United States General Accounting Office

GAO Testimony

For Release
on Delivery
Expected at
9:30 a.m. EDT
October 2, 1991

MEDICARE: Improper Handling of Beneficiary Complaints of Provider Fraud and Abuse

Statement of
Janet L. Shikles, Director
Health Financing and Policy Issues
Human Resources Division

Before the
Special Committee on Aging
United States Senate

SUMMARY

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. 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 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 are the part B beneficiaries. No one has a greater stake in protecting part B benefits than the program's 33 million beneficiaries. For every dollar wasted, the beneficiary risks potential cutbacks in program coverage, increased out-of-pocket expenses for deductibles and coinsurance, and increased Medicare premiums.

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, even though the beneficiary has described the complaint in detail over the telephone, or to resolve them with providers.

Further, when complaints are referred, carrier investigative units often do not fully investigate those that contain substantial indications 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.

GAO recommends that HCFA (1) improve its guidance to carriers on identifying, referring, and investigating beneficiary complaints of potential fraud and abuse, (2) improve its annual carrier evaluations to ensure that complaints are properly handled, and (3) examine the adequacy of carrier funding for fraud and abuse detection efforts.

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss Medicare's responsiveness to beneficiary complaints of provider fraud and abuse. My comments and the report we are releasing today, Medicare: Improper Handling of Beneficiary Complaints of Provider Fraud and Abuse (GAO/HRD-92-1), focus on weaknesses we identified in Medicare carriers' fraud and abuse detection efforts and the Health Care Financing Administration's (HCFA's) oversight of these carrier operations.

This fiscal year, Medicare is expected to pay benefits of about $115 billion, making it the nation's largest payer for health care services and fourth largest category of federal expenditures. The fastest growing portion of Medicare is part B, which covers physician services, outpatient hospital services, durable medical equipment, and various other health services.

Protecting against provider fraud and abuse is essential to the program's efficient operation. No one has a greater stake in obtaining this protection than the program's 33 million beneficiaries. For every dollar wasted, beneficiaries risk potential cutbacks in program coverage, increased out-of-pocket expenses for deductibles and coinsurance, and increased premiums for both Medicare and supplemental insurance.

At your request, Mr. Chairman and Senator Cohen, we reviewed how five Medicare carriers--contractors who process and pay part B claims--receive and investigate beneficiary complaints of provider fraud and abuse. At the carriers, we monitored 1,000 incoming beneficiary telephone calls over several days and reviewed a random sample of 155 beneficiary complaint cases the carriers had investigated.

BACKGROUND

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. The statement asks the beneficiary to call the carrier immediately if he or she did not receive the identified services or if other errors exist. Thus, the program's 33 million beneficiaries 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. When investigations confirm potential fraud or abuse, carriers are

required to refer these cases to the Department of Health and Human Services (HHS) Office of Inspector General for further investigation and possible punitive action.

HCFA monitors the quality of carrier fraud and abuse detection efforts through its carrier evaluation program. 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

Fifty-six 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. HCFA officials told us that, for a complaint to be properly handled, carrier personnel should record it 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 telephone, or to resolve the problem with the provider. In other cases, the beneficiary offered to resolve the problem with the provider. Further, carrier staff did not recognize some complaints as potential fraud and abuse.

For example, 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

Most of the 155 complaint cases in our sample involved 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 the beneficiaries or Medicare.

Let me share one example of the type of situation we're talking about. A 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. That same day, several medical equipment items were delivered to her home by a supplier. The beneficiary called the supplier the following 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. 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.

INADEQUATE HCFA GUIDANCE AND OVERSIGHT CONTRIBUTES TO PROBLEMS

HCFA requires carriers to develop instructions for carrier staff who initially receive beneficiary complaints of provider fraud and abuse on how to identify and refer these complaints for investigation. The instructions of the five carriers we visited were generally confusing, inconsistent, or incomplete. In September 1991, HCFA officials gave us draft instructions that would require carrier personnel to record complaints and forward them to the carrier's investigative unit. Implementing these draft instructions should help correct the problems we identified in this area.

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. 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.

HCFA's instructions to carriers on investigating beneficiary complaints do not provide adequate guidance on when and how to more fully investigate beneficiary complaints of provider fraud

and abuse. As a result, carriers made subjective decisions about when an expanded investigation should be performed and what additional steps an expanded investigation should include.

Carrier officials told us that they lacked enough resources to conduct expanded investigations of each complaint that was not an error or misunderstanding or to perform beneficiary surveys[1] for each complaint in which the provider's history and prior complaints suggested potential fraud and abuse. In some cases the carriers we visited decided not to conduct an expanded investigation or perform a beneficiary survey even though the evidence seemed to warrant such actions.

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.

When complaints are handled properly, the benefits can be significant. For example, in 1986, several beneficiaries in

---

[1]Contacting a sample of other beneficiaries who received similar services from the same provider to determine if other indications of potential fraud exist.

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. The carrier expanded its review to over 100 additional beneficiaries who had received similar services and found the billing agent had submitted about 300 fraudulent claims. 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 over $2.5 million to the federal government.

CONCLUDING REMARKS

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 improve its carrier evaluation program in this area.

Finally, HCFA should examine the adequacy of carrier funding for fraud and abuse detection efforts and, if necessary, seek additional funding. As noted in prior testimony,[2] we found that budget reductions in the program safeguard area undermine fraud and abuse detection activities and result 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.

- - - -

Mr. Chairman, this concludes my prepared statement. My colleagues and I will be pleased to answer any questions you and the other members of the Committee may have.

---

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