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Improper Handling of Beneficiary Complaints of Provider Fraud and Abuse

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The Honorable David Pryor
Chairman, Special Committee
on Aging
United States Senate

The Honorable William S. Cohen
Ranking Minority Member
Special Committee on Aging
United States Senate

Medicare is the nation's largest payer for health care services and, with 1991 estimated expenditures of $115 billion, represents the fourth largest category of federal expenditures. Despite attempts to constrain costs, Medicare spending and beneficiary out-of-pocket costs have risen at troubling rates. The fastest growing portion of Medicare is part B, which will account for an estimated half a billion claims and $45 billion in benefit payments in fiscal year 1991.[1] The growth of these payments also increases Medicare's vulnerability to erroneously paid claims that may result from provider fraud and abuse.

A key line of defense in identifying and correcting provider fraud and abuse[2] are the Medicare contractors (carriers) who process and pay Medicare part B claims. The carriers' primary source of information on possible provider fraud and abuse is part B beneficiaries. No one has a greater stake in protecting part B benefits more than the program's 33 million beneficiaries—those eligible to have services paid. For every dollar wasted, the beneficiary risks potential cutbacks in program coverage, increased out-of-pocket expenses for deductibles and coinsurance, and increased premiums for both Medicare and supplemental insurance.

Objectives, Scope, and Methodology

Because of beneficiary reports that the carriers were not acting on their complaints of provider fraud and abuse, you requested us to review Medicare's responsiveness to these complaints. In discussions with your

[1]Medicare benefits are provided under two parts. Part A covers inpatient hospital, skilled nursing facility, home health, and hospice care services. Part B covers physician services, outpatient hospital services, durable medical equipment, and various other health services, such as laboratory tests and diagnostic X-rays.

[2]The Health Care Financing Administration (HCFA) defines fraud as an intentional deception or misrepresentation that could result in payment of an unauthorized Medicare benefit. HCFA defines abuse as a provider practice that directly or indirectly results in unnecessary costs to Medicare or improper reimbursement.

office, we agreed to determine (1) the extent to which Medicare carrier personnel identify and refer beneficiary complaints to carrier investigative units, (2) the thoroughness of carriers' investigations of complaints, and (3) the impact of proposed budget cutbacks on these activities.

To perform this work, we reviewed how five carriers receive and investigate beneficiary complaints of provider fraud and abuse by visiting the carriers, speaking with HCFA officials about carrier oversight, and reviewing HCFA's investigation requirements. At the carriers, we monitored 1,000 incoming beneficiary telephone calls and reviewed a random sample of 155 beneficiary complaint cases. (See app. I for more details on our scope and methodology.)

Results in Brief

Carriers are missing out on opportunities to detect potential fraud and abuse because telephone personnel who first receive beneficiary complaints of provider fraud and abuse frequently do not refer them to the carriers' investigative units. Instead, carriers often tell beneficiaries to submit their complaints in writing or to resolve them with providers—even though the beneficiary has described the complaint in detail over the telephone.

Further, when complaints are referred, carrier investigative units often do not fully investigate those that contain substantial indications[3] of potential fraud and abuse. Carriers failed to fully investigate almost three-quarters of such complaints in our sample even though thorough investigations can result in substantial savings to the Medicare program. The mishandling of beneficiary complaints results partly from inadequate HCFA guidance and oversight.

The administration's initial fiscal year 1992 budget request for HCFA significantly reduced funding for carrier personnel who answer beneficiary inquiries, including fraud and abuse complaints. However, HCFA officials told us that funds would be reallocated within the fiscal year 1992 budget to minimize this reduction.

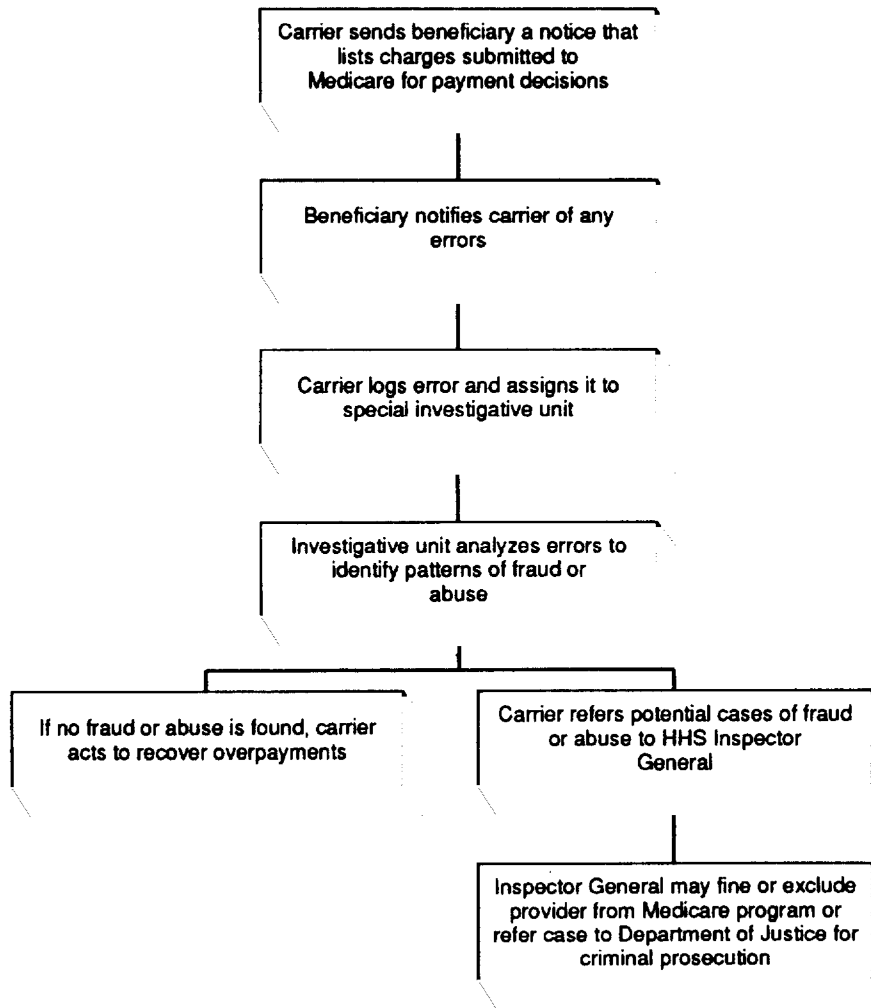
Background

Nearly 900,000 physicians and suppliers bill the Medicare part B program annually. HCFA estimates that during fiscal year 1991, the program's 34 Medicare carriers will process about 500 million claims and

[3]The provider had two or more similar substantiated complaints within the last 2 years, or the current complaint, on its own, strongly suggests fraud or abuse.

pay nearly $45 billion in part B benefits. Given this enormous investment, protecting against provider fraud and abuse is essential to the program's efficient operation.

Figure 1: Key Roles of Medicare Beneficiaries and Carriers in Detecting Fraud and Abuse



After a provider submits a claim to a carrier for Medicare rendered services and the carrier determines whether and how much to pay, the carrier sends the beneficiary an explanation of the actions it took.[4] The statement asks the beneficiary to call the carrier immediately if he or

[4]This is called an explanation of Medicare benefits.

she did not receive the identified services or if there are other errors in the statement.[5] Thus, beneficiaries serve as the primary check on providers' bills because they are in the best position to identify payments for services or medical equipment that were not received or that they believe were unnecessary.

Medicare carriers also play an essential role in detecting fraud and abuse. Each carrier is required to train personnel who receive beneficiary complaints to detect possible fraud and abuse and refer these complaints to its investigative unit. This unit is responsible for integrating information from beneficiary complaints with provider data, such as payment histories and prior complaints, to determine if a provider exhibits a pattern of potential fraud or abuse. When investigations confirm potential fraud or abuse, carriers are instructed to refer these cases to the Department of Health and Human Services (HHS) Office of Inspector General for further investigation and possible punitive action, such as fines, exclusion from the Medicare program, or referral to the Department of Justice for criminal or civil action.

HCFA monitors the quality of carrier fraud and abuse detection efforts through its carrier evaluation program. During its annual evaluations, HCFA reviews carrier instructions and procedures and a sample of carrier fraud and abuse investigations to determine if carriers have been complying with Medicare's investigative requirements.

Carriers Often Fail to Refer Complaints for Investigation

At the five carriers we visited, over half of the beneficiary calls involving complaints of provider fraud or abuse were not properly referred for investigation. Fifty-six (5.6 percent) of the 1,000 calls we monitored involved potential provider fraud or abuse. In most instances, beneficiaries stated they had not received the services billed to Medicare.

Although HCFA has no instructions on the actions carriers should initially take on incoming complaints, HCFA officials agree that, for a complaint to be properly handled, carrier personnel should record the complaint and forward the information to the carrier's investigative unit. Carrier personnel, however, did not properly refer 31 of the 56 complaints for investigation. Instead, beneficiaries were instructed either to write to the carrier, despite having already explained the matter in detail on the

[5] In fiscal year 1990, beneficiaries made about 18 million calls to carriers that included an unknown number of complaints of provider fraud and abuse.

telephone, or to resolve the problem with the provider. In other cases, the beneficiary offered to resolve the problem with the provider. Further, carrier personnel did not recognize some complaints as potential fraud and abuse. (See app. II for details on how each carrier handled complaints not properly referred for investigation.)

For example, in Massachusetts, a beneficiary called the carrier and stated that she had paid a physician in full before leaving his office and wanted to know if Medicare had processed her claim. The carrier representative stated that Medicare had paid the physician, since the claim had been submitted on assignment.[6] By accepting assignment, the physician is precluded from collecting the total billed amount from the beneficiary. The carrier representative suggested that the beneficiary contact the physician to request a refund. The representative's supervisor agreed with us that the complaint should have been referred for investigation because the physician billed Medicare and the patient—both an assignment violation and a potentially fraudulent action.

A beneficiary living in California was notified by the Arizona carrier that Medicare had paid for a diagnostic X-ray taken by an Arizona provider. The beneficiary called the carrier and reported that she had not received the service. Rather than referring the matter for investigation, the Arizona carrier representative asked the beneficiary to write the carrier, restating the same information. A carrier official agreed with us that the representative should have recorded the complaint and referred it for investigation.

In Florida, a beneficiary's wife called to verify that an optician had refunded $433 owed to Medicare. She stated the optician had billed Medicare for services that her husband had not received, and when she brought this matter to the optician's attention, he agreed to return the money to Medicare. The complainant alleged that the optician was cheating Medicare because he frequently billed for nonrendered services. The carrier representative told the complainant that the optician had refunded part of the amount, but there was no record that the entire amount had been refunded. After discussing the matter for nearly 15 minutes, the representative instructed the complainant to submit her complaint in writing to the carrier. The complainant became irate, stating that she was tired of calling and writing Medicare and wanted to speak with the representative's supervisor. The supervisor quickly

[6]"Assignment" refers to a physician's decision to bill Medicare directly and accept the program's allowed charge as payment in full.

solicited the necessary information and referred the matter for investigation. The supervisor agreed with us that the representative had not properly handled the call and should have referred the complaint immediately for investigation.

In Texas, a beneficiary called the carrier, stating that he did not recall going to a particular physician whom Medicare had paid for surgery. The carrier representative did not recognize the complaint as potential fraud or abuse and thus did not refer the complaint for investigation. The representative's supervisor agreed with us that because the complainant alleged nonrendered services, the representative should have referred the matter for investigation.

Carriers Do Not Fully Investigate Some Complaints

In our sample of beneficiary complaints referred to investigative units, the carriers did not adequately investigate almost three-quarters of the complaints where substantial indications of potential provider fraud and abuse existed. Most of the 155 complaints in our sample were due to beneficiary misunderstandings or pertained to providers who carrier records showed had no prior history of substantiated complaints. However, 15 of the cases contained substantial indications of potential fraud and abuse in that the provider had two or more similar, substantiated complaints within the last 2 years, or the current complaint, on its own, strongly suggested fraudulent or abusive behavior. Only four of the cases were fully investigated. In the other 11 cases, the carriers did not fully investigate the complaints to determine if fraud or abuse existed. Instead, carriers treated these complaints as isolated instances and only sought the overpayments due Medicare or the beneficiaries. (See app. III for the results of how carriers handled the 15 cases indicating potential fraud and abuse.)

One beneficiary in Florida complained that a physician and a nurse came to her home, claiming Medicare had sent them because elderly people were dying due to inadequate care. They asked her to sign some papers. The same day, several medical equipment items were delivered to her home by a supplier. The beneficiary called the supplier the next day and requested that the equipment be picked up and not be billed to Medicare because she neither needed the equipment nor ordered it. She later received a notice, however, that Medicare had paid the physician for a home visit and the supplier for the equipment. Even though the beneficiary's complaint strongly suggested fraudulent behavior by the physician and supplier, the Florida carrier did not fully investigate the

matter to determine if fraud or abuse existed. Instead, the carrier merely required the supplier to refund $773.71 in payments.

Carrier officials acknowledged that this case was not properly investigated. At our suggestion, the carrier performed additional investigative work, identifying additional beneficiaries who had been similarly approached by the same providers. The carrier is preparing the case for referral to the HHS Inspector General in Florida for possible punitive action.

For 7 of the 11 cases that we concluded were not fully investigated, carrier officials told us that, in their view, these cases had been sufficiently investigated and cited two principal reasons for believing so. First, they did not consider the number of prior complaints against the provider to be sufficient to warrant an expanded review. Second, they did not believe an expanded review was necessary because the complaints resulted from provider billing errors, and they did not have sufficient resources to investigate every provider that had two or more billing errors.

We disagree with the carriers' position and believe they are missing opportunities to save Medicare funds. One case in which a carrier did not believe an expanded review was necessary had 23 similar complaints against the provider since November 1989. Another had two prior substantiated complaints within the last 2 years for assignment violations that HCFA's guidance states is a clear indication of potential fraud. Even though billing errors may not be due to fraud and abuse, a carrier official acknowledged that prior expanded reviews of billing errors have resulted in overpayment recoveries.

We found other indications that cases are not fully investigated. For example, there was frequently no evidence that a carrier considered a provider's complaint history as part of the investigation, even though HCFA requires investigative units to review this information when the complaint is not the result of an error or misunderstanding. Further, two carriers never prepared written rationales for closing cases, as HCFA requires, and a third carrier occasionally failed to do so. The lack of written rationales makes it difficult to determine what steps carriers took during their investigations.

Inadequate HCFA Guidance and Oversight Contributes to Problems

The failure of carriers to refer some complaints to their investigative units or to fully investigate some complaints for possible fraud or abuse resulted partly because of inadequate HCFA guidance and oversight.

HCFA has not developed instructions for carrier staff who initially receive beneficiary complaints of provider fraud and abuse on how to identify and refer these complaints for investigation. Instead, HCFA requires carriers to develop their own instructions.

The instructions of the five carriers we visited were generally confusing, inconsistent, or incomplete. For example, one carrier's instructions contained conflicting guidelines on whether beneficiaries should be told to submit their complaints in writing or carrier telephone personnel should record the complaint and refer it to the carrier's investigative unit. The carrier clarified its instructions once we brought this matter to its attention. Another carrier followed an informal policy of encouraging beneficiaries to discuss matters involving potential fraud and abuse directly with providers. A third carrier did not have any written instructions for its staff.

In September 1991, HCFA officials gave us a draft of instructions that would require carrier personnel to record beneficiary complaints and forward this information to the carrier's investigative unit. Our review of the draft instructions disclosed that HCFA officials were responsive to our concerns.

HCFA's annual evaluations of carrier fraud and abuse detection efforts were inadequate for the five carriers we reviewed. First, HCFA did not monitor any beneficiary telephone calls to determine if complaints of provider fraud and abuse were appropriately identified and referred to carrier investigative units. A HCFA official told us that such monitoring is not performed because HCFA has no reason to believe that carrier personnel are not referring complaints for investigation. Second, despite the problems we found at the five carriers, HCFA's 1990 evaluations did not raise any concerns about (1) carrier instructions for identifying fraud and abuse complaints or (2) the thoroughness of carrier investigations. During its evaluations, we believe HCFA should more closely examine carrier investigations of beneficiary complaints to ensure that they are thorough.

Another area in which HCFA's instructions do not provide adequate guidance to carriers concerns when the investigation of a beneficiary complaint should be expanded and the additional steps an expanded

investigation should include. HCFA's instructions state that carriers should conduct an expanded investigation of a beneficiary complaint of provider fraud and abuse if the carrier determines that the complaint is not the result of a provider error or misunderstanding. Carriers are to use their discretion in deciding whether or not a complaint is the result of a provider error or a misunderstanding. Carrier officials told us that they lacked enough resources to conduct an expanded investigation of each complaint that was not an error or a misunderstanding. As a result, they made subjective decisions on which complaints should be more thoroughly investigated. We found that in some cases the carriers we visited decided not to conduct an expanded investigation even though there were substantial indications of potential fraud and abuse.

In some cases where carriers decided to expand an investigation, we found that they did not sufficiently develop the cases to determine if fraud or abuse existed. An expanded investigation includes, among other steps, a review of the provider's claims history and documentation on prior complaints. Also, depending on the nature of the complaint, the carrier can decide to contact a sample of other beneficiaries who received similar services from the same provider to determine if other indications of potential fraud exist. The carriers we visited made subjective decisions about when an expanded investigation should include contacting a sample of beneficiaries, and in some cases, carriers did not do so even when the evidence seemed to indicate that such action should be taken. Carrier officials told us they did not have enough resources to perform a beneficiary survey for each complaint in which the provider's history and prior complaints suggested potential fraud and abuse.

Fully Investigated Complaints Result in Significant Benefits

Carrier failure to fully investigate beneficiary complaints of provider fraud and abuse can result in missed opportunities to recover overpayments, impose penalties, and send a message to the provider community that fraudulent or abusive behavior will not be tolerated.

For example, in 1986, several beneficiaries in Massachusetts complained that Medicare had paid for eye care services not rendered. Upon initial investigation, the carrier found that the provider's billing agent was separately billing for portions of eye examinations that Medicare had previously paid. Working with the HHS Office of Inspector General, the carrier later expanded its review to over 100 additional beneficiaries who had received similar services. According to the Department of Justice, the billing agent had submitted about 300 fraudulent claims totaling about $658,000. In September 1990, the agent pleaded guilty to defrauding

Medicare and was assessed a $25,000 fine and excluded from the Medicare program. Also, the provider agreed to refund $2.5 million, plus interest, to the federal government.

Proposed Funding for Fraud and Abuse Detection

The administration's fiscal year 1992 budget request for HCFA reduces funding for carrier personnel who answer beneficiary inquiries,[7] including fraud and abuse complaints, by 57 percent (from $122.6 million to $52.3 million). One carrier we visited estimated that the proposed budget reduction would translate into a 72-percent shortfall, given inflation and an anticipated increased carrier workload. This carrier predicted significant employee layoffs, with a corresponding dramatic decrease in the carrier's ability to answer incoming beneficiary telephone calls and correspondence.

On September 9, 1991, HCFA officials told us that they intend to reallocate funds within the fiscal year 1992 budget to minimize the proposed reduction in beneficiary communications funds. Although the final funding level has not yet been agreed upon, HCFA officials stated that the 1992 budget for beneficiary communications will be between $93 and $115 million, depending on whether HCFA will continue to provide carriers funding for toll-free beneficiary telephone service. HCFA officials stated that these funding levels will enable carriers to respond to all beneficiary inquiries in a timely manner.

Conclusions

The carriers we reviewed had not established effective procedures to ensure that beneficiary complaints of potential fraud and abuse were properly identified and referred to carrier investigative units and that the complaints that were referred were adequately investigated. Moreover, HCFA's evaluations of carrier operations were not identifying these problems. Carrier officials also alleged that they lacked sufficient resources to thoroughly investigate all complaints of provider fraud and abuse.

To partially correct these problems, HCFA should implement its draft instructions to carriers for identifying and referring beneficiary complaints of provider fraud and abuse to carrier investigative units. Also, HCFA should more explicitly define for carriers the requirements for investigating beneficiary complaints of potential fraud and abuse and

[7] Carrier funding for responding to beneficiary inquiries is included in the beneficiary communications budgetary line item.

improve its carrier evaluation program in this area. Finally, HCFA should examine the adequacy of carrier funding for fraud and abuse detection efforts.

As noted in prior testimony,[8] we have found that budget reductions in the program safeguard area are undermining fraud and abuse detection activities and resulting in large program losses. We recommended that the Congress establish a Medicare funding procedure for enforcement activities, similar to that authorized by the Budget Enforcement Act of 1990 to fund Internal Revenue Service (IRS) compliance activities. The act provides for discretionary spending increases for IRS compliance funding outside of domestic discretionary funding caps.

Recommendations

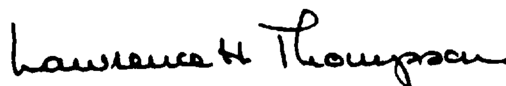
We recommend that the Secretary of HHS direct the Administrator of HCFA to

- implement draft instructions to carriers for identifying and referring beneficiary complaints of provider fraud and abuse to carrier investigative units,
- establish clear guidance to carriers for thoroughly investigating these complaints,
- require that HCFA's annual carrier evaluations be used to monitor a sample of beneficiary telephone calls to ensure that complaints of fraud and abuse are (1) properly identified by carrier staff who initially receive them and (2) referred to carrier investigative units, and
- examine the adequacy of carrier funding for fraud and abuse detection efforts and, if necessary, seek additional funding.

As agreed with your offices, we did not obtain written comments from HCFA on this report. However, we discussed our findings with HCFA officials and incorporated their comments where appropriate.

[8] Medicare: Further Changes Needed to Reduce Program Costs (GAO/T-HRD-91-34, June 13, 1991).

Copies of this report are being sent to other congressional committees, the Secretary of Health and Human Services, and other interested parties. This report was prepared under the direction of Janet L. Shikles, Director, Health Financing and Policy Issues, who can be reached on (202) 275-5451. Other major contributors are listed in appendix IV.



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Abbreviations

HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
IRS	Internal Revenue Service

Scope and Methodology

We performed work at Health Care Financing Administration headquarters in Baltimore and regional locations in Boston and Jacksonville. We also performed work at five Medicare carriers—Aetna Life and Casualty Company (Arizona field office), Blue Cross and Blue Shield of Florida, Blue Shield of Massachusetts, Blue Cross and Blue Shield of Texas, and Transamerica Occidental Life Insurance Company of California. These five carriers received about 25 percent of the 18.3 million calls beneficiaries made to carriers in fiscal year 1990. We visited the carriers in Florida and California at the Committee's request. We selected the remaining carriers with a view toward obtaining (1) a variety of geographical locations and (2) representation of both Blue Cross and Blue Shield organizations and other insurers. During fiscal year 1990, the investigative units at the carriers we visited had about 45 staff to investigate about 14,200 complaints of provider fraud and abuse. Carriers estimated that about 90 percent of these complaints originated from beneficiaries.

To determine if carriers identify and refer beneficiary complaints of provider fraud and abuse for investigation, we (1) reviewed carrier instructions for identifying and referring fraud and abuse complaints, (2) monitored, over several days and at different times of the day, 1,000 incoming beneficiary telephone calls (200 calls at each carrier), (3) identified the calls in which beneficiaries alleged provider fraud or abuse, and (4) determined whether carrier personnel identified and referred complaints to carrier investigative units.

To determine whether potential fraud and abuse complaints were thoroughly investigated by the five Medicare carriers, we (1) reviewed HCFA's instructions on how fraud and abuse complaints should be investigated, (2) reviewed a random sample of 155 beneficiary complaint cases for 1990 (about 30 cases at each carrier), (3) identified all cases where providers had two or more similar substantiated complaints filed against them within the last 2 years or where the current complaint strongly suggested fraudulent or abusive behavior, and (4) determined the final disposition of these cases.

To determine the impact of the proposed funding cuts on carrier fraud and abuse detection efforts, we (1) reviewed the administration's fiscal year 1992 budget submission for HCFA and (2) interviewed carrier and HCFA officials to obtain their views on this subject.

We conducted our work between November 1990 and April 1991 in accordance with generally accepted government auditing standards.

How Carriers Handled Complaints That Were Not Properly Referred for Investigation

Figures are number of complaints

Carrier	Instructed or allowed to settle with provider	Instructed to submit in writing	Not recognized as potential fraud/abuse	Other[a]	Total
Aetna Life and Casualty Co. (AZ)	2	4	0	0	**6**
Blue Cross and Blue Shield of Florida	1	5	0	1	**7**
Blue Shield of Massachusetts	1	0	0	0	**1**
Blue Cross and Blue Shield of Texas	1	0	1	0	**2**
Transamerica Occidental Life Insurance Co. (CA)	7	5	3	0	**15**
Total	**12**	**14**	**4**	**1**	**31**

[a]The carrier representative instructed the beneficiary to contact another carrier regarding the complaint but failed to give the beneficiary the carrier's address or telephone number.

How Carriers Handled Referred Cases Indicating Potential Fraud and Abuse

	Cases where providers had recent prior substantiated complaints[a]		Cases that strongly suggested fraudulent or abusive behavior	
Carrier	Fully investigated	Not fully investigated	Fully investigated	Not fully investigated
Aetna Life and Casualty Co. (AZ)	0	2	0	1
Blue Cross and Blue Shield of Florida	2	1	0	1
Blue Shield of Massachusetts	1	2	0	0
Blue Cross and Blue Shield of Texas	1	1	0	1
Transamerica Occidental Life Insurance Co. (CA)	0	2	0	0
Total	**4**	**8**	**0**	**3**

[a]Two or more similar, substantiated complaints in the past 2 years.

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