing nearly 15 percent of our national output. Concern about this level of spending and its rapid growth has triggered an examination of whether the nation is getting value for its health care dollar. One by-product is increased attention to fraud and abuse.

In response to your concern about the effects of fraud and abuse on rapidly rising health care costs, our report explores the nature of health insurance fraud and abuse, the problems in detecting and pursuing it, and a possible approach to begin systematically addressing these problems. Appendix I discusses our findings in depth. Our review's scope and methodology are contained in appendix II.

We found that vulnerabilities within the health insurance system allow unscrupulous health care providers, including practitioners and medical equipment suppliers, to cheat health insurance companies and programs out of billions of dollars annually. Estimates vary widely on the losses resulting from fraud and abuse, but the most common is 10 percent (or \$70 billion this fiscal year) of our total health care spending. This diverts scarce resources and contributes unnecessarily to the health care cost spiral.

Profiteers are able to stay ahead of those who pay claims because of a variety of factors. These include the (1) independent operations of the various health insurers that limit collaborative efforts to confront fraudulent providers, (2) growing financial ties between health care facilities and the practitioners who control referrals to those facilities, and (3) costs associated with legal and administrative remedies to fraud and abuse. Further, efforts to combat the problems by one insurer can be

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largely negated when fraudulent or abusive providers move their operations to other insurers.

Repairing the system's vulnerabilities presents a dilemma to policymakers: safeguards must be adequate for prevention, detection, and pursuit but not be unduly burdensome or intrusive for policyholders, providers, insurers, and law enforcement officials. Specifically, encouraging more coordination among insurers must be weighed against concerns over privacy and antitrust issues; greater regulation of provider financial arrangements must be weighed against the subsequent administrative burden and the restraints on competition; and increasing resources to investigate and pursue health care fraud must be weighed against competing demands on these resources to address other criminal activities. Currently, because public and private insurers' efforts to address these issues are fragmented, a more collaborative approach to resolve these issues should be encouraged. One way to begin devising strategies for addressing these issues is to establish a national health care fraud commission.

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## The Nature and Prevalence of Fraud and Abuse

Fraud and abuse encompasses a wide range of improper billing practices that include misrepresenting or overcharging with respect to services delivered. Both result in unnecessary costs to the insurer; but fraud generally involves a willful act, whereas abuse typically involves actions that are inconsistent with acceptable business and medical practices. As a practical matter, whether and how a wrongful act is addressed can depend on the size of the financial loss incurred and the quality of the evidence establishing intent. For example, small claims are generally not pursued as fraud because of the cost involved in investigation and prosecution.

Instances of fraud and abuse can be found involving all segments of the health care industry in every geographic area of the country, according to the Department of Justice. Frequently cited fraudulent or abusive practices include overcharging for services provided, charging for services not rendered, accepting bribes or kickbacks for referring patients, and rendering inappropriate or unnecessary services.

Health care fraud has expanded beyond single health care provider frauds to organized activity affecting health care programs in both the government and private insurance sectors.<sup>1</sup> For example, one fraudulent

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<sup>1</sup>Report To Attorney General on Enhanced Health Care Fraud Initiative, U.S. Department of Justice, Office of the Deputy Attorney General, February 3, 1992.

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scheme that has troubled public and private payers in California over the past decade is alleged to have involved over \$1 billion in fraudulent billings from as many as 200 physicians and other providers. The scheme centered around providers specializing in noninvasive tests such as heart and blood-pressure measurements.<sup>2</sup>

Schemes of this nature highlight several serious problems facing public and private payers. First, large financial losses to the health care system can occur as a result of even a single scheme. Second, fraudulent providers can bill insurers with relative ease. Third, efforts to prosecute and recover losses from those involved in the schemes are costly. Finally, schemes can be quickly replicated throughout the health care system.

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## The Vulnerability of the Health Insurance System to Fraud and Abuse

Efforts to detect and prosecute health insurance improprieties are meeting with limited success. Insurers have problems detecting and pursuing fraud and abuse for several reasons. First, insurers have difficulty discerning wrongful acts amidst the multiple activities that take place at the time of processing claims. They also face privacy concerns that limit collaboration among industry members that could help in fraud case development. Third, there is a lack of consensus concerning the appropriate regulation of new provider types and financial arrangements. Finally, the considerable legal and administrative costs of pursuing fraud weigh against the deterrent and financial benefits of doing so. Some of the key vulnerabilities of the health care system are summarized in table 1.

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<sup>2</sup>A separate GAO study is examining the extent of this scheme and its effect on the Medicare program.

**Table 1: Vulnerability of Health Insurance System to Fraud and Abuse**

**Obstacles to Detecting Fraud and Abuse**

Over 1,000 payers process 4 billion claims a year to pay hundreds of thousands of providers using different payment methods and billing regulations. (See app. I, pp. 13-14.)

Providers' claims are paid by many insurers, making billing patterns hard to identify. Thus, a provider who bills for more than 24 hours of visits on a single day might not be discovered when claims are split among many insurers. (See app. I, p. 15.)

Collaboration among insurers to detect improper billing can be hindered by privacy concerns and incompatible claims data. (See app. I, pp. 15-16.)

Insurers must weigh the deterrent and financial benefits of their detection efforts against their legal and administrative costs as well as the administrative burden they may cause providers. (See app. I, pp. 20-21.)

**Complications of Evolving Provider Ownership Arrangements**

Increasingly, health providers are investing in medical facilities, allowing them to control the demand for and supply of services; this creates a potential conflict of interest. (See app. I, pp. 18-19.)

Insurers are limited in their ability to trace and hold accountable the source of fraudulent billings in new, unregulated medical facilities. (See app. I, p. 17.)

Physicians frequently invest in medical facilities but are not always required to disclose their investment in facilities to which they refer patients. (See app. I, p. 19.)

Anti-kickback statutes are not always applicable to providers profiting under private insurance from their patient referrals. (See app. I, p. 19.)

**Problems with Prosecuting Fraud and Abuse**

Successful prosecutions may not result in insurers recovering their money. (See app. I, pp. 12 and 21.)

Federal prosecutors may not accept criminal health care cases involving less than \$100,000 because of limited resources. (See app. I, p. 20.)

An insurer's efforts against unscrupulous providers can result in scams being shifted to other insurers. For example, when Medicare excluded providers who were cheating the program, the providers moved their unlawful operations to private insurers. (See app. I, p. 12.)

**Collaborative Approach Could Help Address Fraud and Abuse**

Both public health insurance programs and private health insurers are vulnerable to fraud and abuse but separately appear unable to combat it successfully. Despite the commonality of fraud and abuse problems, diverse and autonomous insurers have few means of collaborating systematically to solve them. In our view, if the efforts of independent private payers, public payers, and state insurance and licensing agencies as well as state and federal law enforcement agencies were more coordinated, the attack on health care fraud and abuse would be more fruitful.

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A national commission composed of members representing diverse viewpoints could provide a forum for addressing the efficient and effective pursuit of health care fraud and abuse. Such a commission could be responsible for analyzing the trade-offs and developing recommendations to the Congress on such issues as: (1) greater standardization of claims administration, (2) mechanisms to allow more freedom to exchange information for coordinating case development and prosecution efforts, (3) the need for regulation of provider types, and (4) criteria for physician referrals to facilities where they have a financial interest.

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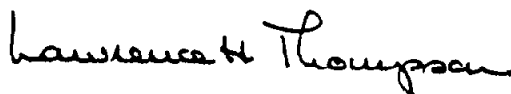
**Matter for  
Congressional  
Consideration**

The Congress should consider establishing a national commission to combat health insurance fraud and abuse with a membership balanced in terms of viewpoints represented. Such a commission could include public and private payers and personnel from federal and state investigative and prosecutorial agencies to develop strategies and evaluate legislative remedies for combatting health insurance fraud and abuse.

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As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 10 days after its issue date. At that time, we will send copies to interested congressional committees; the Secretary of Health and Human Services; and the Director, Office of Management and Budget. We will also make copies of this report available to others on request. This report was prepared under the direction of Janet L. Shikles, Director, Health Financing and Policy Issues. If you or your staff have any questions about this report, you may reach her at (202) 512-7119. Major contributors are listed in appendix V.

Sincerely yours,



Lawrence H. Thompson  
Assistant Comptroller General

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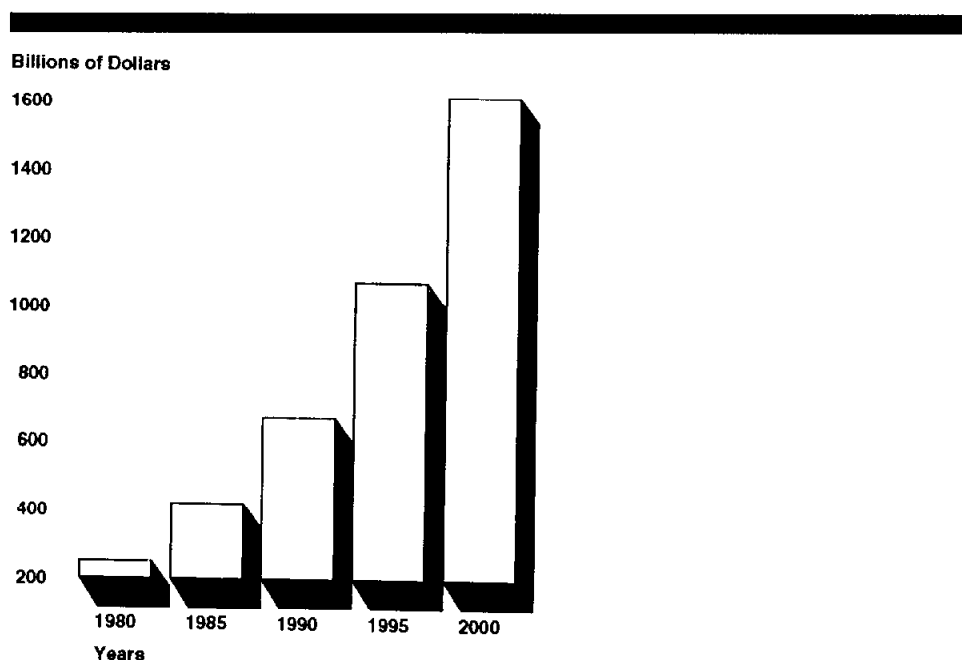
**Abbreviations**

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
FBI	Federal Bureau of Investigation
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
PRO	peer review organization
UPIN	unique provider identification number

# Vulnerable Payers Lose Billions to Fraud and Abuse

Health care spending is a major and rapidly growing segment of our economy. Consuming over 12 percent of the gross national product in 1990, expenditures are expected to boost that share to nearly 15 percent—or over \$1 trillion—by 1995. (The actual and forecasted national health care expenditures are shown in fig. I.1.) Public programs fund over 40 percent of health care spending, and that share is expected to grow over the next 5 years. Though no one knows for sure, health industry officials estimate that fraud and abuse contribute some 10 percent to \$700-plus billion in U.S. health care spending.

**Figure I.1: National Health Spending: Actual and Projected Values**



Source: Data From the Office of National Health Statistics, Health Care Financing Administration, Office of the Actuary.

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## **The Nature of Health Insurance Fraud and Abuse**

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### **What Constitutes Fraud and Abuse**

Both fraud and abuse result in inappropriate expenditures. However, to convict a provider of health insurance fraud, generally there must be proof of a willful act that results in an unauthorized benefit. Absent the proof of intent, an insurer can address a provider's inappropriate billings as abuse, and may bring a civil rather than criminal action. As a practical matter, an insurer or prosecutor may handle even fraudulent acts using civil remedies for several reasons: documentable losses are low, investigative or prosecutorial resources are unavailable, or civil pursuit is more expeditious. Insurers may also decide to bring a civil suit because criminal fraud convictions do not always result in the recovery of financial losses.

Health insurance fraud and abuse encompasses a wide range of practices, such as overcharging for services, billing for services not rendered, and rendering services that are unnecessary or inappropriate. (See fig. I.2.) Paying kickbacks to physicians for referring patients and routinely waiving copayments or deductibles from patients are also practices that are deemed fraudulent by federal payers. Because kickbacks constitute payments to induce services, they increase insurers' vulnerability to claims for unnecessary services. Copayments and deductible waivers eliminate the patient's liability for the portion of the bill that is not reimbursed by health insurance, thus removing cost considerations from patients' decisions about whether to obtain services. Moreover, by forgiving patient copayments and billing an insurer directly, unscrupulous providers may be able to misrepresent services rendered without the patients' knowledge.

**Appendix I  
Vulnerable Payers Lose Billions to Fraud  
and Abuse**

**Figure I.2: Examples of Fraudulent Practices From the Files of the HHS Office of the Inspector General and the National Association of Attorneys General**

<p><b>Overcharging</b></p> <p>Upcoding: Employees of a California hospital upgraded the codes on patient file jackets, usually switching the principal and secondary diagnoses, thereby substituting more costly procedures and services for those actually administered to the patients. Relying on the jacket notations, billing personnel submitted inflated claims for Medicare payment. The hospital signed an agreement to pay \$3.25 million in settling a dispute over Medicare claims.</p> <p>Unbundling: A group of Massachusetts anesthesiologists billed Medicare for the insertion of intravenous lines and catheters that had already been reimbursed as part of the overall anesthesia service. The group also billed separately for supervision of pump oxygenators during surgery. The group agreed to pay \$238,000 to settle its liability under civil monetary penalty provisions.</p>	<p><b>Improperly Acquiring or Soliciting Drugs</b></p> <p>A New York pharmacy and its owners were indicted for billing the state for drugs never provided to Medicaid patients. In their alleged scheme, the owners bought prescriptions from Medicaid recipients at \$10 to \$40 each. The defendants then billed the state for the drugs in question, but never actually provided them. Additionally, many of the pharmaceuticals charged to Medicaid were not actually ordered by a physician. As part of the alleged scheme, the defendants billed the state for fabricated prescriptions purportedly based on physicians' telephone requests. The supervising druggist/co-owner was further charged with permitting and assisting unlicensed employees to dispense prescription drugs, including controlled substances.</p>
<p><b>Billing For Services Not Rendered</b></p> <p>A man and his sons systematically looted more than \$16 million of the \$32 million that Medicaid paid their diagnostic treatment center for claims of treating the city's poor. From 1980 until 1987 they falsely billed Medicaid for close to 400,000 phantom visits. They also programmed the center's computer to generate phony claims and back-up charts for as many as 12,000 fictitious visits a month. Father and sons received prison sentences and their corporation was sentenced to pay restitution of \$32 million. They were also excluded from the Medicare and Medicaid programs for up to 45 years.</p>	<p><b>Rendering Inappropriate Or Unnecessary Services</b></p> <p>Investigators from the HHS Office of the Inspector General and the Postal Inspection Service produced evidence that an Illinois physician billed for services not provided and for tests and services not medically necessary. He used the name of a doctor who suffered from amnesia to bill Medicare, endorsed the checks with the doctor's name, and put the money in an account to which the doctor had no access. The physician must pay restitution of \$100,000 and a fine of \$53,200 and serve 5 years' probation during which he cannot practice medicine for remuneration.</p>

**How Fraud and Abuse Is Investigated and Prosecuted**

Several resources are available to help insurers investigate and deal with fraudulent and abusive providers. These include federal investigative agencies, state insurance commissions, state and local law enforcement groups, a national antifraud association, and state licensing boards.

At the federal level the principal responsibility for investigating fraud and abuse in the Medicare and Medicaid programs resides with the Office of

the Inspector General of the Department of Health and Human Services (HHS). For Medicaid, the Inspector General also has oversight authority over state-administered Medicaid Fraud Control Units that exist in a majority of states. The Federal Bureau of Investigation (FBI) and the Postal Inspection Service also investigate health insurance fraud for both public and private insurers. The FBI investigates violations of mail fraud, wire fraud, bribery and kickbacks, as well as false statements related to submission of Medicare and Medicaid claims. The Postal Inspection Service becomes involved when fraudulent activities involve use of the mail.

Investigative resources have also been expanded in recent years by the development of fraud bureaus within the insurance departments of at least eight states.<sup>1</sup> Insurers have also enhanced their ability to investigate fraud and abuse by forming the National Health Care Anti-Fraud Association. Established in 1985 as a coalition of private payers, the Association was expanded to include federal investigative and prosecutorial agencies. The Association seeks to facilitate the prevention, detection, and prosecution, both civilly and criminally, of health care fraud. It serves as a focal point for collecting information on methods and techniques to identify and prosecute fraudulent and abusive providers.

A variety of federal and state criminal and civil statutes are used by public and private insurers to pursue fraudulent or abusive providers. The federal criminal charge most often used has been mail fraud, followed by false claims, and conspiracy; the use of state statutes varies.<sup>2</sup> In the public sector, civil monetary penalties can be imposed. In conjunction with or in lieu of criminal prosecution, the HHS Inspector General can use this authority to impose administrative penalties and assessments. These can be up to \$2,000 for each false or otherwise improper claim item submitted to the Medicare and Medicaid programs and twice the amount improperly claimed. In these cases, Inspector General investigators must show by a "preponderance of evidence" that the provider was negligent; there is no need to prove intent to defraud. If the provider disagrees with the Inspector General's determination, these cases can be appealed to an administrative law judge and the Secretary of HHS.

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<sup>1</sup>California, New Jersey, Nevada, Florida, Idaho, New York, Ohio, and Pennsylvania have active insurance fraud departments.

<sup>2</sup>Bucy, Pamela H., "Fraud by Fright: White Collar Crime By Health Care Providers," The North Carolina Law Review, Vol. 67, Apr. 1989, No. 4, p. 883.

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**The Rolling-Labs Case  
Example of Health  
Insurance Fraud**

The vulnerability of the health care system to fraud and the financial damage that it can cause is illustrated by a California scheme that has resulted in the loss of millions of dollars. The current case, which has been under investigation for 6 years and remains open, involves an estimated \$1 billion in fraudulent billings, has involved about 200 physicians, and has led to the indictment of 12 individuals. To date, virtually no money has been recovered by the defrauded insurers, although insurers have incurred further losses in detecting improprieties, investigating the fraudulent claims that were paid, and prosecuting the perpetrators.

The case centers around mobile laboratories, known as rolling labs, specializing in heart and blood-pressure measurements and other physiological tests. The rolling labs attracted insured individuals by waiving people's copayments (thereby providing free tests) and by offering physicians kickbacks for referrals. The labs provided patients a battery of costly and often unnecessary tests, which were billed to the patients' insurers. Frequently, the labs and the referring physicians used phony diagnoses in submitting insurance claims to reimburse for the tests.

Investigators involved in the case believe that, over a 10-year period beginning in 1981, the rolling labs operated under more than 600 different organizational names and tax identification numbers (tax-IDs). Indicted in 1986 as a result of an HHS Inspector General investigation, the lab owners ceased treating Medicare beneficiaries and focused on individuals covered by other types of insurance. In 1986, three insurance companies sued the owners of the rolling labs for falsifying patient diagnoses to justify medically unnecessary tests. Although the insurers won a civil judgment of \$18 million, no money has been recovered as a result of this action. In 1987, Medicare's case against the rolling-labs operation was also successfully prosecuted, and one owner was imprisoned. However, Medicare contractors have not been able to recover monies paid to providers affiliated with this operation for fraudulent and abusive claims.

Despite these legal victories, the rolling labs continued to operate, handling only non-Medicare beneficiaries. In July 1991, the owners and others were indicted for mail, wire, and bankruptcy fraud; conspiracy to defraud the United States; and violations of 13 other statutes. The trial was scheduled for May 1992.

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## Health Insurance Fraud and Abuse Hard to Detect

Efforts to identify fraud and abuse occur in an environment of competing objectives. To detect fraudulent claims, for example, reviews must be careful and thorough, but should not interfere with goals to pay claims promptly. Also, insurers may have difficulty establishing patterns of provider wrongdoing because their efforts to share information with other payers can clash with privacy concerns over patients' records and with the desirability of maintaining positive provider relationships. An absence of comparable data can likewise impair the ability of industry members to share information efficiently.

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## Complex Claims Processing Impedes Fraud Detection Efforts

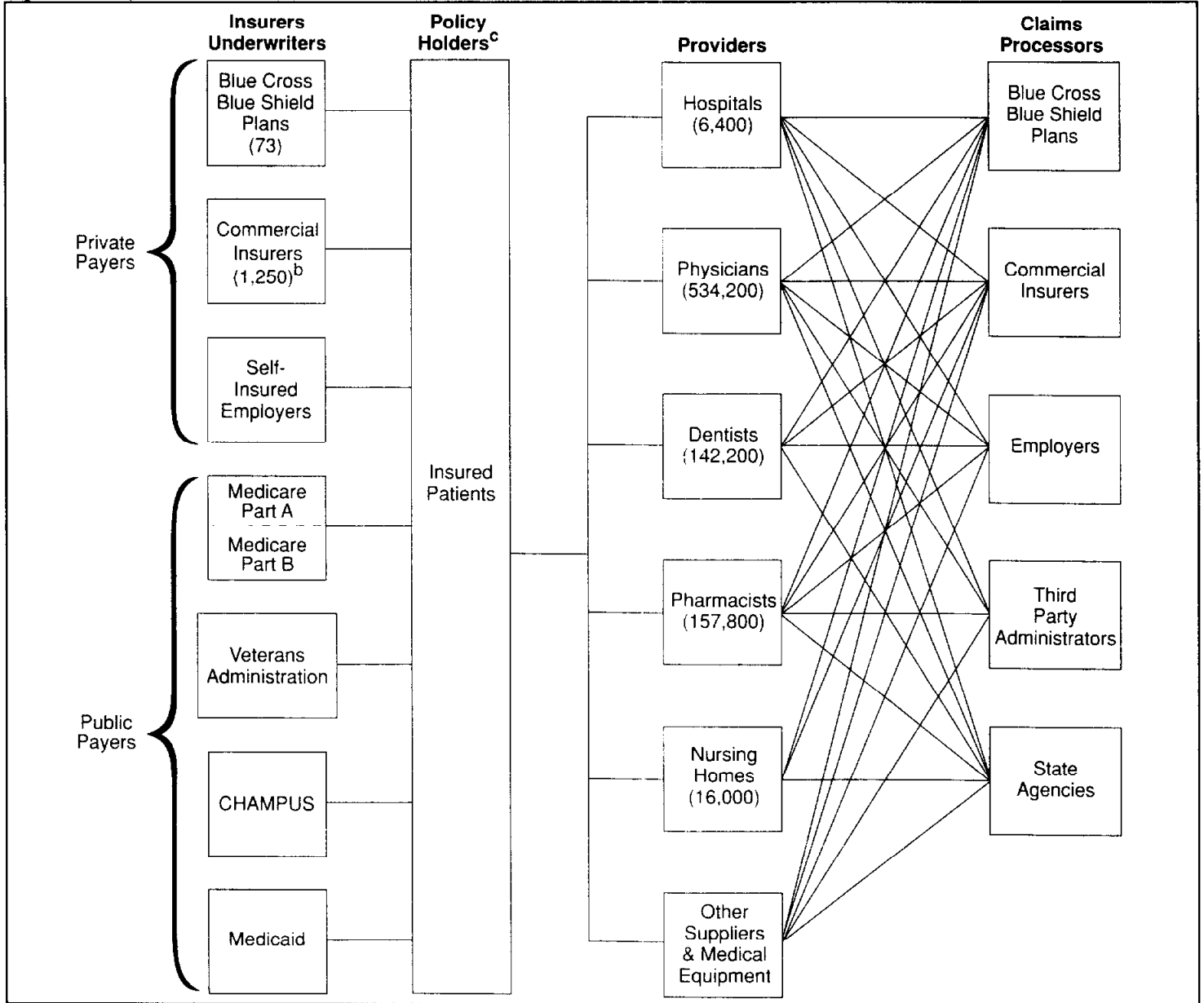
The health insurance system is a myriad of health care payers and methods of reimbursing providers. This complex system itself becomes an impediment to detecting fraud and abuse. The public payers include most notably Medicare and Medicaid, and each has its own system of reimbursement regulations, and claims processing contractors.<sup>3</sup> Private payers number over 1,000 and include Blue Cross and Blue Shield plans, a host of health insurance companies, and many employers who self-insure. An estimated 4 billion claims are processed annually. (See fig. I.3.)

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<sup>3</sup>Civilian Health and Medical Program for the Uniformed Services (CHAMPUS) and the Veterans Administration are also among the public payers of health care services.

**Appendix I  
Vulnerable Payers Lose Billions to Fraud  
and Abuse**

**Figure I.3: Payers Process About 4 Billion Claims Annually in the Fee-for-Service Sector<sup>a</sup>**



<sup>a</sup>HHS estimate.

<sup>b</sup>The top 24 commercial insurers underwrite about half of the insured accident and health insurance policies.

<sup>c</sup>Policyholders may be required to submit claims directly to their processors.



All insurers have at least some controls—claims edits and reviews—prior to payment. However, insurers believe that while these controls may help prevent inappropriate, abusive, or fraudulent payments, they must be balanced against the associated delay in claims processing and payment as well as the inconvenience they often cause providers. Compounding problems with provider acceptance of such controls is the fact that edits and reviews are often based on subjective judgments regarding a medical service’s appropriateness instead of well-developed standards of medical necessity. For example, to ensure that the diagnosis is generally consistent with the billed procedure insurers may employ basic edits that suspend claims for manual review. Depending on the outcome of the review, a claim will either be paid or denied.

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**Difficulties Sharing  
Information Hinders Fraud  
Case Development**

Other detection problems are linked to insurers’ inability or reluctance to share information about provider practices. Working collaboratively could give insurers opportunities to confirm or deny suspicion about a provider and to document the information necessary to develop viable fraud cases. Concerns over privacy of medical records along with the autonomous nature of the many programs and companies that pay for medical services, however, make effective collaboration among insurers difficult to achieve.

A cursory look at claims review explains why sharing claims information on suspected providers could be useful in identifying and developing fraud cases. Data on an individual claim, taken in isolation, rarely suggest a fraudulent practice. Rather, insurers need to detect a pattern of questionable billing. In the case of a physician, for example, insurers need to view claims within the context of the physician’s entire practice or in relationship to other physicians’ billing practices. Because physicians bill many insurers, one insurer cannot get a complete look at a physician’s billings, and the fragmented billing may distort comparisons of billing patterns among physicians. As a result, a physician who bills for more office visits than can reasonably be performed in a day, for example, may not be detected if the billing is split among several payers.

**Privacy Considerations**

Each insurer addresses the claims review process in isolation, which necessarily limits the scope of the fraud that will be documented. To document fraud committed by a single provider against the health care system as a whole requires information from other health insurers. This is largely not feasible for several reasons.

First, insurers and their staff can be held liable for violations of privacy laws and federal antitrust statutes and are subject to defamation suits brought by providers. Currently, a claims investigator for one Medicare contractor is being sued by a provider for malicious prose, defamation of character, and interference of economic advantage. Second, even within a single program—Medicare—information on providers is not always shared among component organizations. In one case, for example, a Medicare part B contractor would not share its list of aberrant providers with the program’s peer review organizations (PRO) for fear of violating federal antitrust laws.<sup>4</sup> Confidentiality concerns also impeded early detection of the rolling-labs scheme. Although one private insurance company was aware of the rolling-labs scheme in 1985, the company could not alert other insurers, according to a company official. Finally, Medicare and Medicaid payers are precluded under the Federal Privacy Act of 1974 from sharing provider-specific information with private entities.

Attempts have been made to accommodate insurers’ concerns over privacy liability issues. New Jersey, for example, protects insurance companies from liability for giving information to the state’s fraud bureau.<sup>5</sup> Some other states also give insurers limited immunity from potential privacy law violations for sharing information on providers, and the National Health Care Anti-Fraud Association has established guidelines to protect members from liability.<sup>6</sup> However, the insurers we spoke with remain hesitant to share provider information.

## Business Autonomy Considerations

Insurers may establish their own documentation guidelines, billing requirements, and terminology for providers to complete claims. Claims formats and content vary by plan, making data comparisons across plans difficult. Because each insurer can provide many plans designed to meet the needs of a variety of covered groups, claims submitted to a single insurer could involve 100 or more different health insurance plans.

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<sup>4</sup>Medicare part B covers claims for physician services, outpatient hospitals, and other health services, such as laboratory tests. Medicare Part A is the program component for administering hospital insurance and covers inpatient hospital services and other services, such as skilled nursing, hospice, and home health care. PROs are private entities that contract with HCFA to review medical necessity and quality-of-care issues for Medicare’s part A program component.

<sup>5</sup>New Jersey’s fraud bureau acts as a clearinghouse for such information. The unit can solicit information from insurers on the providers it is investigating and alert other insurers to providers suspected of fraudulent or abusive activity.

<sup>6</sup>The guidelines provide ground rules for the exchange of investigative information relating to providers. Included are instructions for investigating providers as well as distributing and using provider information. The Association contends that adherence to its guidelines “will help to establish the absence of bad faith and minimize the possibility of common law liability for any exchanges of information with law enforcement officials.”

A recent effort to trim administrative costs coincides with the need for uniform data and signals the potential for coordinating the efforts of independent private insurers with public payers. In November 1991, the Secretary of HHS convened a Forum on Administrative Costs composed primarily of major private health insurers. The goal of the forum was to discuss a national strategy for streamlining the costs of administering health insurance. In doing so, the forum proposed administrative reforms that included electronic billing using standardized formats, streamlining the medical review process, and computerized medical record systems for providers. Work groups have been convened to address the implementation of these reforms.

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## **Unlicensed Providers Can Be Hard to Track**

The development of new, unlicensed medical facilities can impede insurers' ability to trace and hold accountable the source of fraudulent billings. Efforts to control health care costs, rapidly developing technology, and increased competition have resulted in the rapid expansion of a variety of freestanding, ambulatory care facilities, including mobile diagnostic equipment. There is considerable debate over how much to regulate these facilities, which offer services outside the conventional hospital or physician office settings.

Depending on the state in which the provider operates or on the service rendered, freestanding providers may not be required to obtain state licenses and are therefore more difficult to monitor. The primary purpose of licensure is to protect the health and safety of patients by assuring that providers are capable of furnishing services of an adequate quality in a safe environment. Additionally, the license number can provide a single identifier that insurers can use to track providers who bill insurance companies under multiple provider numbers or through different corporate entities. Licenses also enhance regulators' ability to link new and prior businesses.

In 1990 we reported on the limited state licensing of various types of nonhospital providers.<sup>7</sup> For example, only 10 of the 45 states with ambulatory care centers required a license. Among 34 states reported to have diagnostic imaging centers, only 3 required an operating license. No state required licenses for pain control centers or cancer centers providing chemotherapy or radiation treatment, and such centers were operating in from 14 to 18 states.

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<sup>7</sup>Health Care: Limited State Efforts to Assure Quality of Care Outside Hospitals (GAO/HRD-90-53, Jan. 30, 1990).

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## Evolving Financial Arrangements Complicate Pursuit of Fraud

Concern about the appropriate regulation of the new facilities is compounded by physicians' and other health care providers' financial interest in or ownership of facilities where they may refer patients. The potential for conflict of interest arises because health care providers control the demand for health care services as well as profit from the supply of those services. However, the degree to which the ownership of facilities and subsequent patient referrals should be restricted is a matter of ongoing debate.

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## Physician Ownership

Physician ownership of health care facilities has been linked with increased and unnecessary use of services, which, depending on the circumstances, can be viewed as fraudulent, abusive, or legitimate. A recently published study showed that physicians in Florida own 93 percent of the surveyed diagnostic imaging centers. At least 40 percent of physicians involved in direct patient care can refer patients to facilities in which they have an ownership interest.<sup>8</sup> The physician-owned clinical laboratories in Florida furnished nearly twice as many diagnostic tests per patient as those without physician ownership. Physician investment in diagnostic imaging and in physical therapy or rehabilitation facilities was also associated with increased use of services. Other studies have confirmed that physician ownership can provide a financial inducement to prescribe ancillary services.<sup>9</sup>

The medical profession has recently tried to address the line between appropriate and inappropriate physician investment and referral behavior. The American Medical Association's Council on Ethical and Judicial Affairs warns physicians to be alert to possible conflicts of interests in their patient referrals. The Council recommends that, in general, physicians should not refer patients to a health care facility outside their office practice at which they do not directly provide care or services when they have an investment interest in the facility. According to the Council, physicians may invest in and refer to an outside facility in the case of demonstrated community need when alternative financing is not available. However, the Council recommends that physicians disclose their

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<sup>8</sup>Joint Ventures Among Health Care Providers in Florida, State of Florida Health Care Cost Containment Board, January 1991.

<sup>9</sup>Medicare: Referring Physician's Ownership of Laboratories and Imaging Centers (GAO/T-HRD-89-26, June 8, 1989); Financial Arrangements Between Physicians and Health Care Businesses, (May 1989, OAI-12-88-01410) Office of the Inspector General, Department of Health and Human Services; and Hillman, B. J., et al, "Frequency and Costs of Diagnostic Imaging in Office Practice - A Comparison of Self-Referring and Radiologist-Referring Physicians," *New England Journal of Medicine*, Vol. 323, No. 23 (1990), pp. 1604-1608.

investment interest to their patients when making a referral and to third-party payers when requested.

Insurers are aware of the potential for inappropriate referrals where physician ownership of health care facilities is involved, but they nevertheless encounter difficulties in monitoring physician owners. Insurers cannot always untangle a physician's ownership interest in a given facility nor can they easily analyze physician-owners' referral patterns.

Identifying physician ownership of or investment in freestanding facilities, for example, is not always clear-cut. Hundreds of physicians, incorporated individually, might jointly own a venture that in turn is the parent company of a freestanding facility. As a practical matter, insurers rarely have information on physicians' ownership of equipment and facilities. In addition, insurers generally do not have automated methods of monitoring physician referral patterns. Some insurers request, but do not require, that claims for ancillary services identify the referring provider. To date, however, there has been little systematic effort to obtain this information. For example, Medicare assigns a unique provider identification number (UPIN) that can track referring physicians. However, providers' claims often omit the UPIN, and Medicare program officials expect to make the provision of a valid UPIN a condition for being paid in June 1992.

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## **Anti-Kickback Statutes**

Kickback is the term most often used to characterize inappropriate payments for patient referrals. Federal anti-kickback law prohibits soliciting, receiving, offering, or paying anything of value in return for the referral of a health care item or service payable under the Medicare or Medicaid program. Many states have comparable statutes covering providers serving privately insured patients. Determining whether a kickback violation exists is complicated when physicians who make referrals to a medical facility also own or have a management interest in the facility. In the rolling-labs case, kickbacks to physicians and laboratories were an integral part of the scheme. Medicare successfully used its clear authority to prosecute for kickbacks.

Although the law and its application concerning physician ownership and kickback arrangements are still evolving, there are some clear examples of fraudulent behavior in these areas that have been pursued. In New York City, Medicaid profiteers provide an extreme example of the physician-ownership problem: physicians set up management companies

with hidden ownership of clinics and laboratories. In one case, a physician established a network of blood collection and processing stations and testing laboratories in order to defraud Medicaid of millions of dollars for bogus laboratory tests. Physician-owned blood collecting stations paid poor people for vials of their blood and sent the samples to laboratories owned by the same physicians for unnecessary tests. Before indictment, the labs' share of Medicaid payments comprised more than 20 percent of New York's Medicaid laboratory billings, which had grown from \$71 million in 1986 to almost \$200 million in 1988.

Loss of money was only one harmful aspect of the fraud. Early in 1988, physicians in New York City reported treating several previously healthy young patients who acknowledged having sold half their blood to these providers and, as a result, required hospitalization and massive transfusions for life-threatening anemia. Thus, fraudulent care can involve poor quality care that sacrifices patient well-being for profit.

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## **Problems Prosecuting Health Insurance Fraud and Abuse**

As with insurers' efforts to detect fraud and abuse, efforts to apprehend the wrongdoers and recover financial losses occur in an environment of conflicting priorities. The deterrent and financial benefits of pursuing fraud must be weighed against the considerable legal and administrative costs of doing so. Prosecutorial and judicial resources are limited, necessarily restricting the number of cases that can be legally pursued. Public sector insurers have administrative alternatives to prosecution, but most of these alternatives are not available to private insurers. Even in the public sector, however, budget constraints increasingly can hamper case development and pursuit.

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## **Criminal, Civil Prosecution Costly With Recovery Uncertain**

Insurers face significant legal hurdles and expense in prosecuting and recovering losses from fraudulent or abusive providers. Prosecutorial and judicial resources and priorities vary by jurisdiction, often constraining state and federal prosecutors from pursuing health care cases or other cases involving relatively small dollar amounts. In several jurisdictions, for example, federal prosecutors told us that they generally accept only criminal health care cases involving \$100,000 or more. In many instances, caseloads for such crimes as savings and loan fraud and drug trafficking consume a large portion of available prosecutorial resources. An official from a large insurance company with an active fraud detection program told us that only about 1 percent of all cases referred to federal prosecutors were accepted.

An irony of the criminal prosecution approach is that a single large fraud case can itself consume available investigative and prosecutorial resources, leaving other cases unpursued. For example, in the case of the rolling-labs scheme, California state investigators told us that, because of resource constraints, similar schemes allegedly operating in the same geographic area are not likely to be fully investigated or prosecuted until the rolling-labs case goes to trial.

Litigating through the civil courts also has its disadvantages. The high costs of litigation, the hearing delays caused by clogged court dockets, and the uncertainty of collecting on a favorable judgment discourage payers from pursuing many cases. In the rolling-labs case, several insurers spent \$1 million to bring a civil suit against the lab operators in 1986. Although the insurers were awarded a judgment of \$18 million in 1990, as of April, 1992, no money has been recovered as a result of this action.

State health insurance fraud bureaus can enhance the resources and authorities that can be brought to bear on the pursuit of fraud. Some state bureaus have law enforcement powers, provide private payers limited immunity to share information, and frequently use civil remedies to obtain corrective action. The New Jersey insurance fraud bureau, for example, imposes fines of \$5,000 per case (and larger amounts for repeat offenders) and does so when cases are too small to warrant prosecution through the courts. New Jersey also protects insurance companies from civil liability for giving information to the fraud bureau. Acting as a clearinghouse for such information, New Jersey's fraud bureau solicits information from insurers on the providers it is investigating while alerting insurers to providers suspected of fraudulent or abusive activity.

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### **Provider Sanctions Difficult to Impose**

Compared to Medicaid and Medicare, it is much more difficult for private insurers to prohibit fraudulent or abusive providers from continuing to bill their companies. With some limited exceptions, private sector companies cannot refuse to do business with providers who legally offer covered health care services in their states.<sup>10</sup> Often they must wait for punitive licensure actions to hold up provider payments. Yet suspensions or revocations of a provider's license can take years and are difficult to achieve. In fact, a felony conviction may not automatically trigger such actions. For example, California's licensing board has not yet reviewed the

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<sup>10</sup>The principal exception to this in the fee-for-service sector is those insurers who have adopted preferred provider networks. In these cases, providers can be excluded from the provider networks. However, providers who are excluded from the network can still bill the insurers but under less favorable terms.

case of a physician in the rolling-labs scheme who was convicted of felony fraud in January 1990. This doctor is still able to bill private insurers.

Provider types that do not need a license to operate are even more difficult for private insurers to exclude from billing, because the mechanism for official censure is absent. (See p. 17.) Even when insurers believe they have a strong, prosecutable case, an incentive exists to settle out of court to avoid the cost of litigation. For providers who are licensed, if cases are settled out of court, providers do not typically lose their licenses unless they are also shown to be professionally incompetent.

Medicaid and Medicare can employ a number of administrative actions against fraudulent and abusive providers. Certain states' Medicaid programs consider a provider's participation agreement to be a contract that can be terminated for cause after administrative review. At the federal level, the Inspector General has the authority to exclude abusive providers from billing Medicare or Medicaid. In fact, exclusion is mandatory for those convicted of program-related crimes or patient abuse. Exclusions can also be made, among other reasons, for providers whose licenses are revoked or surrendered and for those convicted of fraud against a private health insurer. The administrative effort behind each action is significant, but it affords public insurers some measure of control over the providers with whom they do business.

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### **Declining and Uncertain Budgets Constrain Pursuit of Fraud in Federal Programs**

Public programs have more payment safeguards and greater statutory authority to deal with provider improprieties than private insurers. However, the adequacy of resources and fluctuations in their administrative budgets can disrupt detection efforts and limit enforcement capabilities.

The increase in Medicare and Medicaid providers and beneficiaries and a growing claims volume are placing substantial demands on Medicare's contractors and Medicaid's state administrators, who process and pay claims.<sup>11</sup> During fiscal year 1992, Medicare's contractors are expected to process over 600 million claims. Between 1989 and 1992, however, when claims volume increased by about 40 percent, Medicare cut its contractors' funding for payment safeguards by \$33 million. Also during this period, Medicare contractors faced considerable budget uncertainty because of the lengthy budget deliberation process.

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<sup>11</sup>Private insurance companies and Blue Cross and Blue Shield Association plans serve as Medicare program contractors. A variety of entities process Medicaid claims, including Blue Cross and Blue Shield, other third-party administrators, and state agencies.



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**Appendix I  
Vulnerable Payers Lose Billions to Fraud  
and Abuse**

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Several contractors assert that cutbacks and uncertainty caused them to reduce safeguards staffing and/or curtail activities. For example, the two California carriers' units that perform the program integrity and quality assurance functions were cut by about 25 percent in fiscal year 1992. Carrier officials said the 1992 cuts will either force carriers to reduce the staff hours on each investigation or avoid particularly complex cases. Some contractors advised us that budget cuts and uncertainties have caused problems with their retaining experienced people in program safeguards operations. One contractor, as a result of budget cuts, eliminated several prepayment edits, which were used to detect questionable claims.

Although it is often difficult to clearly demonstrate the effect of budget reductions on program operations, Medicare contractors have emphasized that program safeguard cutbacks will result in the growth of undetected or undeterred fraud and abuse. Our recent work examining how contractors review complaints illustrates the potential effect of such budget reductions. In fiscal year 1990, Medicare contractors reported receiving about 18 million complaints—most of which were from program beneficiaries. In our review of five contractors, however, we found over half of the complaints that involved allegations of fraud or abuse were not referred to contractor investigative staff. Not all complaints that were properly referred, moreover, were adequately investigated.<sup>12</sup>

One Medicare beneficiary's complaint illustrates the fraud detection opportunities missed when complaints are investigated superficially. A physician and a nurse, claiming Medicare had sent them, came to the beneficiary's home. The same day, a supplier delivered several medical equipment items to her home. The beneficiary asked the supplier to pick up the equipment and not bill Medicare for it because she neither ordered nor needed the equipment. She later received a notice, however, that Medicare had paid the physician for a home visit and the supplier for the equipment. Despite the episode's likelihood of revealing fraudulent behavior by the physician and supplier, the contractor did not investigate to determine if fraud or abuse had occurred. Instead, the contractor required only that the supplier refund Medicare for its payments, which totaled about \$700.

When we drew the contractor's attention to this case, the contractor conducted additional investigations of the supplier and affiliated

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<sup>12</sup>Medicare: Improper Handling of Beneficiary Complaints of Provider Fraud and Abuse (GAO/HRD-92-1, Oct. 2, 1991).

physicians. So far the investigations have uncovered over \$450,000 in potential overpayments by Medicare. The contractor is also investigating a medical supply company operating at the same address but under a different name and Medicare provider number.

In its fiscal 1993 budget, HHS proposed significantly increasing Medicare's program safeguards budget. The planned increases in contractor safeguard funding, if implemented in fiscal year 1993, will allow Medicare contractors to begin hiring staff to replace those lost to cutbacks in prior years and to accommodate the growing claims workload. It will take some time, however, to hire and train these staff and thus to implement expanded safeguard programs.

The Inspector General also cites resource constraints as a major impediment to investigating and pursuing many types of fraud and abuse. For example, the Deputy Inspector General stated that his office's responsibility for enforcing civil monetary penalty statutes has substantially increased to more than 80 statutes in recent years. The number of Inspector General investigators has remained virtually unchanged during this time, yet the Inspector General's statutory responsibilities and the size and complexity of the federal programs that the Inspector General investigates has increased significantly.

Similarly, Department of Justice efforts have been adversely affected by resource constraints (see p. 20). Recognizing the need for additional resources to address health care fraud, the FBI announced in February 1992 that 50 agents were being reassigned from other areas to health care. At the same time, the Department of Justice assigned 10 new positions to enforce a health care fraud initiative and formed a health care fraud unit within its criminal division.

## Conclusions

Only a fraction of the fraud and abuse committed against the health care system is identified. Those instances that have been detected have involved substantial sums and can occur at the expense of patients' welfare. At a minimum, health insurance fraud and abuse contributes significantly to national health care costs. This waste is particularly alarming at a time when the portion of the nation's resources spent on health care continues to increase.

Efforts to detect and prosecute health fraud are meeting with limited success, in part, because these efforts are fragmented between the independent operations of the various health insurers. Profiteers' ability to stay ahead of those who pay claims is enhanced by the cost associated with legal and administrative remedies to fraud and abuse. Excessive paperwork and complicated regulations can burden patients and providers as well as insurers. Efforts to recover misspent money are costly and success is far from guaranteed. Finally, declining budgets in recent years for pursuing fraud in federal programs have affected the system's ability to identify and sanction fraudulent providers.

Still, the federal government, with public programs paying for more than 40 percent of the nation's health care bill, has a large incentive to minimize the loss associated with fraud and abuse. By assembling the Forum of Administrative Costs, HHS has provided leadership for increasing the efficiency of processing claims. This forum could serve as a precedent for uniting private and public payers to combat health insurance fraud.

A national commission, composed of diverse members with balanced viewpoints, could foster communication and identify ways to address obstacles that prevent the efficient pursuit of fraud and abuse. Building on the efforts by the Forum on Administrative Costs to minimize differences in billing requirements, the commission could also coordinate law enforcement and regulatory efforts at the state and federal level by including as representatives law enforcement personnel, state insurance regulators, state licensing board members and officials from various public and private payers.

The commission could be responsible for soliciting information from interested parties and developing recommendations on issues such as:

- Developing greater standardization of claims administration that accommodates fraud detection and prevention, such as assigning unique provider numbers.

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- Establishing mechanisms to allow more freedom to exchange information without undermining legitimate patient and provider privacy concerns or violating antitrust considerations.
  - Assessing the need for regulation of new provider types and developing criteria for physician referrals to facilities where physicians have a financial interest.
  - Creating a model statute for the establishment of state insurance fraud units and state laws to strengthen insurers' ability to pursue and recover from fraudulent providers.
  - Considering the extension of administrative remedies that are available to public insurers, as well as other federal legislative actions needed to address health insurance fraud and abuse.

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## **Matter for Congressional Consideration**

The Congress may wish to consider establishing a national health care fraud commission that could provide an impetus to unite the diverse private payers of health insurance claims with their public payer counterparts, state regulators, and law enforcement officials, into a single collaborative body that could address the fraud and abuse problem. The commission could develop strategies and evaluate legislative remedies for combatting health insurance fraud and abuse and make recommendations to the Congress.

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# Objectives, Scope, and Methodology

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The objectives of our report were to explore the nature of fraud and abuse associated with the health care industry and identify the problems insurers have combating fraud and abuse within the fee-for-service sector.

We interviewed officials from three groups. These included officials from (1) private sector insurers, including five health insurance companies, the Health Insurance Association of America, and the National Health Care Anti-Fraud Association; (2) the Medicare and Medicaid programs, including five claims processing contractors, the New York State Department of Social Service, the Maryland Medicaid Fraud Control Unit, and the Maryland Department of Health and Mental Hygiene; and (3) state and federal investigative and prosecutorial agencies, including state departments of insurance, state and federal attorney generals' offices, the Office of Inspector General in the Department of Health and Human Services, the Federal Bureau of Investigation, and the Office of Postal Inspections. In addition, we reviewed GAO and HHS Inspector General reports on health care fraud and abuse and performed an extensive literature search on the subject.

We performed our work between May and November 1991 in accordance with generally accepted government auditing standards.

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# GAO Reports and Testimonies on Health Care Fraud and Abuse, 1986-91

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Medicare: Improper Handling of Beneficiary Complaints of Provider Fraud and Abuse (GAO/HRD-92-1, Oct. 1991) and Testimony before the Senate Special Committee on Aging (GAO/T-HRD-92-2, Oct. 2, 1991).

Beneficiary complaints are a primary source of information on possible fraud and abuse. GAO found that Medicare carriers, contractors that process Part B claims do not investigate beneficiary complaints reported over the telephone nor investigate complaints of possible fraud and abuse thoroughly. Problems with beneficiary complaints may have worsened with federal funding reductions for carrier personnel.

Medicare: Millions of Dollars in Mistaken Payments Not Recovered (GAO/HRD-92-26, Oct. 1991).

Medicare is not the primary insurer for all citizens over 65. Although hospitals are responsible for obtaining information on beneficiaries' additional health insurance and, where appropriate, refunding money due Medicare, GAO found that Medicare was owed \$900,000 in refunds at 17 hospitals. The five Medicare intermediaries that service the hospitals did not have mechanisms to ensure that credit balances were identified and properly recovered.

Fraud and Abuse: Stronger Controls Needed in Federal Employees Health Benefits Program (GAO/GGD-91-95, July 1991).

Fraud and abuse controls in the Federal Employees Health Benefits Program were reviewed. GAO recommended changes to internal controls and program oversight that would minimize vulnerability to fraud and abuse.

Medicare Claims Processing: HCFA Can Reduce the Disruptions Caused by Replacing Contractors (GAO/HRD-91-44, Apr. 1991).

In December 1989, HCFA changed its claims-processing contractor in Georgia and its data-processing contractor in Florida. GAO determined the impact of these changes on beneficiaries and providers and identified actions that HCFA should take to reduce the impact of any future changes.

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Information System: National Health Practitioner Data Bank Has Not Been Well Managed (GAO/IMTEC-90-68, Aug. 1990).

GAO reviewed and assessed the Health Resources and Services Administration's development of the National Practitioner Data Bank.

Medicare: HCFA Can Reduce Paperwork Burden for Physicians and Their Patients (GAO/HRD-90-86, June 1990).

This report discusses the paperwork required in the Medicare part B claims process to determine whether (1) opportunities exist to help providers submit complete claims; (2) notices to beneficiaries explain claims decisions clearly; and (3) electronic services, such as electronic mail, could reduce paperwork.

Health Care: Limited State Efforts to Assure Quality of Care Outside Hospitals (GAO/HRD-90-53, Jan. 1990).

Information on the state requirements relating to quality assurance for health care delivered by both freestanding providers and HMOs is presented. It includes information on state quality assurance activities concerning (1) licensing, inspection, and enforcement for 16 types of freestanding providers and (2) inspection and enforcement activities for HMOs.

Medicare: Internal Controls Over Electronic Claims for Anesthesia Services Are Inadequate (GAO/HRD-90-49, Dec. 1989).

This report discusses the inadequacy of internal controls for claims for anesthesia services submitted by electronic media, such as magnetic tape or disk.

Medicare: Effects of Budget Reductions on Contractor Program Safeguard Activities (GAO/T-HRD-90-42, June 14, 1990). Testimony before the Subcommittee on Health, Committee on Ways and Means, House of Representatives.

GAO discussed the adequacy of Medicare contractor budgets in areas relating to program safeguards.

Medicare and Medicaid: More Information Exchange Could Improve  
Detection of Substandard Care (GAO/HRD-90-29, Mar. 1990).

GAO determined (1) whether peer review organizations, Medicare carriers, and state Medicaid agencies reviewed services provided by the same physicians, (2) whether these review entities regularly exchanged information on such physicians who were found to provide unnecessary or poor-quality care, and (3) whether legal restrictions on such exchanges existed.

Quality Assurance: A Comprehensive National Strategy for Health Care Is  
Needed (GAO/PEMD-90-14BR, Feb. 1990).

GAO addressed the following four elements viewed essential to a comprehensive national strategy: (1) national practice guidelines and standards of care; (2) enhanced data to support quality assurance activities; (3) improved approaches to quality assessment and assurance at the local level; and (4) a national focus for developing, implementing, and monitoring a national system.

Laboratory Accreditation: Requirements Vary Throughout the Federal  
Government (GAO/RCED-89-102, Mar. 1989).

GAO examined laboratory accreditation requirements of the various federal government programs and determined which, if any, had overlapping requirements that could be streamlined. This report also includes information on other issues associated with laboratory accreditation, such as the potential for more universal charging of user fees and possible focussing of accreditation at the national level in the interest of U.S. competitiveness.

Medicare: Referring Physicians' Ownership of Laboratories and Imaging  
Centers (GAO/T-HRD-89-26, June 8, 1989). Testimony before the Subcommittee  
on Health and the Environment, Committee on Energy and Commerce,  
House of Representatives.

GAO provided information on the patterns of physician referrals to clinical diagnostic laboratories and diagnostic imaging centers in Pennsylvania and Maryland. The analysis examined (1) the extent of physician ownership of the two types of facilities, (2) whether physician ownership measurably influenced utilization rates for referral services, and (3) the terms of the investment opportunities and their investment return.



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Medicare: Statutory Modifications Needed for the Peer Review Program Monetary Penalty (GAO/HRD-89-18, Mar. 1989).

This report evaluated HHS's Office of Inspector General policy and procedures for responding to peer review organizations' recommendations for monetary penalties against hospitals and physicians who have delivered improper or unnecessary care.

Internal Controls: Need to Strengthen Controls Over Payments by Medicare Intermediaries (GAO/HRD-89-8, Nov. 1988).

This report discusses (1) HCFA's internal control problems with the resolution of claims processing errors related to Medicare's payments to institutions and (2) the need for incorporating results from external reviews in managing the program.

Medicare: Cutting Payment Safeguards Will Increase Program Costs (GAO/T-HRD-89-6, Feb. 28, 1989). Testimony before the Subcommittee on Labor, Health and Human Services, and Education, Committee on Appropriations, United States Senate.

HCFA's fiscal year 1990 budget request envisioned a 4-percent decrease in the amount allocated per claim for claims processing activities and a one-third reduction in the payment safeguard function. This testimony assesses the impact of such reductions.

Medicare Claims: HCFA Proposal to Establish Administrative Law Judge Unit (GAO/HRD-88-84BR, Apr. 1988).

HCFA's proposal to establish its own hearings and appeals unit to handle Medicare hearings and appeals is assessed.

Medicare: Performance of Blue Shield of Massachusetts Under the Tri-State Contract (GAO/HRD-88-81BR, Mar. 1988).

The performance of Blue Shield of Massachusetts as the Medicare Part B carrier for New Hampshire, Vermont, and Maine is reviewed. The areas of concern included claims payment timeliness and accuracy, telephone service, reviews of denied claims, responses to written inquiries, and requests for information already provided.

Medicare: Contractor Services to Beneficiaries and Providers  
(GAO/HRD-88-76BR, Mar. 1988).

This GAO report on contractors' performance in fiscal years 1983-87 includes data relating to (1) Medicare claims processing times and accuracy; (2) review of appealed claims cases; (3) processing of hearings related to appealed claims; (4) written, telephone, and walk-in inquiries by beneficiaries and providers; and (5) education of beneficiaries and providers about Medicare coverage and requirements.

Medicaid: Improvements Needed in Programs to Prevent Abuse  
(GAO/HRD-87-75, Sept. 1987).

GAO evaluated state Medicaid programs' postpayment utilization review efforts and federal oversight of their effectiveness. A series of recommendations were made to improve states' use of their management information systems to identify provider and recipient abuse.

Health Care Fraud: Characteristics, Sanctions and Prevention  
(GAO/AFMD-87-29BR, July 1987).

Fraud investigations at the Office of HHS's Inspector General were analyzed to identify (1) characteristics of alleged fraud against the government and (2) actions taken against those who have been caught defrauding the government.

Medicaid: Results of Certified Fraud Control Units (GAO/HRD-87-12FS, Oct. 1986).

For states with certified Medicaid Fraud Control Units, GAO presented information on expenditures, results, and changes that could strengthen fraud control efforts.

# Selected Reports and Testimony by the HHS Inspector General on Health Care Fraud and Abuse

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Medicare Contractor Operations: Beneficiary Complaints, Provider Numbers and Carrier Shopping (Oct. 2, 1991). Statement by Richard P. Kusserow, Inspector General, before the Senate Committee on Aging.

Management Advisory Report: Manipulation of Procedure Codes by Physicians to Maximize Medicare and Medicaid Reimbursements (A-03-91-00019, Sept. 1991).

Carrier Maintenance of Medicare Provider Numbers (OEI-06-89-00870, May 1991).

Management Advisory Report: Financial Arrangements Between Hospitals and Hospital-Based Physicians (OEI-09-89-00330, Jan. 1991).

Health Service Brokers (OEI-05-89-00510, Oct. 1990).

State Medical Boards and Medical Discipline (OEI-01-89-00560, Aug. 1990).

Referrals by Medicaid Agencies to Fraud Control Units (OAI-03-88-00170, Oct. 1989).

Ophthalmology/Optometry Relationships Involved in Cataract Surgery (OAI-07-88-00460, Apr. 1989).

Quality Assurance in Physician Office Laboratories (OAI-05-88-00330, Mar. 1989).

Medicare Carriers' Performance of Program Integrity Functions (OAI-04-88-00710, Aug. 1988).

Medicare Physician Consultation Services (OAI-88-02-00650, June 1988).

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