

GAO

Report to the Ranking Minority Member,  
Committee on Commerce, House of  
Representatives

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January 1996

# FRAUD AND ABUSE

## Providers Target Medicare Patients in Nursing Facilities







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

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**Health, Education, and  
Human Services Division**

B-255730

January 24, 1996

The Honorable John D. Dingell  
Ranking Minority Member  
Committee on Commerce  
House of Representatives

Dear Mr. Dingell:

At recent congressional hearings on efforts to trim billions of dollars from the rapidly growing Medicare program, we testified on the program's vulnerabilities to waste, fraud, and abuse.<sup>1</sup> Among the major weaknesses is the Health Care Financing Administration's (HCFA) inadequate array of controls—both for detecting billing abuses and for ensuring the legitimacy of providers billing the Medicare program.<sup>2</sup>

One of your concerns focused on the numerous allegations of fraud and abuse related to services provided to Medicare patients in nursing facilities.<sup>3</sup> In 1995, physicians, medical equipment companies, laboratories, and other providers were reimbursed an estimated \$5.5 billion for the services and supplies they furnished Medicare patients in nursing facilities. Because some portion of this amount is likely to have been paid unnecessarily, you asked us to review (1) the nature and extent of fraud and abuse related to services and supplies provided to nursing facility patients, (2) the conditions that make the provision of services and supplies to nursing facility patients an attractive opportunity for wrongdoers, and (3) options for removing such opportunity.

For this review, we interviewed officials at HCFA, Medicare claims processors, HHS Office of Inspector General (OIG), and several national organizations representing the nursing home industry and providers of services and supplies. We also analyzed documents for ongoing and recently completed investigations by Medicare claims processors and OIG, and interviewed investigators working on those cases to identify factors leading to fraudulent and abusive billing situations. Our work was done between April 1994 and August 1995 in accordance with generally

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<sup>1</sup>See Related GAO Products at the end of this report.

<sup>2</sup>Within the U.S. Department of Health and Human Services (HHS), HCFA establishes regulations and policy guidance for the Medicare program.

<sup>3</sup>In this report, the term "nursing facility" is used to describe a nursing home that could provide services ranging from skilled care for patients with complex medical or rehabilitative needs to custodial care for those patients needing assistance with activities of daily living.

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accepted government auditing standards. Further details of our scope and methodology are provided in appendix I.

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## Results in Brief

Although most providers are honest and bill appropriately, a wide array of provider types—including durable medical equipment suppliers, laboratories, physicians, optometrists, and psychiatrists—have been involved in the fraudulent or abusive billing of Medicare for services and supplies furnished to nursing facility patients. The wrongdoing has generally focused on billing Medicare for unnecessary or undelivered services, or misrepresenting a service to obtain reimbursement. The investigations we reviewed probed activities in over 40 states, with many providers operating in multiple states. Although not quantifiable, the evidence suggests that such fraud and abusive billing activities are frequent and widespread.

Several features make Medicare beneficiaries in nursing homes an attractive target for fraudulent and abusive activity. First, because a nursing facility locates individual Medicare beneficiaries under one roof, unscrupulous billers of services can operate their schemes in volume. Second, in some instances, nursing facilities make patient records available to outside providers who are not responsible for the direct care of the patient, contrary to federal regulations which prohibit such inappropriate access. In such cases, nursing facilities—however inadvertently—enable exploitative providers to obtain the information on Medicare beneficiaries that they need to bill Medicare.

Third, under HCFA's provisions for reimbursement, providers can bill Medicare directly, without the nursing facility or attending physician affirming whether the items were necessary or provided as claimed. Nor is the scrutiny at the claims processor level adequate. Medicare's automated systems do not accumulate data that would flag timely indications of improbably high charges or levels of services. As a result, Medicare claims processors miss opportunities to avoid paying out large sums unnecessarily and to track schemes exploiting groups of vulnerable beneficiaries. Finally, even when Medicare detects abusive billings and seeks recovery of unwarranted payments, it often receives little repayment from the wrongdoers who either go out of business or deplete their resources so that they lack the resources to repay the funds.

Medicare needs to change the way it reimburses for services and supplies provided to beneficiaries residing in nursing facilities. Because these

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facilities have a primary role in planning their residents' care, they are in the best position to monitor the provision of services and supplies. Although options exist for such involvement of nursing facilities, all require structural—and therefore long-term—changes. In the meantime, certain incremental changes would make the nursing facility environment less hospitable to fraudulent or abusive billing activities. These changes include instituting penalties at the federal level for the unauthorized disclosure of patients' medical records and programming various early warning controls in Medicare's claims processing systems to better detect fraud and abusive billings before claims are paid.

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## Background

As the nation's largest health care payer, Medicare provides health insurance coverage to over 36 million elderly and disabled Americans. Medicare part A covers inpatient care in a hospital or skilled nursing facility and home health or hospice care. The care in skilled nursing facilities that part A covers—for which Medicare paid an estimated \$6.6 billion in 1995—is limited to relatively short stays for patients who need daily skilled care following hospitalization. Most elderly people in nursing facilities do not qualify for part A coverage.

Medicare part B covers physician services, outpatient hospital services, durable medical equipment, and various other health services. Although the vast majority of Medicare patients in nursing facilities do not require skilled nursing care, they are entitled to the full range of services and supplies covered by the Medicare part B program when part A does not pay for the nursing facility services themselves.<sup>4</sup> This care is usually billed directly to Medicare by the providers who serve these patients. In 1995, Medicare paid an estimated \$5.5 billion for services and supplies furnished to patients in nursing facilities.

HCFA contracts with insurers, such as Blue Cross and Blue Shield plans, Aetna, and The Travelers Insurance Company, to process and pay claims submitted by providers. These contractors—referred to as carriers under Medicare part B—are responsible for the monitoring and analysis of claims both before and after payment to ensure that Medicare dollars are used to pay only reasonable and necessary claims. Carriers' automated claims processing systems include computerized controls, or screens, that screen claims for diagnosis coding errors, billing abuses, and incorrect or incomplete documentation. Some controls deny or adjust claims payments automatically without human intervention. Others flag claims for further

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<sup>4</sup>Stays in nursing facilities are primarily paid by the individual or Medicaid.

review by carrier personnel if the claims do not conform to payment criteria or are submitted by a provider under carrier scrutiny.

Nursing facility patients—many of whom are cognitively impaired—rely on the facility to manage their care needs. Under the nursing home reform provisions established by the Omnibus Budget Reconciliation Act of 1987, nursing facilities have a major role in designing plans of care for each of their patients. The act imposed requirements that nursing facilities provide those services and activities necessary to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Upon a patient's admission to a facility, a registered nurse must conduct or coordinate a comprehensive assessment of medical, nursing, mental, and psychosocial needs. The facility must then develop a comprehensive plan of care for the patient that includes measurable objectives and timetables to meet the patient's needs identified in the comprehensive assessment. Each assessment must be reviewed at least every 3 months; any revisions must be reflected in the corresponding plan of care.

## Instances of Wrongful Billing Suggest Widespread Activity

Fraudulent and abusive practices by some providers who furnish services and supplies to nursing facility patients entail billing Medicare for unnecessary or undelivered services and supplies or misrepresenting a service or supply item to obtain Medicare reimbursement as the following examples show:

- A company billed Medicare for heart monitoring services provided to nursing facility patients. The diagnoses entered on the Medicare claims forms by the laboratory were false and did not reflect the patients' condition at the time services were ordered and rendered. Medicare overpaid this company an estimated \$4.3 million.<sup>5</sup>
- An optometrist filed Medicare claims for services either not medically necessary or not provided to nursing facility patients from 1991 through 1993. Medicare paid this practitioner over \$190,000 for these services.
- A supplier billed Medicare for ostomy, enteral, and surgical dressing supplies that it had not delivered and forged the attending physicians' signatures on the certificates of medical necessity using samples of signed orders found in patients' files. This case involved about 4,000 fraudulent claims totaling about \$1.5 million.

<sup>5</sup>An additional \$655,000 approved for payment was withheld by the Medicare claims processing contractor once the contractor had identified the problem.

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These fraudulent and abusive activities involve a wide array of provider types, including ambulance service companies, dentists, medical equipment suppliers, general practitioners, internists, laboratories, optometrists, podiatrists, psychiatrists, and psychologists. The actual extent of the problem cannot be quantified, but the evidence suggests that it is widespread.<sup>6</sup> Our review of ongoing and completed investigations by Medicare carriers and HHS OIG included cases encompassing at least 41 states, the District of Columbia, and Puerto Rico. Thirty of the providers in these cases operated in multiple states as these examples illustrate:

- A supplier currently under investigation for allegedly billing Medicare for surgical dressing kits and components that were not provided or medically necessary operates in at least 20 states.
- Another supplier with offices in at least seven states billed Medicare for incontinence supplies that were inflated in price, not provided, or not medically necessary.<sup>7</sup>
- Another company under investigation for inappropriately billing Medicare for heart monitoring services operates in at least 11 states.

Because data on fraud and abuse have not been accumulated based on place of service, investigators cannot quantify the extent of Medicare fraud and abuse involving the provision of services and supplies to nursing facility patients. Medicare carriers and OIG officials believe, however, that fraud involving services provided in nursing facilities is significant. In 1994, the Senate Special Committee on Aging reported a considerable number of cases involving the targeting of nursing facility patients by industries that supply products and services directly to them.<sup>8</sup> Also in 1994, OIG reported on a completed investigation in which Medicare had paid over \$7.4 million to a billing company (representing 70 nursing facilities in 7 states) that had billed for surgical dressings supplied to nursing facility patients who had had no surgery. And in February 1995 testimony before the House Committee on Ways and Means, Subcommittee on Health, the Inspector General reported that about half of the \$230 million Medicare approved in 1993 nationally for incontinence

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<sup>6</sup>See app. II for examples of closed fraud investigations.

<sup>7</sup>The controller of the parent company recently pled guilty to submitting more than \$4.4 million of false and fraudulent claims to one Medicare carrier and similarly submitting millions of dollars of bogus claims to other carriers.

<sup>8</sup>Gaming the Health Care System, Billions of Dollars Lost to Fraud & Abuse Each Year, Investigative Staff Report of Senator William S. Cohen, Ranking Minority Member, Senate Special Committee on Aging (July 7, 1994).

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supplies was questionable. The Inspector General noted that “the potential for great profit provides an incentive for fraudulent marketing and billing schemes which target the entire nursing home population of Medicare beneficiaries.”<sup>9</sup>

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## Services Provided at Nursing Facilities Susceptible to Fraud and Abuse

The nursing facility setting can be an inviting target of opportunity for the unscrupulous provider of part B services and supplies. First, a vulnerable population grouped together at a single location offers the opportunity for volume billing. Second, HCFA’s provisions for reimbursing providers of these part B services and supplies furnish little early warning of egregious overutilization or rapid increases in billings.

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## Nursing Facilities Do Not Always Monitor Services or Supplies Furnished by Outside Providers

Federal requirements call for nursing facilities to perform numerous tasks to monitor and meet patient care needs, but there are no similar requirements to monitor claims submitted directly to Medicare for services or supplies provided to nursing facility patients. HCFA’s reimbursement system for part B services and supplies allows providers to bill Medicare without adequate confirmation that the care or items were necessary or were delivered as claimed. As a result, the program is highly vulnerable to exploitation. Also, despite the emphasis on patient care, the cases we reviewed demonstrate that nursing facilities often do not control provider access to records closely enough and opportunists are permitted to exploit Medicare.

Nursing facilities generally do not have the in-house capability to provide all the services and supplies that patients need. Accordingly, outside providers market their services and supplies to nursing facilities to meet the needs of the facilities’ patients. OIG has reported that provider representatives typically enter nursing facilities and offer to handle the entire transaction—from reviewing medical records to identify those patients their products or services can help, to billing Medicare—with no involvement by nursing facility staff.<sup>10</sup> Some facilities allow providers or their representatives to review patient medical records despite federal

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<sup>9</sup>Statement by Michael Mangano, Principal Deputy Inspector General, Office of Inspector General, HHS, for Oversight Hearings Before the House of Representatives, Committee on Ways and Means, Subcommittee on Health (Feb. 6, 1995).

<sup>10</sup>See Marketing of Orthotic Body Jackets (OEI-04-92-01081, Mar. 1994) and Marketing of Incontinence Supplies (OEI-03-94-00770, Dec. 1994).

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regulations that prohibit such unauthorized review.<sup>11</sup> These representatives gain access to records not because they have any responsibility for the direct care of those patients, but because they want to market their services or supplies. We found that unscrupulous providers can obtain all the information necessary to order, bill, and be reimbursed by Medicare for services and supplies that are in many instances not necessary or even provided. The following are two examples of this practice:

- A supplier obtained a list of Medicare patients at three nursing facilities together with their Medicare numbers from another supplier who had access to specific Medicare billing information for certain patients at these facilities. The first supplier billed Medicare for large quantities of supplies that were never provided to these patients and then paid the second supplier half of the approximately \$814,000 it received in reimbursement.
- A group optometrical practice performed routine eye examinations on nursing home patients, a service not reimbursable by Medicare. The optometrist was always preceded by a sales person who targeted the nursing facility's director of nursing or its social worker and claimed the group was offering eye examinations at no cost to the facility or the patient. The nursing facility gave the sales person access to patients' records, and this person then obtained the information necessary to file claims. Nursing staff would obtain physicians' orders for the "free" examinations, and an optometrist would later arrive to conduct the examinations. The billings to Medicare, however, were for services other than eye examinations—services that were never furnished or were unnecessary.

The OIG and HHS attorneys with whom we spoke agreed that granting providers of services and supplies unauthorized access to medical records contributes to fraud and billing abuse.<sup>12</sup> They stated that except in specific cases in which a resident's safety is jeopardized as a result, HHS lacks clear authority to impose monetary or other penalties on nursing facilities solely for providing such access.

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<sup>11</sup>Based on 42 CFR 483.75(1)(4), all information contained in the patients' records must be kept confidential except when release is required by (1) transfer to another health care institution; (2) law; (3) third party payment contract; or (4) the resident.

<sup>12</sup>OIG refers to this practice in an August 1995 Special Fraud Alert entitled, "Fraud and Abuse in the Provision of Medical Supplies to Nursing Facilities."

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## Little Chance of Timely Detection of Excessive Medicare Reimbursements

Although carriers employ a number of effective automated controls to prevent or remedy some inappropriate payments, such as suspending claims for further review that do not meet certain conditions for payment, our work shows that outlandish charges or very large reimbursements routinely escape the controls and typically go unquestioned. The carriers we reviewed had not put any “triggers” in place that would halt payments when cumulative claims exceed reasonable thresholds.

Our analysis showed that as a result, Medicare has reimbursed providers, who were subsequently found guilty of fraud or billing abuses, large sums of money over a short period without the carrier becoming suspicious. The following examples highlight the problem:

- A supplier submitted claims to a Medicare carrier for surgical dressings furnished to nursing facility patients. In the fourth quarter of 1992, the carrier paid the supplier \$211,900 for surgical dressing claims. For the same quarter a year later, the contractor paid this supplier more than \$6 million without becoming suspicious despite a 2,800-percent increase in the amount paid.
- A carrier’s payments for a supplier’s body jackets claims averaged about \$2,300 per quarter for five consecutive quarters, then jumped to \$32,000, \$95,000, \$235,000, and \$889,000 over the next four quarters, with no questions raised by the carrier.<sup>13</sup>

In other instances, we found that providers subsequently investigated for wrongdoing billed and were paid for quantities of services or supplies that could not possibly have been furnished or necessary as these examples illustrate:

- A carrier reimbursed a clinical psychology group practice for individual psychotherapy visits lasting 45 to 50 minutes when the top three billing psychologists in the group were allegedly seeing from 17 to 42 nursing facility patients per day. On many days the leading biller of this group would have had to work more than 24 uninterrupted hours to provide the services he claimed.
- A carrier paid a podiatrist \$143,580 for performing surgical procedures on at least 4,400 nursing facility patients during a 6-month period. For these services to be legitimate, the podiatrist would have had to serve on average at least 34 patients per day, 5 days per week.

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<sup>13</sup>A body jacket is a custom-fitted spinal brace made of a rigid plastic material that conforms to the body and provides a high degree of immobility.

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The Medicare carriers in these two cases did not become suspicious until they received complaints from family members, beneficiaries, or competing providers. In other cases, the carriers initiated their investigations because of their analysis of paid claims (a practice referred to as postpayment medical review), which focuses on those providers that appear to be billing more than their peers for specific procedures. One carrier, for instance, reimbursed a laboratory \$2.7 million in 1991 for heart monitoring services allegedly provided to nursing facility patients and \$8.2 million in 1992. The carrier was first alerted in January 1993 through its postpayment review efforts when it noted that this laboratory's claims for monitoring services exceeded the norm for its peers.

In all these cases, the large increases in reimbursements over a short period or the improbable cumulative services claimed for a single day should have alerted carriers to the possibility that something unusual was happening and prompted an earlier review. For example, people do not usually work 20-hour days, and billings by a provider for a single procedure do not typically jump 13-fold from one quarter to the next or progressively double every quarter.

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## Limited Recovery of Losses

Although Medicare carrier postpayment reviews do lead to fraud and billing abuse investigations, from the perspective of curtailing fraudulent or abusive billing activities, we found that these reviews often happen too late. In all the cases cited previously, the carriers did investigate the providers, but by the time the investigations began, Medicare had already made millions of dollars in unwarranted payments. The risk to the Medicare program, as evidenced by the fraud cases we reviewed, is that relatively little of the money inappropriately paid out is recovered as the following examples show.<sup>14</sup>

- The owners of a company that had received over \$4.3 million from Medicare based on fraudulent claims for heart monitoring argued before the court that \$250,000 was the most they could repay. In the settlement agreement, they agreed to reimburse Medicare \$250,000, plus interest, and be excluded from the Medicare program for 5 years.
- The optometrist mentioned previously who billed for services never rendered and for undocumented consultations agreed, in a civil settlement, to refund \$30,000 to Medicare over a 35-month period and to

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<sup>14</sup>See also our testimony on this subject, Medicare: Modern Management Strategies Needed to Curb Program Exploitation (GAO/T-HEHS-95-183, June 15, 1995).

be excluded from the program for 3 years. Although Medicare had reimbursed this provider over \$450,000 on the basis of false or misleading claims, the case was settled for less because the provider had no assets from which the overpayments could be recovered.

- Several companies under investigation since early 1993 for the submission of false claims for heart monitoring services have billed Medicare large sums over a 6- to 9-month period and then have gone out of business when Medicare began making billing inquiries. For example, within a month of Medicare's contacting one company for medical records, the company—which had already been paid at least \$1.4 million—closed its operations making it unlikely that Medicare can recover inappropriate payments.

## Options for Reimbursing Part B Claims for Services Provided to Nursing Facility Patients

Our analysis showed that a major contributing factor to fraudulent and abusive billings for services and supplies provided nursing facility patients is that no one is ensuring that what is billed for is necessary or actually provided. Because nursing facilities already have a significant role in planning and providing patient care, they are the likely entity to scrutinize providers' reimbursement claims for services administered to the facilities' patients.

Several options for making nursing facilities accountable for costs incurred on behalf of their patients were suggested during our discussions with federal officials and such nursing facility industry representatives as the American Health Care Association. Each option would require a basic change in the way Medicare reimburses part B services and supplies provided to nursing facility patients:

- **Unified billing by the nursing facility:** Under this approach, the nursing facility would bill Medicare for all services it is authorized to furnish to patients, whether payment is sought from part A or B. This would be the case whether the facility provided the care itself or contracted for the services or supplies to be provided by someone else. Outside providers would be prohibited from billing Medicare directly and would, in effect, have to have agreements with nursing homes. Absent an agreement, the nursing facility could not bill Medicare because it would not be financially liable or medically responsible for the care. By contrast, under the current system, outside providers can bill Medicare directly, without scrutiny by anyone where the care is delivered. Unified billing by the nursing facility would make it easier for Medicare to identify all the services furnished to

residents, which in turn would make it easier to control payments for those services.

- **Capping payments:** An alternative to paying on a fee-for-service basis as Medicare now does is to pay a fixed amount per beneficiary. This approach mirrors the payment method Medicare uses to reimburse most health maintenance organizations (HMO) serving Medicare beneficiaries.<sup>15</sup> As with HMOs, Medicare would pay the nursing facility a fixed amount per month for all part B services and supplies provided to each resident beneficiary.<sup>16</sup> A variant, one that would apply only to skilled nursing facilities, would mirror the way Medicare pays hospitals for inpatient care. As with hospitals, Medicare would pay nursing facilities a predetermined fixed amount per patient based on the type of case or diagnosis-related group into which the patient is classified. Both variants of the capped payment approach would, by definition, limit Medicare outlays for these services, eliminating providers' incentive to provide too many services. By the same token, the incentive for nursing facilities to profit from accepting fixed payments while providing fewer services than necessary would need to be addressed. A further difficulty in these approaches is in establishing reasonable rates given the wide range of services provided individual nursing facility patients.

## Conclusions

Under Medicare neither the nursing facility nor the physician ensure that the services and supplies outside providers claim to have furnished to beneficiaries in nursing facilities are in fact necessary and actually provided. As a result, services provided to Medicare beneficiaries in nursing facilities offer a target of opportunity for the fraudulent schemes and billing abuses of the dishonest provider. To address the root cause of this accountability issue, Medicare needs to change the way it reimburses for services and supplies furnished patients in nursing facilities. Options range from those that can be implemented in the short term, such as allowing only nursing facilities to bill for all services and supplies provided to their patients, to the more difficult long-term solutions, such as capitation or prospective payment systems. All these options address the

<sup>15</sup>HMOs were designed to offer health services less expensively and to constrain the provision of extensive services, primarily through a reimbursement method known as capitation. Under capitation Medicare pays HMOs a fixed amount per month for each beneficiary. This method typically places HMOs at risk for health costs, thereby giving them a financial incentive to control the use of services and avoid unnecessary care. HMOs may use their own staff of physicians and other providers to deliver care or may contract with individual providers or medical groups to deliver services.

<sup>16</sup>The current method for reimbursing risk contract HMOs is not without its problems. See Medicare Managed Care: Program Growth Highlights Need to Fix HMO Payment Problems (GAO/T-HEHS-95-174, May 24, 1995).

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accountability issue, but more study is needed to assess the comparable costs and benefits of these options.

Certain immediate actions would help stem losses. First, carriers could establish computerized payment controls that, before payment, would detect and automatically suspend for further review claims that exceeded established thresholds for charges and utilization. The thresholds need not be based on statistical averages, but they should be based on an assumption about what is reasonable activity for specific procedures, provider types, beneficiaries, and places of service. Such controls could provide timely warnings and trigger investigations of potentially fraudulent and abusive billings before large sums were paid out. Second, nursing facilities should be held accountable for the unauthorized disclosure of patient medical records. Giving providers or their representatives inappropriate access to patient medical records was a major contributing cause to the fraud and abuse cases we reviewed. Although such disclosure is contrary to program regulations, HCFA or HHS generally cannot levy penalties, monetary or otherwise, against a nursing facility for that unauthorized disclosure.

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## Recommendation to the Congress

To curtail the practice of giving providers unauthorized access to beneficiary medical records, the Congress should authorize HHS OIG to establish monetary penalties that could be assessed against nursing facilities that disclose information from patients' medical records not in accord with existing federal regulation.

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## Recommendations to the Secretary of HHS

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

- establish, for procedure billing codes by provider or beneficiary, thresholds for unreasonable cumulative levels or rates of increase in services and charges, and to require Medicare carriers to implement automated screens that would suspend for further review claims exceeding those thresholds; and
- undertake demonstration projects designed to assess the relative costs and benefits of alternative ways to reimburse nursing facilities for part B services and supplies; these alternatives should include such options as unified billing by the nursing facility and some form of capped payment.

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## Agency Comments

We provided HHS an opportunity to comment on our draft report, but it did not do so in time for comments to be included in the final report. We did discuss the report's contents with HCFA officials who generally agreed with our findings.

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As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 15 days from the date of this letter. At that time, we will send copies of this report to the Secretary of HHS, the Administrator of HCFA, interested congressional committees, officials who assisted our investigation, and other interested parties. We will also make copies available to others upon request.

Please call me at (202) 512-7119 or Donald B. Hunter or Roland A. Poirier, Jr. at (617) 565-7500 if you have any questions.

Sincerely yours,



Edwin P. Stropko  
Associate Director  
Health Financing Issues

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# Contents

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Letter	1
Appendix I Scope and Methodology	16
Appendix II Closed Fraud Case Summaries	18
Case A	18
Case B	19
Case C	20
Case D	21
Case E	22
Case F	23
Case G	24
Case H	25
Related GAO Products	28

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## Abbreviations

EKG	electrocardiogram
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
OIG	Office of the Inspector General

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# Scope and Methodology

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To develop the information in this report, we interviewed officials at HCFA's central office and the HHS Office of the Inspector General in Baltimore; three Medicare carriers responsible for processing part B claims in 9 geographic areas; three regional OIG Offices of Investigations with combined investigative jurisdiction over 17 states; one durable medical equipment regional carrier responsible for processing durable medical equipment, prosthetic, orthotic, and supply claims in 14 states and 2 U.S. territories; and trade associations representing both the nursing home industry and providers of services and supplies. Because information we obtained from the three Medicare carriers and OIG offices involves cases under active investigation, we did not disclose the locations of these offices nor did we reveal identifying details about these cases, such as the providers' names and the states in which they operate.

To examine the nature and extent of inappropriate and abusive billing for services and supplies to nursing facility patients, we (1) asked the carriers' fraud units to identify cases involving services and supplies provided to patients in nursing facilities—both ongoing cases and those referred to OIG in the previous 24 months;<sup>17</sup> (2) performed a detailed file review of each identified case and obtained and reviewed copies of relevant documents; (3) discussed cases with carrier officials, as needed, and met with OIG officials to discuss the status of cases that carriers had referred to them for investigation; and (4) asked OIG officials to identify any additional investigations completed within the previous 12 months and ongoing investigations dealing with services and supplies furnished to Medicare patients in nursing facilities. In all, we reviewed 70 ongoing or completed investigations. Nearly all of these investigations were initiated by either the carrier or OIG offices during the 1992 to 1994 time frame. We interviewed carrier and OIG officials. We also reviewed several independent studies related to the provision of services and supplies to nursing facility patients done by OIG and the Senate Special Committee on Aging.

To examine the reasons inappropriate and abusive billings for services and supplies occur in the nursing facility setting, we reviewed carrier case files for each investigation, obtained court documents when applicable, and interviewed carrier and OIG investigators working on those individual cases. We analyzed this information to try to identify the specific programmatic factors that make services for beneficiaries in nursing facilities vulnerable to fraud and abuse.

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<sup>17</sup>The carriers we visited could not reliably identify all cases under investigation that involved the provision of services and supplies by outside providers to nursing facility patients. Carriers, accordingly, had to rely on memory when we asked them to identify such cases.

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**Appendix I**  
**Scope and Methodology**

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Finally, to identify options for removing opportunities for fraud and abuse, we reviewed the literature and held discussions with carrier, OIG, and trade association officials to solicit their views on ways to minimize fraud and abusive billing practices in the nursing facility environment.

We conducted our review between April 1994 and August 1995 in accordance with generally accepted government auditing standards.

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# Closed Fraud Case Summaries

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Following are summaries of fraud cases that were closed by the time we completed our review. The defendants pled guilty or were convicted of the charges brought against them.

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## Case A

In August 1991, a carrier received the first of three complaints from Medicare beneficiaries alleging that an optometrist was billing Medicare for more services than he actually provided. After reviewing the supporting medical records, however, the carrier determined that for these instances the services were documented as billed. In December 1991, another beneficiary called the carrier and stated that she had not received the office services claimed by this optometrist and in fact had not seen any physician during the month he claimed services were provided. Another complaint was received from the daughter of a beneficiary residing in a nursing home. The daughter stated that she had only authorized an eye examination, but the charges submitted to Medicare were for multiple services provided for both eyes—although her father had only one eye. In January 1992, the carrier's claims processing department alerted the carrier's program integrity unit of 98 suspicious claims submitted by this provider for services allegedly rendered in December to nursing home patients. All the claims cited exactly the same procedure codes and diagnoses; the only differences were dates of service and beneficiary identification information. From this universe, the carrier randomly sampled 10 beneficiary records from two nursing homes and found that the nursing homes had no records documenting the services claimed by this optometrist. On May 21, 1992, the carrier summarized this information and referred the case to OIG. By that time, Medicare had paid this provider \$117,534 since 1990.

OIG notified the carrier in June 1992 that it would not pursue this case criminally but that it would retain jurisdiction for civil prosecution. At OIG's request, the carrier placed this provider on 100-percent prepayment review by the end of July, which meant that every claim the provider submitted was reviewed before payment was issued. Additionally, the carrier completed a postpayment review on this provider's billings and reported in January 1993 that medical necessity appeared questionable for many claims and that nursing home visits and consultation requests were not documented. The optometrist requested a hearing before the Medicare hearing officer to review the carrier's continuing reimbursement denials. The hearing officer ruled in November 1993 that all 157 claims submitted for diagnostic eye services for 154 nursing home patients between August and October 1992 were questionable. The carrier had denied all but three

of these claims, but the hearing officer ruled that these too were overpaid. According to carrier files, the optometrist was still on prepayment review in March 1994. Although the optometrist's billing volume had significantly decreased, the carrier noted that he continued to bill for the same type of procedures previously denied. As late as October 1994, the carrier was still receiving complaints about this provider.

On January 16, 1995, the optometrist signed a settlement agreement in U.S. District Court whereby he admitted to knowingly filing false, misleading, or otherwise fraudulent Medicare claims for services either not medically necessary or not provided from 1991 through 1993 for which Medicare had paid him over \$191,276. Under this agreement he would repay \$35,000 and be excluded from the Medicare program for at least 3 years. The exclusion would extend for as long as the \$35,000 assessed against him was not repaid.

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## Case B

A beneficiary's husband complained to the Medicare carrier that a supplier was billing Medicare for more supplies than it actually provided for his wife. The carrier referred this case to OIG, which opened its investigation on December 7, 1990. The company in question focused on publicly funded facilities in several states, such as state veterans homes or state-funded chronic disease or long-term care hospitals. The owner would approach facility administrators and offer to provide supplies for Medicare patients at no cost to the facility. This was an attractive proposition to these facilities, which typically have limited financial resources. The facility administrators gave the provider complete access to patient medical records. The suppliers reviewed all records, identified Medicare beneficiaries, obtained their Medicare numbers, developed lists of supplies based on diagnoses, identified attending physicians, and made copies of signed physician orders in the files. The supplier then billed Medicare for ostomy, enteral, or surgical dressing supplies that it delivered after September 1990, but it also billed for supplies it had never delivered to those beneficiaries over the previous 2 years. The supplier provided certificates of medical necessity by forging the attending physicians' signatures on the certificates using samples of signed orders found in the patients' files. The case involved about 4,000 fraudulent claims totaling about \$1.5 million.

The defendant was indicted on April 6, 1994, and pled guilty on May 5, 1994, to mail fraud, engaging in monetary transactions in criminally derived property, money laundering, and Medicare fraud. The defendant

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agreed to forfeit all property resulting from these fraudulent transactions, including about \$328,000 in several bank accounts. The defendant was sentenced on October 19, 1994. This judgment was amended on November 21, 1994, to finalize the overpayment amounts. He was sentenced to 54 months in federal prison. Upon release from imprisonment, the defendant would be on supervised release for a term of 3 years provided he had made restitution as ordered by the court of \$971,000 to Medicare and \$60,000 to Medicaid.

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## Case C

A Medicare carrier's fraud and abuse unit received over 30 complaints from beneficiaries, family members, and other informants that a provider was billing for supplies that had not been furnished or were not needed. In August 1991, the carrier referred the case to OIG for investigation. OIG found that from April through June 1991, the provider filed claims totaling \$666,560 on behalf of 1,096 beneficiaries for 65,833 liquid skin barriers. In addition, the provider filed claims totaling \$11,406 on behalf of 319 beneficiaries for 1,210 adhesive removers or solvents. Medicare had paid the provider a total of \$263,222 for both items, and most of the claims were for beneficiaries who were residing in nursing homes in another state. In addition to the payments made, the carrier was withholding payment on 9,500 claims totaling about \$3.5 million.

OIG visited the provider and found that the provider rented a small office and apparently did not furnish any supplies from this location. The provider, in effect, was a storefront operation or shell company. OIG believed the supplies originated from the provider's parent company located in another state that also owns supply companies in at least six other states. On the basis of its investigation, OIG believed the provider had (1) billed Medicare for items that were not supplied, (2) misrepresented the items that were supplied, (3) misrepresented the place of service, (4) misrepresented the medical conditions of patients who received the supplies, and (5) paid kickbacks to nursing home officials to induce business. Also, OIG found that the provider gained access to patient medical records, obtaining diagnostic information and the names of beneficiaries' attending physicians. The provider then entered the physicians' names on claim forms; physician orders were often nonexistent. OIG concluded that the supplier served merely as a conduit for submitting claims to the Medicare carrier and receiving checks. The funds were then transferred to the parent company.

On April 24, 1995, an officer of the parent company pled guilty to submitting more than \$4.4 million of false and fraudulent claims to one Medicare carrier and similarly submitting millions of dollars worth of false and fraudulent claims to other Medicare carriers. The provider billed Medicare for supplies at inflated rates as well as for supplies that were not provided or not medically necessary—including billing supplies for patients who had died. In one instance, the provider billed Medicare \$2,790 for surgical dressing kits that were never provided; instead, the provider furnished the patient 62 gauze bandages costing less than \$20. Under a plea agreement, the officer of the company agreed to cooperate with federal authorities in their attempts to identify others involved in the conspiracy. In return, the U.S. Attorney will recommend a prison term not to exceed 15 months.

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## Case D

After reviewing a Medicare explanation of benefits notice, a beneficiary's son questioned why his mother—a nursing home resident—received such large quantities of supplies. In investigating the matter, the Medicare carrier determined that the provider was billing for supplies that were not provided. OIG began its investigation in July 1990. On November 8, 1990, a federal grand jury returned a 623-count indictment against the two providers it alleged obtained payment for false, fictitious, and fraudulent claims submitted for approximately 120 nursing home patients in three facilities in different states. One supplier (supplier #1) submitted the false claims to the carrier knowing that the supplies had never been provided. Another supplier (supplier #2) had given supplier #1 billing information for the patients in the three nursing facilities—patient names, Medicare numbers, diagnoses, treating physicians, and so forth. As part of the conspiracy, supplier #2 received a kickback from supplier #1 equal to 50 percent of the money received from the carrier for the false claims. Between June 7 and August 8, 1990, the carrier paid about \$813,973 for false claims—an average of about \$6,783 per patient.

On September 30, 1991, as a result of plea-bargaining, supplier #2 pled guilty to one count of conspiracy to defraud the United States with respect to claims, one count of submitting false claims, and one count of mail fraud. On January 9, 1992, the vice president of supplier #2 was sentenced to 26 months in jail and ordered to repay \$75,000 to HHS and pay a special assessment of \$150. The company itself was also fined \$5,000 and ordered to pay a special assessment of \$100. On November 6, 1991, supplier #1 was found guilty after trial of all 623 counts. On February 4, 1992, the president of supplier #1 was sentenced to 24 months of incarceration and ordered to

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repay \$300,000 to HHS and pay a special assessment of \$31,150. The company was also fined \$1,000 and ordered to pay a special assessment of \$62,200.

In November 1994, a civil case against supplier #1 was settled with a summary judgment. Supplier #1—which is out of business and bankrupt—was ordered to pay \$4,955,000. Toward this amount, the government applied the \$407,121 seized from the company's corporate account and has up to 30 years to recover the remainder of the funds from the president of the company.

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## Case E

On February 3, 1992, a Medicare carrier received a complaint forwarded from the daughter of a beneficiary. The complaint concerned a wheelchair cushion that should have cost less than \$100 but that was charged to Medicare as a \$1,503 custom-fitted body jacket. After receiving several complaints from family members of other nursing home residents and nursing home staff, the carrier noted the increased billings by the supplier submitting this claim and started to review related nursing home records. Carrier medical staff determined that services the supplier billed Medicare for were not provided, beneficiaries were not measured for a custom fit, the beneficiaries' condition could not be improved by using the jackets, physical therapy was billed for but neither ordered nor received, and the physicians only signed prescriptions that had been prepared by someone else. By mid-May, the carrier had received 38 complaints against this supplier of which 34 pertained to body jackets. By mid-August, the inquiries concerning this supplier had increased to 50. The carrier referred this case to OIG on August 25, 1992.

OIG's investigation revealed that this supplier actually started marketing wheelchair cushions with adjustable straps as Medicare-reimbursable custom-fitted body jackets in 1991. Sales representatives for the supplier would market the body jackets to the directors of nursing as fully Medicare covered and promise that no real attempt would be made to collect the co-payments from the beneficiaries. They would offer to go into the nursing facility files to obtain the patient information needed to prepare claims and certificates of medical necessity. Usually, the facility allowed such access; in other cases, the facility provided the necessary information. In some cases, the supplier gained access to nursing homes by providing kickbacks in the form of payments on insurance policies or to individuals to induce them to order exclusively from this supplier.

The sales people obtained physicians' signatures on the certificates of medical necessity by assuring physicians that the director of nursing had requested the items and that the items would cost the patients nothing. The certificates would be sent to the supplier's headquarters, where employees would add or delete wording from the signed certificates to guarantee Medicare payment. By December 1992, Medicare had paid this supplier over \$1.6 million for wheelchair cushions misrepresented as body jackets.

Seven persons involved in this fraudulent scheme were indicted and pled guilty; all were sentenced in fall 1994. The owner of the company was sentenced to 33 months in jail followed by 3 years on supervised release and was ordered to make restitution to Medicare of \$386,508. Two other principal defendants connected with the firm were placed on probation for 5 years and each was ordered to make restitution of \$386,508. Two persons convicted of receiving kickbacks were each placed on probation for 5 years and fined \$9,000 and \$10,000, respectively. (Two other defendants, who assisted in the investigation, pled guilty to lesser charges and executed agreements for pretrial diversion. Under these agreements, if they provided 100 hours of community service and abided by the conditions of the agreement, charges against them would be dismissed after 1 year and the record would be erased.)

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## Case F

In September 1992, the granddaughter of a beneficiary reported to the carrier that her grandmother had never received a custom-fitted back brace (commonly referred to as a body jacket) that had been billed to Medicare by this supplier. One month later, a similar complaint was received from the husband of another beneficiary. The following month, the daughter of a third beneficiary wrote to the carrier complaining of a claim for a body jacket that her mother did not need or use. When she went to the nursing home, she learned that her mother and others had refused to accept the body jackets and the nursing home had put them in storage. After talking to the administrator and nurses at the home, the daughter learned that a representative of the supplier came to the nursing home, checked patients' records, and left forms to be completed for products the patients qualified for. This complainant stated that this supplier appeared to be operating out of a residence: there was no telephone listing for the company. In December, the daughter of another beneficiary wrote to the carrier complaining about the "ridiculous" charge for a body jacket that was provided without her knowledge or consent.

This supplier was established for the sole purpose of selling body jackets, which it sold primarily to nursing home patients. Company representatives went to nursing homes to sell wheelchair pads, which they asserted were reimbursable by Medicare. These representatives told nursing home personnel and beneficiaries that the beneficiaries would not be responsible for any costs not reimbursed by Medicare. The company representatives also prepared certificates of medical necessity for the wheelchair pads sold and obtained physicians' signatures. The company then billed Medicare for body jackets. According to carrier correspondence, this supplier had been reimbursed \$564,808 for body jackets from July 1, 1992, through December 31, 1993.

On March 24, 1993, the carrier referred this case to OIG, noting that on the basis of the allegations and information it had obtained, the body jackets billed did not appear to be customized and the prescriptions appeared to be completed by someone other than the listed physicians. In its referral letter, the carrier reported that this supplier had received nearly \$416,000 from Medicare during the last 6 months of 1992. All claims were for a \$1,289 body jacket.

On June 16, 1995, a plea agreement was filed in court in which the company pled guilty to one count of mail fraud and agreed to repay \$450,000 to Medicare. As part of the consideration for this plea agreement, the president of this company agreed to testify before grand juries or at trials on matters involving other persons under investigation for this same type of fraudulent scheme.

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## Case G

A Medicare carrier's fraud and abuse unit began investigating a laboratory on January 29, 1991, on the basis of a complaint by a beneficiary's daughter. The daughter stated her mother did not order the services for which Medicare paid the laboratory \$142. Nor had the services been ordered by the beneficiary's doctor or the nursing home where the beneficiary resided. The carrier reviewed the pertinent medical records for 15 beneficiaries in three nursing homes in two different states and found that none of the services were medically necessary. For 14 beneficiaries, there were no physician orders requesting the services, and for the remaining beneficiary, the diagnosis submitted with the claim was not documented. The carrier identified an overpayment of \$10,520 for 19 claims paid during a 4-month period.

On August 13, 1991, the carrier referred this case to OIG for further investigation. Following this referral, the carrier received several additional complaints against this laboratory. For example, a beneficiary's legal guardian learned that Medicare paid the laboratory \$706 for the telephonic transmission of 21 electrocardiogram (EKG) rhythm strips over a 2-week period. She contacted the beneficiary's physician and learned that the physician did not authorize or have any prior knowledge of such tests. In another complaint, a former employee stated the laboratory's salespeople contacted doctors regarding its cardiac monitoring system. If doctors signed up for the service, they had to provide listings of their heart patients in nursing homes. The laboratory then sent people to the nursing homes to perform 21 EKGs on each patient over an 11-day period, with the series of tests to be repeated three more times during the year. The laboratory charged about \$1,000 per patient for the 11-day study, or about \$4,000 per year per patient. However, the doctors generally did not see the results of the studies. The laboratory operated all over the country; one doctor alone had 275 patients on this program.

As a result of its investigation, OIG concluded that most of the laboratory's billings for these services were inappropriate. OIG found that the laboratory was billing Medicare for EKGs that were rendered as routine screening diagnostic tests, with no evidence of a physician evaluation and no indication that the patients were experiencing an arrhythmia, symptom, or complaint. OIG pursued the case as a civil false claims case because the diagnoses entered on the Medicare claim forms by the laboratory were false—they did not accurately reflect the patients' conditions at the time the EKG services were ordered and rendered. OIG estimated that the actual Medicare overpayment in this case was about \$6 million.

On February 10, 1994, the laboratory and its three principal owners entered into an agreement to reimburse HHS \$250,000 plus \$16,118 in interest for inappropriate claims. In addition, the laboratory waived any future demands for \$655,086 in payments (identified through a special prepayment review effort) that the Medicare carrier had withheld—thus resulting in a total settlement of \$921,204. Finally, the provider and its three owners were excluded from participating in the Medicare program for a 5-year period effective February 10, 1994.

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## Case H

The carrier initiated its review of this optometrist and the group optometry practice he owns on September 11, 1990. This review was based on a beneficiary's letter to the carrier dated July 7, 1990, alleging that the

optometrist performed only an eye examination, not the surgery he had claimed and had been reimbursed for by Medicare. By the time the carrier referred the case to OIG on July 30, 1991, it had received 19 complaints against the group practice and 2 against the individual; 19 of these complaints involved beneficiaries in nursing homes. The complaints alleged that the providers had billed Medicare for services that were never furnished or that were not necessary. According to a nursing home administrator, a representative of the group practice would visit nursing homes, review patient records, and obtain the necessary patient information to file Medicare claims. Several days later, an optometrist would visit the nursing home and render services.

After reviewing nursing home medical records for 20 beneficiaries, the carrier concluded that the services billed were not medically necessary or not documented. The provider submitted the same diagnosis and tests on all claims. The claims identified a referring physician and charges for consultations, but the records contained no orders requesting consultations. On May 15, 1992, OIG requested that the carrier place both the individual optometrist and the group practice on 100-percent prepayment review.

While this case was open, this optometrist wrote not only to the carrier but also to his congressional delegation alleging discrimination against him as an optometrist. He also enlisted the help of his patients to write to Medicare of his successes and to provide copies of those letters to their Congress Members and Senators. However, the case had nothing to do with the technical merits of his optometry practice. He was billing Medicare for services never rendered to patients and for consultations for which the medical files showed no physician requests. A civil settlement was signed on December 14, 1994, and filed in U.S. District Court on January 20, 1995. Although Medicare reimbursed this provider over \$451,617 based on false, misleading, or otherwise fraudulent claims, the settlement involved a refund of \$30,000 to be paid over a 35-month period and voluntary exclusion from the Medicare program for 3 years. If the defendant defaults on the financial obligation, the exclusion continues until the obligation is fully satisfied.

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**Appendix II**  
**Closed Fraud Case Summaries**

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# Related GAO Products

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Fraud and Abuse: Medicare Continues to Be Vulnerable to Exploitation by Unscrupulous Providers (GAO/T-HEHS-96-7, Nov. 2, 1995).

Medicare: Modern Management Strategies Could Curb Fraud, Waste, and Abuse (GAO/T-HEHS-95-227, July 31, 1995).

Medicare: Adapting Private-Sector Techniques Could Curb Losses to Fraud and Abuse (GAO/T-HEHS-95-211, July 19, 1995).

Medicare: Rapid Spending Growth Calls for More Prudent Purchasing (GAO/T-HEHS-95-193, June 28, 1995).

Medicare: Modern Management Strategies Needed to Curb Program Exploitation (GAO/T-HEHS-95-183, June 15, 1995).

Medicare: Reducing Fraud and Abuse Can Save Billions (GAO/T-HEHS-95-157, May 16, 1995).

Medicare Claims Billing Abuse: Commercial Software Could Save Hundreds of Millions Annually (GAO/T-AIMD-95-133, May 5, 1995).

Medicare and Medicaid: Opportunities to Save Program Dollars by Reducing Fraud and Abuse (GAO/T-HEHS-95-110, Mar. 22, 1995).

Medicare: High Spending Growth Calls for Aggressive Action (GAO/T-HEHS-95-75, Feb. 6, 1995).

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