

**MEDICARE FRAUD PREVENTION: THE MEDICARE  
ENROLLMENT PROCESS**

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**HEARING**

BEFORE THE  
PERMANENT  
SUBCOMMITTEE ON INVESTIGATIONS  
OF THE  
COMMITTEE ON  
GOVERNMENTAL AFFAIRS  
UNITED STATES SENATE  
ONE HUNDRED FIFTH CONGRESS

SECOND SESSION

JANUARY 29, 1998

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# CONTENTS

---

	Page
Opening statements:	
Senator Collins .....	1
Senator Glenn .....	3
Senator Durbin .....	6
Senator Levin .....	50

## WITNESSES

THURSDAY, JANUARY 29, 1998

Mr. Smith, a Convicted Medicare Fraud Felon .....	8
John M. Frazzini, Former Investigator, Senate Permanent Subcommittee on Investigations .....	16
John E. Hartwig, Deputy Inspector General for Investigations, Office of the Inspector General, Department of Health and Human Services, accompanied by Susan Frisco, Special Agent, New York Field Office, Department of Health and Human Services, and Cathy Colton, Assistant Regional Inspector General for Investigations, Miami, Florida, Satellite Office, Department of Health and Human Services .....	19
H. Donna Dymon, Nurse Consultant, San Francisco Region IX, Health Care Financing Administration (HCFA), Department of Health and Human Services .....	38
Dewey Price, Team Leader, Operation Restore Trust, Miami, Florida, Satellite Office, Health Care Financing Administration (HCFA), Department of Health and Human Services .....	41

## ALPHABETICAL LIST OF WITNESSES

Dymon, H. Donna:	
Testimony .....	38
Colton, Cathy:	
Testimony .....	19
Frazzini, John M.:	
Testimony .....	16
Prepared Statement .....	59
Frisco, Susan:	
Testimony .....	19
Hartwig, John E.:	
Testimony .....	19
Prepared Statement .....	62
Price, Dewey:	
Testimony .....	41
Smith Mr.:	
Testimony .....	8
Prepared Statement .....	57

## APPENDIX

Prepared statements of witnesses in order of appearance .....	57
---	----

IV

EXHIBIT LIST

Page

* May be found in the Files of the Subcommittee	
1. SEALED EXHIBIT: Background material and Indictment of Permanent Subcommittee on Investigations' witness, "Mr. Smith" .....	*
2. Permanent Subcommittee on Investigations Chart: <i>Application Process—Home Health Providers</i> .....	71
3. Permanent Subcommittee on Investigations Chart: <i>Application Process—DME Provider</i> .....	72
4. a. Medicare Application showing DME business location of 1204 Avenue U, Suite 201, Brooklyn, New York .....	73
b. Photograph of <i>The Mail Drop</i> located at 1204 Avenue U, Brooklyn, New York .....	74
5. Photographs of <i>SU Launderette</i> , the reported office location of two New York physicians who submitted \$690,000 in Medicare claims for DME products and MRI tests .....	75
6. Photograph of <i>Mail Box Etc.</i> , the reported location of a Miami, Florida health clinic that performed diagnostic tests .....	78
7. Photograph of vacant store front, the reported location of a Miami, Florida health clinic .....	79
8. Photograph of airport runway, the reported location of fourteen (14) Miami, Florida health care companies that provided DME products and services .....	80
9. Photographs of 2 of the 8 properties purchased by Ulisses Martinez with \$1.2 million in funds fraudulently obtained from the Medicare program .....	81
10. Report of the Department of Health and Human Services, Office of Inspector General, <i>Medical Equipment Suppliers: Assuring Legitimacy</i> , December 1997, June Gibbs Brown, Inspector General, OEI-04-96-00240 ....	82
11. <i>Operation Restore Trust, California Project, A Study of Forty-four Home Health Agencies in California</i> , H. Donna Dymon, Ph.D., December 1997 ...	106
12. Memoranda prepared by Don Mullinax and Eric Eskew, Investigators, Permanent Subcommittee on Investigations, dated January 23, 1998, to Permanent Subcommittee on Investigations' Membership Liaisons, regarding PSI Hearing on <i>Medicare Fraud Prevention: Improving The Enrollment Process For Medicare Providers</i> .....	140
13. <i>Washington Post</i> , January 18, 1998, "Officials Target Equipment Fraud In Medicare: \$510 Million Found In Improper Billing" .....	203
14. Letter to Senator Susan M. Collins, Chairman, and Senator John Glenn, Ranking Minority Member, Permanent Subcommittee on Investigations, dated January 28, 1998, from Nancy-Ann Min DeParle, Administrator, Health Care Financial Administrations (HCFA), regarding HCFA's increased effort to fight fraud .....	204
15. Letter to The Honorable Susan M. Collins, dated December 29, 1997, from John E. Heye, Vice President for Finance and Treasurer, Maine Medical Center, regarding health care fraud .....	210
16. Statement for the Record of Home Care Alliance of Maine, <i>Medicare Fraud and Abuse</i> , Position Statement .....	212
17. Letter to The Honorable Susan Collins, Chairman, Permanent Subcommittee on Investigations, dated February 3, 1998, from James T. Moore, Commissioner, Florida Department of Law Enforcement (FDLE), regarding Medicare fraud .....	214
18. Statement for the Record of Citizens Against Government Waste (CAGW), <i>Medicare Fraud: The Symptoms and the Cure</i> .....	219
19. Statement for the Record of Fraud Investigator Bill Menke, Pensacola, Florida, <i>Institutionalized Medicare Fraud</i> .....	249
20. Statement for the Record of Attorney Mike Papantonio, Pensacola, Florida, <i>Fighting Medicare Fraud</i> .....	251

## **MEDICARE FRAUD PREVENTION: IMPROVING THE MEDICARE ENROLLMENT PROCESS**

**THURSDAY, JANUARY 29, 1998**

U.S. SENATE,  
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS,  
OF THE COMMITTEE ON GOVERNMENTAL AFFAIRS,  
*Washington, DC.*

The Subcommittee met, pursuant to notice, at 9:33 a.m., in room SD-342, Dirksen Senate Office Building, Hon. Susan M. Collins, Chairman of the Subcommittee, presiding.

Present: Senators Collins, Glenn, Levin, and Durbin.

Staff Present: Timothy J. Shea, Chief Counsel/Staff Director; Mary D. Robertson, Chief Clerk; Ian T. Simmons, Counsel; Don Mullinax, Investigator; Eric Eskew, Investigator (Detail, HHS-IG); Dennis M. McCarthy, Investigator (Detail, Secret Service); Lindsey E. Ledwin, Staff Assistant; Kirk E. Walder, Investigator; Stephanie Smith, Investigator (Congressional Fellow); Linda Algar, Investigator (Congressional Fellow); Bill Greenwalt (Senator Thompson); Michael Loesch (Senator Cochran); Chris Dockery (Senator Cochran); Gregory Bouton (Senator Cochran); Allison Dekosky (Senator Specter); Steve Abbott (Senator Collins); Felicia Knight (Senator Collins); Priscilla Hanley (Senator Collins); Bob Roach, Counsel to the Minority; Leonard Weiss (Senator Glenn); Marianne Upton (Senator Durbin); Polly Middlestedt (Senator Cleland); and Myla Edwards (Senator Levin).

### **OPENING STATEMENT OF SENATOR COLLINS**

Senator COLLINS. The Subcommittee will please come to order.

Today, the Subcommittee continues its investigation into fraud in the Medicare program. This is the Subcommittee's second hearing on this subject. At our initial hearing last June, we learned from the HHS Inspector General the disturbing fact that improper payments in the Medicare program are estimated to be 14 percent of total payments. That is close to double previous estimates. This amounts to an astronomical \$23 billion a year in improper Medicare payments.

Medicare is too important a program to have such a significant financial drain on its scarce resources, resources that should be benefiting the millions of older and disabled Americans who depend on the program. About 14 percent of all Americans receive health care services from Medicare. In Maine, the percentage is even higher, as more than 200,000 people, representing 17 percent of our population, are enrolled in Medicare.

Americans across the Nation rely on this vital program to maintain their health and quality of life as they grow older. We in Congress, therefore, have a serious responsibility to older Americans across the country and to our Nation's taxpayers to protect the Medicare program, to ensure the financial integrity of the Medicare Trust Fund so that the program continues to serve older and disabled Americans into the 21st century, to guard against our seniors receiving inferior or sub-standard health care, and to protect the Nation's taxpayers from career criminals whose illegal schemes cost us billions of dollars each year.

We must use common sense and cost-effective solutions to curtail the spreading infection of fraud that threatens the very vitality of Medicare. This hearing is in no way intended to be an indictment of the vast majority of health care providers who are dedicated and caring professionals. In fact, they would be the first to agree on the need to focus on prevention to stop the fraud before it occurs by preventing career criminals, most with absolutely no health care experience, from ever becoming Medicare providers in the first place.

We are now seeing a dangerous and growing trend in Medicare fraud of bogus providers entering the system with the sole and explicit purpose of ripping it off. The front door has been left wide open to criminals who simply walk in, pose as legitimate providers, and steal millions from the Trust Fund. This type of fraud raises the critical, but obvious question, how do they get into the system in the first place?

These are not otherwise legitimate health care providers who unethically pad a bill, but who at least do provide services. Rather, these are completely bogus businesses, such as the fictitious durable medical equipment company that exists only on paper, or individuals who engage in extortion and pay off "recruiters" in order to obtain beneficiary numbers, or phony health care agencies that never deliver any services at all.

Cracking down on this growing type of Medicare fraud is important for two reasons. First, these scams expose the Federal Treasury, the Nation's taxpayers, to a potentially greater amount of fraud. Unlike traditional health care fraud where services are provided, but at an inflated cost, these criminals commit 100 percent fraud, stealing all of the money they bill Medicare while providing no or inferior services to elderly Americans.

Second, these criminals, most with no health care experience, threaten the quality of care for our elderly and disabled. They drive legitimate providers out of business, they deliver sub-standard services and equipment, and they endanger our elderly by not providing needed services.

Our witnesses today will provide the Subcommittee with an understanding of how these criminals can enter the system and how the enrollment process administered by the Health Care Financing Administration should be improved. I want to note that just days before this hearing, the administration announced an initiative that finally recognizes the importance of fraud prevention. This initiative is welcome, albeit long overdue, and needs to be vigorously pursued.

We in Congress are mindful that entry into Medicare should not be so difficult that the process deters legitimate health care providers. But we must have enough of a deterrent so that the truly unscrupulous cannot enter the system. The fact is it is far easier to obtain a Medicare provider number than to obtain a Maine driver's license. The current philosophy, the current process, makes it far too easy for criminals to exploit a system that seems based on a philosophy of pay now, ask questions later.

Why do we have a system that paid \$117,000 to a Medicare provider who rendered no services and whose address is actually a laundromat in Brooklyn? Why did Medicare pay \$300,000 for medical tests never performed and sent the checks to a Mail Boxes Etc. location in Miami? Why did Medicare pay \$6 million to several DME companies that provided no services, when their fictitious location was in the middle of a runway at the Miami International Airport? Simply put, why do HCFA and its contractors write checks first and ask questions later?

These are important questions that I intend to pursue vigorously with my colleagues as this investigation continues and as we strive to protect the integrity of the Medicare program. The elderly in this country deserve no less. It is difficult for me to justify to my constituents in Maine why we need to slow the growth of Medicare when waste, fraud and abuse are rampant in this program.

Before recognizing the Ranking Minority Member and Senator Durbin for their comments, I want to stress one important point about Medicare providers. Perhaps it goes without saying, but it deserves repeating here today. The vast majority of Medicare providers are caring, dedicated health care professionals whose top priority is the welfare of their patients. This hearing is not about those health care professionals, nor is it about honest mistakes or billing errors. It is about career criminals who waltz into the Medicare program without being questioned and who steal hundreds of millions of dollars from the Trust Fund. We must crack down on bogus providers who have no business participating in a program vital to 38 million Americans.

At this time, I am pleased to recognize the ranking minority member of the Subcommittee, the distinguished Senator from Ohio, John Glenn, for his statement.

#### **OPENING STATEMENT OF SENATOR GLENN**

Senator GLENN. Thank you, Madam Chairman, and I want to commend you and your staff for the fine job you have done in putting this hearing together. As you said, it is long overdue that we get into this because Medicare is a valuable program. Over the years, it has improved the health and quality of life for tens of millions of Americans and has a commendable record.

But the size of the program and its decentralized nature mean that any regulatory or management weakness leaves the program highly vulnerable—vulnerable to fraud resulting in the potential loss of billions of dollars, as we will have illustrated here today. Unscrupulous actors are always looking for a way to take advantage of the system, and their actions can threaten the health and lives of Americans and waste billions of taxpayer dollars and undermine the credibility of an essentially good and successful pro-

gram. That is why it is so important for us to continually monitor the program and correct the weak areas.

Today's hearing addresses an area of high vulnerability—the process for enrolling health care providers and suppliers in the Medicare program. Let me add that this is on the GAO's high-risk list. We worked with the General Accounting Office back some years ago. It was approved in 1990 that they assess across all the different departments and agencies of government where the greatest risks to the taxpayers were, where was money likely to be wasted.

And they put out a list in 1992, 1995, and 1997, and in 1995 and 1997 the area we are talking about today was one of the risks that they warned about. So we haven't had adequate action taken within a couple of administrations here to really get to the bottom of this thing and really correct it.

The current qualifications standards are far too weak, and even those are ineffectively enforced. As a result, con artists with no medical background or experience whose sole purpose is to rip off the taxpayers gain access to the Medicare reimbursement system. This result is quite apparent in two of the categories we will focus on today—durable medical equipment, DME, suppliers, and home health agencies, HHA's.

Just a month ago, the HHS Inspector General came to the chilling conclusion that, and I quote, "Presently, HCFA and the National Supplier Clearinghouse are approving many inexperienced, unqualified, and unethical people as suppliers," end of quote. Is it any wonder, then, that a recent HHS IG inspection of 420 enrolled DME suppliers and 35 new applicants revealed that 40 percent of the enrollees and 41 percent of the applicants failed to meet at least one Medicare requirement for DME suppliers, and that a government review of \$6.5 billion in DME billings last year concluded that 16 percent, nearly \$510 million, were improper?

Similar problems afflict HHA's. Last month, the General Accounting Office issued a review of the certification process for HHA's and reported that Medicare's initial certification process does not provide a sound basis for judging whether an HHA does or will provide quality care in accordance with Medicare's conditions of participation. As a result, GAO concluded that State surveyors and HCFA do not have sufficient, adequate information to verify that the HHA is capable of furnishing quality care for all its services or is in compliance with all the conditions of participation.

Similarly, 6 months ago, the HHS IG reported that 25 percent of the 2,700 certified HHA's in five of the largest Medicare States were problem providers with significant or multiple problems, and they received almost 45 percent of all Medicare expenditures in those States. They concluded that current program requirements are woefully inadequate to prevent financially irresponsible or fraudulent home health agencies from becoming Medicare providers.

On the same day it issued that finding, the IG also reported that in four of the largest Medicare States, 40 percent of the payments for home health care over the past 15 months should not have been made, resulting in losses of approximately \$2.6 billion. It should be no surprise, then, that in September of last year the administration

imposed a moratorium on the enrollment of new HHA's, and that freeze was just lifted on January 13th of this year, after new regulations were implemented. But there needs to be far more follow-up to go along with that.

Obviously, the enrollment process is in terrible shape. Yet, it could, and should be our first line of defense against Medicare fraud. If we can deny unscrupulous firms and individuals access to the system, we can stop a lot of fraud before it even starts, and that is a more efficient and effective way to safeguard programs, resources, and quality than to try and catch perpetrators after the fraud is committed.

It is encouraging to note that both Congress and the Health Care Financing Administration, HCFA, have already taken some initial steps toward reform of the enrollment process. The Balanced Budget Act of 1997 included a number of initiatives that will strengthen the enrollment process. HCFA recently promulgated a flurry of reforms, including requirements for DME and HHA applicants to provide more information and post surety bonds, and I hope we get a chance to hear about the changes it has implemented.

However, while the reforms have great potential to improve the enrollment process, we must see how effectively they are implemented and enforced. There is a lot more to do and there are some obvious reforms that have not been taken.

Let me just add, I think we need to look in the mirror here in Congress for the source of some of the problems addressed here today. We have been on a big emphasis on requiring privatization and putting everything, as far as we can, out of government, getting it out and privatizing it. Well, we didn't put enough safeguards in here when we did some of this and so we find people getting too easily into the whole system.

When we have tried to make some changes in the past, they haven't gotten through the Congress because some people were afraid that we were impinging on their small businesses back home to get into some of these areas. So there have been problems right here, too. Protecting small businesses and making easy access for them to get into this system, which is admirable in its intent, meant that crooks got in, also. And we set some of the pricing here so that there couldn't be competitive bidding. We need to correct things like that right here in Congress as part of this clean-up of the whole system. So we need to do some things right here, too.

It is good to say that we are putting it out here and it is going to be competitive. Yet, it should be competitive once we get it out there and it is not now. Anybody gets in and they can charge anything they want, and so on, and it makes no difference to a crook if the service is not being provided. His or her bill may look like it is in line with what the going rate is in a certain area, but the service isn't even provided, so that is a complete rip-off, a complete fraud.

So we need to correct some of the things that right now are permitted in law. We don't require competitive bidding in some of these areas. I had a meeting this morning with the Administrator of HCFA, and there are some areas that we need to look into here, also. I am not trying to excuse them at all, because some of the things that have happened are inexcusable.

The testimony today will dramatically show something as simple as performing an on-site visit to an applicant's reported place of business could identify many scam artists. As the Chairwoman pointed out just a moment ago here, when you are talking about a provider that is on the sixth floor of a five-story building, it doesn't take a big scientist to tell us we have got a problem.

Another important reform to consider is granting HCFA authority to charge applicants a fee to defray the cost of an improved application review process that does include site visits. At least we know there is a business there. HCFA projected that such a fee would be about \$100. It doesn't seem to me that is too far out of line.

By way of comparison, the State Department currently charges individuals \$65 for a passport, and if a citizen can be required to pay \$65 in order to exercise their right to travel, it seems reasonable to require Medicare providers and suppliers to pay a fee for the right to enroll in a program which affords lucrative financial returns.

So I am looking forward to exploring these ideas and other possible reforms during today's hearing. Surely, this is an area where an ounce of prevention is well worth a pound of cure. It is long overdue for curing and it is up to us to work with HCFA to make sure this gets done.

Thank you, Madam Chairman.

Senator COLLINS. Thank you very much, Senator Glenn.

I would now like to recognize another Senator who has been a leader in the fight against Medicare fraud, Senator Durbin.

#### **OPENING STATEMENT OF SENATOR DURBIN**

Senator DURBIN. Thank you, Senator Collins. We are discussing exploitation here, and it is pretty obvious from the figures which have been produced that there is an exploitation of taxpayers and the Treasury, some suggest to the tune of \$23 billion a year in Medicare fraud. But it is also an exploitation of senior citizens, many of whom, because they are alone are confused by the mountain of bureaucratic language that is thrown in their direction, really don't know what their rights are and end up signing forms which give people a license to basically scam the Treasury. They don't get the kind of care and services that they deserve and the taxpayers pay the bill.

Now, we have taken a close look at some of these and one of the operations that I think we should continue to encourage is Operation Restore Trust, which is an effort to try to weed out this Medicare fraud. It has been conducted in my home State of Illinois and four other States to target this problem. For every dollar that we have spent in this effort, we have brought back \$23 to the Federal Treasury. I was pleased that last May, President Clinton expanded this program to 12 additional States.

Let me also say that there is a hotline that I think most people are aware of through the Department of Health and Human Services to allow people to call in. It is 1-800-HHS-TIPS, and if you think that you know of some Medicare fraud, give it a call. Direct action resulting from some 5,500 complaints to that hotline has resulted in approximately \$6.4 million in recoveries.

I really want to close by commending Senator Collins for her initiative in this investigation. This is not the first hearing we have had on this subject. I am sure it won't be the last either. Both she and Senator Glenn understand, as was said in their opening statements, that if we are being called on to tighten the belt in the Medicare program, the first place we are going to turn is the elimination of this kind of fraud. This can be done. And for those of you who have talked to senior citizens, who have been to town meetings, they usually come armed with a handful of bills and examples to tell their elected officials that there are obvious abuses that need correcting.

The one sad part of this and one thing that we have to think about is that the largest complaints against the government, in general, are paperwork and too many employees. How do you police a system? Well, historically, we have policed it with more forms to make sure that anybody who wants to get into this field has to fill out more forms, make more disclosures, swear to the truth of this, that and the other thing. So as we try to reduce paperwork, on one hand, we have to be taking care that we aren't reducing the safeguards that are necessary to keep the bad actors out of this.

And, secondly, of course, we need good people who are taking a look at these Medicare providers and making certain that, as has been said repeatedly, you don't have some business supposedly working off of the sixth floor of a five-story building. So these things are at odds with our efforts to reduce paperwork and reduce Federal employment, but they are absolutely essential if we are going to make certain that the taxpayers are not ripped off.

I thank the Senator for this hearing. I am looking forward to it.

Senator COLLINS. Thank you, Senator Durbin.

Without objection, and for the convenience of all Senators, the exhibits marked and previously made available will be made part of the hearing record.

In addition, Senator Glenn and I each received late last night a letter from HCFA outlining the steps that the administration is taking and the letter will be made part of the record as well.<sup>1</sup>

Senator GLENN. So move.

Senator COLLINS. Thank you.

Our first witness this morning is a former Miami nightclub owner who is currently serving time in Federal prison for Medicare fraud. We will refer to this witness today as "Mr. Smith."<sup>2</sup>

For the record, I would note that the witness has requested that his face be concealed from public view due to concerns about his safety. Under the circumstances, I believe this is an eminently reasonable request, and if there is no objection from the Subcommittee members, it is ordered pursuant to the Subcommittee's Rule 11.

I would note for the record that the witness, as is obvious, will be testifying behind an opaque screen. No cameras will be allowed to photograph this witness from the area in front of the screen. It is also my understanding that members of the media have already been advised of the ground rules and the locations where cameras

<sup>1</sup> See Exhibit 14 which appears in the Appendix on page 204.

<sup>2</sup> Sealed Exhibit labeled as Exhibit 1 is retained in the files of the Subcommittee.

will and will not be allowed during Mr. Smith's testimony in order to maintain security.

Mr. Smith will describe for us today the nature of his Medicare fraud and how he was able to milk some \$32 million from the Medicare program. I would also note that Mr. Smith is accompanied by an interpreter from the State Department, since English is not his native language. Although his English is good, just to ensure that there is no misinterpretation of the questions, the interpreter will translate the questions and assist to ensure that Mr. Smith understands all the questions posed to him.

Pursuant to Rule 6, all witnesses who testify before the Subcommittee are required to be sworn. We usually ask the witness to stand, but for obvious reasons, we will ask today for the witness to remain seated, but to raise your right hand.

Do you swear that the testimony that you will give before the Subcommittee will be the truth, the whole truth and nothing but the truth, so help you, God?

Mr. SMITH. I do.

Senator COLLINS. Thank you very much. Mr. Smith, you may proceed.

**TESTIMONY OF MR. SMITH,<sup>1</sup> A CONVICTED MEDICARE FRAUD FELON, ACCOMPANIED BY LILLIAN NIGAGLIONI, INTERPRETER**

Mr. SMITH. Madam Chairman and Members of the Subcommittee, at your request I am here today to testify about my activities to steal from the Medicare program. Before I begin my testimony, I want to thank you and this Subcommittee for respecting my request to keep my identity protected during this hearing. This is a dangerous world and I sincerely fear for my safety. Thank you again.

My professional training is as an electrical engineer, and at the time when I started billing Medicare, I was the owner of a nightclub in the Miami, Florida, area. Before purchasing a medical supply company in 1988, I had no experience or training in health care services. I also had no idea how the medical supply business worked or anything about the Medicare billing process. Without this experience and with no knowledge of the Medicare program, I purchased a business and started billing Medicare.

It was very easy for me to get approval from Medicare to become a provider. I simply filled out an application and sent it to Medicare. They gave me a provider number over the phone. No one from the government or anywhere else ever came to me or my place of business to check any information on the application. No one ever checked my credentials or asked if I was qualified to operate a medical supply business.

My primary business was supplying nutritional milk to older people in southern Florida. As I understand it, this program was designed to provide the supply kits, like feeding tubes and food such as milk, to old people who were too sick to eat this food without assistance. They were supposed to be so sick that they could

<sup>1</sup> The prepared statement of Mr. Smith appears in the Appendix on page 57.

not swallow whole food. I ended up billing Medicare for patients who were eating steaks and other solid foods.

At first, in order to start billing the government, I bought milk and offered it to elderly people in the Miami area in exchange for their Medicare beneficiary numbers. I hired people to tell the elderly that this was free milk from the government and that they only needed to have a Medicare number to qualify. These recruiters went to community centers and apartment buildings where large numbers of senior citizens were present to get new patients for my companies. Several doctors were also paid to sign Medicare forms certifying that the patients needed this nutritional milk. They were paid about \$100 for each form signed.

In the beginning, I bought the milk in case government investigators came to look at my business. I thought I needed to show them that I bought the milk in order to bill the government. I used these numbers to bill Medicare over and over again for high-cost nutritional services when I just gave them some cheap free milk.

Later, I realized that I did not even need to buy the milk. No one from the government ever came to question my billings, and so I just paid recruiters to get Medicare beneficiary numbers. I used these numbers to bill Medicare month after month. I provided no services and just received checks from the government. I usually received between \$180,000 and \$280,000 per month from Medicare. In 1 month, I billed Medicare over \$500,000 and no services were provided. This program was a gold mine. I know of no other business where I could make the same money without any risk.

The government actually made it easy for me to steal. I was not required to produce any documents in support of the claims I made to Medicare for any of my companies. I became rich very fast billing the Medicare program. My biggest mistake in this fraud scheme was buying the milk. I would have made more money if I did not spend any money on the milk.

By the time I was arrested in 1994, I owned seven medical supply companies and employed approximately 20 people for the sole purpose of billing Medicare. I started new companies so that the government would not discover the large number of claims being paid to any one company. I ran these seven companies out of the same office, using the same people and with the same computers. I was billing Medicare for over 2,000 patients. I provided no services for the claims submitted. In the end, I estimate that my companies billed Medicare about a total of \$32 million, and most of this was fraud.

I was indicted in Federal court for my Medicare fraud scheme and charged with several felony violations of the law. I admitted my involvement with this illegal activity and I willingly cooperated with the government. I pleaded guilty to 17 felony charges, including fraud against the United States, false claims, and paying kickbacks. I am now serving 10 years in Federal prison for these crimes.

That concludes my statement and I will try to answer any questions that you may have.

Senator COLLINS. Thank you very much, Mr. Smith. I appreciate your candor in describing the fraud scheme that you perpetrated.

I want to emphasize a couple of points of your testimony before asking you some further questions.

First of all, you had absolutely no background in health care, either as a health care professional or in the business end of the health care provider, is that correct?

Mr. SMITH. That's correct.

Senator COLLINS. In fact, your training—I think you said you were an electrical engineer, is that right?

Mr. SMITH. Yes.

Senator COLLINS. I want to follow up on a point that Senator Durbin made and that I made in my opening statement, and that is the impact of actions like yours on people who really need services. You mentioned that in some cases, you provided the milk in the initial stages of your scam to people who didn't need it, who were able to eat solid food, like steak, is that correct?

Mr. SMITH. That's correct.

Senator COLLINS. But you also didn't provide services, such as the feeding kits that accompanied the nutritional milk, to people who really needed the service, is that right?

Mr. SMITH. That's correct.

Senator COLLINS. That is one of the concerns about this kind of fraud—is it not only rips off the Trust Fund, but it hurts the quality of care that we are providing to our senior citizens.

You mentioned that you fraudulently billed the Medicare program for about \$32 million. Could you tell us what you used the money for?

Mr. SMITH. Many ways; nice house, boat, car, other business, traveled a lot.

Senator COLLINS. Did you buy some luxury cars with the money?

Mr. SMITH. Yes, I bought luxury cars, houses, and traveled.

Senator COLLINS. Did you buy a Mercedes?

Mr. SMITH. Yes.

Senator COLLINS. Did you do a lot of traveling with the money?

Mr. SMITH. Yes.

Senator COLLINS. Could you give us some idea of where you went with the money?

Mr. SMITH. All over the world, and 14 times to Rio de Janeiro in 1 year.

Senator COLLINS. Did you also invest in a couple of nightclubs in Mexico?

Mr. SMITH. Yes.

Senator COLLINS. And it is my understanding you also bought two boats and a home in Miami and an apartment in Mexico City, is that correct?

Mr. SMITH. That's correct.

Senator COLLINS. So, certainly, Medicare provided you with the good life, I guess you would say, for a while?

Mr. SMITH. Yes.

Senator COLLINS. You worked with others to cheat Medicare, as you mentioned in your statement, but what was your role in the scheme?

Mr. SMITH. I provided the financial support for buying the provider company, and I paid the recruiters.

Senator COLLINS. So the recruiter brought you the Medicare beneficiary numbers which allowed you to bill the government for services that you never provided, is that correct?

Mr. SMITH. Yes, that's correct.

Senator COLLINS. And no one from the government, until you were caught, ever came to visit you or ask you about the information that you provided on your application to become a provider?

Mr. SMITH. Never.

Senator COLLINS. No one from the government ever visited your place of business or attempted to verify the information that you gave on the application?

Mr. SMITH. No, only when they come and arrest me.

Senator COLLINS. How did you get caught?

Mr. SMITH. Somebody who was working with me got caught for other reasons and started to cooperate.

Senator COLLINS. So one of your associates essentially turned you in, is that correct?

Mr. SMITH. Yes, that's correct.

Senator COLLINS. If you hadn't been turned in by one of your associates, do you think that the fraud would have gone on and on and you would still be billing Medicare today?

Mr. SMITH. Oh, yes, for sure, but I was thinking about retiring in 2 years.

Senator COLLINS. You were planning to keep going for a couple of years and then retire, is that correct?

Mr. SMITH. That's correct.

Senator COLLINS. So, in summary, just tell us how easy was it for you to become a certified Medicare provider.

Mr. SMITH. Filled out the paper, sent to Blue Cross and Blue Shield, and they gave me the provider number over the phone.

Senator COLLINS. You got the provider number over the telephone?

Mr. SMITH. Yes, that's right, and started billing.

Senator COLLINS. My final question to you is what do you think the government should do to prevent people from cheating the Medicare system? What would have deterred you? What would have caused you to think twice before getting into Medicare fraud?

Mr. SMITH. I think the government needs to put pressure on the insurance company because the insurance company is the broker between the government and the provider. The insurance company pays the money and the insurance company doesn't have any kind of surveillance to prevent the fraud.

Senator COLLINS. So, by insurance companies, you are talking about the contractors that the Federal Government uses to administer the program and pay claims, right?

Mr. SMITH. Yes.

Senator COLLINS. Thank you.

Senator Glenn.

Senator GLENN. Thank you very much, Madam Chairman.

You say you got about \$32 million, most of it illegal, from the government. How much did the government recover——

Mr. SMITH. That's gross.

Senator GLENN. OK, I have been quickly briefed here and I understand I should not ask that question for other reasons. So I will withdraw that particular question.

How did you get this idea to begin with? Did you know somebody that was doing this?

Mr. SMITH. Yes. One person sold me the business, gave me training on billing and how to do the business.

Senator GLENN. You bought the business, then, where they were doing the same thing?

Mr. SMITH. Yes.

Senator GLENN. Are there other businesses doing this now that you know of?

Mr. SMITH. Yes.

Senator GLENN. Have you told the government about these other people?

Mr. SMITH. Yes.

Senator GLENN. OK. There have been a number of things talked about that might help this situation, such as posting a bond, having to provide a Social Security number, looking into previous criminal history, or insisting that each business file a business plan. Would those have prevented you from doing what you did?

Mr. SMITH. Yes.

Senator GLENN. They probably would have?

Mr. SMITH. Yes.

Senator GLENN. OK. You said you had several companies; I think you said seven at one time. Were they all registered in your name?

Mr. SMITH. No, not all of them.

Senator GLENN. Did you have businesses that had to register with the State to do business?

Mr. SMITH. Yes.

Senator GLENN. You did, OK, and when you made application, there was no check, then, from the State either, as well as from Federal authorities?

Mr. SMITH. No.

Senator GLENN. OK. You mentioned that several doctors participated in this. Did you have any trouble recruiting doctors? I think in your testimony you indicated that doctors were paid \$100 for each form they certified, is that correct?

Mr. SMITH. Yes. Several doctors offer their service.

Senator GLENN. They what? I am sorry.

Ms. NIGAGLIONI. They offered their services. Several doctors offered their services.

Senator GLENN. They offered; didn't even have to go recruit them, is that right? They were coming to you?

Mr. SMITH. Yes.

Senator GLENN. So much for the medics in Miami, OK. No. I retract that last statement.

Mr. SMITH. Not everybody.

Senator GLENN. I don't mean to impugn the medical—

Mr. SMITH. Not everybody.

Ms. NIGAGLIONI. Not everybody.

Senator GLENN. Not everybody, OK. But you didn't have any trouble getting doctors to certify this, apparently.

Mr. SMITH. No.

Senator GLENN. Do you think if we did something just like a site check to see that there is an actual business at a certain address, would that be a major step toward helping eliminate this?

Mr. SMITH. That's correct.

Senator GLENN. Because we have examples where people gave Miami Airport and fictitious buildings and laundromats and all sorts of places as their place of business.

Mr. SMITH. If you do a background check and ask for a bond that would be very important because it will be very hard to get into the system.

Senator GLENN. Well, the bond idea is one that I—I am not quite sure I know how a bond would work because you could have a bond and still be just as fictitious as you were.

Mr. SMITH. No, with the background check and the other measures.

Ms. NIGAGLIONI. With background check and other measures.

Senator GLENN. Oh, background, yes, and an on-site visit to your business place?

Mr. SMITH. That's very important, to see what happened. That's very important.

Senator GLENN. All right, but let us say that I set up a business and they come see my business and I have wheelchairs and I have all sorts of equipment there and I am running a legitimate business. But if I wanted to extend that legitimate business and make false claims, I could have a part legitimate business and one that is many times over not a legitimate business. Would there be any problem with somebody doing that?

Mr. SMITH. No problem.

Senator GLENN. Do you think that is being done?

Mr. SMITH. I do.

Senator GLENN. I would think a front for something like this, that that would be the way a lot of this would occur, would be someone would have a small legitimate business and over-bill to the skies. And unless somebody started actually checking the actual bills, we would never know it.

You didn't even have the overhead of a small legitimate business.

Mr. SMITH. No.

Senator GLENN. Well, we could go on all day here talking about the different parts of this thing, and I compliment you again, Madam Chairman. I have to leave shortly here because I have some Armed Services Committee things I am involved with this morning, and I hate to do that because this is very, very important. But I will try and get back a little later if I possibly can.

Thank you.

Senator COLLINS. Thank you, Senator Glenn.

Senator Durbin.

Senator DURBIN. Mr. Smith, when did you start your business? When did you get the provider number, what year?

Mr. SMITH. December 1988.

Senator DURBIN. And you continued billing the Federal Government until when?

Mr. SMITH. Until 1992.

Senator DURBIN. So 1988 to 1992?

Mr. SMITH. Yes.

Senator DURBIN. Now, I thought it was interesting that you made reference to the insurance company. Which insurance company administered your payments?

Mr. SMITH. Blue Cross and Blue Shield.

Senator DURBIN. And I understand that there are some 70 different companies like Blue Cross-Blue Shield that, in fact, have taken over the responsibility of paying providers like you. I think they contract with the Federal Government to do that, and in your situation your direct contact with the Federal Government—let me restate that.

I am trying to determine the extent of your contact with the Federal Government. You first contacted the department to get your provider number and then you worked with the insurance company from that point forward, is that correct? Could you explain the role there?

Mr. SMITH. I think the provider number is issued from the insurance company.

Senator DURBIN. The provider number came from the insurance company?

Mr. SMITH. Yes.

Senator DURBIN. So all of your contact—I don't want to put words in your mouth. Was the billing process that you used—did it involve Blue Cross-Blue Shield throughout the length of your business?

Mr. SMITH. Yes.

Senator DURBIN. It did, all right. Madam Chairman, that raises another interesting question here because as we privatize these things and create some opportunities for employment in private industry, it clearly is important that the Federal Government, which ultimately pays the bill, makes certain that this surveillance takes place.

One of the points that Senator Glenn raised which I think is important was the question of site visits. It is my understand that the Department of Health and Human Services, in a letter they have just provided us, indicated the President announced site visits for the suppliers nationwide to stop the scam artists. And of nearly 2,000 suppliers visited last year, one-third were either ejected or rejected by Medicare—a third of those who were providing health care services and equipment. That is an incredibly high number, and it really strikes me that we are just scratching the surface of what the problems are in this situation.

Let me ask you, too—we have talked a lot about the senior citizens who were involved in this. Did any of them ever complain to you about having turned over their number and not receiving benefits or not receiving the nutrition that you were supposed to supply?

Mr. SMITH. Many times.

Senator DURBIN. Many times?

Mr. SMITH. Yes.

Senator DURBIN. And obviously that complaint didn't create a problem because you kept doing business until one of your employees basically ratted on you?

Mr. SMITH. Yes and no. The problem is the older people received a statement with the payment from the insurance company, and

when they received the statement, they read it and saw, \$300, or \$200. They said, for what? They started calling.

Senator DURBIN. So the senior citizen whose Medicare number you have picked up from doctors or from other sources and whose name is being fraudulently billed ends up getting this statement back from the government and calls and says, "What is this all about? I didn't get \$600 worth of nutritional supplements." But it didn't result in anything. It didn't result in anybody coming to take a look at your business, did it?

Mr. SMITH. No.

Senator DURBIN. No?

Mr. SMITH. No.

Senator DURBIN. Well, going back to what the Chairman has said about this situation, it is bad enough that we have lost so many millions of dollars, and billions overall. But to have this exploitation of the seniors who are blowing the whistle and nobody is listening, that is the part that really disturbs me as well. We are getting involved in that.

I thank you very much for your testimony. You are paying a price for what you have done, and I hope that the fact that you have come forward today and this hearing will give us some momentum to try to discourage others who are exploiting the system.

Senator COLLINS. Thank you, Senator Durbin.

Mr. Smith, I do thank you for your testimony.

Prior to receiving testimony from our next panel of witnesses, I would ask that everyone remain seated while Mr. Smith exits the room. I will ask that any video or still-camera people please refrain from taking any pictures until the witness has left the room. So with the assistance of the marshals, please proceed.

I also want to thank our State Department interpreter for her assistance here this morning. Thank you.

Senator COLLINS. Our next panel of witnesses today includes people who will tell us about their experiences on the front line of our national effort to combat health care fraud. This panel includes John Frazzini, a former HHS IG special agent who was detailed to this Subcommittee until last December and was very instrumental in the investigation that produced this hearing.

Mr. Frazzini actively participated in health care fraud investigations over the past several years as a special agent at the Office of Inspector General. He will describe the findings and observations of the PSI investigators. I should note for the record that John has now moved on in his law enforcement career and is now a U.S. Secret Service agent in training.

We are also pleased to have with us this morning three witnesses from the Health and Human Services Office of Inspector General—John E. Hartwig, the Deputy Inspector General for Investigations; Susan Frisco, a special agent assigned to the New York field office; and Cathy Colton, an Assistant Inspector General for Investigations assigned to the Atlanta field office, Miami sub-office.

All of these law enforcement professionals are truly on the front lines in this battle. Mr. Hartwig has been in the HHS Inspector General's office for the last 20 years and has a wealth of information. In his capacity of Deputy Inspector General for Investigations, he oversees all the criminal investigations conducted by the Office

of Investigations. I want to compliment these witnesses and the other hard-working professionals in the Inspector General's office for their work in protecting the integrity of the Medicare program.

Pursuant to Rule 6, all witnesses who testify before the Subcommittee are required to be sworn. At this time, I would ask that you all stand and raise your right hands.

Do you swear that the testimony you are about to give before the Subcommittee will be the truth, the whole truth and nothing but the truth, so help you, God?

Mr. FRAZZINI. I do.

Mr. HARTWIG. I do.

Ms. FRISCO. I do.

Ms. COLTON. I do.

Senator COLLINS. Thank you.

Mr. Frazzini, I am going to ask that you proceed first, and then we will hear from Mr. Hartwig. It is my understanding that Ms. Frisco and Ms. Colton do not have separate statements, but are available to answer any questions after we have heard from both of the witnesses who will be presenting oral statements.

Mr. Frazzini, you may proceed.

**TESTIMONY OF JOHN FRAZZINI,<sup>1</sup> FORMER INVESTIGATOR,  
SENATE PERMANENT SUBCOMMITTEE ON INVESTIGATIONS**

Mr. FRAZZINI. Madam Chairman and Members of the Subcommittee, since PSI's June 1997 hearing on emerging fraud in Medicare programs, the Subcommittee has uncovered several weaknesses in the procedures used to enroll Medicare providers. These weaknesses have allowed full-time con artists with little or no experience as health care providers to enter the Medicare program and to defraud millions of dollars from the Nation's taxpayers.

In 1996, the Health Care Financing Administration, or HCFA, standardized the enrollment form when it mandated use of the HCFA 855 form, an application form entitled "Medicare General Enrollment, Health Care Provider/Supplier Application." Using durable medical equipment, or DME, and home health care as examples, I want to briefly show the flow of the HCFA 855 form from preparation to approval.

As these two charts show,<sup>2</sup> the application process for DME and home health care applicants can be divided into four phases. As you can see, there is the submission part of the process, the review, the site visit or verification process, and the approval process, and those are consistent generally with both of these two industries, home health care and DME.

The focus of PSI's investigation was on the adequacy of the third phase of the process, which is the verification of data provided by the applicants on the HCFA 855 forms. As I stated earlier, the HCFA 855 form standardized the Medicare enrollment process with respect to the manner in which information was gathered. However, it did not expand or increase the verification activities related to the information submitted by applicants.

<sup>1</sup> The prepared statement of Mr. Frazzini appears in the Appendix on page 59.

<sup>2</sup> See Exhibits 2 and 3 which appear in the Appendix on pages 71 and 72 respectively.

The HCFA 855 form, for example, requires that a prospective provider include its business location on the form. Preparation instructions for the HCFA 855 form specify that this address cannot be a post office box or a mail drop. HCFA, however, does not ensure that physical verifications are performed on a nationwide basis to determine whether prospective providers are using actual business addresses.

PSI's investigation has revealed that many DME companies have used mail drops that appear on the enrollment form to be legitimate street addresses. As an example, here is a copy of one provider's Medicare application which shows that the business location is 1204 Avenue U, Suite 201, in Brooklyn, New York.<sup>1</sup> Here is the physical location of 1204 Avenue U, Suite 201, a mail drop.<sup>2</sup> If you look closely at the advertisement in the window, you can see on the little—the white board right in the center of the window, it states that there is a summer special, 12-month post office box rentals, \$60 per year, \$5 per month, one-time only. It is a great deal for the bad guys!

As shown by this example, it is difficult to determine from just reading applications whether Medicare providers are using mail boxes or if the addresses are actually physical locations. This makes physical verification even more essential. Before I continue, I would like to point out that this mail drop was the reported location of two New York companies that provided DME products and MRI tests. These companies submitted Medicare claims totaling \$3.4 million and received payments of about \$500,000. But as you might expect, no services were rendered in this particular case.

PSI investigators traveled to New York and Miami to see firsthand the weaknesses in the enrollment process and to meet with special agents from HHS' Office of Inspector General, special agents from the FBI, Federal and State Medicare and Medicaid officials, and two convicted felons. During the PSI visits, we photographed several locations, like the one shown earlier where DME companies and other providers had operated out of mail drops and bogus store fronts.

I would like to show the Subcommittee a few other locations photographed by PSI investigators. The first photographs are the reported office location of two physicians who provided DME products and MRI tests.<sup>3</sup> As you can see, this is a laundrette. As we walked through the door, we saw the usual washers and dryers. However, when we reached the back of the laundrette, we found several mail boxes which is where the two physicians received Medicare payments of approximately \$117,000. These two physicians billed Medicare for claims totaling over \$690,000. But, again, like the other example, no products or services were ever rendered in this case.

The next photograph is the reported location of a Miami health clinic that performed diagnostic tests. As you see, this is a Mail Boxes Etc.<sup>4</sup> Medicare paid at least \$300,000 for tests at this location, but again no tests were ever performed.

<sup>1</sup> See Exhibit 4a. which appears in the Appendix on page 73.

<sup>2</sup> See Exhibit 4b. which appears in the Appendix on page 74.

<sup>3</sup> See Exhibit 5 which appears in the Appendix on page 75.

<sup>4</sup> See Exhibit 6 which appears in the Appendix on page 78.

The next photograph is the reported location of a Miami health clinic, Miami, Florida.<sup>1</sup> As you can see, this is a vacant store front. Medicare paid this clinic, if you want to call it that, approximately \$2 million. But, again, like the other examples, no services or products were ever rendered.

The final photograph is the reported location of 14 Miami health care companies that provided DME products and services. As you can see, this is an airport runway.<sup>2</sup> Medicare paid at least \$6 million for claims submitted by these companies. But, again, like the other examples, no services were rendered.

Senator COLLINS. Mr. Frazzini, could you please explain how an address was given that turns out to be a runway at the Miami International Airport?

Mr. FRAZZINI. Yes, it is kind of magical, really. Actually, what happened in this particular case, as it was explained to me by the HHS special agent who was involved with the case, when he went out to verify the location submitted on the application form, he drove around, I think he told me, for about an hour or so to try to find the address. When he couldn't find it, he went to his map that he had in his car and he looked on the grid and found the street name. The street name existed near the airport.

And what he did is he just—he couldn't find the actual address because it didn't exist on the map either. He just expanded the street to where the address would have been if it actually existed and he found himself at the Miami Airport.

Senator COLLINS. Thank you.

Mr. FRAZZINI. So the address never actually existed in the first place.

So as these photographs show, had HCFA officials required site visits of these companies prior to issuing provider numbers, especially in this particular case where the address didn't even exist, Medicare would not have paid these bogus providers \$9 million, just by simply going out, and the airport is a classic example of that.

While in Miami, PSI investigators also visited an office complex comprised of three buildings that are known to rent office space to DME suppliers. This particular office complex had housed 45 DME suppliers over the past 4 years. These companies billed the Medicare program over \$20 million during this period of time. Of these 45 suppliers, only two had not been under revocation, suspension, or in violation of the supplier standards relevant to DME companies.

Upon physical inspection of one building, PSI investigators found that only one of the offices was open for business, which seemed strange, since it was only 3:30 in the afternoon. Posing as entrepreneurs, PSI investigators questioned the one owner about his business. The owner's office was scantily furnished with a desk, filing cabinet, and a telephone. This DME owner told us that the medical supply business is a lucrative business. He told us that he makes about \$4,000 a month, but he knows of other owners who make approximately \$20,000 a month.

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<sup>1</sup> See Exhibit 7 which appears in the Appendix on page 79.

<sup>2</sup> See Exhibit 8 which appears in the Appendix on page 80.

The owner told us that Medicare has investigated his company several times, three times to be exact, and because of the problems that come with these investigations, he is planning on expanding his business to Orlando and is organizing a consortium of 37 DME suppliers so that when one supplier is investigated by Medicare, the cash flow won't dry up. PSI investigators found that this particular provider had submitted Medicare claims for \$500,000 and was paid approximately \$200,000 for DME supplies.

In conversations with Medicare investigators in Miami, setups such as the one used by this particular supplier are very common amongst fraudulent DME suppliers. These investigators told us that they found hundreds of DME companies that were nothing but mail drops, grimy auto shops, or empty warehouses.

For example, one office had a lady sitting in a room with four desks. Each desk represented a different company. There was a telephone on each desk, along with a different script for the lady to read when answering telephone calls for the several different companies that were housed in the office.

Throughout PSI's investigation, the common theme among the health care experts was that the government must do a better job preventing these con artists from obtaining Medicare provider numbers or law enforcement officials will not be able to weed out the unscrupulous providers fast enough.

That concludes my testimony and I would be glad to answer any questions that the Subcommittee may have.

Senator COLLINS. Thank you, Mr. Frazzini.

Before we turn to questions, I want to hear Mr. Hartwig's testimony and then we will question the whole panel.

Mr. Hartwig, please proceed, and welcome.

**TESTIMONY OF JOHN E. HARTWIG,<sup>1</sup> DEPUTY INSPECTOR GENERAL FOR INVESTIGATIONS, OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY SUSAN FRISCO, SPECIAL AGENT, NEW YORK FIELD OFFICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND CATHY COLTON, ASSISTANT REGIONAL INSPECTOR GENERAL FOR INVESTIGATIONS, MIAMI, FLORIDA, SATELLITE OFFICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Mr. HARTWIG. Thank you. Good morning. We are pleased to appear before you today to describe our experiences with high-risk individuals who have gained access into the Medicare program.

I believe the appropriate descriptors of today's health care crimes are complexity, high dollar amount, and sophistication. Currently, the program outlays exceed \$200 billion and multiple-subject cases are commonplace. We see millions of dollars stolen in a single scheme, and with today's technology, fraudulent providers can bill the system electronically, make quick hits for large amounts of money, and move on before they can be detected.

Today's criminals know where the Medicare radar is and how to fly under it. Let me elaborate briefly. Today's health care providers are typically highly networked through parent companies and sub-

<sup>1</sup> The prepared statement of Mr. Hartwig appears in the Appendix on page 62.

sidiaries with branches all over the country. Where we used to have fraud by a single provider affecting billings in only one or two States, it is now common to find billings by provider groups flowing through 30 or 40 States.

Something that may appear on the surface to be a local scam can unfold into a complex, organized fraud with systematic and sometimes nationwide implications. We sometimes find fairly complex operators who can perpetrate their scheme quickly in an area, close down, and move on to a new locale to evade detection.

When the OIG audited a statistical sample of Medicare's \$168.6 billion in fee-for-service benefit payments reported for fiscal year 1996, we projected a mid-point figure of \$23.2 billion that was paid improperly. Our auditors did not set out to quantify how much of that could be fraud, but our sense is that some of the improper payments more than likely were in the realm of intentional misrepresentation.

An entitlement program that has grown to huge proportions, Medicare provides criminals with a large target. Years ago, Willie Sutton said he robbed banks because that is where the money is. Today, Medicare is where the money is, and today's Willie Suttons are lined up to get what they can. That is why sound program oversight by HCFA and aggressive, well-organized law enforcement are necessary.

Medicare has 38 million beneficiaries, processes and pays 800 million claims annually, contains complex rules, and has a decentralized operation. The Medicare computer system accomplishes its missions of paying claims quickly, but sometimes fails to detect conditions indicative of fraud. The Medicare program was built on a system of trust, trust that medically necessary services, equipment and supplies would be provided appropriately to those who are entitled to them, and that claims for reimbursement would fairly reflect whatever was provided.

This hearing deals with the extreme end of the health care scale; that is, those individuals who single-handedly or as part of a conspiracy set out to rob the Medicare program while providing little, if any, services to beneficiaries. We are talking about people who should never have been allowed to participate in the program and how to keep others like them out. Unfortunately, even a small number of bad individuals can wreak enormous damage on the program.

We found that some benefit categories are more vulnerable than others to participation by criminal elements. For example, the durable medical equipment supply industry has been a high-risk provider group for years. In 1995—and Senator Durbin had mentioned Operation Restore Trust—we initiated Operation Restore Trust as a Department initiative which targeted Medicaid and Medicare fraud and abuse, and one of the targets of that operation was durable medical equipment.

Although some major improvements have been made in HCFA's management of the benefit, DME continues to be fraud-prone and a major concern. Medicare paid more than \$6 billion in 1997 for medical equipment and supplies. Despite current safeguards, HCFA has reported that in a sample of 36 new DME applicants in Miami, Florida, 32 were not bona fide businesses.

Our office recently sampled suppliers and applicants for DME in 12 large metropolitan areas. We found that 1 out of 14 current suppliers and 1 out of every nine new applicants did not have a physical address. A physical address is required for suppliers because it allows beneficiaries a place where they can reach suppliers about DME needs and problems. Also, a physical address provides a place where beneficiary and financial records should be kept for oversight purposes.

We found that businesses had closed, had questionable presence at the address to begin with. Some addresses, as you have seen, are mail drop locations or non-existent at all, a classic example certainly being where you are on a runway of Miami Airport, not a place where I would want to set up business.

Problems with physical addresses such as we have described often indicate potentially non-legitimate businesses. A classic example is a case we uncovered in the Miami, Florida, area. The Miami investigation began in 1994 when a private citizen in Miami forwarded to us dozens of Medicare explanation of medical benefit forms which she had mistakenly received in the mail. The forms showed that multiple beneficiaries were each provided liquid nutrition by six different DME companies. All of the companies billing were paid by Medicare for supplies and services supposedly provided.

We and the FBI initiated an investigation, contacting the beneficiaries. All denied receiving services. We then visited several of the business addresses which these companies reported to Medicare and found that none had an actual office or business location. Instead, all were located at mail drop boxes. Through the use of interviews, surveillance, and other investigative techniques, we found that what we initially believed to be six or so fraudulent companies operating independently were instead part of a larger crime ring that defrauded the Medicare program of over \$6 million.

The ring leader in this operation was Ulisses Martinez, who lived in the Miami area. We found that Martinez had entered the United States illegally some years before through use of a forged Panamanian passport. In 1992, Martinez and some of his associates began buying the names and Medicare numbers of beneficiaries which would provide the fuel for his scheme.

He purchased most of the names and numbers from two different sources. The first was from secretaries in doctors' offices who had easy access to patient information and physicians' Medicare billing numbers; and, second, from recruiters. As we have heard, recruiters are persons who canvass nursing homes, adult living facilities, and private neighborhoods for the sole purpose of finding Medicare beneficiaries.

In exchange for the beneficiaries' names and addresses and Medicare numbers, the recruiter typically offers free groceries, free rides to visit friends or relatives, or even cash. Martinez paid his recruiters \$100 per name and Medicare number, and knew he could make his money back 100-fold from the Medicare program. Martinez sought out other persons to help him run his fraudulent Medicare business and thereby provide a layer of fall guys, in case the scheme was uncovered by law enforcement.

Ultimately, we found 18 fraudulent health care companies linked directly to Martinez, all of which followed a pattern of using similar mail drop locations, billing for services not rendered, and fronted by third parties, while Martinez controlled the fraudulent proceeds. We uncovered that Martinez purchased 8 properties in Miami, using \$1.2 million in funds he fraudulently obtained from the Medicare program, and we have today pictures of two of those properties.<sup>1</sup>

We were able to successfully locate and prosecute nine conspirators for their part in helping Martinez run his DME companies. Eight of the conspirators pled guilty to Medicare fraud charges; a ninth chose a trial by jury. During the trial, the man confidently passed out cigars labeled "compliments of Ulisses Martinez" in the Federal courtroom during his trial. Despite his generosity, he was convicted on all counts.

As of this date, Martinez is a fugitive. Martinez is an example of a criminal who gained access to Medicare and billed the system without any intention of actually providing any services, equipment, supplies for which he billed.

We have investigated a similar case in New York. This time, the investigation began with beneficiary complaints to the Medicare carrier that Medicare was being billed for orthotic supplies the beneficiaries never received. The complaint centered on five durable medical equipment supply companies that all proved to be non-existent.

In expanding our review, we found that Russian criminal elements were billing Medicare under the provider numbers of totally fictitious or inactive companies for supplies and services that were never actually provided. Within a year, our investigation revealed 20 provider numbers that were involved in the billing scheme. None of the provider numbers were representative of a legitimate company that was actually or actively in the business of providing services. In addition to orthotic supplies, the Medicare program was billed for magnetic resonance imaging services and ear implants.

Our investigation of the activities behind the numbers revealed another common scenario by the perpetrators. They used front people in the Medicare provider application process, obtained inactive provider numbers and used them to bill the program, and used mail box drop locations to receive payments for services never rendered. These provider numbers were used to bill the Medicare program for millions of dollars in fraudulent claims.

After interviewing beneficiaries, our agent conducted interviews with mail box rental establishments and confirmed that several mail box drops were being opened by the same individual using five different Russian passports. Our interviews with bank officials revealed that the same individual renting the mail boxes also was opening bank accounts. The cooperation of the banks and the mail box store owners in this investigation was invaluable.

A bank employee recognized the man when he attempted to withdraw \$35,000. The individual was arrested. We were able to have the carrier stop payment on checks totaling \$325,000. The true

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<sup>1</sup> See Exhibit 9 which appears in the Appendix on page 81.

identity of this individual was only revealed through fingerprint analysis. The man, Yury Bizayko, was recently sentenced to 30 months' imprisonment and was ordered to pay restitution in excess of \$1.5 million. A second individual in this investigation has also pled guilty.

I want to take time to emphasize here that the Medicare carriers did a good job in setting up controls and limiting losses during the investigation. Although over \$27 million was billed under this scheme, a little over \$1.5 million was actually paid out. This investigation is continuing today. Other subjects are currently under investigation, and we have found new fictitious companies are being incorporated in other States and that the criminal interests in this investigation are finding new ways to game the system.

In conclusion, we firmly believe that the criminal elements in health care fraud are not isolated to schemes discussed in my testimony. Unfortunately, for true criminals, the only effective safeguards are tough-minded prevention measures and a strong law enforcement presence with equally tough penalties.

This concludes my testimony and my colleagues and I welcome your questions.

Senator COLLINS. Thank you very much, Mr. Hartwig.

Mr. Frazzini, I first want to welcome you back to the Subcommittee. We really enjoyed having you work with us last year on this investigation.

I want to go back to the issue of where PSI did site visits itself, and you mentioned that in doing one site visit, you found that the Medicare provider's address, or physical location, turned out to be a laundrette and another was a Mail Boxes Etc. location. This suggests to me that on-site visits are a very cost-effective and relatively easy way of preventing a great deal of fraud from occurring. Is that your impression? Was it difficult to conduct these site visits, or costly to conduct them?

Mr. FRAZZINI. First of all, glad to be back and it was a pleasure working here last year.

To get to your question, the answer is it was very inexpensive and it took us a rather limited amount of time. I think we traveled—an HHS investigator, an agent from the New York field office, myself, and another PSI investigator went to approximately five or six of these locations, these two being two of the ones that we visited. And I think it took us approximately 45 minutes, tops, to do that, to come up with this type of information.

So the investigative techniques that we employed to unravel this type of scenario was really rather limited. We really didn't have to do much at all and it didn't take us any time, and it wouldn't have taken us more than a few dollars in gas, I think, to get over to Brooklyn and back.

Senator COLLINS. A pretty straightforward way to prevent millions of dollars of fraud if, in fact, site visits had been conducted up front before the Medicare provider number was given to people who could then start billing, is that correct?

Mr. FRAZZINI. Certainly, and in these particular cases, as you can see, there is a high dollar amount associated with these addresses.

Senator COLLINS. Would you agree with that, Mr. Hartwig, that on-site visits, which I understand are being expanded, would have

prevented a lot of this very blatant fraud where there are no services being provided at all?

Mr. HARTWIG. It would have prevented much of it and at least made it more difficult to carry out.

Senator COLLINS. I would like to ask all four of you the same question, and that is, is this a growing trend, a new kind of fraud where we have completely bogus businesses coming into the Medicare system?

It seems to me that traditionally we always thought of health care fraud as being a case where an otherwise legitimate provider of medical services was over-billing the government. And, clearly, that is deplorable, but it seems to me we are into a whole different kind of fraud that is much more serious because no services are being provided at all.

I will start with you, Ms. Colton. Would you agree this is a growing trend?

Ms. COLTON. Yes, I would, and the reason that I would say that is because what we have found is that it is not just in the DME area that this is occurring in. Now, what we see is that it is expanded into the home health agency where they bill for home health visits that have never occurred. We have seen it expanding into community mental health centers where they are billing for either group or individual therapy that has never been provided, as well as we have also seen medical centers where they have billed for diagnostic tests which have never been rendered.

Senator COLLINS. Ms. Frisco.

Ms. FRISCO. In the 2 years that I have been with the agency, I have noticed that more and more individuals are getting into the program that have really no right to be there. I also see that greed has really played a large role in my investigation, and the individuals that I have been in contact with during this investigation have not been in any way deterred by the criminal prosecutions that have taken place so far.

Senator COLLINS. Thank you.

Mr. Hartwig.

Mr. HARTWIG. I have been investigating health care fraud for almost a quarter of a century and I have seen a great change in the type of schemes that are out there. And it started, as you said, Madam Chairman, with individual providers who were in the program and just went bad. Twenty years ago, Medicare was a \$22 billion program, and over the years I have seen a great increase in people who just target the program to steal from it. It is not a recent occurrence, but it is certainly one that has been growing as individuals have adjusted to the Medicare radar, have learned the system, and have understood that you can send in claims and get paid. We see more and more individuals, organized criminal rings, that set up for the sole purpose of defrauding the Medicare program out of millions of dollars.

Senator COLLINS. Your observations are very consistent with our first witness today, who described Medicare as a gold mine and said it was relatively risk-free—if he hadn't been turned in by one of his employees, he would still be billing falsely today—and that it was a lot easier than the other illegal activities he has been involved in over his lifetime.

Mr. Frazzini, you talked to law enforcement investigators in several parts of the country. Do they see this as a growing trend?

Mr. FRAZZINI. Yes, they do. We met with members of the FBI in New York, as well as HHS investigators in New York, HHS investigators in Miami, and the underlying consensus was that there are individuals getting involved in health care fraud with no background in providing health care services.

But one of the things that seemed to be reoccurring was the fact that a lot of these individuals were involved in certain types of criminal activity. So they weren't just a guy who is working on the street corner. I mean, these are people that know how to commit crimes.

Senator COLLINS. They are people who are already engaged in criminal activity?

Mr. FRAZZINI. Other criminal activity, sure, and that really has escalated the danger level for conducting this type of investigation. That is one of the things that I think was consistent throughout what I found throughout this investigation, in speaking to other agents. So, yes, law enforcement in the places we went to certainly would agree with Mr. Hartwig's statements.

Senator COLLINS. Thank you.

Ms. Frisco, in the testimony that you provided for our hearing record, you talked about how certain Russian co-conspirators had defrauded Medicare of millions of dollars with what appeared to me to be a truly egregious scheme of creating 20 different fictitious DME and MRI companies. Could you just briefly describe for the Subcommittee how the scheme worked?

Ms. FRISCO. The scheme initially started with five DME companies that billed for orthotic supplies, and they initially were billing the DME regional carriers. Once they were detected by those carriers, they adjusted their scheme to bill the local carriers for MRI services that were never rendered. Once the local carriers began to detect those companies, they moved on to bill for ear implants. So I guess the bottom line is they have always adjusted their scheme throughout the entire investigation to avoid detection.

Senator COLLINS. Ms. Colton, you also described in your written submission another outrageous example of outright fraud. Could you explain to us what one of your investigations uncovered?

Ms. COLTON. Certainly. What we found was that Ulisses Martinez conspired with friends and relatives to have them apply for the provider number, as well as open up mail box drops which were allegedly where the companies were located. And then he, in turn, had those individuals also open up the bank accounts, so that he would use a billing service to bill for the products that he was allegedly supplying. The payments for those claims would then be delivered to the mail boxes. Then those Medicare payments would be picked up and deposited into the bank accounts, all done without his name appearing on any of the documents. That is how he was able to insulate himself from the system identifying him as owning or truly controlling these 18 different companies.

Senator COLLINS. How was this illegal scam uncovered? What brought it to your attention?

Ms. COLTON. A private individual received a number of EOMB's, explanation of medical benefits, at his residence, and he turned

them over to us. And what we noticed and identified was that there was approximately 20 EOMB's, and each had different beneficiaries' names. There was the commonality of six DME companies that were listed as the providing companies on the EOMB's.

Senator COLLINS. So in this case, but for an alert senior citizen who received all these explanations of benefits that didn't make sense and contacted your office, this fraud might never have been uncovered?

Ms. COLTON. That's correct. The system did what the system is designed to do, which is to pay claims when they are completed properly. And in this case, those claims were completed properly. Therefore, a Medicare check was cut.

Senator COLLINS. Ms. Frisco, what about the case you described? How was that uncovered?

Ms. FRISCO. The case came to my office as a result of beneficiaries making complaints to the local carrier stating that they didn't receive the services that were billed under their number.

Senator COLLINS. Mr. Hartwig, you do have almost a quarter of a century of experience in investigating and pursuing health care fraud. What should we be doing? How can we stop this? How can we curb the ease with which criminals are now getting into the system? What would you recommend to us?

Mr. HARTWIG. Well, there are a few things. First of all, you can curb the ease with which criminals can get into the system, such as with the use of site visits and surety bonds, which were previously mentioned. Our office has recommended charging application fees for a Medicare provider numbers so that the program can take some steps to investigate whether the applicant is a good provider or not. So I think we can make some giant strides in just stopping them from getting into the program in the first place. These activities are a good way of accomplishing this.

I think we can do a better job of program payment safeguards by looking at the claims that are coming in and making sure that the program is paying claims that should reasonably be paid. From a law enforcement perspective, I think the program could do a better job of pricing. That is a difficult issue, but I think some of the basic problems with the program are some of these services are over-priced and somewhat ill-defined, if you understand that we pay large amounts of money for these ill-defined services. And then the last part, for some of these people, the only deterrence that many of them understand is very effective and very aggressive prosecution.

Senator COLLINS. I am going to yield to Senator Durbin for some questions. I do have additional questions for you.

Senator Durbin.

Senator DURBIN. Thank you, Senator Collins.

Could you put two charts back up again, Mr. Frazzini, that talk about the application process for DME providers, as well as for the home health providers?<sup>1</sup>

Mr. FRAZZINI. Certainly.

Senator DURBIN. I would like to ask you a question or two. First, thank you for coming, and thanks to the entire panel.

<sup>1</sup> See Exhibits 2 and 3 which appears in the Appendix on pages 71 and 72 respectively.

But as these charts are brought back up here, I am trying to understand this process a little better. What I gather is that when it comes to the home health care that there are two agencies involved in establishing whether or not someone will be an approved provider—the State agency, which might be in my State, for example, the Illinois Department of Public Health or Department of Public Aid, which determines whether or not someone who wants to provide home health care is, in fact, certified to do so, and then the so-called fiscal intermediary.

Now, in that case, for example, would that be this NSC? Is that the fiscal intermediary for home health providers?

Mr. FRAZZINI. What the NSC is—the National Supplier Clearinghouse relates to durable medical equipment suppliers.

Senator DURBIN. I see.

Mr. FRAZZINI. And that is something separate and different than the home health care process.

Senator DURBIN. So home health under Part A, I suppose, goes through some other one of 70 different agencies that review these?

Mr. FRAZZINI. Yes. It is less than—

Senator DURBIN. Private companies?

Mr. FRAZZINI. Yes, the contractors. That's correct. I am not sure if it is 70, but that's correct.

Senator DURBIN. OK, so when you are a home health provider, or desire to be one, you apply to the Federal Government to get on this train. You are at least going to have to pass through two reviews before that happens, the State agency as well as the fiscal intermediary?

Mr. FRAZZINI. Well, that's essentially correct, although the fiscal intermediary—from my understanding, it is more of a paper review as opposed to an on-site review.

Senator DURBIN. Now, let us take a look at the DME provider. In that case, we are talking about the National Supplier Clearinghouse, which is part of Palmetto Government Benefits Administrators in Columbia, South Carolina?

Mr. FRAZZINI. Blue Cross and Blue Shield of South Carolina, correct.

Senator DURBIN. OK. Am I correct that this company was contracted with in 1993? Was that when they started their responsibilities?

Mr. FRAZZINI. Well, Blue Cross and Blue Shield of South Carolina, I think, has been a contractor with the government for several years. I am not sure on the specific date. I know the National Supplier Clearinghouse—it is my understanding it was either 1992 or 1993 that they started with a more uniform system which is now known as the National Supplier Clearinghouse, and Blue Cross and Blue Shield of South Carolina was awarded that contract.

Senator DURBIN. So before the contract was awarded, how were these DME providers reviewed?

Mr. FRAZZINI. As far as on-site visits, they weren't.

Senator DURBIN. Was there any other type of review?

Mr. FRAZZINI. In speaking with a couple National Supplier Clearinghouse investigators, I asked that exact question, what was done prior to then, and they said other than submitting an application

and possibly doing some paper checks to make sure the i's are dotted and the t's are crossed on the application, nothing was done.

Senator DURBIN. OK. Mr. Hartwig, you and Ms. Frisco and Ms. Colton, I take it, are all Federal employees, is that correct?

Mr. HARTWIG. Yes.

Senator DURBIN. How many people are working in the Federal Government in your area of work reviewing for Medicare fraud? How many Federal employees are involved in that?

Mr. HARTWIG. The Office of Inspector General now has somewhat over 1,000, of which about 300 are in the law enforcement area. You would also have to include here that the FBI has made a greater, increased effort in health care fraud over the last few years, as well as the Department of Justice, and the Kennedy-Kassebaum legislation that was passed. I thank the Members of Congress for passing it.

Senator DURBIN. We weren't here, but we sure liked it. I voted for it in the House.

Mr. HARTWIG. I thank you for not repealing it, then, I guess.

Senator COLLINS. I endorsed it.

Senator DURBIN. Good.

Mr. HARTWIG. It certainly has gone a long way in increasing the resources available to go out, detect, and chase these criminals. I think the Health Care Financing Administration has some funding under that as well.

Senator DURBIN. Now, let me ask you this. Since you have been in this field for 25 years, you have seen a lot of changes, I am sure, but this decision in 1992 or 1993 to create this National Supplier Clearinghouse—was that ostensibly to contract out part of this responsibility?

Mr. HARTWIG. The problem of issuing provider numbers has been an issue that has been around for a long time, and is one that the Inspector General's office and HCFA have worked closely on. I believe at one time, provider numbers were issued by individual carriers throughout the country. So a DME supplier in New York would apply to the Medicare contractors in that area.

Given our experience with durable medical equipment especially over the years, there was an effort made to control the issuing of DME supplier numbers. The Health Care Financing Administration then went to four regional DME contractors that handle all the DME claims in the United States, and, with that, they combined the issuance of DME provider numbers to one contractor, where in the past a DME company could get a number from any carrier. That system was put into place to centralize that provider number issuance.

Senator DURBIN. So they centralized it in an effort to try to reduce the fraud and they contracted out with this National Supplier Clearinghouse, asking them to issue the numbers, and I suppose at some point to review and approve the applications. Is that correct?

Mr. HARTWIG. Yes, I believe so.

Senator DURBIN. How much money does the Federal Government pay the National Supplier Clearinghouse?

Mr. HARTWIG. I have no—I am sorry. I don't know. HCFA actually contracts with the National Supplier Clearinghouse and I am

unfamiliar with the actual amount of money that they would receive.

Senator DURBIN. Do you know how many analysts they have working on these applications?

Mr. FRAZZINI. What I do know—this might get to your question. I know as of last year, they only had one investigator to do on-site visits, a field investigator who is stationed in Miami.

Senator DURBIN. One investigator for on-site visits nationwide?

Mr. FRAZZINI. For the whole country, yes, sir.

Senator DURBIN. And how many applications would the National Supplier Clearinghouse receive in a year?

Mr. FRAZZINI. I am not exactly sure on the exact number, but it is several thousand, I think.

Senator DURBIN. The number I have is 16,000.

Mr. FRAZZINI. Yes, that would be consistent with what you have been talking about. I can say that the National Supplier Clearinghouse is starting to contract out with—

Senator DURBIN. Choice Point.

Mr. FRAZZINI [continuing]. Choice Point, whereas they are starting to delegate through a contract the responsibility of on-site visits. But, again, that is something that has only occurred within the last 6 months or so.

Senator DURBIN. I don't know. Mr. Hartwig, maybe you could add something.

Mr. HARTWIG. I was just going to add that I think there are about 118,000 DME provider numbers throughout the United States issued by the National Supplier Clearinghouse. I think I read a statistic where 18,000 of those are denied each year.

Senator DURBIN. That is a little different than what I have. Here is what I have been told, and I don't know if this is accurate or not, but 16,000 applications a year for new DME provider numbers go through this National Supplier Clearinghouse. A year ago, they had 19 analysts, people who looked at these applications. That is about 800 per person. I don't know how you can do much of a review. You certainly can't do an on-site visit.

I now understand that the number is up to 40, so you have 400 applications per employee, per year, going through this National Supplier Clearinghouse. It would be physically impossible to do even a fraction of those numbers in terms of site visits. And yet we are paying this company, are we not, to do just that, to review these applications? And they have some criteria, do they not, that these applicants are supposed to meet before they are given a number?

Mr. HARTWIG. Yes. I believe there are 11 criteria that a DME company is supposed to meet before they are allowed in the Medicare program.

Senator DURBIN. How could this be physically possible for them to even—let us assume you are one employee and you are working 250 days a year. You have 400 applications coming in for you to analyze each year. So each day, you have to do 1.5 applications, roughly. You have to establish 11 different criteria. It is impossible to consider a site visit, let alone go through each of the applications and make sure that the standards are met.

Mr. HARTWIG. Our office, the OIG, has a number of reviews and we have pointed out some of these similar problems. That is why we have aggressively called for site visits and surety bond requirements, just as a way of trying to stop abuse. We have talked about requiring providers to supply Social Security numbers or EIN's just as a way of stopping the problem. But I think on-site inspection of these providers is absolutely necessary.

Senator DURBIN. Last year, 1997, 16,184 DME applications to the National Supplier Clearinghouse, site visits for 282, 1.7 percent. And we are paying these people to review these applications. I can't imagine what they are doing, other than just entering information into some computer database and issuing numbers. It doesn't strike me that we are getting our money's worth, whatever we are paying them, and I hope that one of our follow-up hearings will bring people in from the National Supplier Clearinghouse to answer some of these questions directly.

Let me ask you this question. In some States—Illinois is one of them—the durable medical equipment providers are licensed. Is there any indication that there is less fraud in those States than in others?

Mr. HARTWIG. I am not aware that there is less DME fraud in Illinois than—

Senator DURBIN. We certainly have our problems, but I just wondered, in the scheme of things, whether State licensure adds anything to this.

Mr. HARTWIG. I think any licensing, any checks, will add to the controls in the program. Any area—we have generally found, where a State has an aggressive licensing system, it will generally stop these kinds of fraudulent providers from entering. I will also say, in 25 years, we also understand how the criminal element can study the system and circumvent the system.

Senator DURBIN. We have a hot case in Illinois—many of them—involving a fellow and the question of whether or not \$28 million in assets are subject to forfeiture. Is this common for us to demand forfeiture if, in fact, people are found guilty, so that Mr. Smith's luxury cars and the other things become the property of the Federal Government?

Mr. HARTWIG. We are trying to make it more common, and the Kennedy-Kassebaum legislation added some criminal forfeiture proceedings in health care fraud that we certainly look at as a deterrent. Where we can take the money back from an individual and can seize property, we think that that has a very visible deterrence to other people that want to cheat.

Senator DURBIN. I would like to ask Ms. Frisco or Ms. Colton and, in fact, anyone on the panel, but to them in particular, what kind of incentives are there for whistleblowers?

Let us start with the basics. I am a senior citizen who just got a bill from Mr. Smith's company saying he provided me \$600 in services or \$600 in equipment. I never heard of him, I didn't get anything, so I get on the hotline and call. Let us assume I do that. What kind of reward is in the process for me if, in fact, Mr. Smith is ultimately prosecuted?

Ms. FRISCO. I don't personally know the answer to that.

Senator DURBIN. Do you know? Other than satisfaction in knowing that I have stopped somebody from cheating the government, is there anything in this for me? Can I get \$1,000, or more, or something?

Ms. COLTON. There is the ability to file a qui tam suit, which is different than what you have indicated, which would be to contact the hotline and report, although I would—

Senator DURBIN. Excuse me. That is an action in Federal court, is it not, or at least Federal agencies—

Ms. COLTON. Correct.

Senator DURBIN [continuing]. That few senior citizens are likely to want to get involved in, correct?

Mr. HARTWIG. In the Health Insurance Portability and Accountability Act, the Kennedy-Kassebaum legislation, there is a section that allows the Department to pay beneficiaries a reward for turning in not just criminal providers, but where there is an overpayment. There is a section that does allow the government the flexibility to pay a beneficiary for reporting.

Senator DURBIN. Do you know how frequently that happens, how frequently we have paid people for—

Mr. HARTWIG. I don't know that we have paid anyone under that provision. I don't know if that has actually been implemented as I sit here today, but there is a provision that would allow that to happen.

Senator DURBIN. Well, I will tell you something. If we are talking about \$20 or \$30 billion being wasted in this program each year, one of the things that I would like to suggest is that we really create a whistleblower opportunity here so that not only senior citizens, but people working in medical offices for doctors who are peddling Medicare identification numbers and all the others who would come into this system would know that a phone call might end up in a reward if, in fact, they have uncovered serious Medicare fraud.

I don't know if that sounds like a reasonable suggestion from where you are sitting, but it sounds to me like in the two cases you have described, someone stepping forward and talking about it made all the difference in the world and that may be what we need in this system to let folks know that people are watching to make sure they are obeying the law.

The second thing that comes up is this whole question about an application fee. Is there no application fee now for a person to receive a provider number?

Mr. HARTWIG. I don't believe there is.

Senator DURBIN. Free, for nothing?

Mr. HARTWIG. Yes.

Senator DURBIN. That is great. And so assuming for a minute that the National Supplier Clearinghouse is doing something for what they are being paid, the question is whether we ought to be charging the providers an application fee that would cover on-site visits, someone actually going through the application, and maybe—and here is a wild suggestion—a follow-up on-site visit, something like that in the course of a year to see if they are still there or whether, in fact, we have washers and dryers tumbling instead of wheelchairs being—

Mr. FRAZZINI. On-site visits, I think, are essential, and I think the fees associated with them are—I cannot see any reason why you wouldn't do that. An analogy that keeps up throughout this investigation is the one of licensing somebody to fly in this country. It costs you a lot of money to get your license to fly a plane. Yet, you can go in and start taking care of elderly people in this country without paying a dime. The obvious purpose is to protect the well-being of others by having a pilot licensed. Why don't you do it for home health care, regardless of the fraud perspective?

Senator DURBIN. Well, if the on-site visits result in a third of them being ejected, it strikes me that it is money well spent, and if these people making the application paid for the actual on-site visit, it is a good thing for the taxpayers and the elderly people.

Thank you, Madam Chair.

Senator COLLINS. Thank you, Senator Durbin.

Mr. Hartwig, I want to go back to the issue of the on-site visits. I notice that the Inspector General put out a December report urging on-site visits, but is this an issue that the Inspector General's office has been urging for some time that HCFA conduct on-site visits or is it only lately that you have come to the conclusion that these need to be done?

Mr. HARTWIG. We have been studying the provider enrollment process for a long time. I think the actual recommendations for on-site inspections has been a recent one. I don't know when we first proposed it. And, actually, the recommendation came to light as we conducted some of the recent investigations that you have heard about today where we find totally fictitious addresses.

Senator COLLINS. And this reflects my conclusion that this is a new and insidious kind of fraud because it isn't a legitimate provider involved. It is a totally bogus business, is that correct?

Mr. HARTWIG. It is clearly the targeting of the health care program solely for greed and solely to steal from it. We find out that the foundation of the program is the ability to obtain provider numbers, making it much more difficult to investigate. We have had cases where once we identify a provider as being aberrant—and I think Special Agent Frisco mentioned that—the company then shuts down. They just take another provider number. Then we have to go track them down again.

One of the difficulties in the New York case was that we didn't even know the real name of the individual doing it. We had to actually arrest him and get his fingerprints before we could actually find out who, in reality, he was.

Senator COLLINS. Mr. Frazzini, Senator Durbin raised the issue of whether the National Clearinghouse is doing enough, and clearly it looks like there needs to be more resources and more emphasis on fraud prevention. But, ultimately, the responsibility for this program is HCFA's. Is HCFA doing enough, the Health Care Financing Administration, in requiring its contractors to make fraud prevention a priority?

Mr. FRAZZINI. The frank answer to that is, no, I don't think so. If they were doing their job, then why do we have the problem that we have right now? From my perspective, it is their responsibility to assure that things that we are talking about here today don't exist. Yet, they exist, so who is looking over this money?

Senator COLLINS. Ultimately, it is the Federal Government that is responsible for preventing this fraud, whether Federal employees are doing it directly or carrying out the functions directly, or whether the function is being contracted out.

Mr. FRAZZINI. Yes. I think blaming the insurance companies or the contractors is looking at the wrong place. I mean, they have a contract to do business with the government and they are doing what the government tells them to do. If the government wants them to do more, then the government can tell them to do more and can pay them more to do that, and I don't think you will have a problem.

I have seen insurance companies and fraud units and various contractors that do a really good job. So I really do believe that it is a lack of oversight on HCFA's part to direct these insurance companies to do what they want them to do. You can't just have the insurance companies say, OK, we are responsible for health care fraud in this particular part of the country, and expect them to be able to do the job properly. They are getting paid to do what they are told to do, so I think HCFA needs to be on top of that.

Senator COLLINS. Thank you. I want to go back to the issue of the use of recruiters. This was something that was described by our preceding witness that struck me again as another insidious trend.

Ms. Colton, I would like to start with you. It is my understanding that the ring leader of the fraud in the Martinez case began buying the names and Medicare numbers of beneficiaries from secretaries in doctors' offices and from recruiters who canvassed nursing homes, adult living facilities, and private neighborhoods to get the Medicare beneficiaries' numbers. And you also noted that in exchange for the Medicare beneficiaries' names and addresses and numbers that the recruiters provided some incentives.

In some cases, undoubtedly, the senior citizens—in most cases, I suspect, were tricked out of their numbers or had no idea that someone else was giving out their numbers. But did you find some cases where the beneficiaries were also unfortunately involved in the fraud or were given inducements to give their numbers?

Ms. COLTON. Yes, we have. As a matter of fact, we have found that the recruiters know that there are beneficiaries out there that are very aggressive and more than willing to sell their Medicare number in order to receive some inducement for it, and they target those beneficiaries, as well as the other ones that you described.

We, along with the FBI, have actually finally influenced the U.S. Attorney's office in the southern judicial district to prosecute some of these beneficiaries that we deem as, "professional beneficiaries" that actively seek to sell their Medicare number and demand money in exchange for doing so.

Senator COLLINS. In other cases, the beneficiaries were totally innocent victims whose numbers had been given out by others, is that correct?

Ms. COLTON. That's correct. It is possible for recruiters to pay an inducement to a secretary or a nurse sitting at a medical facility, and the beneficiary would have no knowledge that that individual had sold their number to that recruiter. Moreover, if the unscrupulous provider that is creating this cottage industry is savvy enough

to direct those EOMB's to go to a particular address other than the Medicare beneficiary, the beneficiary is going to have no idea that services are being billed under their provider number.

Senator COLLINS. That was going to be my next question. In every case, is there an explanation of benefits sent to the supposed beneficiary?

Ms. COLTON. There is supposed to be, but as we have seen, obviously, there isn't because the provider can switch the beneficiary's address in order to have it go somewhere other than where it should go.

Senator COLLINS. And the more sophisticated criminal is clearly going to do that so that he is not tipping off the beneficiary that his or her number is being illegally used?

Ms. COLTON. Correct.

Senator COLLINS. Mr. Hartwig, how prevalent is the use of recruiters? Is this just a regional phenomenon or do you think it is something that is growing nationwide?

Mr. HARTWIG. I obviously think it is growing, and the obtaining of Medicare numbers is a scheme that has—again, changed over the years. At one time, the fraudulent providers used to sell them to each other. We then saw stages where individuals would set up free blood screening or free blood pressure and say just fill out this questionnaire and give us your name and your address and your beneficiary billing number.

I think the use of recruiters is the next step in that process. We have seen it localized in some of the larger areas. Certainly, we see it very active in Florida. I think on the West Coast, we have seen some activity. I don't know if it is a nationwide scheme. As I sit here, I would say that if it works, it will certainly spread.

Senator COLLINS. Mr. Hartwig, I would like to turn to a different issue now with you, and that is we have noticed in our investigation a pattern where an illegal business will be set up. The individual running the business will scam Medicare for hundreds of thousands of dollars, spend all the money, and then declare bankruptcy. What happens when that occurs, and do you think we need any legislative reforms in the bankruptcy law so that the claims that the Medicare has on the remaining assets are eventually honored in some way?

Mr. HARTWIG. We believe, and we have recommended, that Medicare overpayments not be excused through the bankruptcy proceedings. Some of these criminals are 100 percent Medicare; that is all they bill. So if the Medicare program finds out about improper claims and they stop paying, the provider has now lost 100 percent of their income, and they declare bankruptcy. By declaring bankruptcy, they then argue that the government, by cutting off benefits, impeded the provider's ability to repay.

They use the bankruptcy laws to protect themselves. Especially if it is a scam business, they then get away with not having to pay back the overpayment by declaring bankruptcy. And, again, the criminal element tends to study and understand the Medicare billing system. They understand the Medicare radar, and they start to use the bankruptcy system as a way of keeping that money. We think that one of the reforms that could be made is not allowing

these kind of Medicare cheats to use bankruptcy to hide behind paying back improper reimbursements.

Senator COLLINS. I think that is an excellent suggestion and one that the members of this panel should pursue. It is likely that the Congress may well take up bankruptcy reform legislation this year and that is an issue that we would like to work further with you on. I know it is an area where Senator Durbin has been active, as well.

I have one final question that I would like to ask each of you. If we want to focus more on preventing the fraud up front, preventing it from the first place, what one or two recommendations would you have for us that would do the most good to try to stop the fraud from occurring in the first place?

Mr. Frazzini.

Mr. FRAZZINI. Application fees, on-site visits, and scrutinizing the veracity of the information provided on the application form. That is essential. If you don't do that, all bets are off. You have to make sure who you are doing business with, and right now I don't think in a lot of cases the government, through HCFA, knows who they are doing business with and that is a problem.

Senator COLLINS. Thank you.

Mr. Hartwig.

Mr. HARTWIG. I certainly agree with Mr. Frazzini; aggressive on-site visits, stopping them before they get in. The Department now has the ability not to allow convicted felons in the system, and I think we should ensure that we don't allow those convicted felons in the system. I think the use of surety bonds and on-site visits, and aggressively checking out a provider before we give them a number, should ensure that what we are dealing with is a legitimate provider. It goes not just for DME, it goes for all the laboratories, ambulance companies, all those.

I also think that the carriers can do a better job of screening inactive numbers. We have found that many of the people, when they come in the system, will apply for 20 provider numbers up front and then will just use them as they need them, so they might have 18 that are inactive. And I think we can do a much better job where a number is not used for a period of time; and I would make it a very short period of time. Before somebody gets to use that number, make them go through that application process all over again.

Senator COLLINS. Thank you.

Ms. Frisco.

Ms. FRISCO. I agree with all the things that were said so far. Verifying the information on the provider applications and conducting on-site visits, I think, are essential.

Senator COLLINS. Thank you.

Ms. Colton.

Ms. COLTON. I would agree, as well, and moreover I would take an aggressive approach toward interviewing those people that are representing themselves to be the owners and/or operators of these companies. I think what we have found is that when you actually get in there and start to interview these people, they don't have any idea as to what kind of services they are providing. They don't have any idea how many beneficiaries they are seeing, etc.; and it

is very indicative of the fact that there is a problem with that particular provider.

Senator COLLINS. Do we need to do more to educate our senior citizens, as well, to make them be a little more careful about giving out their numbers, and also perhaps publicizing more the 1-800 number or in some way encouraging them to come forward?

Ms. COLTON. We take advantage of opportunities when we are asked to come and speak to beneficiary groups or senior citizen groups. At those times we try to educate them that it is important for beneficiaries to review their explanation of Medicare benefits. If they don't think that they have seen that provider or they don't think that they have had the service rendered as it appears on their EOMB, they should contact the number that is on the bottom and report it.

We also encourage beneficiaries not to sell their Medicare number if they are approached and to report that and to report suspicious activity like people coming to pick up large numbers of their fellow citizens in unmarked vans and transporting them at odd times of the day.

Senator COLLINS. Thank you.

Senator Durbin, do you have further questions for the panel?

Senator DURBIN. I just have one last question. As vexing as this problem is, we may be talking about the easiest part of it, the durable medical equipment, because you can literally visit the site and determine whether or not it is an empty building or a runway or a laundromat, whatever it happens to be. But the whole area of home health care is one that I am not quite sure how we get our hands on because I am a strong advocate of it and I believe it is cost-effective when it is done right and it gives to seniors just what they want, the ability to stay in their own homes for a much longer period of time before they even consider other types of care.

But this is a one-on-one deal. There are very few people involved in it, looking over their shoulders to make sure that the services they have said are actually rendered. And I was curious as to whether, in this area on which we haven't spent a lot of time, there are any safeguards you can think of that might ensure that when someone bills the Federal Government and says, I visited this lady, I helped her with her insulin shots, I did the following, that, in fact, it did occur, that those services were rendered. Are there any ideas along those lines?

Mr. HARTWIG. I think as you look at home health care, again, I can't stress enough the importance of not letting some of these companies in in the first place. A confirmation should be sent out to the beneficiary asking them if they received these services. In home care, I don't know that a beneficiary receives an EOMB like they may on durable medical equipment. We need a procedure where the beneficiary is asked if they were visited by a nurse; and a greater auditing of the services is needed. We have also recommended that physicians take a much greater role in certifying the type and quality of care that a home health agency should provide or is authorized to provide.

Senator DURBIN. That is interesting on that statement of services, and having been through it with my mother recently, I think also you might want to require that it be sent to some member of

the family. Perhaps the elderly person may not have the memory or the understanding to realize what they are receiving, but if some other member of the family sees it and says, wait a minute, nobody visited mom last week, this is bogus, that might also lead to some verification.

Mr. HARTWIG. And the contractor wouldn't have to do it for every claim as long as they are doing it for a sample. And, again, it is just making it more difficult to defraud Medicare. That is what we are really looking to do.

Senator DURBIN. Thank you.

Senator COLLINS. I want to thank you all very much for your extremely valuable testimony today. I also want to thank you for the work that you are doing out there on the front lines. As a member of the baby-boomer generation, I have a great interest in ensuring that the Medicare system is financial solvent. As a United States Senator, I want to make sure that this program is protected from fraud and abuse.

You are the ones who are doing the battle on the front line, and I hope that you will share any further thoughts or recommendations that you might have with us on how we can help you be more effective. So thank you very much for your time and your testimony.

Our final panel this morning includes witnesses from the Health Care Financing Administration, the agency charged with managing the Medicare program. Our witness are Donna Dymon, a nurse consultant detailed from the U.S. Public Health Service to HCFA's Region IX office in San Francisco, and Dewey Price, a team leader for Operation Restore Trust in HCFA's Miami satellite office.

These two witnesses will describe specific weaknesses in the enrollment process for potential Medicare providers and how these weaknesses allow unscrupulous individuals to steal millions of dollars from the Medicare program. They will also provide us with information on another very important part of this problem, and that is the impact of unscrupulous providers on the quality of care provided to elderly citizens in this country.

Pursuant to Rule 6, as you have heard me say repeatedly this morning, all witnesses who testify are required to be sworn in. So I will ask that you stand and raise your right hand.

Do you swear that the testimony you are about to give to the Subcommittee is the truth, the whole truth and nothing but the truth, so help you, God?

Ms. DYMON. I do.

Mr. PRICE. I do.

Senator COLLINS. Thank you.

Dr. Dymon, I am going to ask that we start with you this morning. I would ask that you limit your oral testimony to about 10 minutes in order to allow us time for questions, but your full statement will be made part of the record.

Thank you.

**TESTIMONY OF H. DONNA DYMON, NURSE CONSULTANT, SAN FRANCISCO REGION IX, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Ms. DYMON. Thank you. Madam Chairman and Members of the Subcommittee, I am a career commissioned officer with over 21 years as a health care officer with the U.S. Public Health Service. I hold two master's degrees, one in nursing, and a Ph.D. in business. Currently, I am detailed to the Health Care Financing Administration, HCFA's regional office in San Francisco, California.

My responsibilities include training for home health agency providers, as well as State agency surveyors; working to assess compliance with the Federal regulations; and detecting abuses and curious activity within the home health and hospice programs. I have participated in approximately 100 surveys of home health agencies and hospices.

I am sure this Subcommittee is aware of the Operation Restore Trust project. This was a national initiative to identify and eliminate fraud, waste and abuse in the Medicare program. ORT allowed HCFA's regional offices to focus on specific segments of the Medicare program. In Region IX, we targeted home health agencies and hospices, primarily because between 1993 and 1995, HCFA certified 321 new home health agencies in California. This was a 70-percent increase.

Today, I am going to discuss the results of Region IX's review of these 44 home health agencies in California, as well as other problems detected in conjunction with this review. The results of this review are contained in a report which I have provided the Subcommittee copies of.<sup>1</sup>

The previous witness focused primarily on DME suppliers and the industry, where site visits are rare. Today, I will discuss the home health industry, where site visits are mandatory. These are called surveys. In some cases, the mandatory surveys could be classified as nothing more than a drive-by. HCFA is charged with ensuring that home health agencies meet conditions of participation in the Medicare program that are adequate to protect the health and safety of our beneficiaries.

Medicare has 12 conditions of participation covering all areas of administration, as well as patient care. Most conditions include detailed standards and elements that further define the responsibilities of home health agencies. Of the 44 home health agencies reviewed, 36, or 82 percent, failed to meet compliance with the conditions of participation, and 23, or 52 percent, were terminated from the program. In addition, we found that some home health providers charged \$13,216 per patient, while the national average was only \$4,141.

The current survey process which is used is not adequate to effectively assess home health agencies. The standard survey process contributes to nothing more than cake walk for allowing anyone to establish a certified Medicare home health agency. This is not my own professional opinion, but also the conclusion of the General Accounting Office, who recently reported, "Rarely are new home health agencies found to fill Medicare certification requirements."

<sup>1</sup> See Exhibit 11 which appears in the Appendix on page 106.

GAO further reported that home health agencies self-certify their financial solvency, agree to comply with the provisions of the Civil Rights Act, and undergo a very limited survey, and few fail.

On January 1, 1998, new requirements went into effect as a result of the Balanced Budget Act of 1997, such as use of a surety bond, requiring home health agencies to treat a minimum of 10 patients, and issuing a new enrollment application. These are great first steps, but we need a lot more.

Opening a home health agency is a get-rich-quick opportunity. As reported in a recent Region IX newspaper article, new home health agencies can make \$1 million after the first year. In fact, there have been allegations that foreign countries are offering training courses on how to start a home health agency in the United States.

There are no provisions that specify the setting in which someone must provide home health services. There is no requirement that the setting be a professional location. State surveyors have found home health agencies being run out of basements, garages, kitchens, dining rooms, a janitorial supply service, and even a pawn shop. One survey of a home health agency was conducted in an owner's residence while the father cooked odorous sausages on the stove, the mother vacuumed the living room rug, and dogs jumped at the surveyor's feet.

The standard survey process is an easy walk-through process, often called a drive-by survey. A potential provider only needs to complete a few forms without any validation of information by HCFA or State agency. Prior to Region IX's institution of a strict review process, we allowed convicted felons into the Medicare program, and one felon falsified clinical records, credentials, and defrauded the Medicare program to over \$2.5 million.

The new enrollment application, the HCFA 855, requires that fiscal intermediaries review and approve information. However, there is no provision that sharing this information with other agencies, and especially the regional office, is completed. The new enrollment application provides a vehicle for collection of critical information which the region needs in processing new providers into the system. We need to have region-based systems that unite the application information, survey information, surety bond history, and claims information to the fiscal intermediaries, State agencies, and regional offices so that we can extract this vital information at our fingertips when processing initial applications, changes in ownership, or recertifications.

Home health agencies have falsified clinical and billing records submitted to substantiate their positions while surveyors have questioned patient care. I have personally witnessed a young nurse confessing to falsifying clinical records at the direction of the management of the home health agency. We have found home health agencies that participate in altering documents in an attempt to pass certification standards.

A survey of one home health agency was completed on a Friday. The surveyors documented non-compliance and started termination procedures. On the Monday following that survey, the agency was completely disbanded and the rental space was vacated. There was no mechanism in place to recoup any of the overpayment.

Earlier, I mentioned the standard survey process. This is an abbreviated examination of only 5 of the 12 conditions of participation. For example, the standard survey does not even include review of the skilled nursing regulations which is basic to the definition of a home health agency. The extended survey process is used by Region IX and all initial and targeted providers. We have found that the agencies may provide services as directed under a plan of care that would be surveyed by the standard process, but these same agencies fail to have the administrative underpinnings that are needed to support and sustain the system to provide quality care.

Using the extended process, we have identified such organizations that are truly registries or temp agencies that want to only bill Medicare for their services. The ORT project identified numerous Medicare-certified registries largely because there were no administrative practices in place that were reviewed at the time of the survey.

Currently, HCFA is requiring 10 patients for all new home health agencies to have enrolled under their care prior to the initial survey. Region IX began this practice in April of 1996. We learned, however, it was not enough to just have the 10 patients and verify that these 10 patients were solely under the direction of a new applicant. To pass the initial survey, we required State agencies to submit documentation of these 10 patients, and we ran these numbers with our computer systems to be sure that these patients were not being borrowed from a certified agency.

Why are these safeguards important? Well, to prevent the poor care and abuses, such as excessive services and curious activity, that threaten the health and safety of the beneficiaries. I would like to discuss just a few points.

One Medicare beneficiary lost her leg due to improper care by the home health agency. The home health agency had documented that the beneficiary had a pressure ulcer of the left knee. At the time of admission to the home health agency, the patient was infection-free. About 1 month following admission, the nurse detected a foul odor with a greenish-yellow drainage. The nurse obtained a wound culture and sent it to the medical laboratory for testing. The lab report showed no infection. About 7 days later, the patient was admitted to the hospital for an above-knee amputation. After questioning the agency staff, we learned that the nurse had taken a wound culture from the wrong knee.

During a home visit, surveyors noted a patient was disoriented, agitated, fed with a gastrostomy tube, was an insulin-dependent, diabetic, had congestive heart failure, and used a Foley catheter for bladder drainage. The surveyors learned during the visit that the caregiver was instructed by the agency staff to use ordinary tap water to irrigate a Foley catheter. The standard practice is to use sterile solutions into the bladder.

Nurses fail to check all medications patients take, as required by the regulations. Often, patients took doses that were higher than recommended, and patients exhibited side effects without agency staff notifying physicians. For example, one patient was given four times the recommended dose of an anti-depressant. The patient's daughter reported that she didn't like her father sleeping all the

time. The agency staff failed to alert the physician that the dosage level or the patient's behavior was abnormal.

We also have found that some agencies bill services for homebound patients who are, in fact, not really homebound. For example, a home health agency billed Medicare for services when a homebound patient was actually visiting Las Vegas, Nevada. Another agency billed Medicare when a homebound patient attended the Summer Olympics. In addition, we have found countless examples of beneficiaries who were supposedly homebound and unable to walk a few feet who routinely dined out at restaurants, conducted their own shopping, and went to the movies.

Recommendations, if I may. Greater emphasis is needed to control the entrance of unqualified and unscrupulous individuals into the home health industry. This is needed because once these types of individuals get their provider numbers, they have only a 98-percent [sic] chance of being caught. Medicare contractors review only 2 percent of the home health claims.

I want to close my testimony by discussing some recommendations. I believe that our report will improve the quality of care for our Medicare beneficiaries. First, require the extended survey process for all new applicants and alternative years for certified agencies. Require a thorough verification of information submitted by new applicants, including reviewing the 10 patients required by new home health agencies. Aggressively train surveyors, to include a thorough review of the regulations, review of home health program requirements; teach the surveyors about curious activity and requirements made by the fiscal intermediaries.

Require an application fee by all new applicants. Issue the new applicant a provisional certification only. After a one-year period, with surveyed compliance, a permanent certification would be granted. Develop a computer-based tracking system, as prototyped by Region IX, which would track certified home health agencies and providers. And, last, ban terminated agencies and applicants who fail the initial survey from reentering the Medicare program for at least 1 year.

That concludes my testimony and I would be glad to answer any questions the Subcommittee may have.

Senator COLLINS. Thank you, Dr. Dymon. You are very eloquent in helping us understand that this fraud not only costs us a lot of money, but it leads to just terrible health consequences when inferior or substandard care is provided to some of our most vulnerable citizens.

Before we go to questions, I want to call on Mr. Price and to tell you that we very much appreciate your being here with us today as well. If you will please proceed?

**TESTIMONY OF DEWEY PRICE, TEAM LEADER, OPERATION RESTORE TRUST, MIAMI, FLORIDA, SATELLITE OFFICE, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Mr. PRICE. Thank you, Madam Chairman, members of the Subcommittee. I am an employee of HCFA. I am the team leader of HCFA's Miami satellite office and I have been involved full-time in program integrity activities in Florida since the fall of 1994. In the

old days, I was the senior program integrity specialist in charge of investigations in South Florida in the days before the inspector general was set up and took over that responsibility.

In August of 1994, HCFA's regional administrator in Atlanta asked me to head up the South Florida task force which included representatives of HCFA, OIG, our Florida contractors, and State agency staff. This work group was to study the situation in Florida and make some recommendations to the HCFA administrator on the situation there, and recommendations of things that needed to be done in South Florida because of the special problems going on at that time.

We did that, and in March of 1995 made a report to the HCFA administrator at that time, Bruce Vladeck. And shortly after that, Operation Restore Trust began officially and Florida was one of the states that was involved. And as part of Operation Restore Trust, HCFA opened the satellite office in Miami in July of 1995 and I have been involved in that since that time.

I view our job—our primary goal in Operation Restore Trust in the satellite office in Miami has been to try to change the perception that in South Florida HCFA was not involved sufficiently and adequately in the war against Medicare fraud. We have tried to do this by getting involved in planning and carrying out program integrity activities with our contractors, State agencies, assisting law enforcement entities, and making recommendations to HCFA of whatever changes we thought needed to be made.

This approach of direct involvement in fraud abuse activities has been a new role for many people in HCFA. People have been detailed in to help on this. We have staffed the office with temporary people. Really, it has been an ongoing effort to change the mind set, culture, and priorities of HCFA as it relates to program integrity activities, and I have viewed that as something that has come out of not only our work, but in Operation Restore Trust.

The new HCFA administrator was in Miami just this past week. We took her to a number of provider locations similar to the kind of places that were discussed here. The purpose of this was to give her firsthand and up-to-date knowledge of the kind of problems we are seeing in Florida. There have been some changes from the kinds of overt situations, use of post office boxes and all that, because of some things I will talk about. And I wanted to make the point that in many ways, Miami is a window to Medicare fraud, and has been for a long time, and I think her visit there was a very valuable experience both for her and for the agency.

Basically, we have way, way too many health care businesses in South Florida and this is driving, I think, much of the fraud and abuse. And I would note that I use the word "businesses," but not medical providers because Medicare fraud happens so frequently in Miami with so many of the entities, not just DME companies, but clinics, diagnostic kinds of clinics, community mental health centers, that I really think the problem is so pervasive that HCFA should really rethink and redefine who our providers are.

We have allowed people who are literally business people with no medical backgrounds to get involved into Medicare as providers. And I think that we have got to directly control the issuance of provider numbers in the future based upon whatever direction we de-

cide, who our providers really are and who should really receive the money. I think that is a key aspect of all this.

HCFA has a very major role to play in fraud and abuse, and to be successful, I think program integrity activities is not something our contractors can do or the law enforcement entities can do. HCFA staff, I believe, have to suspend payments when evidence of fraud exist and misrepresentation exists. We have to restrict provider enrollment to legitimate entities. We have to ensure claims are screened and denied up front, when appropriate, rather than afterwards. We have to improve HCFA's fraud and abuse data capability. We need to pay reasonable amounts and we need to change policies and procedures, when we find them, that need to be changed.

I will talk about four provider types that have been mentioned here today already to go over some of the weaknesses in the current enrollment processes that I see in South Florida. First is community mental health centers. These centers are paid by Medicare to provide partial hospitalization services to patients that would otherwise require in-patient psychiatric treatment. Nationally, this program has grown from \$30 million to \$265 million in 3 years, from 1993 through 1996. Unbelievably, \$112 million of that was paid in the State of Florida, which is way more than 40 percent of it. The State of Florida has more than 250 CMHC centers, and more than 100 of these are in the city of Miami.

Because of this tremendous growth, in Operation Restore Trust we did a study over the past 6 months in which we reviewed 140 beneficiaries at seven aberrant billing centers in 1996, using their payments as a basis for picking them. We found overpayments of \$16 million, literally all the money paid to these seven centers. We suspended payments to all 7. We made recommendations to the HCFA regional office to terminate the provider numbers of five of these centers who did not meet the basic criteria to be a community mental health center, and we made referral to the OIG in all seven situations.

Moreover, in the middle of this process, the problems we considered so severe that we recommended immediate corrective action by HCFA to establish a moratorium in the State of Florida on giving out any more CMHC provider numbers so the situation could be cleaned up and so that HCFA could develop standards for these centers. In response, HCFA has committed \$250,000 to employ a subcontractor to evaluate 600 of the CMHC centers in nine States to determine if they indeed meet the criteria to even be a community mental health center. This project has been supported by HCFA management, but we made the recommendation 6 months ago and it has taken that much time for the project to get going. I believe the first on-site review by this contractor is being made this week.

To highlight the need for up-front enrollment and payment scrutiny of these CMHC providers, I will just mention what we found in three of the cases. In one of the centers, the ORT nurses were so concerned with the conditions in the provider location that a call was made to the local health and fire department, who made an inspection, condemned the building, and ordered the evacuation of all patients immediately.

The owner of this center was also found to have set up several other centers in neighboring communities in the area of middle Florida using front owners who were really employees of his, but he showed them as owners. And these people then signed consulting and service contracts with him that paid him up to 50 percent of their revenues.

In another center, the auditors determined the real owner was a physician who had also used front people as owners who signed consulting and other contracts with him and members of his family. The auditors determined that he and people in his family took \$1.3 million out of the center in payments that were made to them for consulting services. He also had set up two additional centers using employees, and consulting payments were made to him, as well, through those centers.

In the third one, we found that the owner of the center also owned an assisted living facility where all the patients lived, and that bribes were being paid to those people who lived there and who would go to the CMHC for treatments. The nurse reviewers were told that most of these patients had substance abuse problems and used this extra money to purchase drugs.

Given these findings, we made referrals to our certification staff back in Atlanta, and we recommended that these providers be terminated. They have been hesitant to terminate these centers as Medicare providers because of legal questions of how to go about doing that. A debate has been ongoing about whether we should merely terminate providers prospectively or whether we have the legal authority to go retroactive and revoke the numbers where people do not meet the criteria and it is determined that they never met it.

Our on-site reviews strongly indicate that many of these centers do not meet, and never met the requirements, and they have been treating ineligible patients, rendering non-covered services, and have been committing massive cost report fraud. And we definitely want to go retroactive in these cases.

The recommendations that we see needed in the CMHC area are that there should be provider enrollment standards that should apply to all centers; that HCFA should make audit and medical review money available to our contractors to review these centers so that the overpayments that exist are determined and recouped; and that HCFA should require a first-claim review of each beneficiary before CMHC claims are paid for beneficiaries. There are so few beneficiaries, we think, that meet the requirement for this type of service that every beneficiary could be reviewed 100 percent up front and a determination made. This would keep us out of the pay-and-chase where we pay claims and then ask questions later.

Second, health clinics. These are the medical clinics that are owned by non-physicians. There are hundreds of these in Miami. They employ doctors part-time. The owners can be anyone; they can be people off the street. They have no history of medical background. They employ doctors part-time and the doctors basically sign forms, and patients come in full-time while the doctors may only be there for certain hours of the day. These type clinics are major players in the fraud and abuse that are going on in many

other scam areas in Florida, including DME and home health, any areas where services are referred to other people.

The recommendations we have for clinics are that surety bonds should be required of reassignees or the people who own these kind of clinics the same as with the people who own DME companies. And, secondly, we discovered that checks were often left at locations by the post office and the places were closed down, and we made a recommendation to HCFA that we should employ the use of “do not forward” envelopes on all checks so that the post office would not forward checks to additional locations or would not leave it at unoccupied locations. This hasn’t been adopted by HCFA, but it has been tested and I understand millions of dollars have been saved in the test, and we would like to see it immediately implemented by HCFA nationwide.

The other two areas I will mention just really very briefly is DME fraud and the HHA problem we still see in Miami. There are now on-site inspections of DME locations; inspections have been done the last year using a subcontractor, and so a lot of the information discussed here today—I don’t believe these entities would be able to get a number because of the on-site inspections. However, the people know that we make on-site inspections and so they set up businesses, and who knows what happens a week later and who knows if they still meet the standards to really be a provider?

We know there are entities who don’t own any equipment and really are phantom providers, and we would like to see requirements in the standards for durable medical equipment suppliers strengthened to do away with businesses who are really nothing more than brokers. They don’t own any equipment and don’t provide service to patients.

In the home health area, the one thing I would mention is that for home health agencies in South Florida—we still have a problem. A lot of the changes that are being made in the law are very good and will take care of many of the problems. However, there are two things that we see that still need to be done; and one is dealing with the use of subcontractors. In Florida, we only have 350 certified agencies who can bill Medicare, but we have 1,300 licensed home health businesses in Florida.

Most of these entities, who can’t bill Medicare under their own name, find patients, render services, and then sell the accounts to the certified agencies who bill Medicare. This drives much of the home health fraud in Florida. We think the rules governing the use of subcontractors need to be strengthened so that more of the visits are done by agency employees. Particularly, skilled nursing and home health aides, we think should always be done, and we would recommend always be done by agency employees, not subcontractors.

The second area is the owners who set up home health agencies and who have multiple numbers. When one location is caught, it goes out of business and the money continues to flow to the others. We have entities who have done that. One entity had \$20 million of overpayments and we can’t recover it because those numbers have been shut down and the people have gone out of business. Yet, the same people own other entities who have Medicare pro-

vider numbers and last year received \$50 million in payments from the Medicare program.

This concludes my testimony and I would be glad to answer questions as well.

Senator COLLINS. Thank you very much, Mr. Price.

To allow us all to get questions in, I am going to put the time on and we will do 5-minute rounds and keep going in rounds.

Mr. Price, I was struck by your comment in your testimony about the explosion in the growth in the number of community mental health centers in Miami. Now, I don't mean to be flippant about it, but I assume that we haven't had an influx into Miami of people who need community health services. Assuming that there hasn't been a large increase in the population eligible for these benefits, to what would you attribute the overnight growth in the number of community mental health centers in Miami?

Mr. PRICE. There has been no change in the coverage requirements or expansion of the program, so the beneficiary population that needs this should be the same. The growth is attributed to the ease with which people could get into the business and phenomenal revenue potential that exists in that. So I think it is those two factors, and it became well-known in Florida that you could get into this business and make a lot of money doing it.

Senator COLLINS. So the people we have been discussing all morning, the criminals who are getting into Medicare, see this as easy pickings, as just a ripe target to get into?

Mr. PRICE. Yes.

Senator COLLINS. You have testified that many of the community mental health centers do not meet the established criteria for a Medicare provider number. So, what is happening? Why is HCFA issuing these provider numbers to people who don't meet the standards?

Mr. PRICE. The only process was that we relied upon an attestation, a statement that was sent in by the provider saying that they met the criteria that existed, which was basically just that they were a community mental health center providing the services that were required under that. And we did no verification of that or validation of that in the past. Again, we have stopped doing that in Florida, so that on-sites are being made to locations to make sure that they are there.

We had community mental health centers who were post office boxes and vacant lots applications. In 1995 after the satellite office was opened up, we were on site in Miami and started going to some of these. So we did at least, by doing on-sites, prevent these kind of entities from getting numbers.

Senator COLLINS. Does HCFA take action in a prompt way to terminate Medicare providers who have not met the certification and enrollment standards?

Mr. PRICE. My experience has been not. The process is weighted towards a review in the regional office by the staff who traditionally have done survey and certification. And a review is made of the findings and we have encountered problems in getting prompt action and have to elevate it to the senior management to get the actions taken, and that has been a frustration.

Senator COLLINS. So there has been a reluctance to move quickly when you do uncover this kind of problem?

Mr. PRICE. Yes.

Senator COLLINS. You have described that there are hundreds of health clinics in Miami that are owned by individuals with no medical experience at all, and we have heard from Dr. Dymon some of the consequences that she has seen. Could you describe for us what kind of problems have resulted because of the lack of health care experience of the owners of some of these clinics?

Mr. PRICE. Yes. A lot of these locations should not even be open as medical providers, I don't think. I have encountered situations where they were unfit. They were dirty and the equipment that was there was not working, and the people we would interview would be untrained or unqualified people. So I think the poor quality of care, because people come there—they are open, they are in business, they take Medicare, and people expect that everything is kosher and it is OK to come there. And I think the quality of care is the biggest problem. There is also an awful lot of fraud and abuse resulting from that, and that is secondary, but the quality of care issues are even worse.

Senator COLLINS. Thank you.

Dr. Dymon, the study that you provided the Subcommittee contained the results of your review of 44 home health agencies in California, and I want to commend you and others in your office who assisted in the project. But one item that I found extremely troubling was that of the 44 agencies that you surveyed, I believe that 36 of them, which is 81 percent of those surveyed, were found to not be in compliance with HCFA's standards. Is that correct?

Ms. DYMON. Yes, it is.

Senator COLLINS. Even more disturbing is the fact that 23 of the 44 agencies surveyed were terminated for providing sub-standard care. It is good they were terminated, but it is disturbing that such a high percentage were providing sub-standard care. Of the 23 agencies that were terminated as a result of your project, could you give us some idea of how much money they received from the Medicare program while they were certified?

Ms. DYMON. Yes. During the fiscal years of 1994 and 1995, these 23 agencies were reimbursed close to \$122 million.

Senator COLLINS. That is a staggering amount to go to agencies that were subsequently found not meeting the standards and not providing good care.

Ms. DYMON. I agree.

Senator COLLINS. I am going to ask you just one quick question before we begin our rotation. Of those 23 home health agencies that were terminated, did all of the patients who were served by them transfer to another home health agency?

Ms. DYMON. Madam Chairman, no, they did not, and this was a real eye-opener for us at Region IX. We did a tracking of these beneficiaries that were terminated from the agency to look at where their care was rendered after they left the terminated agency. We found that about a third, or 33 percent, of these beneficiaries were no longer being cared for by any home health agency.

Senator COLLINS. Does this suggest to you that they didn't need the services in the first place or there may have been some bogus billing going on?

Ms. DYMON. Yes, it does.

Senator COLLINS. Thank you. I have additional questions, but I want to give my two colleagues an opportunity to question as well.

Senator Durbin.

Senator DURBIN. Thanks, Senator Collins.

Now, Dr. Dymon, you make several suggestions here which I think would move us in the right direction. You call for an application fee, which I think should be sufficient so that the people who review the application can not only establish that it is truthful, but also an on-site visit, not just once but perhaps at a later time. I also like your suggestion about provisional certification for 1 year, and I would suggest that there be a second fee paid that would cover the second on-site visit a year later as part of that.

One of the things in Kennedy-Kassebaum was to allow whistleblower provisions for beneficiaries of Medicare. What would you think of the idea of extending that to anyone—a whistleblower provision, with a reward involved, to anyone who witnesses Medicare fraud, so that it goes beyond the elderly? It may include someone who works in a doctor's office or something who sees something that is clearly wrong and illegal.

Ms. DYMON. Senator Durbin, I support that idea. Anything that can go out to help protect the Medicare Trust Fund and the health and safety of our beneficiaries I certainly support.

Senator DURBIN. Let me ask you, too, about this National Supplier Clearinghouse. Are you familiar with this company and what they do?

Ms. DYMON. I am not familiar, Senator Durbin. That is out of my bailiwick.

Senator DURBIN. OK. Let me ask you, Mr. Price, are you familiar with what they do?

Mr. PRICE. Somewhat, yes.

Senator DURBIN. What kind of job do they do? How would you rate them? Give them a grading, A-plus, B, C, D.

Mr. PRICE. I would say C. We tried to get on-site inspections begun in Florida very early on when we saw the scope of the problems. The U.S. attorney's office was saying "I have got fraud cases that came about since you have been here. Why can't we stop this?" And we had to literally get the HCFA administrator to intercede and make on-sites happen. The contractor—I think they indicated they were willing to do it, but, to me, it was not something that was a priority with them or a priority with HCFA.

Senator DURBIN. I hope we can bring them before this Committee. I would like to find out what they are being paid and what they are doing for the amount of money that they are being paid. It appears that there is enough fraud and enough problems in this area that we should take a look at their activities very carefully.

Mr. Price, you raised something that really struck a note with me here. I spent the last two-and-a-half weeks visiting child care facilities in Illinois because I know that debate is coming up, and a very important one. And I ran across in two instances, in

downstate Illinois, a care center which provided not only child care, child day care, but adult day care for seniors.

And I asked them how much they charged for children—it was \$20 a day—and how much they charged and reimbursed for seniors. It was over \$40 a day. Some of these seniors were ambulatory, some were in wheelchairs. But when you talked about the community mental health centers here and the fact that that has turned into a day care operation, is that what I was seeing, people who were being diagnosed as having some mental problem and as a consequence get partial hospitalization and these day care costs defrayed by Medicare?

Mr. PRICE. That is precisely what our nurse reviewers found was happening in the centers we did the studies in in Florida. The people were being brought in. They were being certified as needing partial hospitalization mental health benefits when, in fact, most of them were receiving something that was akin to adult day care, activities that were social in nature and certainly good to have if you live in an assisted living facility and somebody brings you to another place where you can interact with people and go to activities and all.

So, that is what the nurses found was happening in most of the cases, and Medicare is paying a lot more than \$40 when that happens. Medicare doesn't cover adult day care for regular people. We cover partial hospitalization benefits for patients who otherwise would require in-patient psychiatric services.

Senator DURBIN. Could it also be for physical rehabilitation, too? Could they get partial hospitalization for that?

Mr. PRICE. No, that is not covered under the CMHC benefit, although the area of rehab services, in general, are provided by home health care agencies and also individuals.

Senator DURBIN. This is tough because I can certainly see circumstances where someone would want an elderly parent or grandparent to be allowed to go to a care center during the course of a day rather than to be alone and vulnerable. That sounds reasonable. But, like so many of these areas, it sounds like it is so open to abuse. All you need is that doctor certification and you are off to the races, and you have basically day care babysitting services for elderly people being paid for by Medicare. I can understand why you have raised that red flag.

Could you define one term that you use in here, "reassignees," what you are talking about?

Mr. PRICE. Under reassignment of benefits, this happens in the clinic location. We are actually paying for physician services in a clinic setting, and that means a doctor is supposed to treat the patient, and he can also do things such as tests and procedures that a physician would do. So under reassignment, what happens is a doctor says "don't pay me" and he completes a form and gives it to the Medicare contractor that says, "Instead, pay the money to the person I work for, to this clinic or to this company or corporation." So the owner of this clinic is really receiving the money even though it really is for physician services.

I think the reassignment of benefits provision is one of the major things that needs to be dealt with by HCFA and maybe by the Congress because it creates a legal loophole because we have problems

holding the doctor accountable. If he billed under his own name and got the money, we could hold him accountable. But because he works for a clinic and the money is reassigned and paid to someone else, we have a problem establishing an overpayment and holding the doctor accountable.

And these businesses, when they are investigated and have overpayments, just like with DME's, they just go out of business, or like home health agencies they can file bankruptcy. And the program is just left hanging with no recourse, even though the doctor may still be in business and working in another clinic at this point in time.

Senator DURBIN. I want to thank you both for your testimony. What we have heard today—and I thank Senator Collins for calling this hearing—has been not only sad, but disgraceful. And I hope that when we get serious about guaranteeing the long-term solvency of Medicare that our first stop is on Medicare fraud. We have done a lot. We clearly have not done nearly enough. I think there should be zero tolerance in this area and we ought to know that people who are exploiting seniors and taxpayers through this type of activity will be subjected to the harshest penalties.

Thank you.

Senator COLLINS. Thank you, Senator Durbin.

Senator Levin, welcome.

#### **OPENING STATEMENT OF SENATOR LEVIN**

Senator LEVIN. Thank you, Madam Chairman. Let me thank our witnesses here today, and also thank our Chairman for her initiative. It is a very important one and I think the Nation and all of the people who rely on Medicare and on home health care are in her debt for her initiative in convening us.

What I would like to do—and I think previous witnesses have been asked these kinds of questions—is to try to focus on the responsibility, the accountability. But, first, on responsibility, you have both listed a whole series of abuses, studies which have been undertaken to identify these abuses. You have both been involved in these studies. We have heard a lot about fraud. We have heard a lot about lack of regulatory discipline. We have heard a lot about loopholes. There is a whole lack of resources, lack of certification requirements. There is just a whole menu of problems, some of which are the result of criminal activities, others of which are the result of lack of regulation or lack of accountability, and I would like to try to prioritize this a little bit and try to get a better feel for where the problems are.

Are most of the abuses which you have identified, both of you, the result of fraudulent activity, illegal activity, violations of regulations, or sloppy or missing regulation? I know it is both. There are different ones that apply in different categories. In terms of giving us a feel of what we have to focus on, give our greatest emphasis, I will start with you, Dr. Dymon. In your judgment, are the activities and abuses which you have described mainly the result of violations of regulation and law or mainly the result of a lack of effective—or the absence of regulation or enforcement?

Ms. DYMON. Senator Levin, I believe that the regulations can adequately meet the needs of protecting the health and safety of

our beneficiaries. But I think it is partly due to the lack of the survey process that is being used throughout the country to detect the problems we are seeing in home health care. In addition—

Senator LEVIN. Let me just interrupt you there. Detect the problems that we are seeing. I want to identify whether the major source of those problems are criminal activities, violations of law, or activities which are currently legal but which should be made illegal, because there are a lot of things you have mentioned and some fall under both those categories, but I would like to try to allocate to one or the other.

Are these problems, these activities, most of them, you believe, already illegal, in violation of regulations, or not yet illegal, not yet a violation of regulation, but which should be made so?

Ms. DYMON. I believe the latter, that we need regulations to identify and better resource the problems that we are seeing.

Senator LEVIN. That are not now criminal?

Ms. DYMON. Correct.

Senator LEVIN. OK. Now, let me go to Mr. Price. Would you give me a feel on that?

Mr. PRICE. The things I was talking about, I believe, are pretty much covered under current laws and regulations, and we have made referrals, because of that, in all of these kinds situations to the Office of the Inspector General to deal with these specific kinds of provider situations.

Senator LEVIN. Where they are already a violation of regulation or law, but it is a matter of trying to identify them and to enforce existing regulations against those activities? I am not saying it is either/or. I am asking is that the major part of the current problem, in your judgment?

Mr. PRICE. Right.

Senator LEVIN. OK. On the accountability side, let us talk about the certification of existing clinics, for instance. Are these lack of certifications because the persons that we have designated to do the certifications are not doing them adequately, or have we failed to assign responsibility for the certifications? Let me start this time perhaps with Mr. Price. Just talk about certification of community mental health clinics. Whose responsibility is it?

Mr. PRICE. Clearly, it is HCFA's.

Senator LEVIN. Well, that is the ultimate responsibility, but does HCFA assign this to States or to private contractors, or do HCFA employees have the responsibility of making sure that those certifications are there?

Mr. PRICE. We didn't do any assignment to the State agencies in the case of community mental health centers. We, instead of doing that, relied upon the attestation that the providers would send in with their application. So, in effect, no survey or no on-site inspection was done.

Senator LEVIN. So there is no certification on those clinics at all, no requirement?

Mr. PRICE. Other than this attestation statement that accompanies an application.

Senator LEVIN. OK. Now, in terms of the other providers that we—for instance, there was one study where there were, what, 4,000 providers that were certified? Let me go to your testimony.

You indicate that HCFA has certified in this case 350 agencies who can bill Medicare, but the State of Florida has licensed 1,340 home health agencies. Now, in this case, the providers are licensed by the State. Is that what we rely on for licensing, the States?

Mr. PRICE. Correct.

Senator LEVIN. And what we do under Medicare is say, if a State has licensed a home health agency, that satisfies our licensing requirements. Is that it?

Mr. PRICE. Yes, and so most of these people have just chosen not to go through the certification process and get their own number. They function as subcontractors and they make visits and all that.

Senator LEVIN. But are they still licensed?

Mr. PRICE. Yes, they are.

Senator LEVIN. And we rely on State licensing for that, is that correct?

Mr. PRICE. Right.

Senator LEVIN. Should we rely on State licensing for those or not? Should we have our own licensing requirements and enforce them or should we continue to rely on the States?

Mr. PRICE. I think we should do one or the other. I think the certification process—since most of the visits are being done by these other entities, the certification process becomes a sham. Three hundred and fifty of the agencies are certified, and yet most of the visits are being done by this other 1,000 that are just licensed and have not gone through the certification process. So either we ought to just stop doing certification for all of them or we ought to require all of them to be certified by Medicare if they are going to render services that Medicare is going to pay for.

Senator LEVIN. OK, but I just want to be real clear. Under current regulations, if a home health agency is licensed by a State, then that person can act as a subcontractor, is that correct?

Mr. PRICE. Yes.

Senator LEVIN. Now, do we want these agencies to be owned by doctors, or is there not a conflict situation that is created in that situation? You have a problem of doctors referring patients to themselves.

Mr. PRICE. Right.

Senator LEVIN. Now, is that an issue here?

Mr. PRICE. I think that is the question. If the doctor was doing the certification for those patients and he was also the owner, then I think that would be the problem, not his ownership, per se, if he owned stock in the company or something, but didn't do the certification.

Senator LEVIN. So if we don't permit people to be licensed who are not medically trained, we would then have to have some provision to make sure that people are referring folks to entities that they have no interest in. We have that conflict problem, is that correct?

Mr. PRICE. That is correct, and that gets into the need to have good ownership information and honest reporting by providers of who their owners are.

Senator LEVIN. I don't know how we are handling time. Could I ask just one more question and then I will be done?

Senator COLLINS. Sure, absolutely.

Senator LEVIN. I am sorry, Madam Chairman.

Senator COLLINS. No. That is quite all right.

Senator LEVIN. The recommendations which you have both made to agencies—I would like to know the response. You both have been part of an effort by the administration, by HCFA, to get at fraud and needed changes in the Medicare area.

Dr. Dymon, first, you have made a whole series of recommendations. What has been the response of the agencies to whom your report has been made to those recommendations, or is it too early to know?

Ms. DYMON. I think it is probably too early, Senator. Some of these recommendations have been filtered to our central office in Baltimore at HCFA, but I have not yet seen any action on the recommendations.

Senator LEVIN. Mr. Price.

Mr. PRICE. I think it has taken too much effort to get a lot of the priority established and more aggressive action within HCFA, and I have raised that as a problem. However, I have seen a lot of progress in Miami. The on-site reviews began more than a year ago. The number of applications for DME suppliers in Miami in 1997 for the whole year was down 74 percent from 1996. The number of DME suppliers is actually down by more than 100 in Miami, even though it is up in the rest of the State. And I think people have moved out of Miami into other parts of the State and into other parts of the country.

So, what is being done in Miami I have encouraged be done nationwide with suppliers and clinics and all. So I think it is sort of a mixed bag. It is tough to get the priority established for things when there is so much going on in a bureaucracy as big as HCFA and Medicare is.

Senator LEVIN. Madam Chairman, I was unable to be here earlier this morning. You may have already covered this, but if not, I would ask the Chair to refer this testimony and the specific recommendations made this morning either by these witnesses or others to HCFA for their specific response. The provision of home health care, for instance, is just simply too important to be undermined or tarnished by fraud, abuse, waste, or lax administration of the regulations. People count on home health care; it makes a difference in people's lives. It is an important alternative to a nursing home.

And when we run into the situations which you have described and other witnesses have described this morning about violations and abuse and waste, we are jeopardizing a very important program. We cannot allow this program to be destroyed or tarnished or undermined by waste and by abuse and by fraud. We have got to go after the fraud and the waste and the abuse. I have seen too many instances with my own eyes of just how important home health care is, for instance, to human beings, to live-in folks in my own State whom I have visited in their homes. It makes a difference in their lives, and so people who abuse it are not only cheating the taxpayers, they are also undermining a very significant program which makes a huge contribution to the well-being of so many citizens.

So, again, I want to thank our Chair for what she has done here and ask, if it hasn't already been done, that this testimony be referred to HCFA, along with other testimony this morning, for their response in a prompt way to the very specific proposals which have been made by our witnesses.

Thank you, Madam Chairman.

Senator COLLINS. The Senator's suggestion is an excellent one, and therefore you might be interested in my next question to Mr. Price, which is we are aware that HCFA has just recently instituted a requirement for a surety bond. But it is my understanding that the South Florida task force nearly 3 years ago, in March of 1995, recommended to HCFA management that suppliers of durable medical equipment be bonded. Is that correct? Was it back in 1995 that that recommendation was made?

Mr. PRICE. Yes, it was.

Senator COLLINS. I think that points out a very important issue that the Senator has just touched on that frequently those who are on the front lines, as these two individuals are, are the ones who know best how we can tackle this problem in an effective way.

I only have a couple more questions that I want to raise. One, Mr. Price, in your conversations with our staff you described a situation where I think it may have been one of the community mental health centers was actually teaching people the macarena and billing the Federal Government. Is that correct?

Mr. PRICE. Yes, that is correct. The particular session that was observed by the ORT nurse reviewers—that is what they were doing. It was considered dance therapy and the people were standing up and going through the motions with the music and all. So, that is what was observed at one of the sessions that was supposedly the mental health therapy that was being provided.

Senator COLLINS. And how much was the center billing for teaching people to do the macarena?

Mr. PRICE. That facility was being paid \$200 a day for each patient. That was the amount of money, and you are talking 15 to 20 people, normally, in each center, each day, was typical, so you can see how much money is involved.

Senator COLLINS. An expensive dance lesson, I would say. Would you agree?

Mr. PRICE. Yes, ma'am.

Senator COLLINS. My final question to both of you is whether HCFA management is devoting enough resources to training the staff at HCFA in program integrity activities. Do you think that enough emphasis and enough resources are going for that purpose, Dr. Dymon?

Ms. DYMON. In Region IX, we have devoted an abundant resource pool to educating surveyors at the State level in all four States. Recently, HCFA has given approval for Region IX to train Region X, which is the Seattle region, and at the end of next month the State of Idaho surveyors will be trained in home health survey techniques, as well as in detecting curious activity.

I soundly support HCFA's resources be directed toward developing the State agency surveyor, a thorough training course in not only the regulations, but also the Medicare program requirements for home health agencies. A well-trained surveyor can detect fraud

and abuse if they know what the program requires and when they see that the program is not being supplied.

Senator COLLINS. Thank you.

Mr. Price, do you think that it is enough of a priority and has enough resources and people are trained adequately?

Mr. PRICE. No, ma'am, I don't think so. I would say particularly the program integrity aspects and safeguard aspects that should be emphasized, I don't think are enough, and that is true for HCFA staff, but also for the contractors and State agency folks. So often, we only know whatever they choose to tell us and I don't feel like there has been enough training and work to get information and data that we need to know from them either. I think that this is all part of the area of program integrity, is being able to get good information and all.

And I just think it is a lack of priority among management, and that gets back to the emphasis that is placed on it; the corrective actions that come from it in backing and supporting and working with the people. We have had very good experience working with contractor and State agency staff in Florida in the reviews we have done and with the IG audit people and all. And so, working together, you can certainly do more effectively, but it is really a matter of commitment and support by the management to take corrective actions when they are found. Otherwise, people get beat down real easily.

Senator COLLINS. Thank you. I want to thank both of you not only for coming forward and giving us your testimony today, but for the valuable work that you are both doing. I am very proud to have you both working for the Federal Government and I appreciate all your efforts.

It is evident to me, based on the testimony that we have heard today, that if we are ever going to get control of the fraud infecting the Medicare program, we must stress fraud prevention. That has to be our emphasis. There is simply no way that law enforcement efforts alone will be able to curtail the massive amount of fraud that we are seeing.

In 1997, only 363 defendants were convicted in Federal court for health care fraud, and that includes all kinds of health care fraud, not just Medicare fraud. Law enforcement certainly plays an important role, but it seems to me that in combatting this kind of illegal activity that we have to do better at preventing it up front. When you look at the number of existing Medicare providers and compare that to the number entering the system each month, if we don't do more to screen effectively up front, we will never get a handle on this problem.

There are almost 1 million providers that bill Medicare. In fact, since 1993, there were over 100,000 billing numbers issued just for DME companies nationwide. To police this system, there are only 219 HHS criminal investigators nationwide. Clearly, the resources are disproportionate to the problem. If the strategy is to rely on law enforcement alone to solve the problem, then what I fear is that we simply aren't going to make much progress. We can't afford to continue to certify people so easily, to write those checks, and then ask the tough questions later. It reminds me of trying to bail out the Titanic with a plastic bucket. It is just not going to work.

So I appreciate the efforts that you are making, and we would welcome any further thoughts or recommendations that you might have on how we can slam the door shut up front to prevent bogus businesses and outright criminals from entering the Medicare system. Again, I want to thank you very much for your testimony and your assistance to us.

I also want to thank the PSI staff for doing an excellent job in what has been a very complicated investigation, and I want to thank all the law enforcement officials and HHS officials who have assisted us in this regard. In particular, on PSI staff, Tim Shea, Don Mullinax, Eric Eskew, Ian Simmons, Mary Robertson, and Lindsey Ledwin all played key roles, and without them we would not have been able to get the kind of evidence that was presented today. And, finally, I do want to again thank John Frazzini, who played a key role in helping us as a detailee to the Subcommittee and has continued his excellent efforts in this regard.

So thank you very much, and this hearing will stand adjourned.  
[Whereupon, at 12:40 p.m., the Subcommittee was adjourned.]

## A P P E N D I X

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**STATEMENT OF  
CONVICTED MEDICARE FRAUD FELON  
Before The  
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS  
Hearings On  
MEDICARE FRAUD PREVENTION:  
IMPROVING THE MEDICARE ENROLLMENT PROCESS  
January 29, 1998**

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Madam Chairman and Members of the Subcommittee:

At your request, I am here today to testify about my activities to steal from the Medicare program.

Before I begin my testimony, I want to thank you and this Subcommittee for respecting my request to keep my identity protected during this hearing. This is a dangerous world, and I sincerely fear for my safety. Thank you again.

My professional training is as an electrical engineer, and at the time when I started billing Medicare, I was the owner of a nightclub in the Miami, Florida area. Before purchasing a medical supply company in 1988, I had no experience or training in health care services. I also had no idea how the medical supply business worked or anything about the Medicare billing process.

Without this experience and with no knowledge of the Medicare program, I purchased a business and started billing Medicare. It was very easy for me to get approval from Medicare to become a provider. I simply filled out an application and sent it to Medicare. They gave me a provider number over the phone. No one from the government or anywhere else ever came to me or my place of business to check any information on the application. No one ever checked my credentials or asked if I was qualified to operate a medical supply business.

My primary business was supplying nutritional milk to elderly people in southern Florida. As I understand it, this program was designed to provide the supply kits like feeding tubes and food such as milk to old people who were too sick to eat this food without assistance. They were supposed to be so sick that they couldn't swallow whole food. I ended up billing Medicare for patients who were eating steaks and other solid foods.

At first, in order to start billing the government, I bought milk and offered it to elderly people in the Miami area in exchange for their Medicare beneficiary numbers. I hired people to tell the elderly that this was free milk from the government and that they only needed to have a Medicare number to qualify. These recruiters went to community

centers and apartment buildings where large numbers of senior citizens were present to get new patients for my companies.

Several doctors were also paid to sign Medicare forms certifying that the patients needed this nutritional milk. They were paid about \$100 for each form signed.

In the beginning, I bought the milk in case government investigators came to look at my business. I thought I needed to show them that I bought milk in order to bill the government. I used these numbers to bill Medicare over and over again for high cost nutritional services when I just gave them some cheap free milk.

Later, I realized that I didn't even need to buy the milk. No one from the government ever came to question my billings, and so I just paid recruiters to get Medicare beneficiary numbers. I used these numbers to bill Medicare month after month. I provided no services, and just received checks from the government. I usually received between \$180,000 and \$200,000 per month from Medicare. In one month, I billed Medicare over \$500,000, and no services were provided. This program was a gold mine. I know of no other business where I could make the same money without any risk.

The government actually made it easy for me to steal. I was not required to produce any documents in support of the claims I made to Medicare for any of my companies. I became rich very fast billing the Medicare program.

My biggest mistake in this fraud scheme was buying the milk. I would have made more money if I didn't spend any money on the milk.

By the time I was arrested in 1994, I owned seven medical supply companies and employed approximately 20 people for the sole purpose of billing Medicare. I started new companies so that the government would not discover the large number of claims being paid to any one company. I ran these seven companies out of the same office, using the same people and with the same computers. I was billing Medicare for over 2,000 patients. I provided no services for the claims submitted. In the end, I estimate that my companies billed Medicare about a total of \$32 million, and most of this was fraud.

I was indicted in federal court for this Medicare fraud scheme and charged with several felony violations of the law. I admitted my involvement with this illegal activity, and I willingly cooperated with the government. I pleaded guilty to 17 felony charges, including fraud against the United States, false claims, and paying kickbacks. I am now serving 10 years in federal prison for these crimes.

That concludes my statement, and I will try to answer any questions that you may have.

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Statement  
of  
**JOHN FRAZZINI**  
Former Investigator  
Permanent Subcommittee on Investigations  
Before The  
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS  
Hearings On  
MEDICARE FRAUD PREVENTION:  
IMPROVING THE MEDICARE ENROLLMENT PROCESS  
January 29, 1998

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Madam Chairman and members of the Subcommittee.

Since PSI's June 1997 hearing on Emerging Fraud in Medicare Programs, the Subcommittee has uncovered several weaknesses in the procedures used to enroll Medicare providers. These weaknesses have allowed full-time con artists, with little or no experience as health care providers, to enter the Medicare program and to defraud millions of dollars from the nation's taxpayers.

In 1996, the Health Care Financing Administration, or HCFA, standardized the enrollment form when it mandated use of the HCFA 855, an application form entitled Medicare General Enrollment, Health Care Provider/Supplier Application. Using durable medical equipment, or DME, and home health care as examples, I want to briefly show the flow of the HCFA 855 form from preparation to approval.

As these two charts show, the application process for DME and home health care applicants can be divided into four phases: submission, review, verification or site visits, and approval. The focus of PSI's investigation was on the adequacy of the third phase of the process which is the verification of data provided by the applicants on the HCFA 855 forms.

As I stated earlier, the HCFA 855 form standardized the Medicare enrollment process with respect to the manner in which information was gathered, however, it did not expand or increase the verification activities related to the information submitted by applicants.

The HCFA 855 form, for example, requires that a prospective provider include its business location. Preparation instructions for the HCFA 855 form specify that this address cannot be a post office box or a mail drop. HCFA, however, does not ensure that physical verifications are performed on a nation-wide basis to determine whether prospective providers are using actual business addresses.

PSI's investigation has revealed that many DME companies have used mail drops that appear on the enrollment form to be legitimate street addresses. As an example, here is a copy of one provider's Medicare application which shows that the business location is 1204 Avenue U, Suite 201 in Brooklyn, New York. Here is the physical location of 1204 Avenue U, Suite 201 -- a mail drop. If you look closely at the advertisement in the window, you can see "SUMMER SPECIAL, 12 month Post Office Box Rentals, \$60 For Year, \$5 Per Month, One Time Only."

As shown by this example, it is difficult to determine, from just reading applications whether Medicare providers are using mail boxes or if the addresses are actual physical locations. This makes physical verification even more essential. Before I continue, I would like to point out that this mail drop was the reported location of two New York companies that provided DME products and MRI tests. These companies submitted Medicare claims totaling \$3.4 million and received payments of about \$500,000, but no services were provided.

PSI investigators traveled to New York and Miami to see first-hand the weaknesses in the enrollment process and to meet with Special Agents from the HHS's Office of Inspector General, Special Agents from the FBI, Federal and State Medicare and Medicaid officials, and two convicted felons.

During the PSI visits, we photographed several locations, like the one shown earlier, where DME companies and other providers had operated out of mail drops and bogus store fronts. I would like to show the Subcommittee a few other locations photographed by PSI investigators.

The first photographs are the reported office location of two physicians who provided DME products and MRI tests. As you can see, this is a laundrette. As we walked through the door, we saw the usual washers/dryers. However, when we reached the back of the laundrette, we found several mail boxes which is where the two physicians received Medicare payments of about \$117,000. These two physicians billed Medicare for claims totaling over \$690,000, but provided no products or services.

The next photograph is the reported location of a Miami health clinic that performed diagnostic tests. As you see, this is a Mail Box Etc. Medicare paid at least \$300,000 for tests at this location, but no tests were performed.

The next photograph is the reported location of a Miami health clinic. As you can see, this is a vacant store front. Medicare paid this "clinic" approximately \$2 million, but no services were provided.

This final photograph is the reported location of 14 Miami health care companies that provided DME products and services. As you can see, this is an airport runway. Medicare paid at least \$6 million for claims submitted by these companies, but no services were provided.

As these photographs show, had HCFA officials required site visits of these companies prior to issuing provider numbers, Medicare would not have paid these "bogus" providers \$9 million.

While in Miami, PSI investigators also visited an office complex comprised of three buildings that is known to rent office space to DME suppliers. This particular office complex had housed 45 DME suppliers over the past four years. These companies billed the Medicare program over \$20 million during this time period. Of these 45 suppliers, only 2 had not been under revocation, suspension, or in violation of the Supplier Standards.

Upon physical inspection of one building, PSI investigators found that only one of the offices was open for business which seemed strange since it was only 3:30 in the afternoon. Posing as entrepreneurs, PSI investigators questioned the one owner about his business. The owner's office was scantily furnished with a desk, filing cabinet and telephone.

This DME owner told us that the medical supply business is a lucrative business. He told us that he makes about \$4,000 a month but he knows of other owners who make \$20,000 a month. The owner told us that Medicare has investigated his company three times and because of the problems that come with these investigations, he is planning on expanding his business to Orlando and is organizing a consortium of 37 DME suppliers so that when one supplier is investigated the cash flow from Medicare will not dry up. PSI investigators found that this particular provider had submitted Medicare claims for \$500,000 and had been paid about \$200,000 for DME supplies.

In conversations with Medicare investigators in Miami, "set-ups" such as the one used by this particular supplier are very common among fraudulent DME suppliers. These investigators told us that they have found hundreds of DME companies that were nothing but mail drops, grimy auto shops or empty warehouses. For example, one office had a lady sitting in a room with four desks -- each desk represented a different company. There was a telephone on each desk along with a different script for the lady to read when answering calls.

Throughout PSI's investigation, the common theme among the health care fraud experts was that the government must do a better job of preventing these con artists from obtaining Medicare provider numbers or law enforcement officials will not be able to weed out the unscrupulous providers fast enough.

That concludes my testimony. I would be glad to answer any questions that the Subcommittee may have.

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**Medicare Fraud & Abuse**

Testimony of  
**John E. Hartwig**  
Deputy Inspector General for Investigations  
Department of Health and Human Services

Hearing before the  
Senate Committee on Governmental Affairs

Permanent Subcommittee on Investigations

January 29, 1998



Office of Inspector General  
Department of Health and Human Services

June Gibbs Brown, Inspector General

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Testimony of  
**John E. Hartwig**  
Deputy Inspector General for Investigations  
Department of Health and Human Services

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Good morning. I am John E. Hartwig, Deputy Inspector General for Investigations for the Office of Inspector General at the Department of Health and Human Services. I am accompanied by two of our investigators: Assistant Regional Inspector General for Investigations, Cathy Colton from Miami and Special Agent Susan Frisco from New York. We are pleased to appear before you today to describe our experiences with high-risk individuals who have gained access into the Medicare program. First, I would like to share with you my current observations of fraud in the Medicare program and compare it to what we were dealing with when I first became an investigator more than 20 years ago.

I believe the appropriate descriptors of today's health care crimes are complexity, higher dollar amounts, and technological sophistication. Twenty years ago, Medicare expended \$22 billion, and we were primarily investigating single-subject cases. A million dollar case was considered rather large. Currently, the program outlays exceed \$200 billion, and multiple-subject cases are commonplace. We see millions of dollars stolen in a single scheme; and with today's technology, fraudulent providers can bill the system electronically, make quick hits for large amounts of money, and move on before being detected. Today's criminals know where the radar is and how to fly under it. Let me elaborate.

**Complexity.** Today's providers are typically highly networked through, for example, parent companies and subsidiaries with branches all over the country. Where we used to have fraud by a single provider affecting billings in only one or two States, it is now common to find billings by a provider group flowing through many States. Something that may appear on the surface to be a local scam can unfold into a complex, organized fraud with systemic and, sometimes, nationwide implications. Conversely, we sometimes find fairly complex operators who can perpetrate their scheme quickly in an area, close down, and move on to a new locale to evade detection.

**Dollar Amount.** When the OIG audited a statistical sample of Medicare's \$168.6 billion in fee-for-service benefit payments reported for Fiscal Year 1996, we estimated that the range of improper payments was \$17.8 billion to \$28.6 billion. The midpoint was \$23.2 billion--about 14 percent of the payments. Our auditors did not set out to quantify how much of the improper payments could be fraud, but our sense is that some of the improper payments more than likely went beyond error into the realm of intentional misrepresentation. As an entitlement program that has grown to huge proportions, Medicare provides criminals with a large target. Years ago, Willie Sutton said he robbed banks because that's where the money is. Today, Medicare is where the money is; and today's Willie Suttons are lined up to get what they can. That is why sound program oversight by HCFA and aggressive, well-organized law enforcement are necessary.

**Technological Sophistication.** Medicare is a program inherently at high risk for payment errors because it has 38 million beneficiaries, processes and pays 800 million claims annually, contains complex reimbursement rules, and has a decentralized operation. The Medicare computer system is

in an interim state of development in which it accomplishes its mission of paying claims quickly but sometimes fails to detect conditions indicative of fraud with any degree of certainty. The Medicare program was built on a voluntary system of trust--trust that medically necessary services, equipment, and supplies would be provided appropriately to those who are entitled to them and that the claims for reimbursement would fairly reflect whatever was provided. The system was initially designed to pay claims, not to monitor for abusive practices. When people violate this trust, everyone--beneficiaries, taxpayers, and the program--pays.

One alarming aspect of the fee-for-service review I mentioned earlier is that, on the surface, the improper claims appeared to be correct. The claims were prepared in a manner the system would accept and pay. Specifically, 99 percent of the improper payments in our sample were detected through medical record reviews coordinated by the OIG in conjunction with medical personnel. When these claims were submitted for payment to Medicare contractors, they contained no visible errors.

#### **Types of Abusers**

We believe most health care providers are honest in their dealings with Medicare. That is not just a token statement, but a firm belief. When we talk about fraud, we are not including health care providers as a group. We are talking about pockets of illegal activity falling here and there on a relative scale of egregiousness. Those who knowingly and wilfully set out to misrepresent claims to Medicare are the focus of my work as an investigator. I believe, however, that the importance of our work is not only to protect the taxpayers, but to make the Medicare environment one in which honest providers can make an honest living providing honest services without finding themselves in competition with criminals.

This hearing deals with the extreme end of the scale. That is, those individuals who singlehandedly, or as part of a conspiracy, set out to rob the Medicare program while providing little, if any, service to beneficiaries. I do not want anyone to conclude that we believe that even a significant percentage of providers fall into this category. We are talking about people who should never have been allowed to participate in the program and how we need to keep others like them out of the program in the future. Unfortunately, though, even a small number of bad individuals can wreak enormous damage on the program. Before I get into some case examples, I would like to discuss the context in which these crimes occur.

#### **Provider Numbers -- The Key to the Bank**

For many years, the OIG has expressed its support of strengthening the process by which providers are allowed to participate in Medicare, particularly with regard to the system by which they are assigned billing numbers. We have also been concerned that excluded providers continue to bill Medicare because of ineffective monitoring of existing numbers and the ease of obtaining new numbers. We strongly believe better controls at the "front-end" of the Medicare payment system, i.e., the application for and assignment of the provider number, will result in less inappropriate payments and cut down the efforts being expended to recoup past improper payments. Such controls should also deter a substantial amount of fraudulent behavior, although it is unlikely we can ever fully prevent the more sophisticated thieves from gaining access to program participation.

In 1988, the OIG issued a report describing the fact that every Medicare contractor for each State had its own system of issuing provider numbers. The OIG felt that if a uniform provider agreement were instituted, all contractors in all States would be asking for the same information, thus protecting the integrity of the Medicare program. Subsequently, we issued a report on carrier maintenance of Medicare provider numbers in which we were concerned that HCFA's direction to carriers was inadequate and that carriers did not systematically update provider files or deactivate provider numbers without current billing history. We made suggestions to improve the controls over provider numbers. Last year, HCFA expelled several thousand suppliers of durable medical equipment that were believed to be out of business because they had not billed Medicare for more than a year. So, we are seeing some improvement there.

Our office has also expressed concern about Medicare's practice of issuing multiple provider numbers. Medicare contractors may legitimately issue more than one provider number to a provider based on multiple specialties, multiple office locations, or group practice settings. Providers receive different numbers or modifiers if practicing under different specialties or, in the case of durable medical equipment suppliers, when they have different subsidiaries operating under the same company umbrella. Multiple provider numbers compound the risk of improper payments because some unscrupulous individuals use multiple numbers to defraud the system and to make detection of their behavior more difficult.

In the past, the lack of a commonly available unique identifier made it virtually impossible to verify the legitimacy of a program applicant. For example, if a person had been excluded from the programs based on fraudulent activity, he or she could nonetheless obtain employment with another provider or become full or part owner of a business that applies for participation in Medicare. We are very pleased that the Congress and the Administration included provisions to address the need for a standard identifier and other administrative simplifications in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The HIPAA required the Secretary to adopt standards for unique health identifiers for all individuals, employers, health plans and health care providers and to specify the lawful uses of those identifiers. In addition, the Balanced Budget Act of 1997 (BBA) authorized the Secretary to collect SSNs and EINs from entities paid under Medicare Part B, Medicaid, and Child Services Block Grants (after completion of a study on how to protect privacy of the numbers). These numbers are required from the entity, persons with ownership or control interest (5 percent or more), its managing employees, and subcontractors. Entities who do not provide complete ownership and control information can be refused a provider billing number. The OIG, HCFA, and the GAO have been in general agreement in recent years that this authority is critical to monitor provider billing activities effectively and to keep excluded or other problematic providers from coming back into the program under the cloak of a new business arrangement.

#### **New Enrollment Safeguards**

The BBA provides methods to ensure that only stable, legitimate businesses get into the program. For example, the BBA authorizes HCFA to refuse to enter into contracts with convicted felons. The Secretary could stipulate, for example, that individuals convicted of embezzlement not be allowed to enroll as Medicare providers even if the convictions did not occur in connection with a health care business.

Also, program entities owned or controlled by the family or household members of excluded individuals can be excluded. This latter provision prevents an excluded individual from continuing to do business with Medicare through a company allegedly owned by a family or household member. Some excluded providers have been able to escape the impact of their sanctions by expediting transfers on paper of their ownership and control interests in health care entities to family or household members while retaining true, silent control of the businesses.

In addition, the BBA authorizes the Secretary to require surety bonds of some or all providers of items or services, other than physicians or other practitioners. It specifically provides that home health agencies, durable medical equipment suppliers, and certain others, must provide HHS on a continuing basis with a surety bond of not less than \$50,000. We have recommended this in the past as one method for reducing the number of "fly-by-night" and fictitious providers.

#### **Durable Medical Equipment**

The durable medical equipment (DME) supply industry has been a high-risk provider group for years and, although some major improvements have been made in HCFA's management of the benefit, DME continues to be fraud-prone and a major concern.

Medical equipment and supplies include several categories of items. Durable medical equipment (DME) are items that can withstand repeated use and include hospital beds, wheelchairs, and other equipment that physicians prescribe for home use. Prosthetics and orthotics are devices that replace all or part of a body organ and include leg, arm, back, and neck braces as well as artificial legs, arms, and eyes. In addition, Medicare classifies enteral and parenteral nutrition therapy under the prosthetic device benefit. Medical supplies include catheter, ostomy, incontinence, and wound care supplies. Medicare Part B paid more than \$6 billion in 1997 for medical equipment and supplies. In addition, Medicare Part B beneficiaries pay a 20 percent copayment for those items.

Before businesses can bill Medicare for sale and rental of durable medical equipment, they must apply for and receive a billing number. To help assure that applicants are bonafide businesses, HCFA requires that each supplier meet 11 standards. Despite such safeguards, however, HCFA reported in 1996 that out of a sample of 36 new DME applicants in the Miami, Florida area, 32 were not bona fide businesses. Among other problems, some bogus applicants did not have a physical address, or an inventory of durable medical equipment. According to HCFA staff, those companies should not have been issued a supplier number because they were not operational entities.

In light of this situation in Miami, HCFA asked the OIG to determine whether similar problems exist elsewhere in the country. Accordingly, we recently sampled suppliers and applicants in 12 large metropolitan areas in New York, Florida, Texas, Illinois, and California. In that inspection, we found that in 40 percent of the cases, one or more of HCFA's 11 standards were not met. We also found that one out of every 14 suppliers and one of every 9 new applicants did not have a required physical address. A physical address is required for suppliers because it allows beneficiaries a place where they can reach suppliers about DME needs and problems. A physical address provides a place where beneficiary and financial records should be kept for oversight purposes, and the physical address is usually where suppliers keep their inventory. When we checked questionable addresses, we usually found that the business had closed or had a questionable presence at the address. Some

addresses were a mail drop location only or the address was nonexistent or could not be located. Thirteen percent of the suppliers we inspected gave their residence as the business address. This is not to say that home-based companies are automatically suspect, but they do make HCFA's oversight more difficult. Problems with physical addresses, such as we have described, often indicates potentially nonlegitimate business arrangements. A classic example is a case we uncovered in the Miami, Florida area.

#### **The Miami Investigation**

This investigation began in 1994 when a private citizen in Miami forwarded to us dozens of Medicare Explanations of Benefits forms which he mistakenly received in the mail. The forms showed that multiple beneficiaries were each provided liquid nutrition by 6 different DME companies. All of the beneficiaries involved were reported by the DME companies as having the same, incorrect address. All of the companies billed, and were paid by, Medicare for the services supposedly provided to the beneficiaries.

As part of our investigation, we contacted the beneficiaries, and all denied receiving the services. We then visited several of the business addresses which these DME companies reported to Medicare and found that none had an actual office or business location. Instead, all were located at mail box drops, such as "Mail Boxes ETC." We began investigating the claims submitted to Medicare by these companies and interviewed some of the companies' "owners," eventually securing the cooperation of several. Through the use of interviews, surveillance, and other investigative techniques, we found that what we initially believed to be 6 or so fraudulent companies, operating independently, instead were only part of a larger, violent crime ring that defrauded the Medicare program of approximately \$6.2 million.

The ringleader in this operation was Ulisses Martinez who lived in the Miami area. We found that Martinez had entered the United States illegally, some years before, through use of a forged Panamanian passport. In or about 1992, Martinez and some associates began buying the names and Medicare numbers of beneficiaries, which would provide the fuel for the scheme. They purchased most of the names and numbers from two different sources:

- from secretaries in doctors' offices, who had easy access to patient information and physicians' Medicare billing numbers; and
- from recruiters.

Recruiters are persons who canvass nursing homes, adult living facilities, and private neighborhoods to find Medicare beneficiaries. In exchange for the beneficiaries' name, address, and Medicare number, the recruiter typically offers free groceries, rides to visit friends or relatives, or even cash. Martinez paid recruiters \$100 per name and Medicare number, and knew he could make his money back a hundredfold by billing Medicare. Recruiters continue to thrive in the Miami area, and there is no shortage of unscrupulous health care providers who will pay top dollar for legitimate Medicare numbers.

Martinez's sought out persons to help him run his fraudulent Medicare businesses, and thereby provide a layer of "fall guys" in case the scheme was uncovered by law enforcement. Martinez told

several people that he was a member of the "Movement for the Liberation of Cuba," and wanted to open Medicare businesses in order to raise funds for Cuban freedom fighters. This was a persuasive argument in the Miami area. He lured other people with the promise of easy cash.

Martinez paid these co-conspirators between \$1,000 and \$5,000 per month to be the titular heads, or "nominees," of his companies. In return for their monthly salary, each nominee was directed to incorporate the business in their own name and to sign as corporate officer on the Medicare provider application for their company. All of the nominees also signed blank company checks, which they turned over to Martinez.

Some conspirators knew from the beginning that Martinez's businesses were fraudulent, and eventually everyone came to realize that the businesses were a sham. However, conspirators told us they were afraid they would be killed if they backed out of the scheme. Martinez was known for being heavily armed and traveled in the company of bodyguards. It was clear that Martinez was known as a violent, well-armed criminal.

Ultimately, we found more than 20 fraudulent health care companies linked to Martinez, all of which followed the pattern of using mail drop locations, and being fronted by nominees, while Martinez controlled the fraudulent proceeds. By tracing his bank accounts, we found that Martinez purchased 8 properties in the Miami area, which were bought with cash or cashier's checks and totaled about \$1.2 million.

Martinez fled the United States soon after he got word of our investigation; two associates fled with him. We believe Martinez took with him a great deal of the money he stole from Medicare. Although two of the eight properties he purchased with Medicare-derived funds were seized and forfeited, the remaining six were sold before he fled the country.

We were able to successfully locate and prosecute nine other conspirators for their part in helping Martinez run his DME companies. Eight of the conspirators pled guilty to Medicare fraud-related charges, and the ninth chose a trial by jury. This man confidently passed out contraband Cuban cigars, labeled "Compliments of Ulisses Martinez," in the federal courtroom during his trial. Despite his generosity, he was convicted on all counts. All of the conspirators were ordered to pay restitution, ranging from \$70,000 to \$500,000, and several received sentences of imprisonment. As of this date, Martinez remains a fugitive.

Martinez is an example of a criminal who gained access to Medicare and billed the system without any intention of actually providing any of the services, equipment, and supplies for which he billed. We investigated a similar case in New York.

#### **New York Investigation**

Our investigation of the New York case began with beneficiary complaints that Medicare was billed for orthotic supplies the beneficiaries never received. The complaints centered on 5 durable medical equipment (DME) supply companies that proved to be nonexistent. In expanding our review, we found that Russian criminal elements were billing Medicare under the provider numbers of totally fictitious or inactive companies for supplies and services that were never

actually provided. Within a year, our investigation revealed approximately 20 provider numbers that were involved in the billing scheme. None of the provider numbers was representative of a legitimate company that was actually or actively in the business of providing the supplies and services that were being billed. In addition to orthotic supplies, the Medicare program was being billed for magnetic resonance imaging (MRI) services and ear implants.

Our investigation of the activities behind the numbers revealed a common scenario. The perpetrators:

- used front people in the Medicare program application process;
- obtained inactive provider numbers and used them to bill the program; and
- used mailbox "drop" locations to receive payments for services never rendered.

The OIG was drawn into investigating this scheme after numerous Medicare beneficiaries complained to their carriers about not receiving the services for which Medicare was being billed. We interviewed the beneficiaries and verified that claims were being submitted for services that were not actually rendered. These companies billed Medicare for millions in fraudulent claims. In one instance, three of the companies billing for ear implants received checks from Medicare totaling approximately \$1 million in less than a month. The bank where the money was being deposited became suspicious and called the carrier which, in turn, stopped payment on the checks. The Medicare carrier had placed a system alert on these companies if they submitted claims for MRI services, but the fictitious companies began submitting claims for ear implants and were getting paid. As a result of this investigation, HCFA has implemented controls which are now in place to help prevent this type of scheme. In another instance, Medicare payments for over \$5 million for MRI services were discontinued by the carrier after suspicions were aroused.

After interviewing beneficiaries, our agents conducted interviews with mail box rental establishments and confirmed that several mailbox "drops" were being opened by the same individual, using five different Russian passports. Our interviews with bank officials revealed that the same individual renting the mailboxes was also opening bank accounts at their respective establishments. The cooperation of the banks and mail box store owners was invaluable.

We arranged a meeting with representatives from several of the banks at which this individual had opened accounts. The meeting resulted in creation of a flyer that was provided to all bank employees. Several days later, a bank employee recognized the man as he attempted to withdraw \$35,000. The bank security was alerted, who then alerted the New York Police Department. The individual was arrested and later turned over to Federal custody. The local carrier was also notified and, within a 24-hour period, stopped payment on checks totaling over \$325,000.

The true identity of this individual was revealed through fingerprint analysis. Our investigation found that the man, Yury Bizayko, was a "front" person for Russian criminal interests and that he, indeed, used five different aliases. We also discovered that Yury had a criminal history in the United States which included assault and driving while intoxicated. Yury was recently sentenced to 30 months incarceration, three years supervised release, and was ordered to pay restitution in excess of \$1.5 million.

In one situation, Yury, acting on behalf of the criminal enterprise, met with a DME business owner after she placed an ad in a Russian newspaper to sell her medical supply company. Yury advised the owner that he would pay \$5,000 for the company provider number if she also provided him with the names of beneficiaries and doctors. The DME owner allowed Yury to take her incorporation papers for the company, purportedly so that Yury could review them with his attorney. Several days later, Yury went back to the owner and stated that his attorney advised him it was illegal to purchase the company. The Russians then took the name of the business that was for sale, had the provider address changed and began fraudulently billing Medicare under that business name.

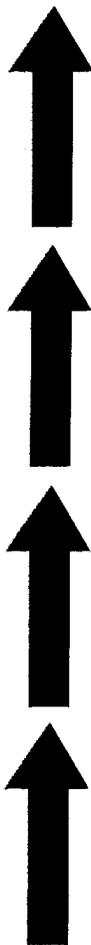
We have also arrested a second individual who claims he worked for Russian criminal interests that instructed him to open accounts, endorse checks, and make deposits and withdrawals. He also pled guilty and was sentenced to six-months home detention, three years probation, and was ordered to pay restitution to the government of more than \$100,000.

I want to emphasize here that the Medicare carriers did a good job of setting up controls and limiting losses during the investigation of this case. Although over \$27 million was billed under this scheme, a little over \$1.5 million was actually paid out. Yury Bizayko has been ordered to repay the \$1.5 million in restitution. However, even with our arrests in this case, the fraudulent scheme is continuing. Federal prosecution has not deterred certain criminal elements from pursuing this fraud. Other subjects are currently under investigation. We have found that, as a part of this scheme, fictitious companies are being incorporated in other States. The criminal interests are finding new ways to "game" the system and take advantage of weaknesses in the reimbursement process.

#### **Conclusion.**

In conclusion, Mr. Chairman, we firmly believe that criminal elements in health care fraud are not isolated to the schemes discussed in my testimony. We will be actively overseeing how the new resources and safeguards provided in the HIPAA and BBA are used to determine their effectiveness in preventing and combating criminal activities. We are also looking forward to the new program of on-site inspections being initiated by the Administration to ensure that medical equipment suppliers are providing the medical devices they claim they are. For true criminals, the only effective safeguards are tough-minded program measures to prevent fraud and a strong law enforcement presence with equally strong penalties applied to defrauders. This concludes my testimony. My colleagues and I welcome your questions.

# APPLICATION PROCESS HOME HEALTH PROVIDERS



## APPLICATION SUBMITTED

- PROVIDER REQUESTS CARE CERTIFICATION FROM STATE AGENCY (usually done in conjunction with State licensing or registration)
- STATE AGENCY SENDS PROVIDER ENROLLMENT PACKAGE (includes HCFA 855 application)
- PROVIDER RETURNS COMPLETED APPLICATION FORMS
- STATE AGENCY KEEPS COPY OF APPLICATION AND FORWARDS ORIGINAL TO THE FISCAL INTERMEDIARY

## APPLICATION REVIEWED

- FISCAL INTERMEDIARY VERIFIES PROVIDER INFORMATION USING COMMERCIAL DATABASES
- ALL PROVIDERS ARE CHECKED AGAINST EXCLUDED/SANCTIONED PROVIDER LISTS

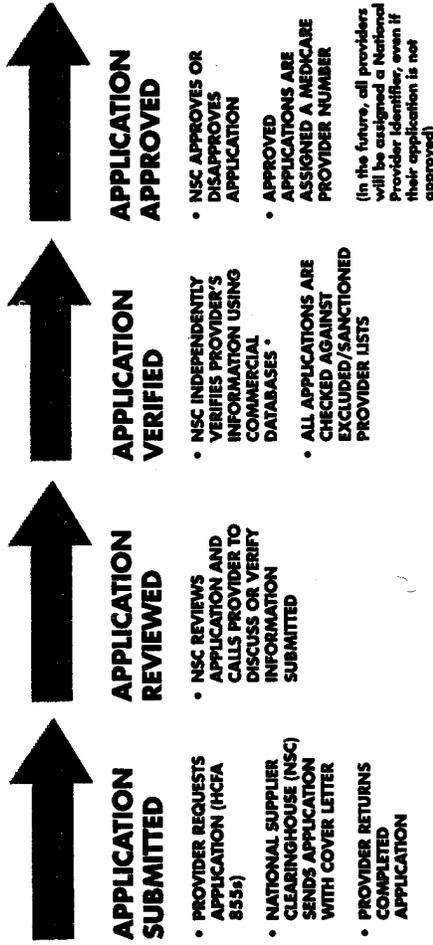
## SITE VISIT

- FISCAL INTERMEDIARY HAS OPTION TO CONDUCT A SITE VISIT (very rare)
- STATE AGENCY IS MANDATED TO CONDUCT A SITE VISIT TO ASSESS THE PROVIDER'S ABILITY TO PROVIDE APPROPRIATE CARE
- SURVEY RESULTS ARE PROVIDED TO HCFA REGIONAL OFFICE TO REVIEW

## APPLICATION APPROVAL

- HCFA APPROVES OR DENIES APPLICATION
- IF APPLICATION IS APPROVED, HCFA ASSIGNS A PROVIDER NUMBER AND FISCAL INTERMEDIARY IS NOTIFIED
- ONCE THE PROVIDER NUMBER IS ISSUED, BILLING MAY COMMENCE

# APPLICATION PROCESS DME PROVIDER



\*In Operation Restore Trust (ORT) states, applications are independently verified including checking business licenses and bankruptcies. In non-ORT states, only applications that raise a "red flag" are verified; however all applications are checked against the excluded/sanctioned provider lists.

The entire enrollment process should take approximately 30-60 days as long as the application is completed accurately and the information is easily verified.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION

Senae Permanent Subcommittee  
on Investigations

EXHIBIT # 4a

**MEDICARE SUPPLIER NUMBER APPLICATION**  
(ONLY AUTHORIZED PERSON MAY COMPLETE THIS FORM.)  
(Please Type or Print Clearly--If Additional Space is Needed, Attach Additional Sheets)

Initial Filing  
 Revised Filing

**1. IDENTIFYING INFORMATION**

A. Name of Supplier as Legally Established  
STIRLING HOROWITZ

B. Business Name(s)  
SAME

C. Street Address  
1204 AVE U STE # 2

City BROOKLYN State NY ZIP Code (9 digit)  
11229

D. Telephone  
(718) 670-3758

E. Tax Number (EIN)  
086345338

F. Mailing Address (if different than C)  
SAME

**2. TYPE OF BUSINESS**

A.  Sole Proprietorship  
 Business Corporation  
 Other

General Partnership  
 Joint Venture  
 Professional Corporation

B. Date Incorporated/Established:

1.	03 12 92	State	1.	NY
2.			2.	
3.			3.	

**3. NATURE OF BUSINESS**

A.  Durable Medical Equipment  
 Parenteral and Enteral Nutrition  
 Drugs/Pharmaceuticals  
 Dialysis Equip. and Supplies  
 Supplies for Nursing Facilities  
 Other

Oxygen  
 Customized Items  
 Orthotics  
 Prosthetics

B. License Number: 086345338-A  
Licensing Agency: NYS Tax Authority  
City/State: New York State  
Date License Issued: 05/03/95  
Expiration: 05/02/97

**4. OWNERSHIP/MANAGEMENT INFORMATION**

A. 1. Does one individual or family own 50% or more of this supplier?  Yes  No  
2. Is this supplier a corporation who stock is listed on the NYSE, AMEX, or NASDAQ?  Yes  No  
3. Do the total assets of this supplier exceed \$100,000,000?  Yes  No

If you answer 4.A.1. "No," and answer 4.A.2. and 3. "Yes," proceed to 5.A.

List each individual owner and managing employee (O/EE) of the supplier. If one or more owners of the supplier are other companies, list the name of each O/EE of each of those companies. For each individual include her/his name, credentials, e.g., M.D., C.O., C.P., etc., title/position and UPIN for physicians or Social Security number (SSN) for nonphysicians; for company owners, include their EINs. Each individual should be identified as an owner (O) or as a managing employee (EE), unless you would answer 4.A.1. "No" and answer 4.A.2. and "Yes" for the parent company.

(1)	STIRLING HOROWITZ	PRESIDENT	086345338	OWNER/O
	Name	Title/Position	UPIN/SSN/EIN	O/EE
(2)				
	Name	Title/Position	UPIN/SSN/EIN	O/EE
(3)				
	Name	Title/Position	UPIN/SSN/EIN	O/EE
(4)				
	Name	Title/Position	UPIN/SSN/EIN	O/EE
(5)				
	Name	Title/Position	UPIN/SSN/EIN	O/EE

C. If any owners are immediate family members of a physician, the following information must be completed.

(1) NONE

(1)	Name	Relationship	Physician Name	UPIN/SSN
(2)	Name	Relationship	Physician Name	UPIN/SSN
(3)	Name	Relationship	Physician Name	UPIN/SSN

Senior Personnel Submissions  
on Investigation  
EXHIBIT # 4b

**Location of 2 New York City Companies  
(DME products and MRI tests)**



**Medicare claims submitted \$3.4 million  
Payments Received \$500,000  
No Services Provided**

Private Payments Submissions  
for Investigations  
EXHIBIT # 2

**Reported Office Location of 2 Physicians  
New York City**



**Medicare claims submitted - \$690,000**

**Payments Received - \$117,000**

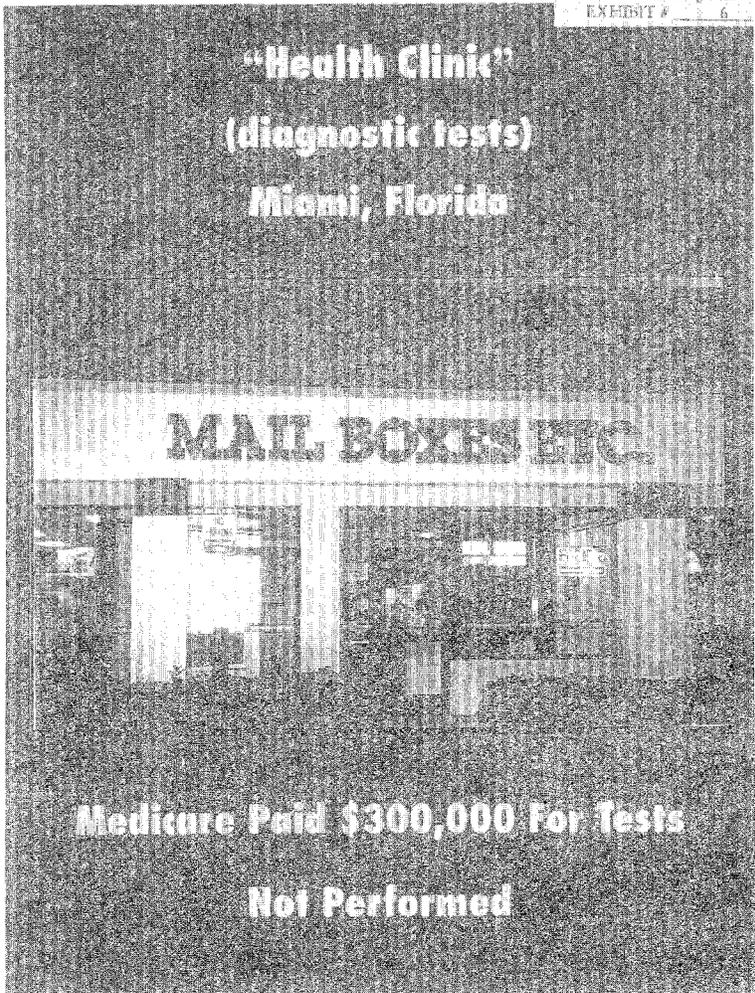
**No Services Rendered**

**Inside Reported Office of 2 Physicians  
New York City**



**Inside Reported Office of 2 Physicians  
New York City**



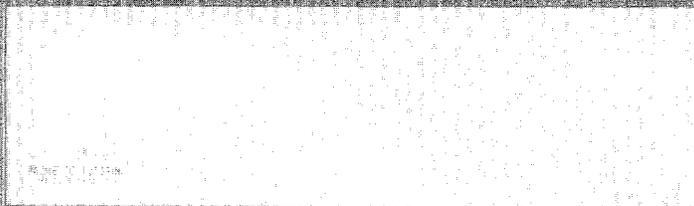


**"Health Clinic"**  
**(diagnostic tests)**  
**Miami, Florida**

**MAIL BOXES ETC**

**Medicare Paid \$300,000 For Tests**  
**Not Performed**

**"Health Clinic"  
Miami, Florida**

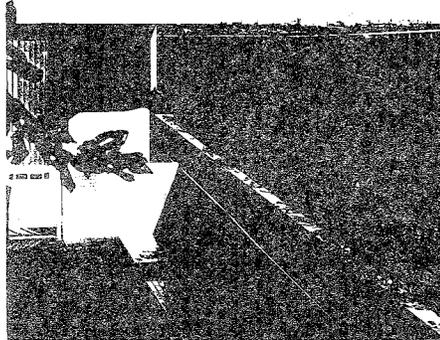
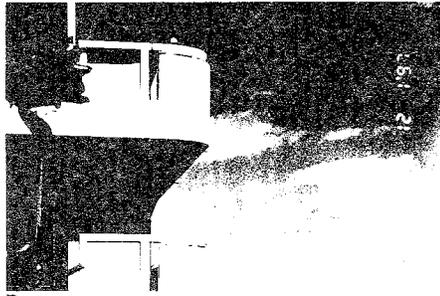


**Medicare Paid \$2 Million  
No Services Rendered**

**Location of 14 Health Care Companies  
(DME Products/Services)  
Miami, Florida**



**Medicare Paid \$6 Million  
for claims submitted  
No Services Rendered**





DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Senate Permanent Subcommittee  
on Investigations

EXHIBIT # 10

## Memorandum

Date DEC 17 1997

From June Gibbs Brown  
Inspector General *June Gibbs Brown*

Subject OIG Final Report: "Medical Equipment Suppliers: Assuring  
Legitimacy," OEI-04-96-00240

To Nancy-Ann Min DeParle  
Administrator  
Health Care Financing Administration

Attached is our final inspection report on whether persons who obtain durable medical equipment (DME) billing numbers are operating bona fide businesses. We inspected 420 enrolled suppliers and 35 new applicants for DME billing numbers located in Operation Restore Trust States.

Some suppliers were not operating bona fide businesses. About 1 of every 14 DME suppliers and 1 of every 9 new applicants either did not have a physical address, or the presence of a business was highly questionable. Forty-one percent of the suppliers and 40 percent of new applicants failed to meet at least one Medicare standard--such as those relating to warranties and information for beneficiaries.

Oversight of suppliers who work out of their homes is particularly difficult. Such suppliers are typically away during business hours, and access to their residences is often restricted.

The ease and low cost of obtaining a DME number facilitates entry of abusers into the program. For example, no experience with medical equipment is required to get a billing number.

To help assure ethical DME suppliers, we recommended several options for the Health Care Financing Administration's (HCFA) consideration. Those options are to charge an application fee, require a surety bond, conduct on-site visits, require program training for new suppliers, increase review of inactive numbers, revise the DME application form, seek authority to require applicants' Social Security and employer identification numbers, and impose a 6-month waiting period for denied applicants to reapply. We were pleased to see that the Balanced Budget Act of 1997 authorized the surety bonds and called for an examination of the use of Social Security numbers and we appreciate HCFA's support for our recommendations.

Page 2 - Nancy-Ann Min DeParle

Could you please submit within 60 days your plan to implement the recommendations. If you have any questions about this report, please call me or George Grob, Deputy Inspector General for Evaluation and Inspections, or have your staff call Mary Beth Clarke at (202) 619-2481.

Attachment

cc:

Melissa Skolfield  
Assistant Secretary for  
Public Affairs

Margaret A. Hamburg  
Assistant Secretary for  
Planning and Evaluation

Richard J. Tarplin  
Assistant Secretary  
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Assistant Secretary for  
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Department of Health and Human Services  
**OFFICE OF  
INSPECTOR GENERAL**

**MEDICAL EQUIPMENT SUPPLIERS**  
**Assuring Legitimacy**



**JUNE GIBBS BROWN**  
Inspector General

DECEMBER 1997  
OEI-04-96-00240

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## EXECUTIVE SUMMARY

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### PURPOSE

To determine whether persons who obtain Medicare durable medical equipment supplier numbers operate bona fide businesses.

### BACKGROUND

Before businesses can bill Medicare for sale and rental of durable medical equipment, they must apply for and receive a billing number. Applicants are approved and issued such numbers by the National Supplier Clearinghouse in Columbia, South Carolina. To help assure that applicants are bona fide businesses, the Health Care Financing Administration (HCFA) requires that each supplier meet 11 standards.

Despite such safeguards, however, HCFA reported in 1996 that out of a sample of 36 new DME applicants in the Miami, Florida area, 32 were not bona fide businesses. Among other problems, some bogus applicants did not have a physical address, or an inventory of durable medical equipment. According to HCFA staff, those companies should not be issued a supplier number because they were not operational entities. Further, HCFA staff said such suppliers are typically involved in fraudulent activities.

In light of the bogus applicants discovered in Miami, HCFA asked us to ascertain whether similar problems exist elsewhere in the country. In response, we conducted unannounced on-site inspections of 420 suppliers who were issued billing numbers between January and June 1996. We also inspected 35 applicants who had not yet been approved. Our sampled suppliers were located in 12 large metropolitan areas in New York, Florida, Texas, Illinois, and California.

### FINDINGS

- ▶ One of every 14 suppliers and 1 of every 9 new applicants did not have a required physical address.
- ▶ Forty-one percent of suppliers and 40 percent of new applicants failed to meet at least one supplier standard, such as those related to warranties, information for customers, and inventories.
- ▶ Oversight of home-based suppliers is particularly difficult, e.g., typically, they are not at home during normal business hours and have answering machines that do not identify the business.
- ▶ The ease and low expense of acquiring a supplier number facilitates entry of abusers into the program.

**CONCLUSION**

Presently, HCFA and the National Supplier Clearinghouse are approving many inexperienced, unqualified, and unethical people for supplier numbers. The desk verification process for approving suppliers is unreliable for detecting unethical and improper practices of bogus suppliers. On-site verification is needed, but not for all suppliers. HCFA and the National Supplier Clearinghouse may determine that some suppliers such as large corporations need no or only occasional site verification. Further, the supplier number application form needs to be revised. Presently, it is inadequate for judging the suitability of supplier applicants.

**RECOMMENDATION**

HCFA should take quick action to ensure the integrity of Medicare suppliers of durable medical equipment. The following options would help accomplish that goal.

- ▶ Charge all applicants an application fee.
- ▶ Require all suppliers to have a surety bond.
- ▶ Conduct on-site visits at applicants' physical locations.
- ▶ Require program training for new suppliers by the Medicare regional carriers.
- ▶ Increase the review of inactive numbers.
- ▶ Further revise the application form.
- ▶ Seek authority to require Social Security and tax identification numbers from applicants.
- ▶ Impose on denied applicants a 6-month waiting period before reapplication.

Implementation of the first option will provide financial resources to implement the others.

**AGENCY COMMENTS**

HCFA concurred with our recommendation. Their comments are in Appendix A. The Balanced Budget Act of 1997 authorized Medicare to collect Social Security and tax identification numbers and required suppliers to have a surety bond.

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**TABLE OF CONTENTS**

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	<b>PAGE</b>
<b>EXECUTIVE SUMMARY</b>	
<b>INTRODUCTION</b> .....	1
<b>FINDINGS</b> .....	5
Physical Addresses .....	5
Other Supplier Standards .....	6
Oversight of Home-Based Suppliers .....	7
Ease of Getting a Billing Number .....	10
<b>CONCLUSION</b> .....	11
<b>RECOMMENDATION</b> .....	13
<b>AGENCY COMMENTS</b> .....	15
<b>APPENDIX A: HCFA COMMENTS</b> .....	A-1

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## INTRODUCTION

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### PURPOSE

To determine whether persons who obtain Medicare durable medical equipment supplier numbers operate bona fide businesses.

### BACKGROUND

#### *Requirements For DME Supplier Numbers*

Before businesses can bill Medicare for sales or rental of durable medical equipment (DME), they must apply for and receive a billing number. In 1993, the Health Care Financing Administration (HCFA) authorized establishment of the National Supplier Clearinghouse (NSC), a contractor that reviews and approves applications. Section 1834 of the Social Security Act requires that applicants and approved DME suppliers meet 11 standards. They are

- fill orders from their own inventory or under a contractual arrangement,
- oversee delivery of equipment,
- answer questions and complaints from beneficiaries,
- maintain and repair rental equipment,
- maintain a physical address at the business site,
- comply with all State and Federal licensure requirements,
- honor warranties on equipment,
- accept the return of substandard equipment,
- disclose consumer information (a list of the standards) to beneficiaries,
- comply with the ownership disclosure provisions of the Social Security Act, and
- have proof of liability insurance.

HCFA has a notice of proposed rulemaking under development which would establish nine new standards that DME suppliers must meet.

#### *The Problem*

Despite the existence of supplier standards and NSC reviews, HCFA reported in 1996 that 32 of 36 new DME supplier applicants in the Miami, Florida area were not bona fide businesses. Among other problems, some bogus DME suppliers did not have a physical address, or an inventory of durable medical equipment. For example, in one location, a small subdivided office supposedly housed four suppliers. Though their business licenses were posted in the office, there was no inventory at the site and no business was being conducted. According to HCFA staff, those companies should not be issued a supplier number because they were not operational entities. Further, HCFA said the bogus DME suppliers were likely established to abuse or defraud Medicare. Other reviewers such as the NSC, DME Regional Carrier in South

Carolina, and Florida Medicaid staff corroborated HCFA's findings and conclusions.

***Potential Significance Of The Problem***

The NSC issued over 300,000 supplier applications, and over 100,000 billing numbers nationwide since 1993.

It is important to determine the extent that such billing numbers were approved for bogus companies that may be intent on defrauding Medicare. Preventing the issuance of billing numbers to such companies could result in a substantial savings to Medicare. Nationwide, Medicare approved DME claims for a total of \$4.7 billion in 1995. In the Miami area alone, Medicare paid \$406.3 million for DME supplies during a 22-month period ending April 30, 1996.

Some staff with HCFA, NSC, and the DME Regional Carrier suggested that problems like those observed in the Miami area may exist in other urban areas. HCFA asked us to determine whether problems similar to those encountered in the Miami area were occurring elsewhere in the country. We conducted this inspection in response to that request.

**METHODOLOGY**

We selected 12 metropolitan areas for review of issuance of DME supplier numbers (see chart below). Generally, we selected the largest cities in California, Florida, Illinois, New York, and Texas. We used U.S. census population data to identify the 12 largest cities. We excluded the Miami, Florida area because of ongoing criminal investigations of DME suppliers.

STATES	SELECTED METROPOLITAN AREAS
California	Los Angeles, San Diego, San Francisco
Florida	Jacksonville, Orlando, Tampa
Illinois	Chicago
New York	New York City, Buffalo
Texas	Dallas, Houston, San Antonio

We limited our review of DME supplier numbers to those located in the major metropolitan areas of the cities selected. We used U.S. Postal Service information to identify zip codes that represented the major metropolitan area of each selected city. For example, in Chicago, Illinois, the zip codes were 60000 through 60799. In many instances, the zip codes covered the selected city and several surrounding cities and towns.

For each zip code, we obtained from NSC the applications of all DME suppliers approved during January through June 1996. During that 6-month period, 1,180 suppliers in our selected cities had obtained approved billing numbers. We selected a purposive sample of 420 of the 1,180 suppliers for inspection.

For each zip code, we also obtained, from NSC, all applications for DME supplier numbers that were pending approval when we began making site visits. From the 53 pending applications, we selected a sample of 35 for inspection.

We selected suppliers and applicants without prior knowledge of the legitimacy of their business practices. However, we designed our sample of suppliers to include a variety of supplier types, including physicians, optical stores, therapists, orthotists, and pharmacies.

Thereafter, we made unannounced visits to 420 suppliers and 35 applicants. This was as many as possible given our staff resources and time frame. Generally, we used two-person teams for each visit. In some instances, an OIG investigator accompanied the teams. Each site visit lasted no more than 20 minutes.

Each team used a standardized checklist designed to document when suppliers clearly did not meet 1 or more of the 11 Medicare standards—or worse, did not appear to be a bona fide business. The prime objective of our site visits was to ascertain whether or not suppliers and applicants had an appropriate physical business address. Without such, compliance with other standards was assumed unlikely. For example, without an identifiable physical address, beyond a mailbox location, on-site business and oversight were not possible.

In instances where violations of standards were not obvious, we did no further inspection work to assure that standards were in fact met. Such a determination would have required a long evaluation period for interviews and record reviews.

#### **Operation Restore Trust**

This inspection was part of the President's Operation Restore Trust (ORT) initiative. The purpose of ORT is to identify and prevent fraud, waste, and abuse in the Medicare and Medicaid programs. ORT is a joint initiative involving the Health Care Financing Administration, Administration on Aging, Office of Inspector General, and various State agencies. In 1995, ORT began targeting home health agencies, nursing homes, hospices, and durable medical equipment suppliers in five States for evaluations, audits, and investigations. The five States are Florida, New York, Texas, Illinois, and California. These States collectively account for about 40 percent of the nation's Medicare and Medicaid beneficiaries and program expenditures.

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We conducted this inspection in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

## FINDINGS

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### ONE OUT OF 14 DURABLE MEDICAL EQUIPMENT SUPPLIERS DID NOT HAVE REQUIRED PHYSICAL ADDRESSES

Medicare standards for DME suppliers require that suppliers have a physical address. Such an address is important to allow beneficiaries a place where they can reach suppliers about DME needs and problems. A physical address also provides a place where beneficiary and financial records should be kept for oversight purposes. Finally, the physical address is usually where suppliers keep their inventory. The application form for DME supplier numbers elicits a supplier's physical, mailing, and billing addresses. These may be three separate addresses. However, failure to accurately list a physical address can result in denial of a billing number to an applicant or revocation of an existing supplier's billing number.

One out of each 14 DME suppliers we inspected (31 of 420) did not have the required physical address—or their presence at the address listed on the application form was highly questionable. This means that 7 percent of the DME suppliers we inspected need further investigation of their legitimacy. Table 1 below shows reasons why the 31 suppliers did not have physical addresses. Likewise, 4 of the 35 new applicants for DME supplier numbers did not have required physical addresses. An additional applicant had an inaccessible address in a secured apartment complex.

TABLE 1

STATUS OF ADDRESS VISITED	SUPPLIERS
Business had closed	14
Had a questionable presence at the address	8
Mail drop location only	4
Address nonexistent or could not be located	5
<b>Total</b>	<b>31</b>

As shown by the table, 14 suppliers had closed. That is, they were no longer operating at the sites shown on their applications for DME numbers—though their applications had just been approved during January - June 1996. Most of the 14 had left no information behind such as is typical for a business merely relocating. For example, according to their landlord, a pair of physicians suddenly closed their office and vanished, breaking their lease. In another instance, a neighboring business person said the supplier had closed over a weekend, without leaving any forwarding information.

Table 1 also shows that eight suppliers had no, or a highly questionable presence at the address listed on the DME supplier application form. Residents at or near the listed addresses were unable to say whether or not a supplier had ever been located there. In such instances, we were unable to ascertain that a supplier was ever located at the address given on the application form. We characterized these eight suppliers as having a "questionable presence."

For example, in Brooklyn, New York, a supplier's address shown on the application form was in a building that consisted of four apartments over a laundromat. The DME company name was not shown on mailboxes or other parts of the premises. We interviewed two tenants at the premises who said they had not heard of the supplier. Since the numbers had been issued within the last 6 months, we expected the tenants to recall the supplier if one existed. One of the tenants said the laundromat space was formerly used as a "post office box operation." Further, the phone number shown on the DME application was out of service. Thus, it was impossible to determine whether the DME business had ever operated at the address.

#### **FORTY-ONE PERCENT OF SUPPLIERS FAILED TO MEET AT LEAST ONE DME SUPPLIER STANDARD**

Forty-one percent (173) of the 420 DME suppliers we inspected failed to meet at least 1 standard. Likewise, 40 percent (14) of the 35 new applicants for DME supplier numbers we inspected failed to meet at least 1 standard. We believe that these percentages are very conservative, however. We only looked for prima facie and obvious failures to meet standards during our brief site inspections. Our site inspections were designed to expeditiously determine when suppliers or new applicants clearly did not meet standards. If we did not readily observe a violation of the standards during our 20 minute inspection, we did no detail examination to find violations. Logically, a more in-depth inspection would have revealed a greater number of violations.

Further, 20 percent of the 420 existing suppliers were absent from their business addresses at the time of our inspection. Therefore, beyond assessing the existence of a physical address, we could not determine whether or not they met the standards. Typically, those businesses were closed at the time we attempted our site visits. However, had we gotten access to those businesses and owners, we believe we would have identified more instances of noncompliance.

Table 2 lists DME standards in effect at the time of our inspection, and the percentage of existing suppliers we inspected that failed to meet each standard. With one exception, "physical address," the percentages in the table are not based on 420 suppliers. The percentages are based on the number of sites where we could assess a particular standard. For example, at 306 sites, we were able to assess whether or not suppliers met the inventory standard. We were able to check for liability insurance at 240 sites. At some locations, we could not assess any standards beyond the existence

of a physical address. Such locations were where no supplier spokesperson was available for an interview and where we could not gain entrance into the business.

TABLE 2

DME SUPPLIER STANDARD	PERCENTAGE/ NUMBER THAT FAILED	
Consumer information (copy of suppliers standards to beneficiaries)	45%	111 of 248
Allow return of unsuitable items	20%	19 of 95
Warranty repairs	17%	17 of 101
Inventory	9%	27 of 306
Liability insurance	7%	17 of 240
Physical address	7%	31 of 420
Maintenance and repair (rented items)	6%	8 of 132
Questions/complaints	3%	7 of 206
Business license	3%	5 of 200
Delivery of items and equipment	1%	2 of 207
Disclosure of ownership	0%	0 of 269

The Medicare standard failed by the most suppliers was the one requiring them to provide a copy of the supplier standards to each beneficiary receiving DME. Because this is perhaps the easiest standard to meet, the high rate of noncompliance was surprising. Most of the suppliers that failed the standard said they were unaware of the requirement.

#### **OVERSIGHT OF HOME-BASED DME SUPPLIERS IS PARTICULARLY DIFFICULT**

Thirteen percent (57) of the 420 DME suppliers we inspected gave their residence as a business address. Of the 35 pending DME applicants, 4 were located in residential locations. This means that about one out of seven existing DME suppliers claim to conduct business out of residences such as a single-family house, mobile home, apartment, or condominium. Similarly, about one out of nine of the new applicants for DME supplier numbers listed such business sites.

Residential DME suppliers create a unique oversight problem for HCFA, NSC, and OIG. First, HCFA's DME application form does not distinguish between home-based suppliers and those at traditional business sites. Second, home-based suppliers often do not post a sign which identifies their business sites. Third, home-based suppliers typically are not at home during normal business hours. Fourth, home-based suppliers sometimes restrict public access to their residences. Finally, home-based suppliers frequently have telephone answering machines that do not identify their business.

*Application Form For DME Numbers Does Not Identify Home-Based Suppliers*

HCFA's DME number application form does not differentiate between home-based suppliers and those at traditional business sites. Such information is important for determining which types of suppliers are engaging in improper or fraudulent activities, i.e., what are the trends relative to supplier types and fraud. Home-based suppliers are not subjected to the same level of public scrutiny as are traditional storefront or corporate suppliers. Similarly, home-based suppliers are less accessible for program oversight. The need for such oversight becomes more important due to the current trend toward home-based businesses.

At the time we completed our inspection, HCFA was in process of revising the application form. However, we understand that the revised form will still not identify home-based suppliers.

*Residences Frequently Not Identified As A Business*

The physical location of a DME supplier is typically where inventories and sales models are kept. It is also the place where beneficiaries come to meet suppliers and obtain needed equipment. However, we rarely found a business sign or other identifier information that a business was in operation at addresses given by home-based DME suppliers we inspected.

Without identifiers such as signs, it is also difficult for HCFA and NSC to locate home-based DME suppliers for oversight purposes. Residential zoning or other similar restrictions may account for the absence of a sign, but the fact remains that this traditional way to identify a business site is simply unavailable with many home-based suppliers.

Given the absence of such identifiers, our inspection teams were unable to readily locate some DME suppliers that we had sampled for inspection. Even after finding the address listed on the application form, we were often not sure that we had located the supplier. As a result, we were unable in many instances to ascertain whether or not DME supplier standards were met. More basic than that, site inspections to home-based suppliers typically cannot even confirm the existence of a business nor ascertain the types of items purportedly being provided to beneficiaries.

***Business Operators Typically Not At Home During Normal Business Hours***

Only 14 of the 57 suppliers purportedly working out of their homes were present at the time of our site inspection, although we conducted our inspections during normal business hours. We ascertained through phone calls with some home-based suppliers that many of them consider their DME business to be a secondary venture. They work on other activities during regular business hours.

This problem hampers access for oversight purposes, and it increases the cost of oversight for HCFA and NSC. To illustrate, monitoring would likely require repeated trips, and the trips would likely have to be done outside of normal work hours. Because home-based suppliers are typically absent from their residences, it is generally useless to conduct on-site monitoring visits during normal business hours. This is particularly true for unannounced visits.

Such difficulty in contacting home-based DME suppliers could affect their ability to serve Medicare beneficiaries.

***Access To Residences Is Sometimes Restricted***

During our site inspections, some neighborhoods and many apartment buildings were secured by gates, guards, and buzz-in locking systems. While we were able to use our credentials to gain access to locations with security guards, entrance through secured gates and into locked buildings was sometimes not possible.

Persons with less imposing credentials would likely get little or no cooperation from security guards whose job is to keep out persons not properly cleared. Gaining access to restricted residences could be particularly difficult for Medicare beneficiaries who need DME.

We identified some residences where individuals were inside, but they refused to answer the door. In some cases, the individuals peeked through the blinds, disappeared from view, and ignored further attempts to speak with them. Without gaining entrance and locating someone to interview, oversight is impossible. Neither the OIG, HCFA, NSC, nor other oversight officials could, for example, verify inventory or determine that beneficiaries are allowed to return unsuitable items.

Conversely, at traditional business sites, such as stores or office buildings, access was not a problem.

***Home-Based Suppliers Are Difficult To Contact By Telephone***

In most instances, home-based DME suppliers used personal telephones for their business activities. In such instances, telephone calls during a supplier's absence are often answered by personal answering machines. However, the recorded message

does not always identify the business. In some instances, a caller cannot be sure he or she reached the correct number for the DME supplier.

**THE EASE AND LOW EXPENSE OF ACQUIRING A DME SUPPLIER NUMBER FACILITATES ENTRY OF ABUSERS INTO THE PROGRAM**

Despite DME supplier standards and an application review process, acquisition of a Medicare DME supplier number is easy. Further, it requires no financial investment. This, combined with the potential high revenue resulting from having a DME billing number, attracts many people—both legitimate and nonlegitimate suppliers.

*No Financial Investment Required*

Supplying durable medical equipment to Medicare beneficiaries can be a profitable business—whether a supplier takes a legitimate or illegitimate approach. Essentially, a person only needs a supplier number to bill the Medicare program. That number can be obtained by merely answering a few questions on a simple application form, and mailing that form to NSC. No investment in a business location nor inventory is required. A supplier may arrange for shipment from a manufacturer or distributor directly to Medicare beneficiaries. Thus, the supplier does not have to bear the cost of keeping an inventory on-site.

The absence of an investment allows unethical persons to enroll and test their fraudulent schemes at no cost to themselves. During our inspection, we found several individuals who applied for and received supplier numbers on a whim. They did not know how or if they would use the numbers. Some persons said they decided not to bill Medicare after getting the number, and a few asked our inspection team to "take their DME number back and cancel it."

*Little Verification Of Application Information*

Applicants for DME numbers are required to do little other than assert that the information they provide on an application form is true. The NSC verifies only a limited amount of information provided on DME number applications. They do so by calling the applicant or some third party, such as local licensing agencies and State offices that issue articles of incorporation.

*No Experience With Medical Equipment Required*

An applicant needs no credentials, and is not required to have any experience with medical equipment to obtain a DME number. Likewise, one does not have to formulate a business plan or purpose showing intent to service Medicare beneficiaries. The absence of such experience and qualifications seems to facilitate entry of abusers into the program. The ease in getting a number unnecessarily opens an opportunity for fraud or abuse. The following examples illustrate the ease of getting a DME billing number, and potential for fraud and abuse.

- ▶ A woman who lives in an upscale house on a lake applied for and received a DME number. She purportedly operates a medical supply company at that address. However, her husband openly told us his wife knew nothing about the DME business. He said, on the other hand, he did know about the business because he is a supplier. Nevertheless, the applicant herself was completely inexperienced—clearly raising questions of why she applied for her own number. The situation showed more potential for impropriety than for operation of a bona fide business.
- ▶ A Florida souvenir dealer whose shop is in his garage applied for and received a DME number. His main business line includes stuffed alligator heads, alligator skin wallets, and stuffed turtles. But because his brother-in-law installs wheelchair lifts on vehicles, he decided to add wheelchairs, lift chairs, and beds to his line of business. He had no experience or credentials for supplying DME. Further, he keeps no DME inventory. He said he has only filed one Medicare claim.

The suppliers described above were only two of many that raised questions on suitability for DME numbers. For example, we found dealers in fancy spas, golf carts, home modifications, and sports shoes to have DME numbers. We did not establish that suppliers such as the above examples abused the Medicare program. However, they clearly raise questions on appropriateness of receiving DME billing numbers.

#### CONCLUSION

It is clear that NSC is limited in preventing issuance of improper DME numbers without conducting site verifications of applicants. HCFA staff advised us that the specialization of one national clearinghouse (NSC) is advantageous for screening and issuing DME numbers. We concur. Nevertheless, desk verifications done in Columbia, South Carolina cannot be as thorough and effective as on-site verifications. We understand the resource implications of site verifications. However, the cost should be easily off-set by a reduction of fraudulent suppliers entering the Medicare program.

Further, on-site verification would not be needed for all applicants. Some low-risk applicants may quickly be relegated to desk verification as is currently done. For example, site verification of corporate suppliers such as a major chain of pharmacies in Wal-Mart or Eckerd Drug stores may need limited verification, or none at all. To the extent it is needed, verification would likely be done at the corporate headquarters. Our logic here is based on two generalizations from our site visits: major chains have a centralized operation, and—as a result—staff in a local store know nothing about the DME number, nor Medicare claims.

Our DME on-site inspections indicate that many unqualified, inexperienced people are getting into the DME business. Many DME suppliers we interviewed had little or no idea how the Medicare DME business worked. Given the present application process,

the only reliable way to discover unethical and improper practices by suppliers is to make on-site inspections.

The current DME application form is inadequate to judge the ability of applicants to meet the needs of the Medicare program and its beneficiaries. Although HCFA has revised the form, our site inspections suggest that further revisions are needed. The current application (Form HCFA-855S) could be more effective, from a program integrity perspective. For example, it would be beneficial to have the application identify residential business locations, and when suppliers are available to conduct business. Similarly, requiring applicants to say whether their business is full-time or part-time would be helpful.

## RECOMMENDATION

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### HCFA should take quick action to ensure integrity of Medicare suppliers of DME.

HCFA and the National Supplier Clearinghouse have recognized many of the problems and issues raised in this report. Both, in fact, supported our data collection effort during this inspection. Their positive and constructive steps should help improve operation of the DME program. Further, they have begun to implement some of the options listed below. Each option should be considered independently, on its own merit.

- ▶ **Application fee:** Charge all DME applicants an application fee. The fee should cover costs of processing an application and verifying, through on-site inspections, legitimacy of the business.
- ▶ **Surety bond:** Require all suppliers to have a surety bond. The bond should be indexed to the volume of Medicare business transacted by a supplier in the previous year. Such a requirement would help indemnify HCFA against fraud and reduce the number of applicants who apply for a supplier number with no clear intent.

We understand that HCFA's proposed revision of supplier standards would require annual surety bonding for all existing suppliers, and as a condition of enrollment for all supplier applicants.

- ▶ **On-site verifications:** Conduct on-site verifications at physical locations of applicants. Several approaches are possible for selecting applicants to be inspected. Primarily, HCFA could inspect the sites of all new applicants, or develop a profile which identifies high risk ones. The OIG would be willing to assist in developing such a profile.

HCFA is presently using a contractor to conduct site visits in South Florida. We did not assess that methodology during our inspection. However, HCFA reports indicate that it is working well. HCFA is currently in the process of implementing similar site verification visits in the Brooklyn and Bronx areas of New York City. We endorse this action. Such site verification visits would be beneficial if done in other geographic areas as well.

- ▶ **Training:** Require DME regional carriers to conduct training for all new suppliers on program requirements, and on proper billing procedures. Suppliers should pay a fee for such training. The amount of the fee should be sufficient to completely pay for the training.

- ▶ **Inactive numbers:** Increase review of inactive DME supplier numbers. Currently, HCFA inactivates billing numbers after four consecutive quarters of inactivity. In view of the inactive suppliers whom we found got a billing number on a whim, HCFA should consider initially reviewing a supplier's billing activities after a reasonable period--i.e., 90 days or 6 months. Such a review and deactivation of inactive numbers could help reduce the number of supplier numbers lying fallow. After the initial review, DME numbers found to be active could be reviewed annually.
- ▶ **Application form:** Further revise the DME application form. HCFA has been revising the supplier application form over the last year in an attempt to better meet the needs of a changing profile of suppliers. HCFA has consulted with their regional offices, NSC, DME regional carriers, and the supplier industry related to those revisions. The new application (Form HCFA-855S) encompasses some of the options in this report. However, the OIG would be willing to work with HCFA in further revising the application form to reflect program integrity concerns raised from this inspection.
- ▶ **Social Security and tax identification numbers:** Seek authority to require Social Security numbers (SSNs) and employer identification numbers from all DME applicants. As part of the overall effort to ensure the integrity of DME suppliers, HCFA should seek legislative authority for the Secretary to require DME number applicants--i.e., all managing employees and owners--to provide their SSNs and employer identification numbers. Access to those unique identifiers will enable HCFA and its contractors to more effectively screen applicants. Those identifiers can also facilitate, when necessary, corrective actions related to billing aberrancies, fraud, or abuse. For example, the SSN could be useful in recovering Medicare funds from a fraudulent DME supplier.
- ▶ **6-month delayed reapplication:** Impose a 6-month waiting period on applicants who are denied DME billing numbers for cause. That reapplication waiting period should discourage applicants from failing to provide pertinent information or failing to cooperate with inquiries by NSC. It should also keep applicants from frivolously overburdening the application process by applying repeatedly. Conversely, applicants who apparently pursue their applications in good faith, but are denied because of certain minor problems could be exempt from the waiting period.

The implementation of the first option will provide financial resources to implement the others.

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**AGENCY COMMENTS**

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HCFA concurred with our recommendation. Their comments are in Appendix A. The Balanced Budget Act of 1997 authorized Medicare to collect Social Security and tax identification numbers and required suppliers to have a surety bond.

**APPENDIX A**

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**HCFA COMMENTS**

Equipix for conducting on-site visits in these areas. Site visits in South Florida are currently being conducted by the NSC. However, the additional funding provided by ORT will allow an expansion of these efforts. Additionally, should we get the legislative authority to charge application fees, we can place more emphasis on ensuring that suppliers meet the specified requirements in the supplier standards.

OIG Option 4

Require program training for new suppliers by the Medicare regional carriers.

HCEA Comment

HCEA concurs with the intent of this recommendation. However, because of limited staffing and financial resources, HCEA is unable to require training for all new suppliers at this time. The DMERCs periodically hold training sessions which include training for new suppliers. Each DMERC has its own supplier manual for the use of the suppliers in its area. These supplier manuals are updated periodically. The DMERCs also publish quarterly bulletins with news, new billing requirements, policies, and reminders. We will explore ways to intensify these efforts.

OIG Option 5

Increase the review of inactive numbers.

HCEA Comment

We concur. We have instituted procedures at the NSC whereby it will deactivate supplier numbers on a quarterly basis for suppliers who have not billed for 4 quarters. The NSC will deactivate supplier numbers every 3 months for non-billing instead of every year.

OIG Option 6

Further revise the application form.

HCEA Comment

We concur. The form has been revised to collect information on whether a supplier applicant is operating from a residence. In fact, we have developed a new enrollment process that requires carriers to verify all data provided on the application, e.g., licensure information, prior sanction or exclusion information, place of business, ownership information, billing contracts, tax identification data, etc. This information is verified with the state licensing board, OIG, and professional associations. We would welcome the OIG's input on future revisions.

**OIG Option 7**

Seek authority to require Social Security and tax identification numbers from applicants.

**HCFA Comment**

We concur. We requested legislative authority under the Administration's "Medicare and Medicaid Fraud, Waste and Abuse Prevention Amendments of 1997" (section 121) to mandate that individuals provide social security numbers on the DME application form (HCFA-855S), including owners and managing employees. This provision was included in section 4313 of the Balanced Budget Act of 1997.

**OIG Option 8**

Impose on denied applicants a 6-month waiting period before reapplication.

**HCFA Comment**

We concur. We requested this legislative authority under the Administration's "Medicare and Medicaid Fraud, Waste and Abuse Prevention Amendments of 1997" (Section 122).

**OPERATION RESTORE TRUST**

**CALIFORNIA PROJECT**

**September 1996-March 1997**

**A Study of Forty-four  
Home Health Agencies in California**

**REGION IX  
San Francisco, California**

**H. Donna Dymon, Ph.D.**

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**December 1997**

**OPERATION RESTORE TRUST**  
**CALIFORNIA PROJECT**

**A Study of Forty-four Home Health Agencies in California**

H. Donna Dymon, Ph.D.

**1.0 Introduction**

Operation Restore Trust (ORT) was a national initiative established by the administration in 1995 to identify and eliminate fraud, abuse and waste in the Medicare Programs. The two year project was a combined, dedicated effort by the Department of Health and Human Services' Health Care Financing Administration (HCFA), Office of the Inspector General (OIG), Fiscal Intermediaries (FI) Department of Justice, and Administration on Aging. The Clinton Administration targeted five states with the largest Medicare population: New York, California, Texas, Illinois and Florida as the initial focus for ORT projects. The combined Medicare expenditures for these five states equaled approximately forty percent (40%) of the nation's total Medicare expenses.

The HCFA ORT projects allowed the Regional Offices included as state targets, to be creative by designing projects to address problems specific to their state. Region IX's Division of Health Standards and Quality, Hospital and Community Care Operations Branch studied both home health agencies and hospices.

In California, as in other states (Texas and Florida), there was a significant increase in home health agencies. During the years between 1993 through 1995, 321 new agencies were certified in California, which was a 70% increase in home health agencies. Eighteen new agencies were included in the study. Twelve of the eighteen new agencies were terminated due to substandard care. Review of the "new agencies" billing histories (Medicare certified between January 1, 1993-December 31, 1994) showed fifteen of the eighteen new agencies were billing Medicare over a million dollars during their first years of operation (See APPENDIX A). (One agency admitted being a registry and never had more than one Medicare patient.) With a flat line survey budget, it was becoming imperative that HCFA develop more effective tools to handle the expanding survey workload, declining number of surveyors, and increasing provider numbers.

The home health study's purpose was to determine the best method to target agencies for surveys, specifically, data showing abnormally high amount of total reimbursement, or average reimbursement per beneficiary. A second goal was to determine whether agencies with high reimbursement had an effect on quality of care. Quality of care was measured by assessing whether the forty-four agencies' home health agencies were in compliance with the Medicare Conditions of Participation 42 CFR 484.10 - 484.52. If an agency had a condition level deficiency, the agency was defined as delivering substandard care. (This operational definition is consistent with the State Operations Manual (SOM) which defines "substandard" care as an agency with a condition of participation out of compliance.)

### **1.1 Project Design**

In May of 1995, California Certified Home Health Agencies were ranked by using 1994 and 1995 reimbursement data which showed the total amount reimbursed, per patient reimbursed, and the average number of visits per patient billed by California Medicare certified home health agencies. When data from 1994 and 1995 were compared, it

showed that most agencies had rapid growth in the dollar per patient reimbursement and overall total Medicare dollars reimbursed. This information was used to identify agencies for study. In addition to the fiscal data, HCFA also used provider history information supplied by the two fiscal intermediaries serving California (Blue Cross of California and Blue Cross of Iowa, now Wellmark), the Offices of the Inspector General, and complaints received by HCFA to select and prioritize the agencies. An initial target list of fifty home health agencies was completed using the data and information available.

The Regional Office's survey format was the extended survey process which is a thorough compliance review, examining each standard and Condition of Participation. The sample size for clinical record review was standardized for each agency which included a total of fifteen clinical records with five home visits. This sample size was maintained regardless of the agency's size or number of admissions per year which was a departure from direction contained in SQM Transmittal 260 which cites a sliding sample size determined by the number of unduplicated admissions a home health agency had during a recent twelve month period prior to the survey date.

The forty-four agencies' survey history was reviewed which showed none of the agencies had been surveyed using an extended survey. The project design was a modification from the direction in SQM Transmittal 260 which directs surveyors to use a standard survey. According to SQM Transmittal 260, October 1993:

the home health agency survey process consists of a standard survey, a partial extended survey and an extended survey. All home health agencies must undergo a standard survey. The standard survey determines the quality and scope of patient care services provided by an HHA as measured by indicators of medical, nursing, and rehabilitative care. Each HHA that is found to have one or more condition-level deficiencies under a standard or partial extended survey must undergo an extended survey to review and identify the policies and procedures which produced the substandard care and to determine if the HHA meets all of the Conditions of Participation.

SOM Transmittal 260 continues with:

Review of the HHA's compliance with: Patient rights (42 CFR 484.10); Federal, State, and Local Laws and regulations, the disclosure of ownership and management information, and accepted professional standards and Principles (42 CFR 484.12); Coordination of Patient Services (42 CFR 484.14 (g)); Acceptance of Patients, Plan of Care, and Medical Supervision (42 CFR 484.18); Home Health Aide Services (42 CFR 484.36); and Clinical Records (42 CFR 484.48).

SOM Transmittal 260 allowed for the project's modification with the following statement: "An HHA may also be subject to a partial extended or extended survey at the discretion of HCFA or the State."

All home health agencies using Blue Cross of California as their intermediary had an additional review of five paid claims. Blue Cross of California randomly selected five paid claims and supplied billing history for the surveyors' review. Clinical records were reviewed in a side by side comparison to verify services were rendered using corresponding billing history. Discrepancies between paid claims and clinical records were referred to the fiscal intermediary.

#### **1.2 Phase I: Federal Surveys**

HCFA's, Federal nurse surveyors conducted the first seven surveys which were later termed "Phase I" of the project. These seven agencies were among the highest per patient reimbursed home health agencies in California (see TABLE 1). After each agency's first survey, surveyors identified substandard care. The certification status from Phase I showed:

- Five of the seven agencies were terminated from the Medicare program, two agencies were re-certified.
- Three agencies had four counts of immediate jeopardy which affected the health and safety of patients and were terminated.
- One of the two agencies recertified had a multi-million dollar overpayment

levied in 1997 by Blue Cross of Iowa. The overpayment was a result of findings from the Phase I survey. In 1997, this agency ceased operation and was terminated from the program.

- Two agencies failed to submit evidence of correction and were terminated without a second re-survey.

Analysis made from the Phase I project supported Region IX's initial belief that an agency's reimbursement data could be useful in identifying agencies with quality of care problems and/or possible fraud or abuse activities. Approval was given to expand the survey process to include an additional forty home health agencies, to enlist help from the State of California State agency surveyors, and to use the same survey format. The project moved into "Phase II."

**TABLE 1: Phase I's Seven Home Health Agencies' Per Patient Reimbursement, Certification Status and 1995 Medicare Reimbursement**

Agency	Per Patient Reimbursement	Total 1995 Reimbursement
Agency 1	\$10,372	\$ 1,192,723
Agency 2	\$10,566	\$ 1,574,347
Agency 3	\$ 6,111	\$ 1,423,819
Agency 4	\$12,338	\$ 3,313,909
Agency 5	\$ 8,632	\$ 526,547
Agency 6	\$ 3,794	\$12,297,773
Agency 7	\$ 7,160	\$ 8,341,360

### **1.3 Phase II: State Surveys**

As mentioned previously, a new routine survey approach was undertaken to conduct the Federal ORT surveys. To involve the State of California surveyors, we first

developed an in-depth training program. Previously, the State did not dedicate specialized staff to perform home health surveys. After the training and survey activity that followed, the State adopted specialized teams to survey home health agencies.

In February 1996, a special four-day training program was held to prepare four, two-member survey teams to conduct the forty surveys. The training included classroom sessions provided by the Office of the Inspector General and Region IX nurse surveyors, plus one week in-field training with a Region IX nurse surveyor. The Regional Office supplied historical data extracted from the OSCAR-ODIE System detailing past survey history and demographics for the ten agencies assigned to the four teams. The survey schedule required five days on-site to conduct the survey, including travel time and one week at the surveyor's home office to write their reports.

The forty agencies were geographically located throughout the state with twenty-six agencies concentrated in Los Angeles County. The State of California requested the project begin in the Los Angeles County area. During each team's first survey, regional office nurse surveyors were on-site with the state team for the entire week. This ensured integration and application of material learned during the training and allowed on-site answers to questions. Thereafter, and for each team's Los Angeles County survey, a regional office staff member was on-site for at least one to two days.

Regional Office staff continued their support by maintaining telephone liaison, technical assistance, review and documentation edits for all Phase II HCFA 2567s "Statement of Deficiencies and Plan of Correction." The regional office served as the hub for all termination actions, informal meetings with providers; publication of reports citing deficient practice (HCFA 2567); reviewer of evidence of correction and/or plans of correction following a survey; and determinations for scheduling a second survey.

### **2.0 Analysis of Compliance and Quality of Care of the Forty-four Agencies**

The study identified an overwhelming number of agencies provided substandard care. Eighty-one percent of the agencies surveyed (36 agencies) had at least one Condition of Participation out of compliance after the first survey. Fourteen percent of these agencies (five agencies) were terminated with Immediate Jeopardy identified and with multiple Conditions of Participation out of compliance. Fourteen agencies had between eight and eleven conditions out of compliance after the second survey and each was terminated.

After completion of the project, twenty-one agencies were terminated for providing substandard care. TABLE 2 shows the certification states of the forty-four agencies selected for review.

**TABLE 2: Compliance status of the Forty-four Agencies**

<b>Compliance Status</b>	<b>Number of Agencies</b>
Compliance after the 1st survey	8
Compliance after the 2nd Survey	13
Compliance after the 3rd survey	2
Voluntary Terminations	3
Terminated after the 1st survey	6
Terminated after the 2nd survey	7
Terminated with Immediate Jeopardy	5

### **2.1 Areas of Non-Compliance**

The agencies were analyzed to determine compliance with the general requirements according to Section 1861 (o) of the Act (Social Security Act). The following analysis shows the numbers and percentages of agencies that did not meet compliance.

- Nine agencies (20%) failed to provide at least one of the qualifying services directly through agency employees as required by the regulations.
- Fourteen agencies (32%) failed to identify a Group of Professional Personnel that met compliance with the professional discipline component; and, twenty-five agencies (57%) of the Groups of Professional Personnel failed to establish and/or annually review the agency's policies.
- Thirty agencies (68%) failed to maintain a clinical record in accordance with accepted professional standards.
- Seven agencies, (16%) operated branch offices without formal notice to the State or approval by HCFA.
- Twenty-four agencies (55%) did not have an overall plan and budget for institutional planning.
- Thirty-six agencies (82%) failed to meet compliance with the Conditions of Participation after the first survey. (Under 42 CFR §498.53(a)(1) and (3) and §488.24(c), HCFA is authorized to terminate the Medicare provider agreement of any provider if it finds the provider no longer meets the appropriate Conditions of Participation.)

#### **2.2 Agencies Initially selected but Omitted from the Project**

Two agencies that were included in the targeted forty agency group withdrew from the Medicare program prior to a scheduled survey, and one agency was eliminated after learning the Federal Bureau of Investigation (FBI) began an investigation. With the elimination of these three agencies, the state surveyors reviewed thirty-seven agencies.

The case involving the FBI terminated after the agency's owners pleaded guilty to charges; thereby, the Regional Office terminated the agency's Medicare certification. One agency voluntarily withdrew their Medicare Certification three days prior to a Federal team's planned entry. The third agency reported to HCFA Region IX that the agency did not have any Medicare patients. HCFA Region IX terminated the Medicare

provider agreement as a voluntary termination. These three agencies are included in discussion within this paper because the target criteria used for their selection was validated by the agencies' actions.

### **2.3 Agencies terminated with Immediate Jeopardy**

Six of the forty-four agencies were cited for having a state of immediate jeopardy affecting the patient's and/or staff's health and safety. Five of the six were terminated using the fast-track termination process (23-day termination) due to the immediate jeopardy incidents. In each case agencies failed to provide evidence of correction responding to the immediate jeopardy situation, or to the HCFA 2567 Statement of Deficiency.

- One agency had two cases of immediate jeopardy identified during a first survey, and submitted evidence of correction warranting a second survey. This agency was terminated after the second survey, but not with immediate jeopardy.
- One agency filed for bankruptcy during the termination process and was terminated for not providing evidence of correction.
- Three agencies failed to submit evidence of correction to address the cause of the immediate jeopardy situation, and did not submit evidence to correct the system problem that caused the situation.
- One agency submitted altered documents claiming the immediate jeopardy situation never existed, and used these documents as support for their evidence the situation, if in their opinion, had occurred was corrected.

Some examples of cases where immediate jeopardy was identified include:

1. One patient's diagnosis was listed as a Decubitus Ulcer, Stage IV which actually was a wound dehiscence (a separating of layers of a wound) resulting from a previous surgery for a total knee replacement to the patient's left limb. The patient was infection free at the time of agency admission. The agency staff treated the patient with dressing changes with no apparent complication or progress for one month. Approximately, one

month after admission, the skilled nurse documented the wound had a "foul odor with a greenish-yellow drainage" and obtained a wound culture to the **right** knee. The laboratory report documented the **right** knee was cultured and the gram stain showed no organism. The skilled nurse documented the wound status was deteriorating, and clinical notes stated, "drainage increasing, saturated through dressing edges." The clinical record documented the patient was worried and concerned about losing her limb. Seven days after the first documented change in the patient's wound, the patient was admitted to the acute hospital for amputation of the **left** leg. The surveyor questioned the agency's staff about the laboratory report which documented the nurse cultured the opposite limb. The agency notified the laboratory about the questionable report and later obtained a copy of a new laboratory report which showed Methicillin Resistant Staphylococcus Aureus (MRSA) was cultured from the left wound.

2. A patient's clinical record documented the patient was disoriented and agitated, fed via a gastrointestinal tube, was an insulin dependent diabetic with congestive heart failure, and had a Foley catheter. During a home visit interview, the surveyor learned the care giver irrigated the Foley Catheter daily using tap water. The clinical record failed to document an order for irrigations. The surveyor questioned the care giver and learned the agency's visiting nurse instructed the care giver to irrigate the Foley catheter using tap water, and nurse demonstrated the technique during her visits.

3. A beneficiary's home was a locked board and care facility. The patient's diagnoses were Alzheimer's Disease and cellulitis, and was treated for gangrene of the left toe. The surveyor noted a second, advanced lesion on the left, lateral aspect of the foot which was not being treated. The physician was not notified of the second lesion and no treatment orders were documented. The patient was in obvious pain during the dressing change; no analgesics were ordered; and the agency failed to respond to the patient's needs. The agency took no action to respond to questions concerning the need to alert the physician to the condition change, to secure orders to treat the

advanced lesion, or to address the patient's pain and discomfort during the dressing changes.

4. A beneficiary's diagnosis was Decubitus Ulcer, State IV with recent small bowel surgery. Documentation showed the lesion was located in the right, lower abdominal area. The skilled nurse documented the wound was consistently treated with NaCl, or table salt. The clinical record documented the patient experienced constipation and other bowel problems. Due to incongruent information documenting the pressure ulcer's location and recent surgery, the surveyor interviewed the agency's nurse to learn whether the ulcer was "elevated or depressed," and learned the ulcer was elevated, suggesting the "ulcer" was instead, exposed bowel.

The agency staff failed to react to the "concerns" of the survey team, or, to the information learned from the interview. Only after the team called immediate jeopardy, did the agency conducted a home visit to re-assess the patient. It was confirmed the "ulcer" was indeed small bowel, and the patient admitted to a hospital.

5. A patient was treated with two medications used for treatment of pulmonary tuberculosis. The clinical record failed to document a diagnosis warranting anti-tuberculin medications, however, more important to this case was that the clinical record failed to document why the medications were abruptly discontinued. No documentation was available to learn the patient's current status or, rationale for the medication to be discontinued. The surveyors were not only concerned about the beneficiary's health status, but, also concerned about the safety of the family members living with the patient and agency personnel who contacted this patient.

6. A beneficiary with peripheral vascular disease had a leg lesion identified as a "non-healing, vascularly caused lesion." The physician ordered a dermal stimulator unit to encourage wound healing. The agency staff admitted they had no experience using a

dermal stimulator, and their experience began after the unit was delivered to the home. The nurse performing the treatment was the owner of the company and a licensed vocational nurse (LVN), the only practitioner delivering care to the patient. The surveyor accompanied the nurse to the patient's home, and observed the wound which appeared extremely red, elevated, and inflamed. The LVN telephoned a physical therapist who had previously treated the patient for ambulation exercises, and enlisted the physical therapist's consultation for assistance with the wound and adjustments to the dermal stimulator unit. (Later it was learned the therapist also was not familiar with the unit's operation.) Neither the therapist nor the LVN notified the physician regarding the wound's status. While the therapist and LVN conversed about the wound's status, the therapist first learned the nurse was not a registered nurse. The therapist assumed the LVN was a registered nurse from previous patient encounters, since the LVN presented herself as a registered nurse. More important to this patient's health and safety was that the wound deteriorated and the procedure was complicated, justifying a registered nurse's collaboration to initially perform treatments, assess the status of the leg lesions, and supervise the LVN. There was no registered nurse who treated or participated in this beneficiary's care.

These examples are but a few egregious examples of poor quality of care. However, numerous citations were made cases where beneficiaries did not receive quality care. The following examples are clustered into general topics documenting situations when Medicare beneficiaries failed to receive prescribed services as ordered by physicians.

- Insulin injections were given with incorrect dosages of insulin. For example, if the physician ordered a sliding scale response to blood glucose values, nurses gave either too much or not enough insulin. Physicians were not notified of abnormally high or low blood glucose values, changes in patients' eating habits, body weights or exercise patterns (all could influence insulin requirements); and patients were treated without orders for necessary insulin dosages.

- One agency's clinical notes documented a psychiatric patient had suicidal ideation. The patient reported she wanted "to walk into the street and get hit by a truck." The agency's staff failed to take any action. The agency's policy for emergency treatment for suicidal behavior was outlined to respond to action yet, the agency staff failed to follow their policy or take action.
  
- Several agencies provided physical therapy services using contract therapy services. The agencies' contract agreements specified services would be rendered with registered physical therapists. The physical therapists clinical notes were routinely typed, documenting the patient's ambulation progress in five foot increment gains after each visits. The notes were signed by registered therapists. Interviews with beneficiaries treated by these therapists stated they were routinely treated by individuals other than the names documented on the clinical notes (typically the visits were made by therapy assistants); and registered therapist only conducted initial visits. These agencies failed to identify how the qualified therapist supervised or delegated the visits to the therapy assistant.
  
- Frequently, in Los Angeles County, medical social services were provided through contract arrangements. The surveyors found one contractor (who was contracted to provider services at most of the surveyed agencies) employed unqualified social work assistants. The regulations require a social work assistant:
  - have a baccalaureate degree in social work, psychology, sociology, or other field related to social work and had at least one year of social work experience in a health care setting; or had 2 years of appropriate experience as a social work assistant, and achieved a satisfactory grade on a proficiency examination.

Employees of the contractors were graduates with degrees in Chinese language, urban studies, or zoology. The agencies using this contractor had high utilization

statistics for social work evaluations and services.

- Wound Dressing were not changed according to physician's orders. For example, when a physician ordered an explicit treatment using specific dressing materials or procedure(s) the clinical notes failed to document the treatment as the physician ordered. In many cases, various nurses treated the same patient, each documenting different dressing materials and procedures.
- Nurses failed to check all medications patients may be taking as required by the regulations. Often patients took medications that were contraindicated, had higher than recommended doses, or they exhibited side effects without agency staff notifying physicians. One beneficiary had a physician's order for Paxil 30 mg. Q.I.D. (four times daily or 120 mg. per day). According to the Physician's Desk Reference the recommended daily dosage is 50 mg. per day. The daughter reported to the surveyor that she liked her father sleeping all the time. The agency's staff failed to check this medication and alert the physician to the dose or the patient's behavior.
- Several agencies used non-acceptable practices when documenting clinical records. For example, agencies used "white out" to change clinical notes. Agencies often expunged visit dates, and photocopied clinical notes which re-appeared as subsequent visits. Rubber stamp signatures were used to represent physician signatures for orders or plans of care. One agency used a "cut and paste" method documenting clinical records, photocopied the same text which appeared in several different clinical records.
- Over-utilization of services was a common finding at most agencies with high per patient reimbursement, especially home health aide services, physical and/or occupational therapy and medical social services. Agencies routinely ordered

physical and occupational therapy evaluations for patients who did not present with diagnoses remotely related to problems requiring such therapy. Often agencies routinely ordered medical social service at admission for all patients.

- One agency billed Medicare for a "companion type" aide service by providing "respite" for patient's care givers. Home health aide services were ordered twice daily (BID), three times per week. For the most part, the beneficiaries did not need skilled services and were not homebound. Home health aide clinical notes documented assistance for personal care such as manicures, pedicures, hair styling, or "just talking." For example, two couples' clinical notes and/or interviews documented the agency promised the care givers four hours of respite care three times per week. Each beneficiary had physician orders for twice daily visits either three or five times per week. The agency staff never left the home during the four hours, documented and billed services on alternate hours for each beneficiary totaling four hours: the husband was seen from 8:00 - 9:00 A.M., the wife from 9:00 - 10:00 A.M., the husband was re-visited from 10:00 - 11:00 A.M., and the wife again from 11:00 - 12:00 Noon.
- The same agency supplied home health aides to accompany patients to medical and dental appointments. Clinical records documented supplemental physician orders to "cover" this arrangement as "PRN orders" (as needed) visits including twice daily orders for such visits if appointments lasted longer than one hour. Clinical notes showed one aide accompanied a patient to a four-hour cardiology appointment. The fiscal intermediary confirmed the agency billed and was paid for the visits disguised as visits typically rendered as in-home care.
- Another beneficiary, not requiring any skilled nursing services, had orders for twice daily home health aide services. The home health aide's services were confined to walking with the patient to the bathroom and washing the patient's

back each evening as assistance preparing for night-time sleep. The patient stated the aide spent about an hour and a half assisting the beneficiary since she ambulated slowly. The physician's orders continued for months, unchanged, each ordering twice daily visits for personal care. The clinical record documented two clinical notes: one documented a visit between 5:00-6:00 P.M.; the second, clinical note documented identical services as the earlier note with the time documented as 6:00-7:00 P.M. The fiscal intermediary confirmed Medicare paid for twice daily visits.

- Several beneficiaries' clinical records were requested using fiscal intermediary data. When one agency could not locate records for beneficiaries requested from the list, the agency claimed they never treated the patients. At another agency the surveyor received some clinical records from the list only to find: no clinical notes contained in the requested record; blank clinical notes with only a nurse's signature; or, clinical notes with the patient's vital signs recorded but no documentation concerning the visit. When one agency was asked about the missing documentation, the agency stated the nurse left the company and "absconded" with the documentation. This agency billed and was paid by Medicare for these visits.

#### **2.4 Agencies Terminated after the First Survey**

Four agencies were terminated after the first survey due to their failure to meet compliance with eleven of the eleven Conditions of Participation that applied to their agencies. (42 CFR Part 484 Conditions of Participation: Home Health Agencies cites twelve Conditions of Participation. One Condition, 42 CFR 484.38 applies specifically to home health agencies furnishing out-patient therapy services on their own premise. None of the sampled home health agencies furnished out-patient therapy services on their own premise, consequently each agency in the study had eleven conditions apply.) Analysis of the four agencies with eleven of eleven conditions of participation

out of compliance with the first survey.

- Two of the agencies failed to submit evidence of correction or an acceptable plan of correction in response to the Statement of Deficiencies (HCFA 2567).
- One agency admitted to altering clinical records while the survey was in progress and was terminated.
- One agency admitted the agency was a registry and did not function as a Medicare Certified home health agency. During the twelve month period prior to the survey date, the agency served only one Medicare patient who was discharged approximately twelve months prior to the survey.

#### **2.5 Analysis of the Three Agencies that Voluntarily Terminated Their Medicare Certification after the First Survey**

Three agencies voluntarily terminated their provider agreements and withdrew their Medicare Certification after the first survey found Conditions of Participation out of compliance. One agency had eleven Conditions of Participation out of compliance, a second had six and the third failed to meet five Conditions of Participation. The agency with eleven conditions served the majority of their patients in Board and Care and/or Residential Care Facilities. The agency showed high utilization rates of home health aide services billing Medicare for visits at least three to five times per week for each beneficiary. This agency did not have any Medicare liability outstanding as of their termination date.

A second agency primarily used services from nurse registries, and had poor control and monitoring of all contracted services. Patient visits exceeded physician orders and records showed patients were seen without physician orders. The owner had a second, Medicare certified agency geographically close to the surveyed agency. After the survey closed documenting multiple condition level deficiencies, the agency voluntarily terminated their agreement with Medicare and transferred their patients to the second agency. When the surveyed agency notified HCFA of their voluntarily

termination, their liability totaled \$5,556,182.

The large majority of patients served by these three agencies and the forty-four agencies surveyed, maintained the same patient for repeated certification periods. (A certification period is 62-days.) Discharges were rare. Clinical records failed to contain instructions for timely discharge (as required under 42 CFR 484.18), and beneficiaries were kept on service typically for home health aide services to provide personal care. The attitude presented by agency staff typically was that "patients were allowed," or, "patients had the right to," continuous care in 62-day segments. Two important messages were delivered in these statements. First, the typical plan of care encompassed 62-days, whether the patient needed 62-days of care, or five visits for a two week period. Agency staff executed a "carte blanche" attitude assuming each patient's care would last at least 62-days, and typically supplied home health aide services when patients required no qualifying service. Second, with regard to the patients "right" to home care, these agencies documented beneficiaries' plans of care and clinical notes presenting a patient as homebound, however, home visits and even clinical notes documented numerous cases when patients were not homebound. For example, plans of care were identical to other patients and/or were repetitive for consecutive certification periods. The plans cited a skilled nursing visit was needed at least once every week, and clinical notes documented the patient's condition required intermittent skilled nursing services. The agencies' goal was only to supply home health aides to assist patients with activities of daily living. During home visits interviews surveyors learned patients were not homebound, had paid care givers or family that could provide aide services.

A second problem was identified: home health aides providing care to beneficiaries residing in Board and Care Facilities. California Board and Care licensure requires the facility to provide services virtually identical to home health aide services. The Federal Government determined this practice is "double billing" and denied payment for home

health aide services when beneficiaries resided in Board and Care Facilities. Currently, there is no tracking system identifying a patient's home address as a Board and Care facility. Consequently, aide services to this population go undetected.

Many of the home health agencies with clients primarily domiciled in Board and Care Facilities had "ties" to the Board and Care homes. Their connections were described by one informant as "payments to ensure continued access," since the Board and Care facility provides home health agencies a single-source client population, thus ensuring new referrals. Payments were made in the form of medical supplies, food and entertainment. (Informants have alleged home health agencies gave freezers full of meat, weekly grocery supplies, plus entertainment tickets with choice box locations.)

Two of the six agencies with seven conditions of participation not in compliance after the first survey achieved compliance with the second survey. One of the six agencies was re-surveyed and determined to have four conditions out of compliance. This case was appealed before an Administrative Law Judge who overturned the termination decision. HCFA pursued an appeal to this decision with no avail. The agency was eventually terminated from the Medicare program because the agency did not have Medicare patients.

#### **2.6 Agencies' Status after a Second Survey**

Seven of the forty-four agencies were terminated after the second survey for failure to meet one or more Conditions of Participation. Fourteen agencies met condition level compliance after the second survey and were re-certified in the Medicare program. Two agencies had three surveys, and were recertified after the third survey.

#### **3.0 Compliance Analysis: Focus Los Angeles County**

In Los Angeles County the Medicare enrollment of aged and disabled beneficiaries is

approximately one million, or 27.4 percent of California's Medicare enrollment of 3.7 million. The 1995 expenditures for Los Angeles County for all services was \$5.6 billion. Los Angeles County expenditures for home health agencies in 1995 was \$465.8 million, and \$1.7 billion in California. The number of new home health agencies grew sharply during the early and mid 1990's, as did the expenditures per beneficiary in the Los Angeles County area. The majority of agencies identified through the selection criteria were concentrated in Los Angeles County (59%).

### **3.1 Analysis of Home Health Nursing Services in Los Angeles County**

Los Angeles home health agencies showed the highest number of agencies delivering poor quality of care. Fifty percent of the Los Angeles County agencies surveyed used contractual arrangements to provide skilled nursing services. The majority of agencies developed arrangements with nurse registries to render skilled nursing and home health aide services; or, used individual contractors who worked for several different agencies. (According to the Federal guidelines an individual who works for the home health agency on an hourly or per visit basis may be considered an agency employee if the home health agency is required to issue a form W-2 on their behalf.) Agencies hired independent contractor nurse to meet compliance with Federal Regulations. An administrator reported these nurses traditionally brought their "own" patient census when hired, treated only these patients, and the nurses required as condition to employment, the agency pay the nurse a monthly or flat fee for the "nurse's patients."

The standards and conditions were analyzed to determine whether the Los Angeles County agencies failed the administrative and patient care regulations which addressed coordination of services and maintaining liaison between agency staff. We found failure to meet compliance was due to a predominant use of non-agency employees, high use of registry personnel, and for failure to provide one service directly by agency staff. The findings showed what typically was presented as a Medicare Certified Home Health Agency was in fact a "Medicare Certified Registry" or, a home health care registry with

Medicare certification.

Los Angeles County data was studied to determine whether the twenty-six agencies met compliance with patient care delivery regulations as required by the Act and Conditions of Participation. The citations under the following conditions were used for this analysis: 42 CFR 484.18 Acceptance of Patients, Plan of Care and Medical Supervision and 484.30 Skilled Nursing Services. Each agency was categorized into a group defining how skilled nursing services were provided: directly through agency staff, under arrangement, or, in combination using agency staff and under arrangement. (See TABLE 3.) Eleven agencies supplied nursing services in combination, using both their own staff and contracting with nurses under arrangement; thirteen agencies provided skilled nursing services directly by their own employees (using independent contractors, part-time, or per diem staff); and two agencies contracted for skilled

**TABLE 3: Compliance with the Conditions of Participation: 42 CFR 484.18 Acceptance of Patients, Plan of Care and Medical Supervision and 484.30 Skilled Nursing Services in Los Angeles County.**

<b>Method used to Supply Skilled Nursing Services</b>	<b>Number and Percent of Agencies that failed compliance with 42 CFR 484.18 Acceptance of Patients, Plan of Care and Medical Supervision</b>	<b>Number and Percent of Agencies that failed compliance with 42 CFR 484.30 Skilled Nursing Services</b>
Combination (N=11)	11 (100%)	7 (64%)
Contract or Arrangement (N=2)	2 (100%)	1 (50%)
Directly by Agency Employees (N=13)	10 (77%)	10 (77%)

nursing services in their entirety. Sixteen of the twenty-six agencies used either nurse registries or individual nurses under contract to supply nursing services.

At the conclusion of the study the surveyors reported a correlation between quality of patient care and the method agencies used to provided nursing services. Their comments included that when agencies regularly used registries (contract or arrangement) the quality of patient care was poorer, and there was non-compliance with coordination, monitoring and liaison among other disciplines providing care. The eighteen, state-wide surveys showed none of the agencies solely provided nursing services under arrangement, thirteen provided skilled nursing services directly using their employees and five used a combination of their employees and contract staff. TABLE 4 shows a comparison of how skilled nursing services were provided by the forty-four agencies and their compliance with 42 CFR 484.14 and 484.30.

**TABLE 4: Comparison of Forty-Four Surveyed Agencies Provision of Skilled Nursing Services, Los Angeles and State-wide Surveys**

<b>How Agencies Provide Skilled Nursing Services</b>	<b>Number of Agencies not in Compliance with 42 CFR 484.14</b>	<b>Number of Agencies not in Compliance with 42 CFR 484.30</b>
<b>Directly with their Own Employees</b>		
Los Angeles County (N=13)	11 (85%)	12 (92%)
State-wide (N=13)	5 (38%)	4 (31%)
<b>Under Arrangement</b>		
Los Angeles County (N=2)	1 (50%)	2 (100%)
State-wide (N=0)	0	0
<b>Combination</b>		
Los Angeles County (N=11)	7 (64%)	10 (91%)
State-wide (N=5)	4 (80%)	2 (40%)

An analysis was made to determine whether a correlation existed between substandard

quality of care and an agency's ability to meet compliance with the administrative requirements. The regulations were divided into two groups: one group clustered the regulations addressing administrative regulations; the other group included delivery of patient care and services regulations. TABLE 5 shows Los Angeles County and state-wide comparison.

**TABLE 5: Comparison of Twenty-Six Los Angeles County Home Health Agencies and Eighteen Agencies located state-side for compliance with Administrative and Patient Care Regulations**

Condition of Participation Administrative=A Patient Care = PC	Number and Percent of Los Angeles County Agencies not meeting Compliance (N=26)	Number and Percent of State-wide Agencies not meeting Compliance N=18
A 42 CFR 484.12	19 73%	6 33%
A 42 CFR 484.14	25 96%	10 56%
A 42 CFR 484.16	20 77%	5 28%
A 42 CFR 484.52	21 81%	6 33%
PC 42 CFR 484.18	23 88%	9 50%
PC 42 CFR 484.30	19 73%	8 44%
PC 42 CFR 484.14(g) G143	22 85%	7 39%
PC 42 CFR 484.14(g) G144	23 88%	7 39%

TABLE 5 clearly shows the majority of the deficiencies with patient care delivery and administration occurred in Los Angeles County. Home health agencies in Los Angeles County were twice as likely to be non-compliant with Conditions of Participation when compared to the agencies surveyed state-wide.

#### **4.0 Analysis of the Conditions and Standards out of Compliance**

The most frequently cited condition out of compliance was 42 CFR 484.52 Evaluation of

the Agency's Program, followed by 484.14 Organization, Services and Administration; 484.18 Acceptance of Patients, Plan of Care and Medical Supervision, and 484.30 Skilled Nursing Services. TABLE 6 details the results of the forty four surveys.

**TABLE 6: Results of Forty-four Home Health Agency Surveys in California**

Condition of Participation	Condition Title	Number of Agencies N=44
42 CFR 484.10	Patient rights	6 14%
42 CFR 484.12	Compliance with Federal, State and local laws, disclosure of ownership information, and accepted professional standards and principles	25 57%
42 CFR 484.14	Organization, services and administration	35 80%
42 CFR 484.16	Group of professional personnel	25 57%
42 CFR 484.18	Acceptance of patients, plan of care, and medical supervision	32 73%
42 CFR 484.30	Skilled nursing services	27 61%
42 CFR 484.32	Therapy services	17 39%
42 CFR 484.34	Medical social services	18 41%
42 CFR 484.36	Home health aide services	13 30%
42 CFR 484.48	Clinical records	15 34%
42 CFR 484.52	Evaluation of the agency's program	27 61%

Why did these agencies fail to maintain compliance? The following discussion may explain the results: SQM Transmittal 260 directs the State Agency to conduct a standard survey (five conditions and one standard) during an initial survey. Agencies were never surveyed for compliance using all Conditions of Participation (administrative, therapy and even skilled nursing services) since these conditions are not included in the standard survey. Agency staff frequently stated either they never

read these portions of the regulations, or attempted to comply with the requirements after obtaining their initial certification. The ORT protocol required the extended survey process. Region IX concluded the standard survey process was not a thorough assessment of an agency's compliance with the Conditions of Participation.

Second, annual recertification surveys in the State of California were not conducted routinely as required. In 1994, HCFA Region IX required 100% of the home health agencies be surveyed. Prior to the initiative agencies could have believed their opportunity to be surveyed was remote. If this was the case, an agency may not have "bothered" to comply with the standards or conditions not included in a standard survey. This thinking would preclude an agency from conducting an annual program evaluation, quarterly clinical record reviews, involve a Group of Professional personnel to function or comply with the provisions of the Social Security Act.

Third, SOM Transmittal 260 directs surveyors to conduct initial surveys even when agencies have as few as one, or no patients. Consequently, some agencies were never surveyed for their compliance with the patient care standards (for example: the skilled nursing, plan of care, therapy or social service regulations). These factors coupled with infrequent recertification activity that preceded the 1994 initiative, could contribute to an agency's failure to maintain compliance.

#### **5.0 The Influence of Payment and Assessment of Quality of Care**

The study showed a correlation between the quality of care and the amount of Medicare dollars reimbursed per patient, which is analogous with the number of visits per patient. For example, in 1995 the national average reimbursement per patient was \$4,438, yet the top 25% of surveyed agencies showed the average reimbursement was \$11,257. Eight of the top agencies in the 25% highest average reimbursement per patient group were terminated for substandard care; with immediate jeopardy cited at

two agencies. Use of the cost per patient reimbursement is a reliable indicator for questioning the quality of care delivery.

**5.1 Reimbursement's Influence on Quality of Care. An Analysis of the Highest Reimbursed Agencies (25% or Eleven Agencies).**

Using the 1995 paid claims data, the top 25% of the forty-four agencies (11 agencies) were analyzed to learn the effect reimbursement had on the quality of care, and compliance with the regulations. The agencies were divided into two groups, those agencies with the highest total Medicare dollars reimbursed in 1995 and those agencies with the highest reimbursement per patient. Eleven agencies for each group were identified (25%). There were no duplicate agencies named in both lists. TABLE 7 shows the characteristics of both groups and the certification (compliance) status.

**TABLE 7: Three characteristics of the top 25% (eleven agencies) with the highest total Medicare dollars compared with the top 25% agencies with the highest reimburse per Patient**

	<b>Top 25% Agencies with the highest Total Medicare Dollar Reimbursement</b>	<b>Top 25% Agencies with the highest Per Patient Reimbursement</b>
Total Medicare Dollars reimbursed in 1995	\$6,014,143-\$12,297,773	\$9,310 - \$5,235,762
Number of Patients	790 - 2,344	1 - 450
Per Patient Reimbursement	\$3,794 - \$7, 613	\$7,891 - \$15,958

The findings confirmed agencies with the highest per patient reimbursement did have an influence on the compliance status of agencies. The higher the per patient reimbursement, the more likely the agency did not comply with the conditions of participation. Agencies with high reimbursement frequently showed these common characteristics: redundant, meaningless clinical notes; repeated certification periods;

care not provided according to the plan of care; visits generated without a physician's order; and patients who were not homebound.

#### **5.2 Provider Liability as of October 1, 1996**

TABLE 8 shows the certification status and provider liability on October 1, 1996 for the forty-seven agencies surveyed or identified for study. The total Medicare dollars held outstanding by the these agencies was \$34,121,628 with \$30,593,725 owed by terminated agencies.

**TABLE 8: Provider Liability of the Forty-Seven Agencies Surveyed and the Three Agencies Voluntarily Terminated Prior to the Surveys**

<b>Provider Status or Cause of Termination</b>	<b>Number of Agencies</b>	<b>Total Dollar Liability</b>
Voluntary Termination prior to Survey	3	\$21,872,000
Voluntary Termination	3	\$6,013,817
Immediate Jeopardy	5	\$1,410,874
Terminated after the first survey	5	\$885,004
Terminated after the second survey	7	\$412,030
Compliance after the first survey	8	\$1,036,506
Compliance after the second survey	12	\$1,413,397
Agency under appeal	1	\$1,078,000
Continued Medicare certification after the third survey	2	0
Agency in Hearing Process	1	0
<b>TOTAL</b>	<b>44</b>	<b>\$34,121,628</b>

#### **6.0 Region IX Policy Changes**

HCFA Region IX responded to these overwhelming findings. For example, State

Agency Letters were promptly issued to alert the Region's four states (Hawaii, Nevada, Arizona and California) to Regional policy changes. The following list summarizes those changes:

- a. All Initial home health certification surveys required the new agency must have at least ten patients and their clinical records available for surveyors at the time of the initial certification survey. This policy included allowance for seven active patients with three closed records. Surveyors were required to conduct at least three home visits for the Medicare and/or Medicare eligible patients.
- b. Home Health Agency Branch locations were re-defined. The ultimate decision for new branch locations rested with the Regional Office.
- c. The Fiscal Intermediary for all new home health agencies would be Blue Cross of California. Formerly agencies could select either Blue Cross of California or the former Blue Cross of Iowa.
- d. Agency are limited to one follow-up survey when condition level deficiencies are identified at the first survey.
- e. All new applicants must undergo a Fiscal Intermediary accounting capability verification prior to an initial survey.
- f. All initial certification surveys must be surveyed using the extended survey process.

Region IX anticipated marked changes in the posture of home health agencies in the Region due to the new policies. The Region realized an astounding deterrent effect as a result of the ORT project showing a decrease in California Medicare expenditures. In 1996, the total Medicare payment to Home Health Agencies in California decreased 13.4% from 1995, almost 100% more than the national average.

#### **7.0 Recommendations**

1. The extended survey is a comprehensive assessment of an agency's

performance and should be required at least for alternating survey sequences for every provider. The California project demonstrated that in all likelihood agencies relied on "false security" suggesting, surveyors would never request portions of the information required for review during an extended survey. Consequently, agencies failed to maintain compliance.

2. The sample size must be reduced from the current SOM protocol saving valuable money and resources. The California project used the same sample size regardless of the agency's size or number of unduplicated admissions. (A total of fifteen clinical records with five home visits.) The sample size was adequate to assess compliance at large agencies with over 9,000 unduplicated admissions and at the smallest agencies. According to the current sampling guidelines, six agencies in this project would be subjected to the highest numbers for sampling for a 1997 survey, requiring surveyors review at least fifteen clinical records and make twenty-five home visits with clinical record reviews, or a total of forty clinical records. To complete this assignment at least one hundred twenty hours would be required. A two-member team would need two weeks (allowing for an eight hour work day) to complete these surveys. This is too much valuable time, money and resources to spend surveying an agency that could be successfully surveyed with only fifteen clinical records and five home visits. We demonstrated when an agency has system problems, those system problems will be apparent and detected in all clinical records, regardless of a large sample size.
3. SOM requires the sample of clinical records include a case mix, stratified sample. This includes patients with varied diagnoses and patients requiring several different services such as skilled nursing, home health aide, physical, occupation and speech therapy. The California project followed this guidance, however, the sample also included patients with diagnoses not usually requiring skilled services. For example, diagnoses were included such as Non-insulin

dependent diabetics, Stage I pressure ulcer (no break in the skin integrity, only a reddened pressure area), and Acute Rhinitis/Bronchitis (a common cold). We found patients with these diagnoses were not homebound nor required skilled services.

4. The fiscal intermediaries should participate with the state agencies to identify patients for sampling. It was not uncommon for surveyors to be delayed up to two days for a list of active patients. This tardiness could be attributed to the agency deleting patient names who were particularly "troublesome," private pay patients, managed care patients, or patients not requiring skilled services. If surveyors had a list with recent paid claims prepared by the intermediary, surveyors could use these clinical records to verify paid claim history; verify names of patients against an agency generated list and possibly to detect curious activity.
5. The surveyors should request lists of patients discharged during the past 12 months. The list should include physician names, patient addresses, diagnosis and start of care. Such a list proved very help to verify the true size of agencies, showed how infrequent agencies discharged patients, identified patients living in board and care homes, and patterns of physicians referrals.
6. Agencies with condition level deficiencies are required to submit Evidence of Correction with their response to the HCFA 2567, Statement of Deficiencies. Frequently, the Regional Office learns the required Evidence of Correction was not provided to a State Agency, accompanied by complaints surveyors cited a condition level deficiency during a previous survey, however, the same problem continues to exist at the next survey, or at the next annual survey. The reason may be linked to the agency's failure to deliver evidence of correction or take action by implementing a plan to address the system problem causing the deficiency. State Agencies should have a thorough understanding of what evidence of correction constitutes and not conduct follow-up surveys until the

evidence is presented.

7. The success of the California project was largely attributed to the training program emphasizing a thorough understanding of the regulations; field training; intense review of the HCFA 2567's documentation; and the dedicated response time Regional home health team practiced to answer surveyors' questions. First, reviewing each regulation was the most vital component, but equally important was the inclusion of programmatic and fiscal information which is not typically taught in the "basic health and safety training courses." Second, the classroom training must be followed with on-sight team participation during a survey with state agency surveyors. Third, techniques need to be taught to "streamline" surveyors' work to accelerate reviewing time. Region IX developed forms and documentation programs that trimmed hours and organized surveyors' time. The surveyors reported their "surveyor acuity," improved, and the time needed to assess clinical records, review administrative requirements, and write deficiencies was streamlined.
8. The California ORT project emphasized the need to use surveyors in a more contemporary role than just a "surveyor for quality care." A paradigm shift was realized with surveyor attitude and improved motivation when approaching their work. Surveyors detected numerous instances of "curious activity", and were frequently the contact supplying information to the Inspector General's Office and to the Federal Bureau of Investigation. Surveyors are the best resource to evaluate home bound status, since they are mandated to make home visits at every agency. Surveyors need to be challenged to approaches and responsibilities to address the overwhelming abuses with home care.
9. All providers must be screened prior to certification in the Medicare program. Systems must be available for the Regional Office to thoroughly check a new applicant's history. Without sophisticated screening systems, HCFA is prone to continue allowing convicted felons, former providers who owe the Medicare

program for prior overpayments, and nurses who are suspended from practice to become our future providers.

10. TABLE 8 showed the number of agencies with outstanding Medicare payment liability. The data showed agencies with poor quality of care also were agencies that either failed to re-pay the Medicare program for over-payments when terminated, or continue to owe the Medicare program money even when the agency was in termination action. We recommend an agency's re-certification status be dependent on the agency's payment for their outstanding debt. Prior to a second re-survey, the Regional Office should notify the State Agency the provider owes the Medicare Program money. The agency should take action to secure a reasonable time period to repay the Medicare Program. The agency should be banned from new admissions; and the re-certification visit should be held until the agency re-pays the overpayment.

#### **8.0 Post Script**

This study was made possible with the dedication of the following Federal and State Agency employees: Wayne Moon, Ruth Patience, Deanna Ashford, Sue Blankenship, Lilly Martinez, Raymond Montgomery, Vic Resurreccion, Theresa Roy, Josefina Sabino, and Pat Smith.

## APPENDIX A

**EIGHTEEN SURVEYED AGENCIES CERTIFIED BETWEEN  
JANUARY 1, 1993 THROUGH DECEMBER 31, 1994:  
Reimbursement per patient and Total Reimbursement in 1995**

Agency Identifier	Date of Medicare Certification	Reimbursement per Patient	Reimbursement: 1995
Agency 1	10/07/93	\$5,606	\$4,086,819
Agency 2	04/20/93	\$5,400	\$4,023,055
Agency 3	08/03/93	\$6,258	\$2,640,905
Agency 4	01/14/93	\$7,338	\$1,995,891
Agency 5	09/19/94	\$4,354	\$1,341,000
Agency 6	12/16/93	\$10,297	\$4,633,775
Agency 7	10/19/93	\$12,565	\$3,254,247
Agency 8	06/15/93	\$7,867	\$3,744,480
Agency 9	11/01/94	\$6,051	\$1,597,544
Agency 10	09/28/94	\$7,891	\$568,140
Agency 11	01/07/94	\$6,304	\$1,084,310
Agency 12	04/16/93	\$6,779	\$3,877,639
Agency 13	10/18/93	\$7,580	\$2,819,643
Agency 14	10/13/94	\$6,771	\$2,207,414
Agency 15	08/09/93	\$10,372	\$1,192,723
Agency 16	10/22/93	\$8,632	\$526,547
Agency 17	08/18/94	\$13,216	\$3,052,980
Agency 18*	01/07/94	\$9,310	\$9,310

\*Agency 18 had one Medicare patient.

MEMORANDUM

January 23, 1998

TO: PERMANENT SUBCOMMITTEE ON INVESTIGATIONS  
MEMBERSHIP LIAISONS

FROM: DON MULLINAX, Investigator *DM*  
ERIC ESKEW, Investigator *EE*  
Permanent Subcommittee on Investigations

VIA: TIMOTHY J. SHEA, Chief Counsel/Staff Director *TJS*  
IAN SIMMONS, Counsel  
Permanent Subcommittee on Investigations

RE: PSI HEARING ON MEDICARE FRAUD PREVENTION: IMPROVING THE  
ENROLLMENT PROCESS FOR MEDICARE PROVIDERS

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	<u>Page</u>
I. Introduction .....	2
II. Background .....	5
A. Fraud Prevention Responsibilities .....	6
B. Medicare Enrollment Process .....	7
C. White House Initiatives .....	10
D. GAO Review and Oversight .....	12
E. Legislative History .....	13
F. Health Insurance Portability and Accountability Act .....	13
G. Balanced Budget Act of 1997 .....	14
H. The Future of Medicare -- HMOs .....	16
I. Costs Associated With Medicare Fraud Investigations .....	16
J. User/Application Fees .....	17
III. Enrollment Schemes and Regulatory Flaws .....	18
A. Home Health Agencies .....	18
B. Durable Medical Equipment Companies .....	20
C. Community Mental Health Centers .....	20
IV. Conclusion .....	23

V. Witnesses . . . . . 23

    A. Convicted Medicare Fraud Felon . . . . . 23

    B. Former PSI Investigator John M. Frazzini . . . . . 24

    C. Department of Health and Human Services, Office of Inspector General . . . . . 24

        (1) John E. Hartwig, Deputy Inspector General for Investigations . . . . . 24

        (2) Bruno Varano, Supervisory Special Agent (New York) . . . . . 25

        (3) Cathy E. Colton, Supervisory Special Agent (Miami) . . . . . 26

    D. Health Care Financing Administration (HCFA) . . . . . 26

        (1) H. Donna Dymon, PhD, (San Francisco) . . . . . 26

        (2) Dewey Price (Miami) . . . . . 27

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I. INTRODUCTION

The Permanent Subcommittee on Investigations (PSI) has scheduled a hearing on Thursday, January 29, 1998, at 9:30 a.m. in SD-342 on Medicare fraud prevention, with particular emphasis on the Medicare provider enrollment process.

Since PSI's June 1997 hearing on Emerging Fraud in Medicare Programs, the Subcommittee has uncovered several weaknesses in the procedures and processes used to enroll Medicare providers. These weaknesses have allowed scam artists, with little or no experience as health care providers, to enter the Medicare program and to defraud millions of dollars from the nation's taxpayers. PSI's investigation has revealed, in some cases, that it is more cost effective to verify and disqualify prospective providers on the front-end before payments are made than to audit and investigate allegations on the back-end.

Traditionally, criminal investigators, auditors and Congressional committees have focused on medical service providers who, in an effort to line their pockets with the taxpayers money, have skimmed billions of dollars from the Medicare program while providing some services to the elderly and disabled. However, in part because of lax enrollment procedures, PSI investigators have uncovered a new and growing trend among Medicare fraudsters: full time Medicare con-men who have no professional medical background and who provide little, if any, service to the elderly and disabled. These con-men increase program costs, reduce quality of care and in some cases, force legitimate providers out of the health care business.

PSI investigators have discovered several dramatic examples of these full time Medicare fraudsters: durable medical equipment (DME) companies having no physical addresses or inventories that literally operate out of post office boxes; home health agencies that share patients and budgets; and community mental health centers charging \$300 a day to teach Medicare beneficiaries how to dance the Macarena. These examples were discovered without using sophisticated investigative techniques. PSI investigators simply made site visits to locations listed on several Medicare enrollment applications and those locations included a Mail Boxes Etc. store, a laundromat in New York City and a runway at the Miami International Airport.

The bottom line is, the Health Care Financing Administration (HCFA) does not ensure that the information supplied by prospective providers is adequately verified by the contractors before a provider number is issued. In the case of DME applicants, site visits have only recently begun in large metropolitan areas. In the past, site visits were never performed. In the case of home health agency applicants, state agencies perform initial surveys (site visits) of all prospective providers. HCFA reimburses the state agencies for these surveys. The individuals performing the surveys, however, are often not properly trained. Therefore, they are not always able to identify certain problems or discrepancies. PSI's investigation confirmed that these inadequate verifications result in significant waste, fraud and abuse and can be directly linked to the deterioration in the quality of health care received by the elderly in some geographic areas of the United States.

Some individuals enrolling in the Medicare program are not interested in providing quality health care, but rather, they are interested in making money. The enrollment process is simple and requires minimal financial investment by the provider. This ease of entry into the system, combined with the possibility of significant financial gain, attracts many people--both legitimate health care providers and illegitimate con-men.

In the case of DME suppliers, no investment in an inventory is required. A supplier may arrange for shipment from a manufacturer or distributor directly to the Medicare beneficiary. Thus, the supplier does not have to bear the cost of keeping an inventory on site. In addition, there is no requirement that a DME supplier have any credentials or experience with medical equipment. The absence of medical experience and lack of financial investment seem to facilitate the entry of abusers into the Medicare program.

For a home health agency, there are virtually no startup costs or capitalization requirements. Home health providers do not pay user fees to Medicare; they do not reimburse Medicare for the cost of the state agency survey, and many times, they do not even have enough cash on hand to meet their first payroll. If it were not for accounts receivable, several agencies would have almost nothing to report as assets. Agencies many times lease their office space, equipment and vehicles. They are not required by HCFA to own anything. Relying almost exclusively on Medicare for income and assets, entrepreneurs are able to open and operate home health agencies without fixed assets or startup costs. The owners and principals can continue to receive Medicare payments because HCFA has few preventative measures.<sup>1</sup>

In the past, Medicare contractors took significantly longer to process and pay claims submitted by providers; however, with today's technology, unscrupulous providers can submit numerous claims in a short period of time, receive reimbursements electronically, then relocate before they are discovered by auditors or law enforcement officials. The Medicare computer

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<sup>1</sup> OIG Final Report, *Home Health: Problem Providers and Their Impact on Medicare*, July 1997, page 10.

system is in an interim state of development in which it pays claims quickly, but fails to identify indicators of fraud.

The witnesses called for this hearing will offer an opportunity for the Subcommittee to examine Medicare fraud from the perspective of those who are on the front-line, combating health care fraud on a daily basis. The witnesses are:

**John M. Frazzini**, former PSI investigator, has actively participated in health care fraud investigations over the past several years as a Special Agent with HHS-OIG (who will discuss the enrollment process as well as some of its weaknesses and will describe the findings and observations of PSI investigators that were discovered during their first-hand visits to New York and Miami);

**John E. Hartwig**, Deputy Inspector General for Investigations, HHS-OIG (who will testify that HHS IG is finding, with greater frequency than even five years ago, egregious instances of health care fraud and who will offer some theories as to why that is so);

**Bruno Varano**, Supervisory Special Agent with HHS-OIG's New York Field Office (who will respond to questions about the experiences of the New York field office in general and about one case in particular dealing with 20 fictitious DME and MRI companies);

**Cathy E. Colton**, Supervisory Special Agent with HHS-OIG's Miami Sub-Office (who will respond to questions about the experience of the Miami field office in general and about one case particular case involving six fictitious DME companies);

**H. Donna Dymon, Ph.D.**, former California Team Leader of Operation Restore Trust (who will testify about her recent report and personal observations with regard to the weaknesses in the Medicare enrollment process and how these weaknesses have affected the quality of care in home health agencies); and

**Dewey Price**, South Florida Team Leader of Operation Restore Trust, the Health Care Financing Administration's anti-fraud initiative (who will testify about how the weaknesses in the enrollment process have allowed unscrupulous individuals to enter all facets of the Medicare Program, including community mental health centers, durable medical equipment suppliers, health clinics, and home health agencies).

In addition, a **convicted health care fraud con-man** will describe the ease by which he was able to enter and bilk the Medicare program out of approximately \$32 million dollars. Through their respective testimony, these witnesses will describe the vulnerabilities and weaknesses of the Medicare enrollment process.

## II. BACKGROUND

The Medicare program is one of the most generous federal entitlement programs in the United States. The program, created during the Johnson Administration, used large financial rewards in the early years to entice a reluctant medical establishment to participate.<sup>2</sup> The concept underlying the administration of the Medicare program was to create a decentralized system that was unencumbered by a government bureaucracy so that health care providers would enter and remain in the program. From its inception, the Medicare program has placed considerable emphasis on encouraging health care providers to enroll, while at the same time, largely subordinating the issue of screening providers before allowing them to participate in the program.

The policy of encouraging health care providers to enter the Medicare program is a double edge sword. On the positive side, this approach has resulted in the Medicare program being able to attract an abundance of qualified providers, which undoubtedly has satisfied the initial concerns of the program's founders. Regrettably, however, this system has created an opportunity for unscrupulous individuals to reek serious financial havoc on the program. In July 1997, the HHS-OIG reported that an estimated \$23 billion of Medicare funds were attributed to improper payments associated with waste, fraud or abuse during fiscal year 1996.<sup>3</sup> This estimate was developed using a random sample of Medicare expenditures. This sample did not include expenditures related to DME suppliers or health maintenance organizations (HMOs).<sup>4</sup> The HHS-OIG, however, is currently conducting another review which includes a sample of Medicare expenditures of both DME suppliers and HMOs.

Medicare expenditures for 1998 are estimated at \$208.6 billion,<sup>5</sup> up from \$159.9 billion in 1995. Even more alarming is the fact that under current law, Medicare net spending is projected

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<sup>2</sup> "Never Mind the Fraud; What Ails Medicare Is Often Perfectly Legal," *The Wall Street Journal*, Oct. 9, 1997.

<sup>3</sup> REPORT OF THE FINANCIAL STATEMENT AUDIT OF THE HEALTH CARE FINANCING ADMINISTRATION FOR FISCAL YEAR 1996, Department of Health and Human Services, Office of Inspector General, July 1997.

<sup>4</sup> The statistically valid random sample was conducted of Medicare's fee-for-service benefit payments only.

<sup>5</sup> CRS Report to Congress: *Medicare: FY 1998 Budget* (updated April 15, 1997).

to increase to \$436.4 billion by 2007.<sup>6</sup> Similarly, the number of health care fraud investigations has nearly doubled from approximately 1,000 in 1993 to approximately 2,000 in 1996.<sup>7</sup>

As Medicare payments continue to soar, it is important to closely examine the lax enrollment process that has contributed to the excessive waste, fraud and abuse. During the Johnson Administration, this may have been seen as a "cost of doing business," but today it must be seen as an infection that continues to spread. Medicare fraud compromises the solvency of the program and in some cases affects the quality of care delivered to Medicare eligible elderly Americans.

The Subcommittee's investigation into the enrollment process for Medicare's various provider groups, such as home health care and durable medical equipment, revealed considerable short-comings in the administration of the program by HCFA. Described below are examples of how HCFA fails to prevent Medicare waste, fraud and abuse through its lax enrollment process.

#### A. Fraud Prevention Responsibilities

HCFA was created in 1977 to administer the Medicare and Medicaid programs. While HCFA primarily acts as a purchaser of health care services for the Medicare and Medicaid beneficiaries, it also has the responsibility to:

- Assure that Medicare and Medicaid are properly administered by its contractors and state agencies;
- Establish policies for the reimbursement of health care providers;
- Conduct research on the effectiveness of various methods of health care management, treatment and financing; and
- Assess the quality of health care facilities and services.

Ultimately, HCFA is responsible for maintaining the integrity of the Medicare program. HCFA, however, delegates the majority of the waste, fraud and abuse functions to contractors. Thus, these contractors are responsible for administering the enrollment process for prospective providers to ensure that only legitimate, qualified individuals are enrolled. In addition, each contractor has a component responsible for identifying cases of suspected fraud and abuse. These fraud units investigate beneficiary complaints and ensure that Medicare Trust Fund monies are not inappropriately paid. The fraud units also refer cases to the HHS-OIG for criminal investigations, civil monetary penalties, or administrative sanctions.

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<sup>6</sup> CRS Report to Congress: *Medicare Provisions in the Balanced Budget Act of 1997* (BBA 97, P.L. 105-33), August 18, 1997, page 3.

<sup>7</sup> Issue Brief: *Fighting Health Care Fraud and Restoring Trust*, George Washington University (no. 710), November 18, 1997, page 2.

#### B. Medicare Enrollment Process

Prior to July 1997, HCFA required prospective providers to enroll in the Medicare program through one of the 43 Medicare Part A (hospital insurance) intermediaries or 27 Part B (supplemental medical insurance) carriers i.e., private insurance companies that entered into contractual relationships with HCFA to process Medicare claims. Collectively, these entities are known as contractors. Since there were 70 contractors,<sup>8</sup> there was no uniform application form or process for enrolling Medicare providers. In 1996, however, HCFA standardized the enrollment form when it mandated use of the HCFA 855, an application form entitled, MEDICARE GENERAL ENROLLMENT, Health Care Provider/Supplier Application (attachment #1).

Although the HCFA 855 form standardized the Medicare enrollment process with respect to the manner in which information was gathered, *it did not expand or increase the verification activities related to the information submitted by the applicant.* As a result, the requirement that prospective Medicare providers complete the HCFA 855 form will not by itself reduce waste, fraud and abuse or prevent unscrupulous providers from entering the program. UNLESS there is an effective process that verifies the accuracy of the information provided on the enrollment form. In other words, collecting the information is one thing; doing something with it to reduce waste, fraud and abuse is another.

The HCFA 855 form, for example, requires prospective Medicare providers to furnish their social security number. Although collecting social security numbers in the past was not permitted by law, this restriction was recently changed by the Balanced Budget Act of 1997.<sup>9</sup> Notwithstanding this revision, PSI's investigation has revealed that no verifications are performed by HCFA to assure that social security numbers provided belong to applicants or that they are even valid numbers.

Another example of HCFA's lax verification procedures involves the address/location a prospective provider lists on an application. The HCFA 855 form requires that a prospective provider include its business location. Preparation instructions for the HCFA 855 form specify that this address cannot be a P.O. Box or a mail drop. However, very few site visits are made to determine whether prospective providers are using legitimate business addresses. For example, PSI's investigation has revealed that many DME companies have used mail drops or P.O. Boxes that appear on the enrollment form to be legitimate street addresses. In many cases, the post office box number is described on the form as a "suite," so that P.O. Box 201 becomes Suite 201. Therefore, it is difficult to determine, from just reading the form, whether Medicare providers

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<sup>8</sup> In FY 98, Part A intermediaries decreased to 40 and Part B carriers decreased to 25. There are four DME regional carriers (DMERCs) and nine regional home health intermediaries (RHHIs).

<sup>9</sup> P.L. 105-33.

are simply using a mail box or if the address is an actual physical location. This makes physical verification even more essential.

More specifically, PSI's investigation reveals that there are several examples of "fronts" being used in a wide variety of Medicare billing scams. Subcommittee investigators traveled to New York and Miami where they found several examples of DME companies and other providers "operating" out of bogus store fronts. In New York, for example, PSI investigators found that the reported location of two physicians was located within a laundromat and was part of a scheme that combined several other mail drops and defrauded the Medicare program out of approximately \$1.5 million. In Miami, PSI investigators found that the reported location of 14 health care companies (DME products/services), if it actually existed, would have been located on the runway of the Miami International Airport. This particular case involved several defendants that used several different mail drops to defraud the Medicare program out of approximately \$6.2 million. Another example observed by PSI investigators was a "mail drop" which was the reported location of two New York City companies (DME products and MRI tests) that submitted Medicare claims totaling about \$3.4 million but provided no services.

HCFA's apparent inability to recognize the need for more up-front scrutiny of its prospective providers is made quite clear in its own HCFA 855 enrollment form. The HCFA 855 form contains a section that calls for the prospective provider to furnish information related to professional and business licenses, certifications, and/or registration information. However, the section states that, "Notarized or 'certified true' copies are optional, but may speed the processing of this application."<sup>10</sup> Perhaps the word optional should be changed to required. The government places absolutely no responsibility or burden on prospective providers to submit valid documents, and as our investigation has revealed, there are several prospective providers who take advantage of this rather trusting process.

Despite the lack of verification of the information submitted on the Medicare provider enrollment form, certain processes were designed to assure that providers meet the conditions of participation. For example, as part of the home health care enrollment process, an initial survey is conducted on each home health care provider. The purpose of this survey is to identify deficiencies that a home health care provider may have with respect to Medicare rules and regulations. Several documents are required by HCFA, including an agency's budget, capital expenditure plan for a three year period and evidence that a group of professional personnel has been established to oversee an agency's quality of care. These surveys are funded by HCFA, but are usually conducted by each respective state's Department of Health. PSI's investigation revealed that these procedures look good on paper; however, many times, the individuals conducting the surveys have not been properly trained, and therefore, are not capable of conducting an effective review.

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<sup>10</sup> HCFA 855 Sec.#3, *Professional and Business License/Certification/Registration Information*, page 2.

Before businesses can bill Medicare for sales or rental of durable medical equipment, they must apply for and receive a billing number. In 1993, HCFA authorized the establishment of the National Supplier Clearinghouse (NSC), a contractor that reviews and approves applications.<sup>11</sup> The NSC is also responsible for issuing a provider's billing number. Section 1834 of the Social Security Act requires that applicants and approved DME suppliers meet eleven standards:

- Fill orders from their own inventory or under a contractual arrangement;
- Oversee delivery of equipment;
- Answer questions and complaints from beneficiaries;
- Maintain and repair rental equipment;
- Maintain a physical address at the business site;
- Comply with all State and Federal licensure requirements;
- Honor warranties on equipment;
- Accept the return of substandard equipment;
- Disclose consumer information (a list of the standards) to beneficiaries;
- Comply with the ownership disclosure provisions of the Social Security Act; and
- Have proof of liability insurance.

The NSC currently has approximately 40 application analysts that are responsible for processing over 16,000 applications a year.<sup>12</sup> Just one year ago, there were only 19 analysts. The application analysts receive completed applications from the prospective providers and perform a  cursory  verification of most applications. The analyst then contacts the prospective provider on the phone and verbally reviews the information provided on the application. The analyst also contacts the various state agencies that have licensed the prospective provider.<sup>13</sup> These agencies vary depending upon the location and type of provider. All prospective providers are checked against the excluded/sanctioned provider list. If any "red flags" are raised during this cursory review, the provider is sent a letter requesting detailed information in order to verify compliance with the Medicare standards (attachment #2). If the supplier is located in an Operation Restore Trust (ORT) state, or if the provider does not satisfactorily answer the letter requesting additional information, the application is forwarded to the Supplier Audit and Compliance Unit for further review. The NSC has sent out over 300,000 supplier applications and has issued over 100,000

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<sup>11</sup> The National Supplier Clearinghouse is part of Palmetto Government Benefits Administrators located in Columbia, South Carolina.

<sup>12</sup> From October 1996 through September 1997, the NSC received 16,184 applications.

<sup>13</sup> The only states that require a DME supplier to be licensed are: Arkansas, Illinois, Maryland, Mississippi, North Carolina, New Hampshire and Tennessee.

billing numbers nationwide since 1993.<sup>14</sup> Of the 16,184 DME applicants received in fiscal year 1997, site visits were made for only 282, or 1.7 percent.

The NSC has recently contracted with ChoicePoint<sup>15</sup> in several large metropolitan areas to perform cursory site visits of DME suppliers. Typically, this visit is nothing more than verifying that the company actually exists at the location provided on the application form. In south Florida, however, every new applicant is required to have a more extensive site visit that determines if the DME supplier has met all the requirements of the Supplier Standards. The NSC currently has one investigator located in Miami, Florida who performs site visits throughout south Florida and three other investigators in its main office in Columbia, South Carolina. These investigators train and oversee the personnel from ChoicePoint who conduct the site visits. HCFA has authorized the NSC to hire an additional twelve investigators; however, even an additional twelve investigators will not allow the NSC to conduct thorough site visits for the majority of prospective providers.

The NSC only verifies a limited amount of information on the application by calling the applicant or some third party, such as a local licensing board or the state agency that issues articles of incorporation. These desk verifications are not as thorough and effective as site visits. Last year, the NSC began conducting site visits in south Florida for all new DME providers. The NSC plans to extend these site visits to several large metropolitan areas this year. The cost of conducting these site visits could be off-set by charging a nominal application fee,<sup>16</sup> not to mention the inevitable reduction of fraudulent suppliers entering the Medicare program. Further, site visits would not be needed for all DME applicants. Some low-risk applicants such as Wal-Mart, may quickly be relegated to a desk verification. While site visits are a step in the right direction, this alone will not prevent abusers from entering the Medicare program.

#### C. White House Initiatives

On September 15, 1997, the White House and HHS announced a moratorium on the enrollment of home health providers into the Medicare program.<sup>17</sup> Interestingly, this moratorium was announced by the White House and HHS while some HCFA officials privately objected. PSI obtained an internal HCFA e-mail which indicated that at least some HCFA officials did not support the moratorium. The e-mail cited that the moratorium was "indefensible legally."

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<sup>14</sup> OIG Final Report, *Medical Equipment Suppliers: Assuring Legitimacy*, December 1997, page 2.

<sup>15</sup> Formerly Equifax.

<sup>16</sup> HCFA estimates an application fee of \$100 would be sufficient to cover the expense of conducting a site visit.

<sup>17</sup> At the time of the announcement, the moratorium was expected to last for approximately six months.

According to recent HCFA congressional testimony, HCFA staff expressed reservations about a moratorium until their new Deputy Administrator expressed concern that current home health program requirements and safeguards were not sufficient to protect the integrity of the Medicare program.<sup>18</sup> The moratorium was a meat axe approach to solving the Medicare fraud problem. The moratorium not only prevented future con-men from billing Medicare, but it also prevented legitimate health care providers, like York Hospital in Maine, from serving elderly and disabled Americans.

The simple fact that the Administration ordered the moratorium, irrespective of HCFA's reservations, is indicative of HCFA's overall inability to identify needed change. If HCFA had been effectively administering the Medicare program, there would have been no need for a blanket moratorium on new enrollees. This fact is even more compelling when viewed in connection with the position taken by HHS's Office of General Counsel. According to the Office of General Counsel, the provisions set forth in the Social Security Act section 1981(b) established a "strong duty and responsibility" for the Secretary to assure the quality and fiscal integrity of the home health benefit.<sup>19</sup> This opinion raises a very important question: Why does HCFA wait for executive or congressional action before taking steps to address waste, fraud and abuse issues?

After approximately four months, the White House lifted the moratorium on January 13, 1998. At that time, President Clinton stated "New tougher regulations are in place to root out fraud and abuse in the home health industry. . . these regulations will keep the bad apples -- the providers who commit fraud -- out."<sup>20</sup> Medicare officials say more than 300 new home care companies have waited out the hiatus and could get approval to do business within a few weeks if they meet the new requirements.<sup>21</sup>

In a January 19, 1998 press release, White House officials said the new Medicare rules will guard against fraud by companies that sell medical equipment to senior citizens. Health and Human Services Secretary Donna Shalala stated: "We need to make sure that those who sell durable medical equipment for Medicare beneficiaries are legitimate and responsible businesses, not fly-by-night companies, inexperienced individuals without adequate resources or even criminals who will defraud and abuse the Medicare program."<sup>22</sup> Medical equipment purchases accounted for about \$6 billion of Medicare's budget in fiscal year 1997. However, audits and

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<sup>18</sup> Statement of Linda A. Ruiz, Director of Program Integrity, Health Care Financing Administration on "Fraud and Abuse in the Home Health Care", before the House Committee on Commerce, Subcommittee on Oversight and Investigations, October 29, 1997.

<sup>19</sup> Id.

<sup>20</sup> Home Health Care Moratorium Lifted, Associated Press, January 13, 1998.

<sup>21</sup> Id.

<sup>22</sup> Medicare Rules Guard Against Fraud, Associated Press, January 19, 1998.

investigations uncovered about \$4 million in improper equipment bills that were paid by the government, and an additional \$509.7 million that were caught before being paid.<sup>23</sup>

#### D. GAO Review and Oversight

The recurring theme in most of GAO's efforts relating to health care fraud is clear -- HCFA is not doing an adequate job preventing and detecting fraud in the Medicare Program. It is difficult to overstate the efforts that GAO has committed in the area of Medicare waste, fraud and abuse. GAO identified the Medicare program as a highly vulnerable program and has studied it as a part of a High Risk Series.<sup>24</sup> Comprehensive GAO reports, as well as GAO testimony before the Congress, have been consistently critical of HCFA's ability to effectively implement changes that would properly address waste, fraud and abuse issues. For example, GAO testified at PSI's Medicare Fraud hearing in June 1997 that, "HCFA's efforts to fight Medicare fraud and abuse have not been adequate to prevent substantial losses because the tools available over the years have been underutilized or not deployed as effectively as possible."<sup>25</sup>

In June 1997, GAO testified before the Subcommittee that, "weak monitoring, poor coordination, and delays have characterized HCFA's past efforts to oversee fee-for-service contractors, the Medicare Transaction System (MTS) acquisition process, and the Medicare managed care plans.<sup>26</sup> Thus, even with the promise of HIPAA<sup>27</sup> and the potential enactment of additional legislation, the prospects for HCFA's success in combating Medicare fraud and abuse remain uncertain."<sup>28</sup>

With respect to the Medicare enrollment process, GAO cited in a November 1995 report that one of the factors contributing to the persistence of fraud and abuse in the DME area is the

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<sup>23</sup> Id.

<sup>24</sup> GAO High-Risk Series: Medicare, February 1997 (GAO/HR-97-10).

<sup>25</sup> Control Over Fraud and Abuse Remains Elusive, page 1 (GAO/T-HEHS-97-165).

<sup>26</sup> MTS is a computer system that is intended to connect the Part A and Part B databases and replace the nine different processing systems currently in use. The implementation of the MTS has been delayed and the prime contractor removed after HCFA had spent at least \$40 million on the new system.

<sup>27</sup> Health Insurance Portability and Accountability Act of 1996, also known as the Kassebaum-Kennedy legislation (P.L. 104-191).

<sup>28</sup> Control Over Fraud and Abuse Remains Elusive (GAO/T-HEHS-97-165).

fact that Medicare (HCFA) “does not adequately screen providers for credibility.”<sup>29</sup> This observation gets to the heart of the problems with regard to the enrollment process.

GAO’s work on the Medicare program is currently focusing on the following issues for fiscal years 1998-2000: i) identifying actions to improve the management and financial integrity of the Medicare and Medicaid programs, ii) examining new strategies for paying for Medicare and Medicaid services that promote cost containment while preserving quality and access, iii) assessing how financing arrangements affect Medicare and Medicaid beneficiaries’ access to quality of care, iv) analyzing the interactions between the Medicare and Medicaid programs and the private health care marketplace, and v) identifying and addressing new oversight issues as changes occur in various health care markets.<sup>30</sup>

#### E. Legislative History

The original Medicare and Medicaid statutes, as enacted in 1965, did not contain program specific anti-fraud provisions; however, Congress did provide that the penalties for fraud which were contained in the Old Age, Survivors and Disability Program were also applicable to the new Medicare and Medicaid programs.<sup>31</sup> Then, in 1972, Congress added anti-fraud provisions to both the Medicare and Medicaid statutes that included misdemeanor penalties for false statements as well as penalties for kickbacks and bribes. In 1977, Congress passed Medicare and Medicaid Anti-Fraud and Abuse Amendments which strengthened the existing fraud and abuse penalties by replacing misdemeanor penalties with felonies.<sup>32</sup> In addition, exclusion authority for providers convicted of program fraud and disclosure of ownership and financial information requirements were added for providers and suppliers.<sup>33</sup>

#### F. Health Insurance Portability and Accountability Act (HIPAA)

In 1996, significant new health care fraud and abuse provisions were added to the existing laws, including the Social Security Act and the Federal criminal code. Enacted as Title II of the HIPAA, these changes increased civil monetary penalties from \$2,000 to \$10,000. New

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<sup>29</sup> FRAUD AND ABUSE: Medicare Continues to be Vulnerable to Exploitation by Unscrupulous Providers (GAO/T-HEHS-96-7).

<sup>30</sup> Health Financing and Systems Issues: Issue Area Plan for Fiscal Years 1998-2000, July 1997. (GAO/IAP-97-13).

<sup>31</sup> 42 U.S.C. § 408 (1972).

<sup>32</sup> P.L. 95-142.

<sup>33</sup> CRS Report for Congress, *Health Care Fraud: A Brief Summary of Law and Federal Anti-Fraud Activities*, September 24, 1997, page 3.

violations were also added to the list of prohibited activities, such as “upcoding,” billing for unnecessary medical services and false certification of home health services.<sup>34</sup>

Additionally, significant new criminal provisions were added to the Federal criminal code. These include new criminal offenses specifically relating to health care fraud, such as false statements, theft or embezzlement, obstructing justice and money laundering. Finally, the forfeiture of property obtained from a federal health care offense was added.<sup>35</sup>

In addition to these added criminal provisions, the amendments in HIPAA also established a number of new programs to combat waste, fraud and abuse. These amendments included a fraud and abuse control program to coordinate federal, state and local law enforcement efforts with respect to both public and private health care programs; a Medicare integrity program providing for contracts with private companies to carry out activities such as audits and reviews of provider payments; a beneficiary incentive program to encourage individuals to report fraud; and a national health care fraud and abuse data collection program containing reports of final adverse actions against health care providers and suppliers.<sup>36</sup> Most of these provisions however, relate to enforcement issues rather than to enrollment integrity.

#### G. Balanced Budget Act of 1997

Most recently, initiatives to combat Medicare fraud and abuse were enacted as part of the Balanced Budget Act of 1997 (BBA). Although the primary purpose of the Medicare provisions of the BBA of 1997 is to slow the rate of growth in payments to hospitals, physicians, and other providers, the law also establishes new payment methodologies for skilled nursing facilities and home health care agencies.

Certain provisions and improvements are geared towards enhancing program integrity. These provisions and improvements include:

- Permanent exclusion for those convicted of three health care related crimes;
- Authority to refuse Medicare enrollment to individuals or entities convicted of a felony;
- Exclusion of an entity when a person transfers ownership or control to an immediate family member or member of the household, in anticipation of, or following, a conviction, assessment, or exclusion;

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<sup>34</sup> CRS Report for Congress, *Health Care Fraud: A Brief Summary of Law and Federal Anti-fraud Activities*, September 24, 1997, page 4.

<sup>35</sup> Id.

<sup>36</sup> Id.

- Providers are required, with certain exceptions, to report their employee information numbers and social security numbers of each person with an ownership interest and subcontractors with a direct or indirect ownership interest of five percent or more;
- DME suppliers, home health agencies, comprehensive outpatient rehabilitation facilities and rehabilitation agencies are required to provide a surety bond of at least \$50,000;
- Civil monetary penalties of up to \$10,000 can be levied when a person arranges or contracts with an individual or entity for the provision of items or services when it knows, or should have known, that the individual or entity has been excluded from a Federal health care program. The individual or entity would also be subject to an assessment of up to three times the amount claimed and to exclusion from Federal health care programs; civil monetary penalties of up to \$50,000 plus up to three times the amount of remuneration offered, paid, solicited or received could be levied for each violation of the anti-kickback provisions of title XI of the Social Security Act;
- Anti-fraud message in the Medicare handbook and the Explanation of Medicare Benefits form must contain a list of items or services which have been provided and the amount of payment for each item or service, as well as a notice of the beneficiary's right to request an itemized statement;
- HHS Secretary must issue advisory opinions as to whether a physician referral for certain designated health services (other than clinical lab services) is prohibited;
- HHS Secretary to implement statewide or other area wide fee schedules for specified items and services currently paid on a "reasonable charge" basis;
- Non-physician practitioners to provide diagnostic codes for items and services furnished by the practitioner (already required for physicians);
- GAO to report on the operation of the Medicare fraud and abuse control program no later than June 1, 1998;
- Implementation of up to five demonstration projects of competitive bidding for Part B items and services, except physician services; xiii) prohibiting unnecessary and wasteful Medicare payments for certain items; and
- Hospital discharge planning evaluations must include the availability of home health services in the area, may not limit qualified providers of home health services, and must disclose financial relationships with home health service entities.<sup>37</sup>

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<sup>37</sup> As found in the Balanced Budget Act of 1997 (P.L. 105-33).

#### H. The Future of Medicare -- HMOs

As the health care system in the United States gravitates towards managed care it is likely, if not inevitable, that the Medicare program will follow suit.<sup>38</sup> Medicare HMO enrollment is growing by about 85,000 beneficiaries per month. The Congressional Budget Office estimates that nearly 15 million Medicare beneficiaries will be enrolled in a HMO by the year 2007.<sup>39</sup>

As Medicare's managed care enrollment grows, it is essential that HCFA ensures that the oversight of HMO payments is more effective than the lax oversight that continues to plague the fee-for-service environment, especially in the home health and DME industries.

GAO has criticized HCFA's ability to monitor HMOs, citing in a recent report that HCFA conducted only "paper reviews" of HMOs' quality assurance plans and examined only the description rather than the implementation of HMOs' quality assurance processes. Moreover, GAO stated that HCFA was reluctant to take action against HMOs who were found to have subjected beneficiaries to abusive sales practices, unduly delayed beneficiaries' appeals of HMOs' decisions to deny coverage, or exhibited patterns of poor quality care.<sup>40</sup>

As the future of Medicare expenditures is almost certainly geared towards managed care, it is essential that HCFA address these concerns as early as possible. However, given HCFA's track record with respect to fee-for-service waste, fraud and abuse, and their early report card related to HMO monitoring, one wonders whether HCFA will be able to rise to the occasion.

#### I. Costs Associated With Medicare Fraud Investigations

Compared to routing out potential abusive Medicare providers on the front end, the cost of investigating and prosecuting Medicare fraudsters is astronomical. Medicare fraud investigations are some of the most complex investigations conducted by federal law enforcement officers. The HHS-OIG estimates that a Medicare fraud case takes an average of three years to complete -- from the receipt of a complaint to prosecution. Of course, not all cases are prosecuted. Over the past five years, the HHS-OIG has opened approximately 2,900 criminal health care cases and approximately 2,700 civil health care cases. For fiscal year 1997, the HHS-OIG had 162 health

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<sup>38</sup> By 1996, about 57 percent of the U.S. population was covered by some type of managed care -- including 60 to 70 million people covered by HMOs and 80 to 90 million covered by preferred provider organizations (PPOs). See CRS Report for Congress, *Managed Health Care: A Primer*, September 30, 1997, page 1.

<sup>39</sup> GAO Medicare Managed Care: HCFA Missing Opportunities to Provide Consumer Information, April 1997 (GAO/T-HEHS-97-109)

<sup>40</sup> GAO High-Risk Series: Medicare, February 1997 (GAO/HR-97-10).

care convictions, 1,255 civil impositions and 2,719 exclusions (providers excluded from participating in the Medicare program for a specified period of time).

There is no "typical" Medicare fraud case. Medicare fraud cases range from multi-million dollar companies upcoding laboratory procedures (billing Medicare for a higher reimbursed procedure than was actually performed) to individual physicians billing for services not rendered. While it is impossible to determine the TOTAL costs associated with investigating Medicare fraud cases, the HHS-OIG has developed a methodology for creating a reimbursable rate that reflects all of its costs. This reimbursable rate is correlated to the number of direct investigative hours worked by its agents. The reimbursable rate for fiscal year 1997 was \$76.93 per hour. The reimbursable rate established for fiscal year 1998 is \$78.60 per hour. This cost does not include the cost of prosecutions, courts, probation officers or incarcerations. Using HHS-OIG's estimate that it takes an average of three years to complete a Medicare fraud case, it could cost the OIG almost \$500,000 for using just one agent on a case (2,080 hours x 3 years x \$78.60 = \$490,464).

The voluminous, and often times confusing, Medicare regulations frequently deter federal prosecutors from pursuing a Medicare fraud case (and some times lead to billing mistakes by ethical providers). These cases are very complex and time consuming. Prosecutors must conduct extensive research of the Medicare rules and regulations to combat the inevitable defense that defendants did not realize that their actions were against the law and that they did not *intend* to commit a wrongdoing. It is extremely difficult to prove intent in these cases. Typically, the defendant claims ignorance and promises never to do it again.

In the years preceding the HIPAA legislation and BBA of 1997, there was a significant increase in the number of Medicare providers, while at the same time, the number of investigators pursuing Medicare fraud cases declined. With the advent of the HIPAA legislation and the BBA of 1997, additional resources have been added to help prevent the waste, fraud and abuse. For example, the HIPAA legislation provided increased funding for Medicare fraud investigations. In fiscal year 1997, HHS received a minimum of \$60 million, the Federal Bureau of Investigation received \$47 million, and the Medicare contractors received \$430 million (attachment #3).

#### J. User/Application Fees

Currently, HCFA does not charge any fees to become a Medicare provider. A moderate user fee would help defray the increasing cost of processing an application as well as the expense associated with conducting site visits. Several other government programs charge user or application fees as a means to offset the significant financial burden placed on the program. For example, the District of Columbia charges residents \$20 to simply obtain a driver's license (even if you already have a driver's license from another state) and the State Department charges individuals \$65 to obtain a new passport. Participation in the Medicare program is a privilege, not a right. Thus, charging a user fee would be a legitimate way to "share" the expense with the prospective provider.

### III. ENROLLMENT SCHEMES AND REGULATORY FLAWS

PSI's investigation has revealed that the easiest and most cost effective way to raid the Medicare trust fund is straight through the front door, especially since only 10 percent of the 800 million claims paid by HCFA each year are audited or checked. Once a provider number is obtained, a bogus Medicare provider has easy access to what one convicted health care fraud felon described as "a gold mine."<sup>41</sup>

PSI's investigation primarily focused on fraud in the home health care, durable medical equipment and community mental health industries. Examples of the schemes and regulatory flaws that were uncovered as part of our investigation are described below.

#### A. Home Health Agencies

Medicare covers health care to homebound beneficiaries who need intermittent skilled nursing care and/or physical or speech therapy. Medicare does not limit the number of visits or the length of home health coverage. Services are covered if they are reasonable and necessary to treat the patient's illness or injury. There are no beneficiary co-payments or deductibles for home care visits.<sup>42</sup>

The home health industry is the fastest growing segment of health care in the United States. This growth began in 1989, when, as a result of the lawsuit *Duggan v. Bowen*,<sup>43</sup> changes in Medicare regulations expanded eligibility and eliminated the cap on the number of visits. Since that time, the number of Medicare-certified home health agencies has risen from 5,730 in 1990 to 8,949 in 1995 -- a 56 percent increase. While the number of beneficiaries receiving home health agency services has grown, costs to the Medicare program have increased disproportionately. Total annual Medicare expenditures for home health grew from \$3.7 billion in 1990 to \$16.7 billion in 1996 -- a 351 percent increase.

Problem home health agencies can accumulate substantial and uncollectible Medicare overpayments. When overpayments are determined by the fiscal intermediary, or even before it has a chance to do so, many home health agencies file bankruptcy or merely cease business to avoid debt. After these home health agencies declare bankruptcy or disappear, Medicare has little

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<sup>41</sup> Interviewed by PSI investigators at the Miami Detention Center, Miami, Florida.

<sup>42</sup> OIG Final Report: *Home Health: Problem Providers and Their Impact on Medicare*, July 1997, Page 1.

<sup>43</sup> *Duggan v. Bowen*, 691 F. Supp. 1487; (D.D.C. 1988) (plaintiff challenges the Department of Health and Human Services' definition of part-time or intermittent care regarding home health visits).

chance of recovery because the debts apply only to the defunct corporation, not to the individual owners or their other businesses.<sup>44</sup>

HCFA procedures require that an initial survey be conducted at a home health care agency before a provider number is issued. These surveys are conducted by a state agency, usually operating out of the respective state's Department of Health. The surveys are funded by HCFA. The purpose of the initial survey is to assure that the agency is operating according to the regulations that have been established for home health care providers as set forth by HCFA. If any deficiencies are identified as a result of the initial survey, a compliance program is established and future compliance surveys are conducted.

According to HCFA procedures, various aspects of a home health agency's business are reviewed during the initial survey. In order to determine the operational viability of an agency, various business documents are reviewed such as an agency's budget and capital expenditure plan for a three year period. In order to determine whether an agency is able to provide quality services, a quality assurance clinical record review is conducted and a determination is made into whether a group of professional personnel has been established, as required, to oversee the agency's services as they relate to quality of care.

PSI's investigation revealed that this survey process is deficient in several respects. For example, even though a home health agency is required to have a budget, there is no determination made to verify the budget produced. In one region of the country, information has been obtained which indicates that the *same budget* was produced by several different home health care agencies. In another region, a HCFA official advised PSI investigators that on many occasions home health care agencies do not have a budget as of the initial survey and simply prepare one while the survey is being conducted. This same official stated that a surveyor, in general, is not armed with the responsibility to verify the veracity of the information provided on the enrollment form or the documents it reviews throughout the survey. With respect to the request to have a "budget," the guidelines simply require that an agency have a budget. The guidelines do not require that the surveyor determine the legitimacy of the budget produced during the initial survey.

Efforts are also made during the initial survey to assure that a home health agency has established a group of professional personnel to oversee the agency's quality of care. In order to operate according to HCFA guidelines, a home health agency must have a physician as part of their group of professional personnel. However, according to one HCFA official, virtually no verification is conducted to determine whether or not the physician identified during the survey is actually a participating member of the group. Once a surveyor obtains evidence that a physician is a member of the group, no further action is taken. According to the HCFA official, an agency only needs to produce a list of the members of their group to satisfy this requirement, thus making it rather easy for illegitimate agencies to by-pass this requirement.

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<sup>44</sup> *Id.*

As a result of the PSI investigation into the enrollment process established for home health agencies, we have determined that there are serious deficiencies in that process, in that there is inadequate verification of the information submitted on the initial enrollment form and the initial survey is nothing more than a burden, not a road block, to a bogus home health agency.

#### B. Durable Medical Equipment Companies

DME suppliers must operate according to the Supplier Standards as set forth by law. One of these standards is that the supplier must maintain a physical address at the business site. PSI's investigation reveals, however, that several DME suppliers have simply rented small offices to satisfy the physical facility standard.

During a September 1997 trip to Miami, PSI investigators visited one office complex that is known to rent office space to several suppliers. This particular office complex has housed 45 DME suppliers over the past four years. These companies billed the Medicare program over \$20 million during this time period.<sup>45</sup> Upon physical inspection, it was determined that many of these offices were scantily furnished, and at the time of our visit, only one of the offices was open for business. Interestingly, one of the only items displayed on the wall of the occupied office was a local tax license, and on the desk in front of the person was a letter from the NSC which indicated that several attempts have been made to conduct a site visit. According to this particular DME owner, Medicare has investigated his company three times and because of the problems that come with the investigations, he is planning on expanding his business to Orlando and is organizing a consortium of 37 DME suppliers so that when one supplier is investigated the cash flow from Medicare will not dry up. According to information received from Medicare, this particular provider has been paid almost \$200,000 for DME supplies.

In conversations with Medicare investigators in Miami, "set-ups" such as the one utilized by this particular supplier are very common among fraudulent DME suppliers and are created as a means to continue operations in compliance with the Supplier Standards. They further commented that they have seen one office rented to several different companies with one operator answering the various phone lines that have been set-up.

Based on PSI's investigation, it is clear that the DME standards are crudely drafted at best, and do not provide investigators who perform site visits with the ammunition they need to exclude the DME suppliers that are obviously not operating legitimately.

#### C. Community Mental Health Centers

Based on a preliminary review in south Florida, PSI investigators have identified the Community Mental Health Program (CMHC) as one that is vulnerable to large scale fraud. In

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<sup>45</sup> Billing information obtained from Palmetto Government Benefits Administrators, a regional DME carrier.

1990, Congress passed legislation which changed the Medicare Part A partial hospitalization requirements. This change created the opportunity for partial hospitalization related to mental health services to be rendered at CMHCs. In theory, the changes to the partial hospitalization requirements were designed to lower the government's costs by allowing Part A reimbursement for the provision of these services outside of a hospital setting.

As a result of this change, there has been tremendous growth in partial hospitalization services provided at CMHCs over the past few years. In 1995, approximately \$100 million was paid by HCFA; in 1996, there was approximately \$250 million paid; and by the end of 1997, the number was expected to reach \$500 million annually.<sup>46</sup> According to HCFA's Operation Restore Trust south Florida Team Leader, this increase can be attributed to the lack of enrollment standards because Medicare "never got around to establishing any standards." An individual can qualify for a provider number as a CMHC based on a written Self-Attestation alone.

The criteria for a CMHC provider is outlined in the Public Health Services Act. That statute required that a CMHC must perform five core services in order to qualify as a CMHC provider with respect to Medicare reimbursement. These required services are:

- Provide outpatient services for children, the elderly, chronically mentally ill individuals and individuals recently discharged from inpatient treatment centers;
- Provide 24-hour-a-day emergency care services;
- Provide day treatment or psychosocial rehabilitation services;
- Provide screening for patients being considered for admission to state mental health facilities; and
- Provide consultation and education services.

A recent random audit of seven CMHCs in South Florida<sup>47</sup> resulted in all seven centers being excluded from participation with the Medicare program after millions of Medicare dollars were spent.<sup>48</sup> In one example, the kitchen of a CMHC was found to be extremely unsafe and as a result the local fire department closed the facility. In another example, one CMHC was found to provide its beneficiaries with fast food lunches and another had its beneficiaries dancing the

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<sup>46</sup> Final figures for 1997 expenditures were not available at the time of this writing.

<sup>47</sup> The audit was conducted by HCFA officials from its Operation Restore Trust initiative in South Florida.

<sup>48</sup> Information obtained during a PSI interview of HCFA's Operation Restore Trust south Florida Team Leader.

Macarena as a sponsored activity. All of this at a cost to the Medicare program of \$300 per day per beneficiary.<sup>49</sup> Further review by the auditors called into question the qualifications of the owners and operators of these facilities and whether the services provided were ordered by a physician or whether they were even medically necessary.<sup>50</sup> Even more disturbing is the fact that these CMHCs performed 100 percent of their services on Medicare beneficiaries, which is contrary to the definition of CMHCs as established in the Public Health Services Act.

In January 1998, PSI investigators made an unannounced visit to a CMHC provider in south Florida. Investigators observed a "social worker" playing a guitar to a room of five elderly individuals. The CMHC owner stated that these individuals were potential new patients and were being evaluated to determine if they qualified for the CMHC program. In another very small room, PSI investigators observed three Medicare beneficiaries who were discussing their "goals" with an individual that the CMHC owner described as a doctor. Although the CMHC had office space dedicated for a nurse, the nurse was not present. During PSI's visit, one elderly patient became ill, but since the nurse was not present, the patient was taken outside for some fresh air. The CMHC did not have any kitchen facilities but the owner stated that she had food catered in for the patients. In addition, the owner stated that the CMHC's patient count fluctuated -- at one time the CMHC had 15 patients but had only seven at the time of PSI's visit. According to the owner, the CMHC only provided services to Medicare beneficiaries.

Ironically, the same general theory that prompted the change to the partial hospitalization requirements was the same general theory which created home health care reimbursement in the 1980's. Again, with the home health care program, the idea was to reduce government expenditures for nursing home services by allowing reimbursement of Part A skilled and other nursing services to be reimbursable when rendered outside of the more institutional setting of a nursing home. As home health care expenditures have ballooned to over \$22 billion,<sup>51</sup> and rampant fraud within the industry is not disputed, a strong case can be made that HCFA's implementation of this change has failed miserably.

Given the fact that HCFA implemented the changes to the Part A hospitalization billing regulations related to community mental health centers, without taking into consideration the lessons learned from the home health changes, is indicative of HCFA's overall inability to recognize waste, fraud and abuse issues when administering new programs.

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<sup>49</sup> *Id.*

<sup>50</sup> *Id.*

<sup>51</sup> A threefold increase over the past 5 years.

#### IV. CONCLUSION

An uncontrolled and poorly administered enrollment process for the Medicare program not only subjects the government to excessive financial loss, but it also compromises the quality of care that is being provided to the nation's elderly population. Throughout PSI's investigation, the common theme among the health care fraud experts was that as the amount of waste, fraud and abuse escalates within the Medicare program, the quality of care is invariably reduced.

Common sense tells you that when convicted felons with no background in health care are allowed to enroll in the Medicare program as providers, there are some significant flaws in the system that need immediate attention. Unlike most organizations, HCFA writes the check first, then asks questions later. Most financial institutions would go broke if they loaned money first, then verified if the applicant had the ability to repay. Just as a financial institution verifies the information submitted by a loan applicant, so must HCFA verify the information supplied by applicants. A small investment in verifying information will prevent the current "pay and chase" that has resulted in an estimated \$23 billion loss annually.

#### V. WITNESSES

##### A. Convicted Felon

The convicted felon will testify about how he ripped off approximately \$32 million from the Medicare Program over a two-year period, using several different companies. The felon told PSI investigators that he was making approximately \$180,000 to \$200,000 per month and at one point was billing the Medicare program for over 2,000 patients.

The felon (whose identity will be protected at the January 1998 PSI hearing) is now serving ten years after being convicted of federal Medicare care fraud charges in Miami. He is also serving concurrent time for a felony drug conviction.

In November 1988, the felon purchased a medical supply company. Before becoming a Medicare provider, the felon had no experience as a health care provider, and in fact, he was a Miami night club owner and a former electrical engineer. He also has a history of drug trafficking.

The felon's business scam consisted of paying recruiters to visit senior citizen centers, offering free nutritional milk in exchange for Medicare account numbers. The felon also paid others to sign-off on medical charts and forms indicating that the patients needed the milk for medical reasons. The felon stated that his companies delivered milk on only one occasion. According to the felon, even on this one delivery, the supplies were not medically necessary.

Shortly after he purchased the company thinking it was a legitimate operation, he realized that the business was "bogus" because there was too much money coming in for the amount of

supplies purchased. The felon confronted the person who sold him the company and was informed that the medical supply business was "bogus."

According to the felon, because of the amount of money that he was making, he continued the scam and expanded his business. By the time the felon was arrested in January 1994, he owned seven medical supply companies and employed approximately 20 individuals for the primary purpose of processing fraudulent Medicare claims. He stated that he was earning almost \$500,000 every three months. A federal indictment charged that the felon's companies defrauded the Medicare program for a total of about \$14 million; however, the felon told PSI investigators that he stole around \$32 million.

PSI investigators asked the felon to describe his perspective of the Medicare program. The felon stated that "it's a gold mine." The felon added that there is no other business available where someone could make the same amount of money with such a low risk of getting caught. The felon stated that the government (Medicare) made it easy for him to steal. He stated that he was never required to produce any documentation in support of the claims his companies submitted.

The felon told PSI investigators that he used the proceeds from his Medicare fraud to buy extravagant luxury items and services, such as residences in the United States and overseas (including Miami, New York, Spain and Mexico), extensive travel throughout the world (including Brazil, Asia, and Europe), luxury automobiles, boats, nightclubs in Cancun, Mexico, fine art, a \$100,000 wedding for his niece in Miami, among other items and services.

#### B. Former PSI Investigator John M. Frazzini

Mr. Frazzini will testify about the results of PSI's investigation of the weaknesses in the Medicare enrollment process. Mr. Frazzini's testimony will focus on the information obtained by PSI investigators during their visits to New York and Miami. He will describe how, unlike the typical Medicare scam where a doctor, clinic, or supply company provides legitimate services and supplies but occasionally "pads" their bills at the end of the day, these new scam artists are committing 100-percent fraud by billing for medical services or supplies they do not provide. Mr. Frazzini will discuss how HCFA has taken actions to improve the application form by requesting more information from prospective providers. HCFA, however, does not adequately verify this information to determine if it is valid. Mr. Frazzini will show photographs taken by PSI investigators that highlight how unscrupulous Medicare providers are using mail drops, store fronts, and even the runway of an airport as business locations for medical clinics and supply companies.

#### C. Department of Health and Human Services, Office of Inspector General

(1) John E. Hartwig, Deputy Inspector General for Investigations. Mr. Hartwig is a twenty-year veteran of the HHS IG's office. He is the former chief of the Philadelphia HHS IG field office. Although as of this writing PSI staff has not seen Mr. Hartwig's testimony, our

meetings with him indicate that he will testify that his office's case load of egregious cases of fraud (*i.e.*, fraud perpetrated by those enter the system the system with the goal of ripping it off) has increased. Mr. Hartwig will also testify that the magnitude (*i.e.* dollar value) of HHS-OIG cases continues to grow. He states a large case ten years ago was perhaps worth \$100,000, whereas now a large case is in the hundreds of millions of dollars. He attributes the rise in fraud to the fact that Medicare is known to be a gold mine for crooks and that, as a decentralized program, it is very easy to break into. He faults HCFA for not being more rigorous in verifying enrollment data, though he notes that the states often are the agents responsible for verification, and they thus often do not make the grade. Mr. Hartwig feels the 1997 Balanced Budget Act goes a long way to creating stronger up-front protections (such as surety bonds), but he also believes greater attention must be given to verification. He also believes that there is no substitute for strong enforcement and severe penalties as the greatest deterrent.

(2) Bruno Varano, Supervisory Special Agent (New York). Mr. Varano will respond to questions about one particularly egregious Medicare fraud case and the enrollment process in general. As to the latter, he is very critical of the verification process and he believes it is more difficult to get a cab license in New York City than it is to get a Medicare provider number. As to the former, Mr. Varano will describe his office's investigation of one case dealing with approximately 20 fictitious provider numbers that were involved in billings for fake DME (orthotic supplies and ear implants) and MRI companies; these companies were created "for the sole purpose of defrauding the Medicare program." None of the provider numbers was representative of a legitimate company that was actually in the business of providing the supplies that were being billed. This fraud occurred over a two-year period (1995-1996). These fictitious companies basically billed Medicare with impunity over this period, making off with millions of dollars. In one instance, three of the companies billing for ear implants received checks from Medicare totaling approximately \$1 million in less than a month. In another example, Medicare payments for over \$5 million for MRI services were discontinued by the carrier after suspicions were aroused.

The perpetrators used front people in the Medicare program application process; obtained provider numbers for doctors that no longer bill the Medicare program; and used mailbox drop locations to receive payments for services never rendered. Remarkably, the Medicare system failed to identify claims submitted for deceased beneficiaries. All of the fictitious companies had addresses that were mail box rental establishments, thus a short, up front visit to the premises would have raised serious suspicions as to whether the companies in fact existed. The conspirators thus far have proven to be individuals of Russian origin, and the investigation is leading to other possible violations.

The OIG began its investigation after numerous Medicare beneficiaries complained to their carriers about not receiving the services for which Medicare was being billed. Even after a number of arrests, OIG believes that the fraudulent scheme is continuing. "We have found that, as part of this scheme, fictitious companies are being incorporated in other states. The criminal interests are finding new ways to 'game' the system and take advantage of weaknesses in the reimbursement process."

(3) Cathy E. Colton, Supervisory Special Agent (Miami). Ms. Colton will respond to questions that egregious fraud is pervasive in Southern Florida and she laments the woeful verification functions of the enrollment process. She also indicates that hard-core fraudsters are clever at migrating into various specialities falling under Medicare; a couple of years back, the DME industry was white-hot with fraud and now, though fraud is highly embedded in that industry, the fraud *de jour* is Community Mental Health Centers (CMHCs).

Ms. Colton also will testify to one particularly egregious case whose investigation began in 1994. In this case, a private citizen in Miami mistakenly received in the mail dozens of Medicare explanations of benefits forms, which he forwarded to the Office of Inspector General. The forms showed that multiple beneficiaries were each provided liquid nutrition by six different DME companies. All of the beneficiaries were reported by the DME companies as having the *same, incorrect* address. All of the approximately 20 fraudulent companies billed and were paid by Medicare for the services supposedly provided to the beneficiaries. OIG investigators contacted the "beneficiaries", and they all denied receiving the services. OIG investigators then visited several of the DME "business addresses" and all were located at mail box drops, such as "Mail Boxes Etc." Thus, had up-front verification occurred in this instance, suspicions would have been raised as to the validity of the "providers" upon discovering their business address was a "Mail Boxes Etc." In total, Ms. Colton estimates total losses on the order of \$6.2 million.

Moreover, an interesting aspect of this case was that the conspirators relied heavily on "recruiters" from whom the conspirators would buy the names and Medicare numbers of beneficiaries. "Recruiters" are persons who canvass nursing homes, adult living facilities and private neighborhoods to find Medicare beneficiaries, often 'bribing' them for their numbers by doing them favors such as buying groceries, for example. The conspirators also obtained beneficiary information from secretaries in doctors' offices and often from doctors themselves, to whom kickbacks would be paid.

The ringleader was a Mr. Martinez, who is now a fugitive. Martinez paid off co-conspirators between \$1,000 and \$5,000 per month to be the titular heads or nominees of his companies. Martinez required his nominees to open corporate bank accounts to begin cashing and depositing the Medicare checks. All of the nominees also signed blank company checks which they turned over to Martinez.

#### D. Health Care Financing Administration

(1) H. Donna Dymon, Ph.D. (San Francisco). Dr. Dymon is a Commissioned Officer with over 21 years in the U.S. Public Health Service with degrees in business and nursing. She is currently detailed to the HCFA's Region IX Office in San Francisco. Dr. Dymon has participated in approximately 100 surveys of health care entities. HCFA contracts with state agencies who conduct surveys of home health agencies to determine if the agencies meet the Medicare conditions of participation. Dr. Dymon will testify how the inadequacies in the current survey process contributes to a "cake-walk" allowing anyone to establish a home health agency certified to do business in the Medicare Program. She will describe how the weaknesses in the

enrollment process has contributed to a "get rich quick opportunity" for those unscrupulous individuals who want to enter the home health business. Dr. Dymon will describe, for example, how surveyors had found home health agencies that were located in basements, pawn shops and garages. In addition, she will provide some graphic examples of how the quality of care has been seriously affected by allowing non-qualified individuals into the Medicare Program, such as one Medicare patient whose leg had to be amputated because of improper care by a home health employee.

(2) Dewey Price (Miami). Mr. Price is the Team Leader of HCFA's Miami Satellite Office. He has been involved in the Medicare program integrity activities in the State of Florida since 1994. In August 1994, HCFA's Atlanta Regional Administrator selected Mr. Price to head the South Florida Task Force, a workgroup of representatives from HCFA, the OIG, a Medicare contractor, and State Medicare/Medicaid agencies. Mr. Price will testify that there must be a commitment by HCFA to: (i) suspend payments when evidence of fraud or misrepresentation exists, (ii) limit program participation to legitimate entities via a stringent provider enrollment process, (iii) stop pay and chase by screening and denying claims up-front rather than performing audits/investigations after the money is gone, (iv) improve HCFA's data analysis capability, (v) only pay reasonable amounts, and (vi) change regulations, policies and procedures that make fraud and abuse easy and profitable. He will describe how the weaknesses in the enrollment process have allowed unscrupulous individuals to enter all facets of the Medicare Program, including community mental health centers, durable medical equipment suppliers, health clinics, and home health agencies. Specifically, Mr. Price will testify how an unscrupulous individual can open a community mental health center with only 15 patients and make \$1 million in one year through the Medicare Program. He will also testify how owners of health clinics have no background or experience to operate/administer a medical facility and how some owners have a criminal history. Further, these same owners hire non-medical staff who perform and order services at the clinics. In addition, Mr. Price will describe how Medicare provider numbers have been issued to post office boxes, vacant buildings and residences.

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**PSI BACKGROUND MEMO**

**ATTACHMENT #1**



Medicare  
Palmetto Government Benefits Administrators

Post Office Box 100142, Columbia, South Carolina 29202-3142

**National Supplier Clearinghouse**

July 28, 1997

Dear Supplier,

Please read all of this short note because it contains information of great importance to you. *The enclosed HCFA application form is an all new form. Examine it carefully before you fill it out and return it to NSC.* When your application has been completely and successfully verified, you will be assigned a National Supplier Clearinghouse number. That 10 digit number will identify you as an authorized MEDICARE Durable Medical Equipment Supplier and is the key to your claims being successfully processed for payment. There has been a procedural change which implements the policy associated with that number of which you must be aware from the beginning *the effective date of your number is the date on which it is assigned.* That means that any and all claims that you send to the DMERCs for services rendered before your effective date will not be paid. That is a change; there is no "grace period"

Here are some things that will help us process your application faster and get a supplier number for you sooner:

- Please contact National Supplier Clearinghouse for your application form; the applications change over time, and when they do, the systems into which the data are entered change. *If you use the wrong form, it will be returned to you noting that it is unprocessable along with a current form for you to refill out.* That causes delays for you. When we can not process the form, we do not consider it as received.
- Be sure to read the whole application and the instructions for filling it out carefully before you start to complete it. We really do require all of the information requested.
- Section 13 (Managing/Directing Employees):
  - a) The term *managing/directing employee* is defined as an individual including: general manager, business manager, administrator, or director who exercises operational or managerial control for the provider/supplier or who directly or indirectly the day - to-day operations of the supplier. During the application verification process, NSC must be able to contact the supplier or a person listed on the application who is authorized to represent the supplier at that location to verify information about that location. That is particularly important when we verify information about that location. That is particularly important when we verify applications for Doctors and for business with multiple locations.

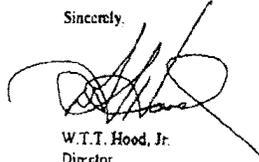
- Be sure to give complete and accurate answers. A partial address, telephone number, TIN/EIN, social security number, or an abbreviation which the post office does not accept or recognize will slow or stop the application verification process.
- Please double check all of your entries to ensure that the correct information is in the proper box.
- Be sure to have the person required to sign the application sign it in the right place.
- As silly as it may sound, please check the entire application one more time before you mail it to us.
- Please be aware that the laws, rules, and regulations which apply to getting a DME supplier number change, and the best way to avoid problems is to call the NSC Service Center at (803) 754-3951 and check for changes before you mail the application to us.

All of those suggestions address common items which we encounter that cause us to return the application to you for more information or corrections. Our sincere desire is to assign NSC numbers to each of you who qualify as quickly as possible, but to do that we need your help.

And by the way, if you move, you must send us a change of address form, or you will not get your claims checks; those checks *will not be forwarded* to your new address by the post office. NSC must receive your new address and pass the new information to the DMERCs electronically for the computers to be able to address the mail to you. Call our service desk, and we will send you a change of address form that same day.

Don't forget, the effective date of your NSC Supplier Number will be the date we assign that number to you. Best wishes. You are important to us and to our MEDICARE beneficiaries.

Sincerely,



W.T.T. Hood, Jr.  
Director

# MEDICARE

## GENERAL ENROLLMENT



### Health Care Provider/Supplier Application



# Medicare General Enrollment Health Care Provider/Supplier Application

## Privacy Act Statement

The Health Care Financing Administration (HCFA) is authorized to collect the information requested on this form in order to ensure that correct payments are made to providers and suppliers under the Medicare program established by Title XVIII of the Social Security Act. See sections 1814 and 1815 of the Social Security Act for payment under Part A of Title XVIII (42 U.S.C. §§ 1395f(e)(1) and 1395g(a)) and section 1833(e) (42 U.S.C. § 1395f(e)) for payment under Part B. In addition, HCFA is required to ensure that no payments are made to providers or suppliers who are excluded from participation in the Medicare program under section 1128 of Title XVIII (42 U.S.C. § 1320a-70) or who are prohibited from providing services to the federal government under section 2455 of the Federal Acquisition Streamlining Act of 1994, (P.L. 103-355) (31 U.S.C. § 6101 note). This information must, minimally, clearly identify the provider and its place of business as required by the Budget Reconciliation Act of 1985 (P.L. 99-272) (42 U.S.C. § 8202(g)) and provide all necessary documentation to show they are qualified to perform the services for which they are billing.

The Debt Collection Improvement Act (DCIA) of 1996 (P.L. 104-134) (31 U.S.C. §§ 3720B-3720D) requires agencies to collect the Taxpayer Identification Number (either the Social Security Number or the Employer Identification Number) from all persons or business entities doing business with the federal government. Under section 31001(i)(1) of the DCIA (31 U.S.C. § 7701(c)(1)), the taxpayer identification number will be used to collect (including collection through use of offset) and report any delinquent amounts arising out of the business relationship with the Government. Therefore, collection of this data element is mandatory.

The purpose of collecting this information is to determine or verify the eligibility of individuals and organizations to enroll in the Medicare program as providers/suppliers of goods and services to Medicare beneficiaries and to assist in administration of the Medicare program and other Federal and State health care programs. All information on this form is required, with the exception of those sections marked as optional on the form. Without this information, the ability to make payments will be delayed or denied.

The information collected will be entered into either system number 08-70-0525 titled Unique Physician/Practitioner Identification Number (UPIN) System (published in the Federal Register in Vol. 61, no. 88, May 7, 1996), or the National Provider Identifier (NPI) System (OMB approval 0938-0684 (R-187)). The information in this application will be disclosed according to the routine uses described below.

Information from these systems may be disclosed under specific circumstances, to:

- (1) Contractors working for HCFA to carry out Medicare functions, collating or analyzing data, or to detect fraud or abuse;
- (2) A congressional office from the record of an individual health care provider in response to an inquiry from the congressional office at the written request of that individual health care practitioner;
- (3) The Railroad Retirement Board for purposes of administering provisions of the Railroad Retirement or Social Security Acts;
- (4) Peer Review Organizations in connection with the review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XVIII of the Social Security Act;
- (5) To the Department of Justice or an adjudicative body when the agency, an agency employee, or the United States Government is a party to litigation and the use of the information is compatible with the purpose for which the agency collected the information;
- (6) To the Department of Justice for investigation and prosecuting violations of the Social Security Act to which criminal penalties attach;
- (7) To the American Medical Association (AMA), for the purpose of attempting to identify medical doctors when the Unique Physician Identification Number Registry is unable to establish identity after matching contractor submitted data to the data extract provided by the AMA;
- (8) An individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or to the restoration or maintenance of health;
- (9) Other Federal agencies who administer a Federal health care benefits program to enumerate/enroll providers of medical services or to detect fraud or abuse;
- (10) State Licensing Boards for review of unethical practices or nonprofessional conduct;
- (11) States for the purpose of administration of health care programs; and/or
- (12) Insurance companies, self insurers, health maintenance organizations, multiple employer trusts, and other health care groups providing health care claims processing, when a link to Medicare or Medicaid claims is established, and data are used solely to process provider/supplier's health care claims.

The applicant should be aware that the Computer Matching and Privacy Protection Act of 1988, (P.L. 100-503) amended the Privacy Act, 5 U.S.C. § 552a, to permit the government to verify information through computer matching.

## Protection of Proprietary Information

Privileged or confidential commercial or financial information collected on this form are protected from public disclosure by Federal law 5 U.S.C. 552(b)(4) and Executive Order 12600.

## Protection of Confidential Commercial and/or Sensitive Personal Information

If any information within this application (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by HCFA under 5 U.S.C. § 552(b)(4) and/or (b)(6), respectively.



**MEDICARE HEALTH CARE  
PROVIDER/SUPPLIER ENROLLMENT  
APPLICATION INSTRUCTIONS  
General Application - HCFA 855**

Upon completion, return this application and all necessary documentation to:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0685. The time required to complete this information collection is estimated to average 90 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, P.O. Box 29684, Baltimore, Maryland 21207 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

**General**

This application must be completed by all providers of services and suppliers of medical and other health services for enrollment in the Medicare program. Some applicants may also need to be surveyed and/or certified by the appropriate State Agency or Regional Medicare Office when required, to meet Medicare enrollment requirements. If you need assistance or have any questions concerning the completion of this application, contact your local Medicare contractor.

A separate application must be submitted for each classification of provider/supplier type (e.g., physician in private practice, physician in group practice) even if the different types of services are furnished within the same organization or entity (hospitals and all affiliated units). Each entity of an organization shall submit a separate application (e.g., hospital based skilled nursing facility, hospices, outpatient clinics, etc.). Each entity of a chain organization must submit a separate application. (Provider/suppliers enrolling in the Medicare program as a group/partnership or a group member/partner must also complete HCFA Form 855G (Individual Group Member Application). Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies must enroll in the Medicare program using HCFA Form 855S (DMEPOS Supplier Application) instead of this application.

**Note: Any changes in the information reported in this application must be reported to the Medicare Contractor within 30 calendar days of said change.**

**Definitions.**

**Authorized Representative:** The appointed official who has the authority to enroll the entity in the Medicare program as well as to make changes and/or updates to the applicant's status.

**Chain Organization:** Multiple providers/suppliers (chains) are owned, leased or through any other devices, controlled by a single business entity. The chain organization must consist of two or more health care facilities. The controlling business entity is called the chain "Home Office". Each entity (chain) may have a different owner (generally chains are not owned by the Home Office).

Typically, the chain home office:

- maintains uniform procedures in each facility for handling admissions, utilization review, preparation and processing admission notices and bills;

- maintains and controls centrally, individual provider/supplier cost reports and fiscal records and a major part of the Medicare audit for each component can be performed centrally.

Examples of provider types that would typically be chain organizations are: Certified Outpatient Rehabilitation Facilities (CORFs), Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs), Clinical Laboratories (CLIA Labs), etc.

**Clinical Laboratory Improvement Amendments Number (CLIA):** This number is assigned to laboratories who are certified by HCFA under the Clinical Laboratory Improvement Amendments.

**Note:** As stated in Medicare Carrier Manual (MCM) section 1180, Clinical Laboratory Improvement Amendments Licensure, any laboratory soliciting or accepting specimens in the interstate commerce for laboratory testing is required to hold a valid license or letter of exemption from licensure issued by the Secretary of the United States Department of Health and Human Services. As stated in MCM section 1184, a separate CLIA number is required for each laboratory location.

**Consolidated Cost Report:** A cost report compiled for multiple facilities joined together and filed under the parent facility's Medicare Identification Number.

**Contractor:** Any individual, entity, facility, organization, business, group practice, etc., receiving an Internal Revenue Service (IRS) Form 1099 for services provided to this applicant (e.g., independent contractor, subcontractor, etc.).

**Note:** Contractors affiliated with this applicant should be identified in Sections 13 or 14 as applicable.

**Distinct Part Unit [of a facility]:** A separate psychiatric, rehabilitation, or skilled nursing unit that is attached to a hospital paid under the Prospective Payment System (PPS) but which is paid on a cost reimbursement or other non-PPS basis. It must be a clearly identifiable unit, such as an entire ward, wing, floor, or building, including all the beds and related services in the unit, that meets all the requirements for a type of facility other than the one in which it is located, and houses all the beneficiaries and recipients for whom payment is made under Medicare for services in the other type of facility.

**Employer Identification Number (EIN):** Internal Revenue Service (IRS) tax identification number.

**Food and Drug Administration Number (FDA):** This is the certification number assigned by the FDA for equipment used in mammography screening and diagnostic services.

**Group:** Two or more physicians, non-physician practitioners or other health care providers/suppliers who form a practice together (as authorized by State law) and will bill Medicare as a unit. This excludes contracted physicians, non-physician practitioners and other contracted health care providers/suppliers. A group has individual members. The individual members must be enumerated and enrolled in the Medicare program as an individual in order to enroll as a member of the group.

Only those health care practitioners who are authorized to bill Medicare directly in their individual capacities are allowed to form a group. A group can only be enrolled if it can meet the conditions for reassignment (see instructions for section 18).

The above definition of a group is to be used for Medicare enrollment purposes only. It is not the group definition described in section 1877(h) of the Social Security Act.

**Group Member:** A physician or non-physician practitioner who renders services in a group practice and who reassigns his/her benefits to the group.

**Legal Business Name:** The legal name of the individual or entity applying for enrollment. This name should be the same as the individual or entity uses in reporting to the IRS.

**Management Service Organization:** An organization contracted by the provider/supplier to furnish some or all administrative, clerical and claims processing functions of the applicant's practice.

**Medicaid Number:** This number uniquely identifies the applicant as a Medicaid provider/supplier in a given State. Please identify the State for which the number was issued.

**Medicare Identification Number (MID):** This number uniquely identifies the applicant as a Medicare provider/supplier and is the number used on claim forms. The Medicare Identification Number is also known as Medicare Provider Number and Provider Identification Number (PIN). Examples of Medicare Identification Numbers are the UPIN, OSCAR number, NSC number, etc.

If the applicant is enrolling in the Medicare program for the first time, the applicant will receive a Medicare Identification Number upon enrollment.

**National Provider Identifier (NPI):** This number is assigned using the National Provider System to identify health care providers/suppliers. It will replace the MIN.

**National Supplier Clearinghouse Number (NSC):** This number uniquely identifies the applicant as a supplier of durable medical equipment, prosthetics, orthotics and supplies. It is the number used by DMEPOS suppliers on claim forms.

**On-Line Survey Certification and Reporting System (OSCAR):** National database used for maintaining and retrieving survey and certification data for certified providers/suppliers that are approved to participate in the Medicare, Medicaid and CLIA programs. OSCAR numbers are assigned by the Regional Medicare office.

**Definitions (continued)**

**Provider Based Organization:** Entities operating under the control of a parent organization (e.g., hospital based End Stage Renal Disease Unit, Skilled Nursing Facility)

**Unique Physician Identification Number (UPIN):** Number assigned to physicians, non-physician practitioners and groups to identify the referring or ordering physician on Medicare claims.

**Organizations** complete sections 1b, 1d, 2, 3, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18 and 19. **Ambulance Service Suppliers** must also complete Attachment 1, and **Independent Physiological Laboratories** must also complete Attachment 2.

**Note:** **Partnerships** see group instruction.

**Group:** Two or more physicians or non-physician practitioners who go into practice together (as authorized by State law) and function bill Medicare as a single unit. This excludes contracted physicians, non-physician practitioners and other contracted health care providers/suppliers. A group has individual members. The individual members must have already been enumerated/enrolled in the Medicare program in order to enroll as a member of the group.

**Groups/ Partnerships** complete sections 1c, 1d, 2, 3, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18 and 19. **Each group member/partner must complete HCFA Form 855G.**

**Note:** **PARTNERSHIPS:** For purposes of this application, **partnerships** should indicate that they will be enrolling as a group.

**Note:** **RURAL HEALTH CLINICS:** Rural Health Clinics that meet the definition of a group, should also submit HCFA Form 855G (Individual Group Member Application) for each member of the group. This is not applicable to all Rural Health Clinics that are organizations or are provider based.

**Mass Immunization Biller Only:** A health care provider/supplier who roster bills Medicare solely for mass immunizations.

**Mass Immunization/Roster Billers** complete sections 1a, 1b, 1d, 2, 3, 6, 7, 8, 9, 10, 13, 14, 15, 16, 17, 18 and 19.

**Note:** Applicants enrolling in the Medicare program as mass immunization/roster billers cannot bill Medicare for any other services. The applicant agrees to accept assignment of the influenza/pneumococcus benefit as payment in full and cannot "balance bill" the beneficiary.

For those who are only applying to enroll in the Medicare program to roster bill for mass immunization enter "Roster" under primary specialty in Section 1A or enter "Roster" under type of facility in Section 1B.

**APPLICATION COMPLETION INSTRUCTIONS**

Furnish all requested information in its entirety. If a field is not applicable, write N/A in the field. If entire section is not applicable, check the box at the beginning of the section indicating the entire section is not applicable. Any section of the application that does not have a check box at the beginning of the section indicating the entire section is not applicable **must** be completed by applicant.

**Check Type of Business:** (For administrative purposes only)

Check appropriate box indicating how applicant's business is structured. The answer to this item will not affect the amount of Medicare reimbursement or enrollment status.

**Note:** If applicant's business structure is a **partnership**, applicant must provide a copy of its partnership agreement signed by all parties and identifying the general partner (if any) and attest that the partnership meets all State requirements.

**Check "Applicant Enrolling As" Type:** (For administrative purposes only) The answer to this item will not affect the amount of Medicare reimbursement or enrollment status.

See the instructions below which identify the sections the applicant is responsible for completing.

**Individual:** An individual physician or non-physician practitioner (e.g., physician, nurse practitioner, midwife, etc.)

**Individual Practitioners** complete sections 1a, 1d, 2, 3, 4, 5, 6, 7, 8, 9, 10, 13, 14, 15, 16, 17, 18 and 19.

**Sole Proprietor:** An individual registered as a business and issued a tax identification number from the IRS and operating under the business name.

**Sole Proprietors** complete sections 1a, 1b, 1d, 2, 3, 4, 5, 6, 7, 8, 9, 10, 13, 14, 15, 16, 17, 18 and 19.

**Organization:** A company, not-for-profit entity, governmental agency (Federal, State, or Local) or health care delivery system which renders medical care (e.g., pharmacy, equipment manufacturer, hospital, Public Health Clinic, laboratory, skilled nursing facility, Ambulance Service Suppliers, Independent Physiological Laboratories, etc.) An organization has employees and qualifies as a health care delivery system.

**All applicants must sign and date the certification statement (Section 19).**

**Check Application For:**

**Initial Enrollment:** Applicant is enrolling in the Medicare program for the first time, or re-activating a prior Medicare billing number.

**Enrollment of Additional Location(s):** Currently enrolled provider/supplier is applying to enumerate a new practice location.

**Re-certification:** Currently enrolled provider/supplier is completing application to comply with mandatory periodic re-survey and/or re-certification through the State agency or Regional Medicare Office.

**Change of Ownership:** Currently enrolled entity is completing application to report new ownership and notify the Medicare contractor of the deletion of the current (prior) owners. The application must be completed with information applicable to the new owner(s). The new application should be submitted to the Medicare contractor where the entity is currently enrolled.

**Change of Information:** Currently enrolled provider/supplier is completing applicable sections of the application to report a change in information other than ownership changes. Currently enrolled provider/suppliers can use HCFA Form 855C (Change of Information) to report changes in name, specialty, e-mail address, practice location address, billing agency address, pay to address, mailing address, pricing locality, telephone number(s), fax number(s), and deactivation of Medicare billing number(s).

When using this form to notify the Medicare program that a practice location(s), owner(s), or various personnel are no longer associated with this entity, please check the appropriate deletion box in the applicable section(s).

All changes must be reported in writing and have an original signature. For individuals, the provider/supplier must sign and for organizations and group practices, an "Authorized Representative" must sign to confirm the requested change. Faxed or photocopied signatures will not be accepted.

**Check Where Applicant Will Be Submitting Bills:**

**Fiscal Intermediary:** Applicant will be enrolled to bill the fiscal intermediary only. The fiscal intermediary is also known as the Part A Medicare Contractor. The applicant will generally be a hospital or other facility.

**Carrier:** Applicant will be enrolled to bill the carrier only. The carrier is also known as the Part B Medicare Contractor. The applicant will generally be a physician, non-physician practitioner, or DMEPOS supplier.

**Both:** Applicant's application will automatically be forwarded to bill both the fiscal intermediary and the carrier for enrollment consideration.

**Regional Home Health Intermediary:** Applicant will be enrolled to bill the regional home health intermediary.

**1. Applicant Identification****A. Individuals Only**

Complete all items in this section if applicant plans to bill Medicare as an individual physician or non-physician practitioner (e.g., nurse). All physicians and non-physician practitioners who are members of a group must apply as individuals for Medicare enrollment.

Complete applicant's full name, date and place of birth (county and /or city). If applicant has previously practiced or operated a business under another name, including applicant's maiden name, supply that name under Other Name.

Gender and Race/Ethnicity information is optional. This information will be only used to further identify the applicant as a unique individual.

If applicant is a resident or intern at a hospital, check appropriate box.

If applicant is enrolling as an individual or sole proprietor, furnish the applicant's primary specialty (e.g., cardiologist, pathologist, nurse practitioner, etc.). Designation of a secondary specialty is optional.

If applicant is employed by an entity that will receive payments for the applicant's services, applicant must sign a Reassignment of Benefits Statement (Section 18).

**B. Organizations Only**

Complete this section if applicant is a sole proprietor of the business or if applicant is a publicly or privately held business entity.

Complete all items in this section. For Legal Business Name, supply the name that the business, organization or group practice uses to report to the IRS. For Type of Facility give the classification that designates the entity (e.g., hospital, skilled nursing facility, home health agency, ambulance company, etc.), and check whether this facility is accredited or non-accredited.

**Note:** Clinical laboratories and independent physiological laboratories should annotate this section "LABORATORY" (LAB).

Check whether applicant is a Distinct Part Unit, a Provider Based Facility, Branch, or an entity that files a Consolidated Cost Report under another facility's number. If yes, provide name and Medicare identification number of the parent provider and complete section 7 for each distinct part unit, provider based facility, branch, or entity that files a consolidated cost report under another facility's number. The final determination as to whether an entity is provider based or independent (free standing) will be made by HCFA prior to completion of the enrollment process.

If applicant receives payment for any services rendered by a practitioner who is an employee or when permitted by Medicare requirements a contractor, the practitioner must sign the Reassignment of Benefits statement (Section 18).

**C. Physician and Non-Physician Practitioner Groups Only**

Complete all items in this section. Furnish the group's legal business name. This should be the official name used in reporting to the IRS. Furnish the group's primary specialty (the primary specialty of the majority of the group's members). Designation of a secondary specialty is optional. All group members who may bill for Medicare services must be individually enrolled in Medicare. Each group member must also complete the HCFA Form 855G (Individual Group Member Enrollment Application).

Each group member must sign the Reassignment of Benefits statement found in HCFA Form 855G (Individual Group Member Enrollment Application).

**Note: PARTNERSHIPS:** When completing this section, provide legal business name of partnership, date partnership was incorporated, and the State where the partnership is incorporated. Place "Y's" in the specialty block.

**D. All Applicants**

Furnish all names under which applicant conducts business at this location (doing business as name).

Complete applicant's mailing address. (This is where the applicant can receive correspondence from HCFA and Medicare bulletins from the Medicare contractors. This address may be the applicant's home address or a Post Office Box.) Applicant must supply fax number and e-mail address if available. If applicable, complete applicant's previously assigned Medicare Identification Number(s) and the name(s) of the Carrier and/or Fiscal Intermediary to which applicant most recently submitted bills using this number. If applicable, complete applicant's most recent Medicaid number and the State in which it was issued. Applicant must provide, when applicable, either their Social Security Number (SSN) and/or their Employer Identification Number(s) (EIN(s)).

**Note:** All applicants must provide either their Social Security Numbers (SSNs) or their Employer Identification Numbers (EINs). If applicant has more than one EIN, list all EINs for identification purposes, starting with the EIN to be used for Medicare tax reporting to the Internal Revenue Service.

**2. Pay To Address**

Supply all requested information. This address may be a Post Office Box.

Payments will be made in the legal business name that the individual, organization, or group/partnership uses to report to the IRS, as reported in Section 1a. (individual), 1b. (organization), or 1c. (group) of this application.

In most circumstances, payment will be made in the name of the individual who furnished the service unless a valid reassignment has been completed.

**3. Professional and Business License, Certification, and Registration Information**

All applicants are required to furnish information on all Federal, State and Local (city/county) professional and business licenses, certifications and/or registrations required to practice as applicant's provider/supplier type in applicant's State (e.g. State medical license for physician, State certification and/or registration for Nurses, Federal DEA number, Business Occupancy License, local business license, etc.). The local Medicare contractor will supply specific credentialing requirements for applicant's provider/supplier type upon request.

Notarized or "certified true" copies of the above information are optional, but may speed the processing of this application.

**Notarized:** A notarized copy of an original document that will have a stamp which states "Official Seal" along with the name of the notary public, State, County, and the date the notary's commission expires.

**Certified True:** This is a copy of the original document obtained from where it originated (or is stored), and it has a raised seal which identifies the State and County in which it originated or is stored.

In lieu of notarized or "certified true" copies of the above requested documents, the applicant may submit a Certificate of Good Standing from the applicant's State licensing/certification board or other medical associations. This certificate cannot be more than 30 days old.

Non-physician practitioners who must meet HCFA requirements for professional experience should submit evidence of practice and the dates of employment.

If applicant's enrollment requires a State survey and certification, the applicant is required to forward copies of State survey and certification documents to the Medicare contractor once they are received from the State agency or Regional Medicare Office.

**Note:** Temporary licenses are acceptable submissions with this application. However, once received, a copy of the applicant's permanent license must be forwarded to the Medicare contractor.

**Note:** A business license is required for each practice location.

**4. Professional School Information**

If applicable, supply information about the educational institution from which applicant received medical, professional, or related degree or training as required by applicant's State. Enclose copies of diploma, degree or evidence of qualifying course work.

Non-physician practitioners who must meet HCFA requirements for education must provide documentation of courses or degree taken that fulfill Medicare requirements. See attached list or contact the local Medicare representative for instructions or requirements for applicant's provider/supplier type.

**5. Board Certification**

If applicant is board certified, supply information requested.

**6. Exclusion/Sanction Information**

Supply all requested information, and, if applicable, attach a clear copy of the applicant's reinstatement letter(s).

**7. Practice Location(s)**

Complete all information requested for each location where applicant will render services to Medicare beneficiaries.

Individual practitioners should include all hospitals or other health care facilities where they render service or have privileges to treat their patients. Hospitals must list all off-site clinics, distinct part units, and provider based facilities (e.g., skilled nursing facility, rural health clinic, etc.) and multi-campus sites. Home health agencies and hospices must list all branches.

Note: Listing the facilities controlled by a hospital or other entity does not automatically enroll them in the Medicare program. These facilities must also complete HCFA Form 855 (General Application).

Post office boxes and drop boxes are not acceptable as a practice location address. The phone number must be a number where patients and/or customers can reach the applicant to ask questions or register complaints. Furnish name of highest ranking managing/directing employee for this location. If applicable, provide the CLIA number or FDA certification number associated with each piece of equipment at each practice location and submit a copy of the most current certification.

Indicate whether patient records are kept on the premises. If records are not kept at the practice location, supply the name of the storage facility/location and the physical address where the records are maintained. Post Office Boxes and drop boxes are not acceptable as the physical address where patient records are maintained.

**8. Prior Practice Information**

If applicant has previously billed Medicare or Medicaid, supply requested information. Indicate whether applicant has any outstanding overpayments with the Medicare program. If applicant has not previously billed the Medicare or Medicaid programs, continue to Section 9.

**9. Managing/Directing Employees**

Note: This section is not to be completed with information referring to billing agency/management service organization employees (see section 15).

Complete this section for all applicant's managing/directing employees, including, but not limited to, general manager(s), business manager(s), administrator(s), or director(s), or other individuals who exercise operational or managerial control over the provider/supplier, or who directly or indirectly conduct the day-to-day operations of the applicant.

**Managing/Directing Employees (continued)**

Note: For large entities, only furnish the top 20 compensated managing/directing personnel.

All organizations should list the corporate officers along with the managing/directing employees for each practice location or provider/supplier unit.

Supply all requested information about the managing/directing employee's past and present billing relationships with Medicare.

Supply all requested sanction information, and, if applicable, attach a clear copy of the managing/directing employee's reinstatement letter(s).

**10. Ownership Information**

Complete this section for all individuals and/or entities who have an ownership or control interest in the applicant's business/entity. If owner is an individual, complete owner name, social security number and employer identification number. If applicant is owned by another entity, complete legal business name and employer identification number. Entities with ownership interest must provide their legal business name(s).

A person or entity with an ownership or control interest is one that

- has an ownership interest totaling 5 percent or more in the provider/supplier;
- has a direct, indirect, or combination of direct and indirect ownership interest equal to 5 percent or more in the provider/supplier, where the amount of an indirect ownership interest is determined by multiplying the percentages of ownership in each entity (for example, if A owns 10 percent of the stock in a corporation that owns 80 percent of the provider/supplier, A's interest equates to an 8 percent indirect ownership interest in the provider/supplier and must be reported);
- owns an interest of 5 percent or more in any mortgage, deed of trust, note or other obligation secured by the provider/supplier if that interest equals at least 5 percent of the value of the property or assets of the provider/supplier;
- is an officer or director of a provider/supplier that is organized as a corporation; and/or
- is a partner in a provider/supplier that is organized as a partnership.

Supply all requested information about the owner's past and present billing relationships with Medicare.

Supply all requested sanction information, and, if applicable, attach a clear copy of the owner's reinstatement letter(s).

Attach copy the entity's IRS form W-9 pertaining to this provider/supplier/business/entity. The IRS form W-9 will be used to verify the employer identification number. In lieu of the IRS form W-9, the applicant may use any official correspondence from the IRS showing the name of the entity as shown on this application and the tax identification number.

**11. Parent/Joint Venture or Subsidiary Information**

If applicant is a subsidiary (wholly or partially owned by another organization or business), or a joint venture (equally owned by another organization(s) or business(s)), complete all information requested in this section about the parent company or joint venture. Attach a copy of parent company's or other owner's IRS W-9 form pertaining to this provider/supplier/business/entity.

**12. Chain Organization Information**

This section to be completed by Part A Institutional provider/suppliers ONLY.

If applicant is a chain organization, check appropriate action block for this chain, then supply all information requested about the chain home office.

Note: This section applies to all institutional chain provider/suppliers, (e.g., Independent Physiological Laboratories, Portable X-Ray suppliers, Home Health Agencies, Ambulance companies, etc.) whether they bill a carrier or fiscal intermediary.

**13. Contractor Information (Physician and Non-Physician Individuals)**

Note: Section 13 refers to contracting with a physician or non-physician individual.

If applicant currently contracts with a physician(s) and/or a non-physician individual(s), complete all information about each contractor with whom the applicant does business.

Supply all requested sanction information about the contractor(s), and, if applicable, attach a clear copy of the contractor's reinstatement letter(s).

**14. Contractor Information (Business Organization(s))**

Note: Section 14 refers to contracting with a business organization.

If applicant currently contracts with a business organization, complete all information about each contractor with whom the applicant does business.

Supply all requested sanction information about the contractor(s), and, if applicable, attach a clear copy of the contractor's reinstatement letter(s).

**15. Billing Agency/Management Service Organization Address**

If the applicant currently uses or will be using a billing agency/management service organization to submit bills, complete all requested information and attach a current copy of the signed contract between the applicant and the billing agency or management service organization.

**Billing Agency/Management Service Organization Address (continued)**

Note: If applicant has a relationship with a billing agency/management service organization but no written agreement/contract exists between applicant and billing agency/management service organization, an agreement/contract must be written and furnished with this application.

Complete all requested information.

Medicare will only pay a health care provider/supplier benefit in the provider/supplier name or the entity's legal business name to a billing agency or management service organization if:

- the agent receives the payment under an agency agreement with the provider/supplier;
- the agent's compensation is not related in any way to the actual dollar amounts billed or collected;
- the agent's compensation is not dependent upon the actual collection of payment;
- the agent acts under instructions which the provider/supplier may modify or revoke at any time; and
- the agent, in receiving the payment, acts only on the provider's/supplier's behalf.

Limited Exception: An acceptable mailing/billing arrangement could exist, e.g., where, for bookkeeping purposes, the applicant has his/her checks mailed to a billing agent/management service organization who is ineligible to receive the payments, and both the agent/organization and the applicant state in writing that the agent/organization will forward the checks to the applicant's bank for deposit into his/her business account on the condition that the check is deposited in the applicant's bank account and funds from this account can only be drawn in the name of the applicant and the applicant certifies that he/she will continue this payment arrangement in effect only so long as the applicant has sole control of the account and the bank is subject only to the applicant's instructions regarding the account. If applicant is unsure his/her billing agent/management service organization qualifies for this exception, contact the local Medicare contractor for further clarification.

Note: Any change in the contract/agreement between the applicant and the billing agency/management service corporation must be reported to the Medicare contractor within 30 calendar days of said change.

Note: See instructions in Section 18 (Reassignment of Benefits Statement) for further information concerning Federal requirements for reassignment of benefits.

**16. Electronic Claims Submission Information**

If applicant plans to submit bills electronically, or would like information about electronic billing, supply a contact name and phone number. The Medicare contractor will be in contact with further instructions about qualifying for electronic billing submissions.

**17. Contact Person**

Provide the full name and telephone number of an individual who can be reached to answer questions regarding the information furnished in this application.

**18. Reassignment of Benefits Statement**

In general, Medicare only makes payment to the beneficiary or the individual or entity that directly provides the service. Any applicant who allows another entity to receive payment for the applicant's services must sign the Reassignment of Benefits Statement. Failure to do so will cause a delay in processing the application and limit the Health Care Financing Administration's ability to make payment. There are, however, a few specific exceptions (see note).

**Note:** The applicant is permitted by Federal law to reassign Medicare benefits to an employer, the facility in which the applicant provides services, or to a health care delivery system. The applicant may reassign benefits to an agent, but only if it meets the requirements found in 42 CFR 424.73 (see section 15 (Billing Agency/Management Service Organization)). For further information on Federal requirements on reassignment of benefits the applicant should contact his/her Medicare contractor before signing the application.

If enrolling as a group member, see HCFA form 855G for completion of the reassignment of benefits statement. Do not complete this section. Use Section 4 of the HCFA 855G (Individual Group Member Application).

**19. Certification Statement**

This statement includes the minimum standards to which applicant must adhere to be enrolled and to participate in the Medicare program as a provider/supplier. Read these statements carefully.

By signing the certification statement, applicant agrees to all the conditions listed in the certification statement and may be disenrolled from the program if any conditions are violated. The certification statement must contain an original signature. Faxed or photocopied signatures will not be accepted.

**Note:** If applicant is applying as an individual, applicant must sign and date the statement. If applicant is applying as an organization or as a group practice, an authorized representative of the organization/group practice (Officer, CEO, or general partner) must sign the application. If applicant has more than one authorized representative, furnish names and signatures of those authorized representatives who will be directly involved with the Medicare contractor.

**Attachment 1 Ambulance Service Suppliers**

Complete all information requested and supply copy(s) of all applicable licenses.

**Note:** If applicant is currently State licensed and certified to operate as an ambulance service supplier, attach copies of all State documents and skip sections 1 and 2 when completing this attachment.

A copy of applicant's current license or certificate must be attached to this form. The effective date and expiration date must be stated on the license or certificate. Claims will be paid based on these dates. Applicant must provide this office with a copy of the renewal license in order to receive payment after the renewal date.

**1. Description of Vehicle(s)**

Applicant must identify the type (automobile, aircraft, boat, etc.) of each vehicle(s), and furnish year, make, model, and vehicle identification number.

Applicant's vehicle(s) must be specially designed and equipped for transporting the sick or injured. It must have customary patient care equipment including, but not limited to, a stretcher, clean linens, first aid supplies, oxygen equipment, and it must also have such other safety and lifesaving equipment as required by State and local authorities. If the ambulance will supply Advanced Life Support (ALS) services, list all the necessary equipment and provide written documentation of certification from the authorized licensing and regulation agency for applicant's area of operation.

Vehicles must be regularly inspected and recertified according to applicable State and local licensure laws. Evidence of recertification must be submitted to the Medicare contractor on an ongoing basis.

**Note: Air Ambulance**

To qualify for air ambulance, the following is required:

- a written statement signed by the President, Chief Executive Officer, or Chief Operating Officer that gives the name and address of the facility where the aircraft is hangared; and
- proof that the air ambulance provider/supplier or its leasing company possesses a valid charter flight license (FAA 135 Certificate) for the aircraft being used as an air ambulance. If the air medical transportation company owns the aircraft, the owner's name on the FAA 135 Certificate must be the same as the provider/supplier's name on this enrollment application. If the air medical transportation company leases the aircraft, a copy of the lease agreement must accompany this enrollment application. The name of the company leasing the aircraft must be the same as the provider/supplier's name on this enrollment application.

**2. Qualification of Crew**

The ambulance crew must consist of at least two members. Those crew members charged with the care or handling of the patient must include one individual with adequate first aid training, i.e., training at least equivalent to that provided by the standard and advanced Red Cross first aid courses. If the ambulance crew will provide ALS services, they must list their ALS training courses.

Training "equivalent" to the standard and advanced Red Cross first aid courses include ambulance service training and experience acquired in military service, successful completion by the individual of a comparable first aid course furnished by or under the sponsorship of State or local authorities, an educational institution, a fire department, a hospital, a professional organization, or other such qualified organization.

Applicant must enclose a certificate(s) showing that crew members have successfully completed the required first aid training, or give a description of the equivalent military training and where and when it was received. Crew must continue to pursue and complete continuing education requirements in accordance with State and local licensure laws. Evidence of recertification must be submitted to the Medicare contractor on an ongoing basis.

**3. Billing Method**

Answer all applicable questions regarding billing methods. Supply the name of the Medical Director and the geographic area the applicant services.

**Note: Paramedic Intercept Services:**

- A basic life support (BLS) ambulance supplier may arrange with a paramedic/EMT organization or another advanced life support (ALS) ambulance supplier to provide the advanced life support services while it provides for the transportation component. The BLS would bill for the advanced life support services and make arrangement to pay the organization providing the advanced life support services. As an alternative, the BLS could arrange for the organization providing the advanced life support to be its billing agent.
- If this arrangement exists, applicant must complete section 15 (Billing Agency/Management Service Organization) and submit a copy of the signed contract.

Check appropriate box indicating if applicant bills for nautical miles or statute miles.

**4. Exclusion/Sanction Information**

If applicable, supply all requested information for the company or any owner or employee of the company and attach a clear copy of the reinstatement form(s)

**Attachment 2      Independent Physiological  
Laboratories (IPLs)****1. Identification of Supervising/Directing Physician(s)**

The information in this section is required only if applicant's State requires that a supervising physician be associated with every IPL. Supervising physicians must perform their duties as described by State requirements. Each supervising/directing physician is required to be enrolled as a Medicare provider/supplier (complete HCFA Form 855 (General Application)).

**2. Service Performance**

List all CPT-4 and HCPCS codes this IPL or its contractors intend to perform, supervise, interpret, or bill. Describe the setting where the service will be rendered, and identify each physician who will be performing, supervising, and/or interpreting the test results.

**3. Description of Service Site**

Complete all required information. If operating mobile units, the vehicles must be regularly inspected and recertified according to State and local licensure laws. Evidence of recertification must be submitted to the Medicare contractor on an ongoing basis. Enclose copies of all vehicle registration(s). In addition, complete all information concerning applicant's business/practice location.

**4. Referral Records**

Explain how referral records, physician's written order and the name of the technician who rendered the service are maintained.

**5. Signature of Supervising/Directing Physician(s)**

Each supervising/directing physician identified in Section 1 of this attachment must complete and sign this section.

**MEDICARE HEALTH CARE PROVIDER/SUPPLIER ENROLLMENT APPLICATION**  
**General Application**

PLEASE CHECK APPLICABLE BOX (for administrative purposes only)  
 Type of Business:  Individual  Corporation  Partnership  Other (specify) \_\_\_\_\_

PLEASE CHECK APPLICABLE BOX (for administrative purposes only)  
 Applicant Enrolling As:  Individual  Sole Proprietor  Organization  Group  Mass Immunization Biller Only

PLEASE CHECK APPLICABLE BOX  
 Application For:  Initial Enrollment  Re-certification  Change of Ownership  
 Enrollment of Additional Location(s)  Change of Information

Where will applicant be submitting billings?  Fiscal Intermediary  Carrier  Both (OR)  Regional Home Health Intermediary

**1. Applicant Identification**

**A. Individuals ONLY**  
 Check here  only if this entire section does not apply to the applicant.

Name: First Middle Last Jr., Sr., MD., etc.

Other Name: First Middle Last Jr., Sr., MD., etc.

Residency Status (if applicable)  resident  intern

Name of Facility Where Resident or Intern: \_\_\_\_\_

Are services rendered in the above setting part of the applicant's requirements for graduation from a formal residency program?  YES  NO

Primary Specialty (e.g. pathology, cardiology, nurse practitioner, etc.) (required) Secondary Specialty (if applicable)

Gender (optional)  male  female

Race/Ethnicity (optional)  Asian or Asian American or Pacific Islander  Hispanic or African-American  Black (not Hispanic) or Alaska Native  North American Indian or Alaska Native  White (not Hispanic)

Date of Birth (MM/DD/YYYY) County of Birth State of Birth Country of Birth

**B. Organizations ONLY**  
 Check here  only if this entire section does not apply to the applicant.

Legal Business Name Fiscal Year End Date (MM/DD) Incorporation Date (if applicable) (MM/DD/YYYY)

Type of Facility (e.g., hospital, nursing home, clinical laboratory, roster biller, etc.)  Accredited  Non-Accredited

State Where Incorporated: Date Business Established at This Location (MM/DD/YYYY) All other states in which applicant does business:

Is this a provider based facility?  Yes  No Is this a distinct part unit?  Yes  No

Does this entity file a consolidated cost report under another Medicare provider/supplier's number?  Yes  No

IF YES to any of the above three questions, furnish name of parent provider. Parent Medicare Provider Number

Does applicant operate other units, off-site clinics, or have multi-campus sites or branches?  Yes  No

If Yes, how many of each? \_\_\_\_\_ other units \_\_\_\_\_ off-site clinics \_\_\_\_\_ multi-campus sites \_\_\_\_\_ branches

Complete Section 7 for each unit, clinic, site, and/or branch operated.

**C. Physician and Non-Physician Practitioner Groups ONLY (For each group member, complete form HCFA 855G.)**  
 Check here  only if this entire section does not apply to the applicant.

Legal Business Name Incorporation Date (if applicable) (MM/DD/YYYY) State Where Incorporated

Group's Primary Specialty (required) Group's Secondary Specialty (if applicable)

**D. All Applicants**

Under what name does applicant conduct business at this location?

(\*Doing Business As\* Name)

Mailing Address Line 1

Mailing Address Line 2

City	County	State	ZIP Code + 4
Telephone Number ( )	Fax Number ( )	E-mail Address	
Employer Identification Number (if applicable)	Social Security Number (if applicable)	Medicare Identification Number(s) (if applicable)	

Does applicant now have or has applicant ever had a Medicare or Medicaid provider number in this or any other state?

Yes  No IF YES, supply all current and prior information requested below.

Current Carrier Name (if applicable)	Current Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)
Current CLIA Number (if applicable)	Prior CLIA Number (if applicable)	

**2. "Pay To" Address**

Mailing Address Line 1

Mailing Address Line 2

City	State	ZIP Code + 4
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**3. Professional and Business License/Certification/Registration Information**

Attach a copy of each required Federal, State, and/or local city/county business and/or professional license, certification or registration. Notarized or "certified true" copies are optional but may speed the processing of this application.

Has applicant ever had any Federal, State, and/or local city/county business and/or professional business license, certification or registration revoked or suspended?  Yes  No IF YES, explain below and attach copy of reinstatement letter

**4. Professional School Information**

Check here  only if this entire section does not apply to the applicant.

Attach a copy of each degree or certificate. Notarized or "certified true" copies are optional but may speed processing of application.

School Name	Graduation Year (YYYY)
City	State
	Country

**5. Board Certification**

Check here  only if this entire section does not apply to the applicant.

If applicant is Board Certified in his/her primary specialty complete the following information.

Certification Board Name	Certification Number	Effective Date (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)
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**6. Exclusion/Sanction Information**

**A. Has the applicant ever been sanctioned from the Medicare/Medicaid program, or debarred, suspended, or excluded from any other Federal agency or program?**  Yes  No **IF YES, supply the following information.**

Date(s) of Sanction, Debarment, etc. (MM/DD/YYYY)	Date(s) of Reinstatement (Attach copy(ies) of the Reinstatement letter(s)) (MM/DD/YYYY)
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**B. Have civil monetary penalties ever been levied against the applicant by the Medicare or Medicaid program or any Federal agency or program?**  Yes  No

IF YES, has penalty been paid? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date(s) of Penalty (MM/DD/YYYY)
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**7. Practice Location(s)**

Check here  if deleting this practice location.

**A. How many practice locations does applicant utilize?** \_\_\_\_\_ **For each location, copy this page and complete section 7.**

**B. "Doing Business As" name for this location** \_\_\_\_\_ Medicare Identification Number for this location (if applicable) \_\_\_\_\_

Business Street Address Line 1 \_\_\_\_\_

Business Street Address Line 2 \_\_\_\_\_

City	County	State	ZIP Code + 4
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Telephone Number ( )	Fax Number ( )	E-mail Address
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Is this location an  off site clinic?  distinct part unit?  multi-campus site?  branch  or none of these?

Date applicant began practicing at this location? (MM/DD/YYYY)	If applicable, date applicant ceased practicing at this location? (MM/DD/YYYY)
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**C. "Pay To" address for this practice location. If same as practice location in section 7 B., check here  and skip to section 7 D.**

Check here  if applicant wants all payments sent to address furnished in Section 2 "Pay To" address.

Mailing Address Line 1 \_\_\_\_\_

Mailing Address Line 2 \_\_\_\_\_

City	State	ZIP Code + 4
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D. Name of managing/directing employee for this location?	First	Middle	Last	Jr., Sr., MD., etc.
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E. CLIA Number for this location (if applicable)	FDA Mammography Certification Number(s) at this location (if applicable)
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**F. Are all patient records stored at this practice location?**  Yes  No **IF NO, supply storage location below**

Name of Storage Facility/Location \_\_\_\_\_

Street Address Line 1 \_\_\_\_\_

Street Address Line 2 \_\_\_\_\_

City	County	State	ZIP Code + 4
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Telephone Number ( )	Fax Number ( )	E-mail Address
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**8. Prior Practice Information**

Check here  only if this entire section does not apply to the applicant.  
 If applicant has previously billed the Medicare or Medicaid programs furnish requested prior practice information below.  
 For each prior practice, copy and complete Section 8.

Type of Practice	Status <input type="checkbox"/> Inactive IF INACTIVE, supply date of termination (MM/DD/YYYY) <input type="checkbox"/> Active
Legal Business Name	Doing Business As Name
Medicare Identification Number(s)	Medicaid Number/State
Telephone Number ( )	
Business Street Address Line 1	
Business Street Address Line 2	
City	County
State	ZIP Code + 4

Was applicant a  participating or  non-participating provider/supplier in this prior practice?  
 Does the applicant have any outstanding overpayments with Medicare?  Yes  No

**9. Managing/Directing Employees**

Check here  if deleting this Managing/directing employees' association with this entity.  
 Effective date of deletion? (MM/DD/YYYY)  
 How many managing/directing employees does applicant employ at this location? (maximum of 20)  
 For each managing/directing employee, copy this page and complete Section 9.

**A. Identifying Information**

Name: First	Middle	Last	Jr., Sr., MD, etc.	Title/Position
Social Security Number	Employer Identification Number (if applicable)	Medicare Identification Number (if applicable)		
Date of Birth (MM/DD/YYYY)	County of Birth	State of Birth	Country of Birth	

**B. Does this Managing/Directing employee now have or ever had a Medicare or Medicaid provider number in this or any other state?**  Yes  No IF YES, supply all current and prior information requested below.

Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)

**C. Has this managing/directing employee ever managed/directed or had ownership interest in other organizations that have bill or are billing Medicare for services?**  Yes  No IF YES, how many? Complete below for each organization.

Legal Business Name	Medicare Identification Number	Employer Identification Number
Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if appli
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applica

**D. Has this managing/directing employee ever been sanctioned from the Medicare/Medicaid program or debarred, suspended, excluded from any other Federal agency or program?**  Yes  No IF YES, supply the following information.

Date(s) of Sanction, Debarment, etc. (MM/DD/YYYY)	Date(s) of Reinstatement (Attach copy(ies) of the Reinstatement letter(s)) (MM/DD/YYYY)
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**E. Have civil monetary penalties ever been levied against this managing/directing employee by the Medicare/Medicaid program or any Federal agency or program?**  Yes  No  
 IF YES, has penalty been paid?  Yes  No

Date(s) of Penalty (MM/DD/YYYY)

**10. Ownership Information**

Check here  if deleting this owners' association with this entity.  
 Effective date of deletion? \_\_\_\_\_ (MM/DD/YYYY)

How many owners have 5 percent or more ownership interest in this entity? \_\_\_\_\_ (maximum of 20)

For each owner, copy this page and complete Section 10.

Check here  if applicant listed in Section 1A is the sole owner AND attach IRS form W-9, and skip this section

**Applicants must submit a copy of the entity's IRS form W-9.**

**A. Identifying Information**

Owner Name: First	Middle	Last	Jr., Sr., MD, etc.
Other Name: First	Middle	Last	Jr., Sr., MD, etc.

Legal Business Name \_\_\_\_\_

"Doing Business As" Name \_\_\_\_\_ Effective Date of Ownership (MM/DD/YYYY) \_\_\_\_\_

Date of Birth (MM/DD/YYYY)	County of Birth	State of Birth	Country of Birth
Social Security Number	Employer Identification Number	Medicare Identification Number (if applicable)	

**B. Does this owner now have or has owner ever had a Medicare or Medicaid provider number in this or any other state?**  
 Yes  No **IF YES, supply all current and prior information requested below.**

Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)

**C. Has this owner ever managed, directed, or had ownership in other organizations that have billed or are billing Medicare for services?**  Yes  No **IF YES, How many? \_\_\_\_\_ and complete the following for each organization:**

Organization's Legal Business Name \_\_\_\_\_

Employer Identification Number	Medicare Identification Number	
Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)

**D. Has this owner ever been sanctioned from the Medicare/Medicaid program or debarred, suspended, or excluded from any other Federal agency or program?**  Yes  No **IF YES, supply the following information.**

Date(s) of Sanction, Debarment, etc. (MM/DD/YYYY)	Date(s) of Reinstatement (Attach a copy(s) of the Reinstatement letter(s)) (MM/DD/YYYY)
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**E. Have civil monetary penalties ever been levied against this owner by the Medicare or Medicaid program or any Federal agency or program?**  Yes  No **IF YES, has penalty been paid?**  Yes  No

Date(s) of Penalty (MM/DD/YYYY) \_\_\_\_\_

**11. Parent/Joint Venture or Subsidiary Information**

Check here  only if this entire section does not apply to the applicant.

If this entity is a subsidiary company or joint venture, check appropriate box below.

Subsidiary Company  Joint Venture

Is this a free standing site?  Yes  No

Attach a copy of parent company's or other owner's IRS form W-9 pertaining to this provider/business/entity.

**IF Subsidiary Company or Joint Venture, complete the information below about the PARENT company/JOINT venture.**

Legal Business Name

Doing Business As Name		Effective Date of Affiliation (MM/DD/YYYY)
Employer Identification Number		Medicare Identification Number
Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)
Business Street Address Line 1		
Business Street Address Line 2		
City	County	State
Telephone Number ( )		Fax Number ( )
E-mail Address		
ZIP Code + 4		

**12. Chain Organization Information**

This section to be completed by Part A institutional provider/suppliers ONLY.

Check here  only if this entire section does not apply to the applicant.

Does the applicant need to register a chain action? (see list below)  Yes  No

IF YES, check the appropriate action:

- Applicant in chain for first time
- Applicant in a different chain since last report
- Applicant dropped out of all chains
- Applicant in same chain under new chain name

**Complete the following information about the chain Home Office:**

Name of Home Office		Effective Date of Linkage (MM/DD/YYYY)
Name of Home Office Administrator or CEO:	First Middle Last	Jr., Sr., MD, etc.
Home Office Business Street Address Line 1		Title of Home Office Administrator or CEO:
Business Street Address Line 2		
City	County	State
Telephone Number ( )		Fax Number ( )
E-mail Address		
Chain Number	Name of Home Office Intermediary/Carrier	
Applicant's Affiliation to Chain:	<input type="checkbox"/> Joint Venture/Partnership	<input type="checkbox"/> Managed/Related
	<input type="checkbox"/> Operated/Related	<input type="checkbox"/> Wholly Owned
		<input type="checkbox"/> Leased
		<input type="checkbox"/> Other
Fiscal Year End Date of this Chain (MM/DD)	Do all the providers/suppliers of the chain use the same Part A fiscal intermediary? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**13. Contractor Information (Physicians and Non-Physician Individuals)**

Check here  if deleting (no longer using) this contractor.  
 Check here  only if this entire section does not apply to the applicant.

How many physician and non-physician contractors does the applicant use? \_\_\_\_\_  
 For each physician and non-physician contractor, copy this page and complete Section 13.

**A. Does the applicant contract for any medical or diagnostic services with an individual physician or non-physician practitioner for which the cost or value is \$10,000 or more in a 12-month period?**  Yes  No

**IF YES, complete the information below for each physician and non-physician contractor with whom the applicant has a contract.**

Name: First		Middle	Last	Jr., Sr., MD., etc.
Doing Business As Name			Effective Date of Relationship/Reassignment (MM/DD/YYYY)	
Business Street Address Line 1				
Business Street Address Line 2				
City			State	ZIP Code + 4
Telephone Number ( )	Fax Number ( )		E-mail Address	
Social Security Number	Medicare Identification Number (if applicable)		Date of Birth (MM/DD/YYYY)	

**B. Does this contractor now have or has this contractor ever had a Medicare or Medicaid provider number in this or any other state?**  Yes  No **IF YES, supply all current and prior information requested below.**

Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)

**C. Has this contractor ever been sanctioned from the Medicare/Medicaid program or debarred, suspended, or excluded from any other Federal agency or program?**  Yes  No **IF YES, supply the following information.**

Date(s) of Sanction, Debarment, etc. (MM/DD/YYYY)	Date(s) of Reinstatement (Attach a copy(s) of contractor's Reinstatement letter(s)) (MM/DD/YYYY)
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**D. Have civil monetary penalties ever been levied against this contractor by the Medicare or Medicaid program or any Federal agency or program?**  Yes  No **IF YES, has penalty been paid?**  Yes  No

**14. Contractor Information (Business Organizations)**

Check here  if deleting (no longer using) this contractor.  
 Check here  only if this entire section does not apply to the applicant.

How many business organization contractors does the applicant use? \_\_\_\_\_  
 For each business organization contractor, copy this page and complete Section 14.

A. Does the applicant contract for any medical or diagnostic services with a business organization for which the cost or value is \$10,000 or more in a 12-month period?  Yes  No  
 IF YES, complete the information below for each business organization contractor with whom the applicant has a contract.

Legal Business Name		Effective Date of Relationship/Reassignment (MM/DD/YYYY)	
Doing Business As Name			
Business Street Address Line 1			
Business Street Address Line 2			
City		State	ZIP Code + 4
Telephone Number ( ) ( )	Fax Number ( ) ( )	E-mail Address	
Employer Identification Number		Medicare Identification Number (if applicable)	

B. Does this contractor now have or has this contractor ever had a Medicare or Medicaid provider number in this or any other state?  Yes  No IF YES, supply all current and prior information requested below.

Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)

C. Has this contractor ever been sanctioned from the Medicare/Medicaid program or debarred, suspended, or excluded from any other Federal agency or program?  Yes  No IF YES, supply the following information.

Date(s) of Sanction, Debarment, etc. (MM/DD/YYYY)	Date(s) of Reinstatement (Attach copy(s) of contractor's Reinstatement letter(s)) (MM/DD/YYYY)
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D. Have civil monetary penalties ever been levied against this contractor by the Medicare or Medicaid program or any Federal agency or program?  Yes  No  
 IF YES, has penalty been paid?  Yes  No

**15. Billing Agency/Management Service Organization Address**

Check here  if deleting (no longer using or changing) this billing agency/service management organization.  
 Check here  only if this entire section does not apply to the applicant.

Complete this section if applicant will be using a billing agency or management service organization.  
 Applicant MUST submit a copy of the applicant's current signed billing agreement/contract with this application.

Name of Billing Agency/Management Service Organization				Employer Identification Number
Agency/Organization Contact Person Name:	First	Middle	Last	Jr., Sr., MD., etc.
Business Street Address Line 1				
Business Street Address Line 2				
City		State	ZIP Code + 4	
Telephone Number ( ) ( )	Fax Number ( ) ( )	E-mail Address		

**16. Electronic Claims Submission Information**

Check here  only if this entire section does not apply to the applicant.

Furnish a contact person in this section if the applicant would like to submit claims electronically.

Contact Person Name:	First	Middle	Last	Jr., Sr., MD., etc.
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Mailing Address Line 1

Mailing Address Line 2

City	State	ZIP Code + 4
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Telephone Number ( )	Fax Number ( )	E-mail Address
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**17. Contact Person**

Furnish the name and telephone number of a person who can answer questions about the information furnished in this application.

Name:	First	Middle	Last	Jr., Sr., MD., etc.	Telephone Number ( )
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**18. Reassignment of Benefits Statement**

Check here  only if this entire section does not apply to the applicant.

Medicare law prohibits payment for services to entities other than the practitioner who provided the services unless the practitioner specifically authorizes another entity (employer, facility, health care delivery system, or agent) to bill for his or her services, per Federal Regulation 42 CFR 424.73 and 424.80. The Reassignment of Benefits Statement below authorizes an entity for which you have an agreement to bill for your services on your behalf.

This contract must be in compliance with HCFA regulations, as outlined in number 18 of the application instructions. A Reassignment of Benefits Statement must be signed by all providers, suppliers, and individuals who allow an employer, facility, health care delivery system, or agent to receive payment for the provider's services.

I acknowledge that, under the terms of my employment or contract,  
(Legal Business Name of Entity) \_\_\_\_\_  
is entitled to claim or receive any fees or charges for my services.

Applicant Name (printed)	First	Middle	Last	Jr., Sr., MD., etc.
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Applicant Signature	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	Date (MM/DD/YYYY)
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**Penalties for Falsifying Information on the Medicare Health Care Provider/Supplier Enrollment Application.**

1. 18 U.S.C. section 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry.

**Individual offenders are subject to fines of up to \$250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to \$500,000. 18 U.S.C. § 3571. Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender, if it is greater than amount specifically authorized by the sentencing statute.**

2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against an individual who "knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a program under a Federal health care program

**The offender is subject to fines of up to \$25,000 and/or imprisonment for up to five years.**

3. The Civil False Claims Act, 31 U.S.C. section 3729, imposes civil liability, in part, on any person who

- knowingly presents, or causes to be presented, to an officer or an employee of the United States Government a false or fraudulent claim for payment or approval;
- knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
- conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

**The Act imposes a civil penalty of \$5,000 to \$10,000 per violation, plus 3 times the amount of damages sustained by the Government.**

4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency, or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency, . . . a claim . . . that the Secretary determines is for a medical or other item or service that the person knows or should know:

- was not provided as claimed; and/or
- the claim is false or fraudulent.

**This provision authorizes a civil monetary penalty of up to \$10,000 for each item or service, an assessment of up to 3 times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.**

5. The government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment."

**Remedies include compensatory and punitive damages, restitution and recovery of the amount of the unjust profit.**

**19. Certification Statement**

I, the undersigned, certify to the following:

- 1.) I have read the contents of the application and the information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare Contractor of this fact immediately.
- 2.) I authorize the Medicare Contractor to verify the information contained herein. I agree to notify the Medicare Contractor of any changes in this form within 30 days of the effective date of the change. I understand that a change in the incorporation of my organization or my status as an individual or group biller may require a new application.
- 3.) I am familiar with and agree to abide by the Medicare laws and regulations that apply to my provider/supplier type. (The Medicare laws and regulations are available through the Medicare Contractor.)
- 4.) Neither the individual practitioner, nor the company, nor any owner, director, officer, employee of the company, or any contractor retained by the company or any of the aforementioned persons, currently is subject to sanction under the Medicare/Medicaid program or debarment, suspension, or exclusion under any other Federal agency or program, or otherwise is prohibited from providing services to Medicare beneficiaries.
- 5.) I agree that any existing or future overpayment to me by the Medicare program may be recouped by Medicare through withholding future payments.
- 6.) I understand that only the Medicare billing number for the provider/supplier who performed the service or to whom benefits have been reassigned under current Medicare regulations may be used when billing Medicare for services.
- 7.) I understand that any omission, misrepresentation or falsification of any information contained in this application or contained in any communication supplying information to Medicare to complete or clarify this application may be punishable by criminal, civil, or other administrative actions including revocation of Medicare billing number(s), fines, penalties, damages and/or imprisonment under Federal law.
- 8.) I further certify that I am the individual practitioner who is applying for the billing number, or in the case of a business organization, I am an officer, chief executive officer, or general partner of the business organization that is applying for the Medicare billing number.

Applicant Name (printed)	First	Middle	Last	Jr., Sr., MD., etc.
Applicant Signature	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY)

**FOR GROUPS AND ORGANIZATIONS:** (Please list all "Authorized Representatives" for this group/organization)

Check here  if deleting this representative from this entity.

Authorized Representative Name (printed)	First	Middle	Last	Jr., Sr., MD., etc.	Title/Position
Authorized Representative Signature	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY)	

Check here  if deleting this representative from this entity.

Authorized Representative Name (printed)	First	Middle	Last	Jr., Sr., MD., etc.	Title/Position
Authorized Representative Signature	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY)	

Check here  if deleting this representative from this entity.

Authorized Representative Name (printed)	First	Middle	Last	Jr., Sr., MD., etc.	Title/Position
Authorized Representative Signature	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY)	

**ATTACHMENT 1**

OMB Approval No. 0335-0045

**Ambulance Service Suppliers**

Is applicant licensed as a Supplier of Ambulance Services by applicant's State?  Yes  No

IF YES, attach a copy of the applicant's current State license and skip sections 1 and 2 when completing this attachment.

**1. Description of Vehicle (Copy and complete Section 1 as needed for additional vehicles.)**

For each vehicle, attach copy of the vehicle registration.

1. Type (automobile, aircraft, boat, etc.) Vehicle Identification Number

Make	Model	Year (YYYY)
------	-------	-------------

Does this vehicle have the following:

- |  |  |
|--|--|
| first aid supplies? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>oxygen equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>warning lights? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>sirens? <input type="checkbox"/> Yes <input type="checkbox"/> No | other safety/life saving equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>two-way telecommunications radio? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>mobile communication? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|--|

List other medical equipment this vehicle has.


Does this vehicle provide:

- |   |   |
|---|---|
| Basic Life Support (BLS)? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Advanced Life Support (ALS)? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Emergency Runs? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Non-Emergency Runs? <input type="checkbox"/> Yes <input type="checkbox"/> No | Land Ambulance? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Air Ambulance? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Marine Ambulance? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|---|

How many crew members accompany this vehicle on runs?

2. Type (automobile, aircraft, boat, etc.) Vehicle Identification Number

Make	Model	Year (YYYY)
------	-------	-------------

Does this vehicle have the following:

- |  |  |
|--|--|
| first aid supplies? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>oxygen equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>warning lights? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>sirens? <input type="checkbox"/> Yes <input type="checkbox"/> No | other safety/life saving equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>two-way telecommunications radio? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>mobile communication? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|--|

List other medical equipment this vehicle has.


Does this vehicle provide:

- |   |   |
|---|---|
| Basic Life Support (BLS)? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Advanced Life Support (ALS)? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Emergency Runs? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Non-Emergency Runs? <input type="checkbox"/> Yes <input type="checkbox"/> No | Land Ambulance? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Air Ambulance? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Marine Ambulance? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|---|

How many crew members accompany this vehicle on runs?

**2. Qualification of Crew (Copy and complete this page for additional crew as necessary.)**

Name:	First	Middle	Last	Jr., Sr., MD, etc.	Social Security Number
-------	-------	--------	------	--------------------	------------------------

List training completed by this crew member (i.e., First Aid, CPR, ACLS, etc.) and attach copy(s) of training certificate(s).

_____	_____
_____	_____

Name:	First	Middle	Last	Jr., Sr., MD, etc.	Social Security Number
-------	-------	--------	------	--------------------	------------------------

List training completed by this crew member (i.e., First Aid, CPR, ACLS, etc.) and attach copy(s) of training certificate(s).

_____	_____
_____	_____

Name:	First	Middle	Last	Jr., Sr., MD, etc.	Social Security Number
-------	-------	--------	------	--------------------	------------------------

List training completed by this crew member (i.e., First Aid, CPR, ACLS, etc.) and attach copy(s) of training certificate(s).

_____	_____
_____	_____

**3. Billing Method**

**A. Certified Basic Life Support (BLS) companies complete the following:**

Contact the local Medicare contractor for information on the billing Method that applies in the state where applicant will operate.

- Does company bill Method 1 (an all-inclusive base rate)?  Yes  No
- Does company bill Method 2 (base rate plus a separate charge for mileage)?  Yes  No
- Does company bill Method 3 (base rate plus a separate charge for supplies)?  Yes  No
- Does company bill Method 4 (separate charges for services, mileage, and supplies)?  Yes  No
- Is company certified to perform defibrillation? (IF YES, attach certification.)  Yes  No

Does company provide Advanced Life Support (ALS) Services under contract with a paramedic or Emergency Medical Technician (EMT) organization or an Advanced Life Support (ALS) ambulance supplier?  Yes  No

IF YES, submit a copy(ies) of the signed contractual agreement(s) and complete Section 13 and/or 14, as applicable.

If the company provides Paramedic Intercept Service, does the contract allow the supplier of the life support service to submit the Medicare claim for the paramedic service and the transport on the company's behalf under the company's provider number?  Yes  No

**AIR AMBULANCE ONLY:** Do you bill nautical mileage  or statute mileage  ?

Name of	First	Middle	Last	Jr., Sr., MD, etc.
---------	-------	--------	------	--------------------

Medical Director: \_\_\_\_\_

What geographic area does company serve? \_\_\_\_\_

**B. Certified Advanced Life Support (ALS) companies complete the following:**

Contact the local Medicare contractor for information on the billing Method that applies in the state where applicant will operate.

- Does company bill Method 1 (an all-inclusive base rate)?  Yes  No
- Does company bill Method 2 (base rate plus a separate charge for mileage)?  Yes  No
- Does company bill Method 3 (base rate plus a separate charge for supplies)?  Yes  No
- Does company bill Method 4 (separate charges for services, mileage, and supplies)?  Yes  No
- Does company have a contract with any municipality?  Yes  No
- If Yes, submit copy(ies) of the signed contractual agreement(s).  
is company certified to perform defibrillation? (IF YES, attach certification.)  Yes  No

**AIR AMBULANCE ONLY:** Do you bill nautical mileage  or statute mileage  ?

Name of Medical Director:	First	Middle	Last	Jr., Sr., MD., etc.
What geographic area does company serve?				

**4. Exclusion/Sanction Information**

Copy and complete this page for additional owners and/or employees as necessary.

**A. Has the company, any owner, or employee ever been sanctioned from the Medicare/Medicaid program, or debarred, suspended or excluded from any other Federal agency or program?**  Yes  No **IF YES, supply the information below.**

Name:	First	Middle	Last	Jr., Sr., MD., etc.	Social Security Number OR Employer Identification Number
Date(s) of Sanction, Debarment, etc. (MM/DD/YYYY)			Date(s) of Reinstatement (Attach a copy(s) of the Reinstatement letter(s)) (MM/DD/YYYY)		

**B. Have civil monetary penalties ever been levied against the company, any owner, or employee by the Medicare or Medicaid program or any Federal agency or program?**  Yes  No **IF YES, who was the civil monetary penalty levied against?** Date(s) of Penalty  
(MM/DD/YYYY)

Name:	First	Middle	Last	Jr., Sr., MD., etc.	Social Security Number OR Employer Identification Number
Has penalty been paid? <input type="checkbox"/> Yes <input type="checkbox"/> No					

ATTACHMENT 2

OMB Approval No. 0938-0055

**Independent Physiological Laboratories (IPLs)**  
**For each additional Supervising/Directing Physician or Contractor, copy and complete this page.**

**1. Identification of Supervising/Directing Physician(s)**  
**List all Supervising/Directing Physicians affiliated with this entity.**

Name: First	Middle	Last	Jr., Sr., MD., etc.	Social Security Number
Medicare Identification Number		Current Medicaid Number/State (if applicable)		Prior Medicaid Number/State (if applicable)
Name: First	Middle	Last	Jr., Sr., MD., etc.	Social Security Number
Medicare Identification Number		Current Medicaid Number/State (if applicable)		Prior Medicaid Number/State (if applicable)

**2. Service Performance** (For each additional CPT-4 or HCPCS code, copy this page and complete Section 2.)

List all Current Procedural Terminology, Version 4 (CPT-4) codes or HCFA Common Procedure Coding System codes (HCPCS), equipment, and model number which this entity or its contractors intend to perform, supervise, interpret, or bill.

CPT-4 or HCPCS Code	Equipment	Model Number
1		
2		
3		
4		
5		

Where will these services be rendered? (Check all that apply.)  Physician's Office  Skilled Nursing Facility  Hospital  Other (Explain.) \_\_\_\_\_

Will this entity be billing for both the technical and professional components?  YES  NO

IF YES, fill out the following information for each physician who will be performing the interpretations:

Name: First	Middle	Last	Jr., Sr., MD., etc.	Social Security Number	Title
Name: First	Middle	Last	Jr., Sr., MD., etc.	Social Security Number	Title
Name: First	Middle	Last	Jr., Sr., MD., etc.	Social Security Number	Title

Will tests be taken by employees or contractors who are licensed or approved by the State in:  
 X-Ray Technology,  YES  NO Nursing, or  YES  NO  
 Other  YES  NO (IF YES to "Other", explain and give qualifications below.) \_\_\_\_\_

IF YES to any of the above, provide the following information for each employee/contractor licensed or approved:

Name: First	Middle	Last	Jr., Sr., MD., etc.
Social Security Number	License Number	License Issue Date (MM/DD/YYYY)	
Name: First	Middle	Last	Jr., Sr., MD., etc.
Social Security Number	License Number	License Issue Date (MM/DD/YYYY)	
Name: First	Middle	Last	Jr., Sr., MD., etc.
Social Security Number	License Number	License Issue Date (MM/DD/YYYY)	

**Are all diagnostic tests/services performed at the business/practice locations?**  YES  NO

**IF NO, is applicant operating a mobile unit?**  YES  NO

**IF YES, please list the vehicle(s) identification number(s) for all mobile units and submit copies of all vehicle(s) registration(s).**

1	3	5
2	4	6

**Is the practice location used for any other purpose?**  YES  NO

**IF YES, please answer the following questions:**

**Is the practice location used for another type of business?**  YES  NO

**IF YES, what type?** \_\_\_\_\_

**Is the practice location used for residential purposes?**  YES  NO

**IF YES, explain reason for dual use as residence.** \_\_\_\_\_

**If above two questions are both answered "no", please explain the other uses for the practice location.** \_\_\_\_\_

**Referral Records**

Does applicant maintain records of:

the name of the attending or consulting physician who ordered the test(s)?  YES  NO

a copy of the physician's written order(s) for the test(s)?  YES  NO

the name(s) of the technician(s) who rendered the service(s)?  YES  NO

**IF YES to any of the above, explain how the referral records are maintained (e.g., electronic, paper, by patient name, or by physician name, etc.).**

\_\_\_\_\_

\_\_\_\_\_

**Signature of Supervising/Directing Physician (1)**

Each Supervising/Directing Physician must sign the following statement:  
For additional Supervising/Directing Physician signatures, copy this page and complete Section 5.

*I hereby acknowledge that I have agreed to provide the (IPL Name) \_\_\_\_\_ with general supervisory and/or directing responsibilities for tests performed by this laboratory. If I terminate my relationship with the aforementioned IPL, I will report the date of termination to the Medicare Contractor within 30 days of termination.*

Printed Supervising/Directing Physician:	First	Middle	Last	Jr., Sr., MD, etc.	Title/Position
Signature of Supervising/ Directing Physician	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)				Date (MM/DD/YYYY)

*I hereby acknowledge that I have agreed to provide the (IPL Name) \_\_\_\_\_ with general supervisory and/or directing responsibilities for tests performed by this laboratory. If I terminate my relationship with the aforementioned IPL, I will report the date of termination to the Medicare Contractor within 30 days of termination.*

Printed Supervising/Directing Physician:	First	Middle	Last	Jr., Sr., MD, etc.	Title/Position
Signature of Supervising/ Directing Physician	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)				Date (MM/DD/YYYY)

**PSI BACKGROUND MEMO**

**ATTACHMENT #2**



**Medicare**  
**Palmetto Government Benefits Administrators**  
 Post Office Box 107140, Columbia, South Carolina 29202-0140  
**National Supplier Clearinghouse**

December 22, 1997

XX  
 XX  
 XX  
 XX, XX XX

XX

Dear Supplier:

Upon submission of your application for a Medicare supplier number (Form NCA-102) to the National Supplier Clearinghouse, you certified your company's compliance with the Medicare supplier standards. We must request the following information from your company in order to verify compliance with the Medicare standards:

1. Provide a list of companies with whom you contract with, do business with, or manufacturers or other suppliers used to obtain equipment or supplies. The list must include the company's name, address and telephone number(s).
2. Provide a copy of your procedures for the delivery and set-up of equipment or supplies.
3. Provide a copy of your procedure for receiving and responding to beneficiary complaints. The telephone number that a beneficiary should call in case of a complaint must be included in your procedures.
4. Provide a list of companies that perform, or you have contracted with to perform, your maintenance of rented equipment. Include the name of the company or individual, address and telephone number for each company or individual.

Forward this information to the National Supplier Clearinghouse within 35 days from the date of this letter. Failure to respond within the 35-day period will be grounds for revocation of your Medicare supplier billing number.

If you have any questions concerning this request, please call the National Supplier Clearinghouse at (803) 754-3951.

Thank you.  
 William T. T. Heed, Director  
 National Supplier Clearinghouse  
 CKEY: XX  
 0E00

**PSI BACKGROUND MEMO**

**ATTACHMENT #3**

"(3) APPROPRIATED AMOUNTS TO ACCOUNT FOR FRAUD AND ABUSE CONTROL PROGRAM, ETC.— (A) DEPARTMENTS OF HEALTH AND HUMAN SERVICES AND JUSTICE.—

"(i) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund such sums as the Secretary and the Attorney General certify are necessary to carry out the purposes of the program, without further appropriation, in an amount not to exceed—

"(i) for fiscal year 1997, \$104,000,000; "(ii) for each of the fiscal years 1998 through 2003, the limit for the preceding fiscal year, increased by 15 percent; and "(iii) for each fiscal year after fiscal year 2003, the limit for fiscal year 2003.

"(B) MEDICARE AND MEDICAID ACTIVITIES.—For each fiscal year, of the amount appropriated in clause (i), the following amounts shall be available only for the purpose of the activities of the Office of Inspector General of the Department of Health and Human Services with respect to the medicare and medicaid programs:—

"(i) for fiscal year 1997, not less than \$60,000,000 and not more than \$70,000,000; "(ii) for fiscal year 1998, not less than \$80,000,000 and not more than \$90,000,000; "(iii) for fiscal year 1999, not less than \$90,000,000 and not more than \$100,000,000; "(iv) for fiscal year 2000, not less than \$110,000,000 and not more than \$120,000,000; "(v) for fiscal year 2001, not less than \$120,000,000 and not more than \$130,000,000; "(vi) for fiscal year 2002, not less than \$140,000,000 and not more than \$150,000,000; and "(vii) for each fiscal year after fiscal year 2002, not less than \$150,000,000 and not more than \$160,000,000.

"(C) FRAUD AND ABUSE CONTROL PROGRAM.—There are hereby appropriated from the general fund of the United States Treasury and hereby appropriated to the Account for transfer to the Federal Bureau of Investigation to carry out the purposes described in subparagraph (C), to be available without further appropriation—

"(i) for fiscal year 1997, \$47,000,000; "(ii) for fiscal year 1998, \$68,000,000; "(iii) for fiscal year 2000, \$76,000,000; "(iv) for fiscal year 2001, \$88,000,000; "(v) for fiscal year 2002, \$101,000,000; and "(vi) for each fiscal year after fiscal year 2002, \$114,000,000.

"(C) USE OF FUNDS.—The purposes described in this paragraph are to cover the costs (including equipment, salaries and benefits, and travel and training) of the administration and operation of the health care fraud and abuse control program established under section 1128C(a), including the costs of—

- (i) prosecuting health care matters (through criminal, civil, or administrative proceedings); "(ii) investigations; "(iii) financial and performance audits of health care programs and operations; "(iv) inspections and other evaluations; and "(v) provider and consumer education regarding compliance with the provisions of title XL.

"(4) APPROPRIATED AMOUNTS TO ACCOUNT FOR MEDICARE INTEREST PROGRAM.—

"(A) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund for each fiscal year such amounts as are necessary to carry out the Medicare Integrity Program under section 1893, subject to subparagraph (B) and to amounts specified in the appropriations made under paragraph (A) for a fiscal year as follows:—

"(i) For fiscal year 1997, such amount shall be not less than \$430,000,000 and not more than \$440,000,000. "(ii) For fiscal year 1998, such amount shall be not less than \$490,000,000 and not more than \$500,000,000. "(iii) For fiscal year 1999, such amount shall be not less than \$550,000,000 and not more than \$560,000,000. "(iv) For fiscal year 2000, such amount shall be not less than \$620,000,000 and not more than \$630,000,000. "(v) For fiscal year 2001, such amount shall be not less than \$670,000,000 and not more than \$680,000,000. "(vi) For fiscal year 2002, such amount shall be not less than \$630,000,000 and not more than \$700,000,000. "(vii) For each fiscal year after fiscal year 2002, such amount shall be not less than \$710,000,000 and not more than \$720,000,000.

"(B) ANNUAL REPORT.—Not later than January 1, the Secretary and the Attorney General shall submit jointly a report to Congress:— (A) the amounts appropriated to the Trust Fund for the previous fiscal year under paragraph (2)(A) and the source of such amounts; and (B) the amounts appropriated from the Trust Fund for such year under paragraph (3) and the justification for the expenditure of such amounts.

1824(c)(15) which are subject to prior authorization under such section.

(c) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract under the Program to carry out any of the activities described in subsection (b) if—

(1) the entity has demonstrated capability to carry out such activity;

(2) in carrying out such activities, the entity agrees to cooperate with the Inspector General of the Department of Health and Human Services, the Attorney General, and other law enforcement agencies, as appropriate, in the investigation and the prosecution of any offenses relating to this title and in other cases arising out of such activities;

(3) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement, and

(4) the entity meets such other requirements as the Secretary may impose.

In the case of the activity described in subsection (b)(5), an entity shall be deemed to be eligible to enter into a contract under the Program to carry out the activity if the entity is a carrier with a contract in effect under section 1849.

(d) CONTRACTS.—The Secretary shall enter into contracts under the Program in accordance with such procedures as the Secretary shall by regulation establish, except that such procedures shall include the following:

(1) Procedures for identifying, evaluating, and resulting awarding of contracts.

(2) Competitive procedures to be used—

(A) when entering into new contracts under this section;

(B) when entering into contracts that may result in the elimination of responsibilities of an individual from intermediate or carrier under section 202(b) of the Health Insurance Portability and Accountability Act of 1996; and

(C) at any other time considered appropriate by the Secretary.

Except that the Secretary may continue to contract with entities that are not eligible to enter into contracts under this section pursuant to agreements under section 1816 or contracts under section 1849 in effect on the date of the enactment of this section.

(3) Procedures under which a contract under this section may be terminated or modified.

(4) Procedures under which a contract under this section may be terminated or modified.

(5) Procedures under which a contract under this section may be terminated or modified.

(6) Procedures under which a contract under this section may be terminated or modified.

(7) Procedures under which a contract under this section may be terminated or modified.

(8) Procedures under which a contract under this section may be terminated or modified.

(9) Procedures under which a contract under this section may be terminated or modified.

(10) Procedures under which a contract under this section may be terminated or modified.

(6) GAO REPORT.—Not later than January 1 of 2000, 2002, and 2004, the Comptroller General of the United States shall submit a report to Congress which—

(A) identifies amounts appropriated to the Trust Fund for the previous two fiscal years under paragraph (2)(A) and the source of such amounts; and

(B) the amounts appropriated from the Trust Fund for each fiscal year under paragraph (2)(A) and the source of such amounts.

(7) Identifies any expenditures from the Trust Fund with respect to activities not involving the Medicare program under title XVIII;

(8) Identifies any savings to the Trust Fund, and any other savings, resulting from expenditures from the Trust Fund; and

(9) analyses such other aspects of the operation of the Trust Fund as the Comptroller General of the United States considers appropriate.

SEC. 518. MEDICARE INTRASTATE PROGRAMS.

(a) ESTABLISHMENT OF MEDICARE INTRASTATE PROGRAM.—Title XVIII is amended by adding at the end the following new section:

“MEDICARE INTRASTATE PROGRAM

“Sec. 1893. (c) ESTABLISHMENT OF PROGRAM.—There is hereby established the Medicare Integrity Program for the State of [State] to carry out the activities described in this section.

(1) The Secretary shall promote the integrity of the Medicare program by entering into contracts in accordance with this section with eligible entities to carry out the activities described in subsection (b).

(2) ACTIVITIES DESCRIBED.—The activities described in this subsection are as follows: (A) Review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this title (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review (employing medical auditors and other personnel); (B) review of equipment and software technologies which surpass the capability of the equipment and technologies used in the review of claims under this title as of the date of the enactment of this section.

(3) Determinations as to whether payment should not be, or should not have been, made under this title by reason of section 1869(b), and recovery of payments that should not have been made.

(4) Selection of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues.

(5) Developing (and periodically updating) a list of items of durable medical equipment in accordance with section

THE WASHINGTON POST  
Sunday, January 18, 1998

## Officials Target Equipment Fraud In Medicare

### \$510 Million Found In Improper Billing

By Judith Havemann  
*Washington Post Staff Writer*

Almost 8 percent of the bills submitted for wheelchairs, walkers and other medical equipment under the massive Medicare program are unjustified, according to federal investigators, because of outright fraud or other inadequacies in the information filed.

An investigation of medical equipment suppliers to elderly Medicare recipients found that they submitted nearly \$510 million worth of improper bills last year out of a total of \$6.5 billion.

Federal officials are targeting the 135,000 suppliers of medical equipment as part of the government's latest effort to crack down on Medicare fraud. Last year an intensive, four-state probe of home health care found that nearly 40 percent of the services provided to frail elderly Americans under the Medicare program were unjustified.

Since the home health care crackdown began, investigators have recovered \$1.2 billion in fines, restitutions and other payments from shady operators.

The equipment arena has long been identified as another prime area for potential fraud, according to the government.

A Florida survey of new entrants into the field found that 32 of 36 applicants checked at random in the Miami area were not bona fide businesses.

Federal officials say the \$510 million in unjustified bills were discovered in time and never paid, while another \$4 million in improper payments turned up later and had to be recovered.

The most recent in a series of Medicare fraud investigations by the inspector general looked primarily at whether businesses existed in the first place, not whether they had cheated Medicare patients. But federal officials said that in the past they have discovered that shady operators sell inappropriate or unneeded equipment to the elderly, promise them that items will be paid for by Medicare when they are in fact ineligible, and deliver either shoddy products or none at all.

To reduce the potential for fraud, Medicare officials will announce new rules on Tuesday requiring that companies supplying such equipment post a \$50,000 bond to insure that they are legitimate, have physical offices and listed telephone numbers, and stop telemarketing products to the elderly.

"There have been a number of situations where the... supplier isn't really supplying anything," said Nancy-Ann Min DeParle, administrator of the Health Care Financing Administration, which runs Medicare.

Equipment suppliers already are required by law to meet various federal standards, including responding to questions and complaints from beneficiaries, maintaining and repairing rental equipment, honoring warranties and accepting returns on substandard equipment.

But the recent 12-city survey of 420 suppliers by the inspector general's office found that 1 out of every 14 suppliers and 1 in 9 new applicants did not even have a real address.

In Brooklyn, N.Y., the address one supplier listed on the application form was in a building consisting of four apartments over a laundry. The company was not listed on the mailboxes, and tenants had never heard of the individual who claimed to be the principal supplier. The laundry had been used as a post office box operation, according to one tenant, and the phone number was out of service.

Senate Permanent Subcommittee  
on Investigations

EXHIBIT # 13

A Florida souvenir dealer whose shop features alligator skin wallets and stuffed turtles decided to go into the medical equipment business because his brother-in-law installs wheelchair lifts on vehicles, he told inspectors. He had no experience in the field and maintained no inventory.

Inspectors discovered that other dealers whose primary businesses were health spas, golf carts, or even sports shoes also had received Medicare certification to sell medical equipment.

In some residences, individuals were inside but refused to answer the door when investigators knocked, according to the report. Others "peeked through the blinds, disappeared from view and ignored further attempts to speak with them," according to the inspector general's report, which was released in December.

The proposed new rules, which have been in the works for more than a year, will be published in the Federal Register for public comment over the next 60 days.



DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Health Care Financing Administration

JAN 28 1998

The Administrator  
Washington, D.C. 20201**Senate Permanent Subcommittee  
on Investigations****EXHIBIT #** 14

Senator Susan M. Collins  
Chairman  
Permanent Subcommittee on  
Investigations  
United States Senate  
Washington, D.C. 20515

Senator John Glenn  
Ranking Member  
Permanent Subcommittee on  
Investigations  
United States Senate  
Washington, D.C. 20515

Dear Chairman Collins and Senator Glenn:

In light of the hearing being held tomorrow by the Permanent Subcommittee on Investigations, I want to share with you our increasing efforts to fight fraud. As I made clear at my confirmation hearing last fall, fighting fraud is one of my highest priorities. Last week, I spent a day in Florida with Senator Bob Graham getting a first-hand look at anti-fraud activities there and discussing new ways to fight fraud with law enforcement and our regional staff. We simply cannot tolerate those who would cheat our beneficiaries and the taxpayers. I am committed to stepping up the crackdown on fraud begun by the President in 1993.

We already are achieving record success in increasing fraud and abuse investigations, indictments, convictions, fines, penalties, and restitutions. Last year, nearly \$1 billion was returned to the Medicare Trust Fund, thanks to our partnership with the HHS Inspector General, Department of Justice, and state and local authorities. Medicare alone saved an estimated \$7.5 billion in FY 1997 - mostly by preventing inappropriate payments -- through audits, medical reviews, and ensuring that Medicare does not pay for claims owed by private insurers.

Just this month we have taken several new steps to combat fraud. One of our prime targets is durable medical equipment (DME) fraud.

- Last week, the President announced site visits for DME suppliers nationwide. Site visits are a proven way to thwart scam artists. Of nearly 2000 suppliers visited last year, about one third were either ejected or rejected by Medicare.
- Also last week we published a proposed regulation to tighten standards and strengthen enforcement against unscrupulous DME suppliers. It requires surety bonds of at least \$50,000, requires firms to have physical offices and listed phone numbers, bans telemarketing, and takes other steps to fight fraud and abuse.

Page 2 -- The Honorable Susan M. Collins and the Honorable John Glenn

- We recently revised the supplier application form to get information that will help us fight fraud, and mandated training for suppliers on proper billing procedures. We must ensure that only legitimate suppliers and claims are paid.

Home health is another prime target for us. Earlier this month we set tougher requirements for home health agencies, including a requirement that they obtain surety bonds. With these new protections in place, we were able to lift a moratorium announced last September by the President on new agencies entering Medicare. We now ask new agencies about any "related business interests," which unscrupulous providers have used to cover up fraud. Later this year we will issue regulations requiring home care agencies to re-enroll every three years so we can remove those with integrity or quality problems.

We are expanding our crackdown on fraud and abuse by community mental health centers, as well. On-site inspections have found patients not receiving the outpatient mental health care they do need, others getting services they do not need, and unsafe and unsanitary conditions. We suspended payment to several centers in Florida based on site visit findings, and are now starting site reviews in other states. We also are seeking legislative authority to bar these services in residential settings, and to fine providers who falsely certify that a patient needs these services.

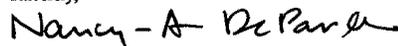
The President has just unveiled more initiatives to fight fraud and abuse, including authority to charge providers a fee so we can do more audits, eliminate excessive payments for certain drugs, and prevent providers from using bankruptcy to avoid paying money back to Medicare.

Beginning next month, a toll-free number will appear on the statements we send to Medicare beneficiaries so they know where to call to report suspected fraud.

Many of our successes in fighting fraud are due to contractor and regional staff finding problems and suggesting solutions. In fact, in the case of Russian criminals bilking Medicare through false billing schemes, Medicare and its contractors in New England created a special task force with the HHS Inspector General and the FBI, which has identified and stopped four such schemes. As the President noted in his radio address last Saturday, one of these Russian criminals was in December sentenced to 30 months in jail and ordered to pay back more than \$1.5 million.

We have stopped a great number of unscrupulous dealings but, as you know, there is much more that we can and must do. The nature of health fraud demands that we continuously find new ways to stay ahead of those who would misuse Medicare Trust Fund dollars. I look forward to working with you and members of this Subcommittee in this continuing effort.

Sincerely,



Nancy-Ann Min DeParle  
Administrator

Enclosure

### RECENT MEDICARE ANTI-FRAUD INITIATIVES

Medicare is taking strong action to combat fraud and abuse in key areas. Our goal is to make sure Medicare only does business with legitimate providers and suppliers who will provide Medicare beneficiaries high quality services.

#### Durable Medical Equipment

Medicare concurs with all eight recommendations made in a recent HHS Inspector General's report, "Medical Equipment Suppliers: Assuring Legitimacy." Several actions have already been taken, including expansion of site visits.

- o Last week, the President announced that Medicare has begun requiring site visits for DME suppliers before certification on a nationwide basis. Visits by Medicare staff as part of Operation Restore Trust and studies by the HHS Inspector General show that many purported DME suppliers have only mail drops and no actual offices.
  - Site visits to two thousand suppliers in five states with the most suspected DME fraud problems resulted in 650 suppliers being ejected or rejected by Medicare in FY 1997.
  - Site visits are expanding initially to an additional 10 states this month and are being expanded nationwide this year.
- o Medicare proposed a regulation on January 20 to make it more difficult for unscrupulous DME suppliers to enter Medicare and to strengthen enforcement against such suppliers. Among the new supplier requirements are:
  - a surety bond of at least \$50,000,
  - a ban on DME telemarketing and a requirement for a physical location with working business phone at that location,
  - a prohibition on reassigning supplier numbers, and
  - criminal and civil sanctions for false information on billing number applications
- o Other Medicare actions to assure that DME suppliers are legitimate include:
  - requiring periodic training on billing procedures for new and existing suppliers,
  - eliminating 36,000 supplier billing numbers that had not been used for at least one year, eliminating the chance they will be exploited by scam operators,
  - modifying the DME application form to obtain additional information about prospective DME suppliers, and
  - seeking authority to charge all applicants an application fee that will help us fund increased enforcement efforts.

#### Home Health Agencies (HHAs)

Over the last several months Medicare has established new requirements for HHAs. On September 15, 1997 the President announced a moratorium on new HHAs until Medicare could

implement a range of new rules and management tools that enhance oversight of HHAs and ensure that new Medicare home health agencies are not "fly-by-night" or low quality providers.

- o The moratorium was lifted earlier this month with the publication of a regulation requiring all HHAs that participate in Medicare to:
  - obtain a surety bond of at least \$50,000, and
  - have enough capital to fund operations for the first 3 months.
- o In addition, we have taken administrative steps to require HHAs to:
  - reveal "related business interests" that can be the conduit for fraudulent and abusive activities, and
  - serve at least 10 patients before they are admitted to the Medicare program so that their quality of care can be reviewed. ( We have provided state survey agencies specific instructions to verify that a new agency has indeed cared for 10 patients itself, and has not simply "borrowed" patients from an already certified agency. )
- o Later this year Medicare will issue regulations to require HHAs to re-enroll every three years. And the President has proposed assessing a fee on providers so we can do more audits that help ensure Medicare only pays appropriate provider costs.

#### **Community Mental Health Centers (CHMC)**

Medicare has identified significant increases in numbers of CMHCs in states which do not require licensing of CMHCs for Medicare purposes. On-site inspections have found centers in which patients do not need services being provided, are not receiving services they do need to treat their illness, and are being served in unsafe and unsanitary conditions.

- o Site visits in Florida have resulted in suspending payments to approximately 10 CMHCs.
- o We are expanding site reviews to other states.
- o The Administration is seeking legislative authority to:
  - prohibit outpatient mental health care from being provided in a residential setting,
  - impose civil monetary penalties on providers who falsely certify a patient's need for such services.

#### **ON-GOING ANTI-FRAUD INITIATIVES**

The Clinton Administration has focused unprecedented attention on the fight against fraud and abuse. In May 1995, President Clinton launched Operation Restore Trust (ORT) to develop several innovations in fighting fraud and abuse in Medicare.

- o During a two-year demonstration, ORT identified:
  - \$23 in overpayments for every \$1 spent looking at home health care, skilled nursing facilities and suppliers of DME,
  - 2,700 fraudulent health care providers and entities who were then excluded from

doing business with Medicare and other federal and state health care programs.

- o Because of its successes, ORT has been expanded to 24 states that will conduct pilot projects to test alternative approaches to program integrity. This includes projects that will integrate state survey and certification functions with those of fiscal intermediaries so that the state agencies can review whether Medicare quality and coverage requirements are met. In FY 1997 these projects identified over \$80 million in overpayments which we are now collecting.
- o Medicare has incorporated many of the methods first piloted in ORT to put illegitimate providers and suppliers out of work. For example, our efforts to fight DME fraud and abuse in 1997 have produced the following results:
  - convicting 59 suppliers on fraud and abuse charges, and
  - denying \$509.7 million in improper payments before they were made.
- o Medicare and its contractors actively work to prevent attempts to defraud Medicare and to support investigations and prosecutions of such defrauders. Many of the successful law enforcement actions were begun through Medicare contractor and regional office staff identification of problems and issues, and through referrals by the contractors to the HHS Inspector General. In fact, in the case of Russian immigrants bilking Medicare through false billing schemes, Medicare and its contractors in New England created a task force with the HHS Inspector General and FBI to investigate and prevent fraudulent incursions in the Medicare payment system by members of immigrant communities. Since 1996, Medicare has identified and stopped 4 such schemes.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provided powerful new tools and more than \$100 million dedicated to fight fraud. In just one year HIPAA helped return nearly \$1 billion to the Medicare Trust Fund from collections of fines, judgements, settlements, and administrative actions. Health fraud convictions are up nearly 20 percent and the number of civil health fraud cases increased 61 percent.

The Balanced Budget Act of 1997 added more tools we had sought to fight fraud and abuse. These let us: exclude providers convicted of felonies or health related crimes, levy new civil monetary penalties on hospitals who contract with providers who have been excluded from Medicare, levy civil monetary penalties on providers who take kickbacks, require applicants to provide Social Security numbers and employer identification numbers so we can check the applicant's histories, and tighten eligibility for home health services so providers can no longer game the system by certifying that a patient is eligible for home health services simply because they need blood drawn.

#### **NEW PROPOSALS**

Last week, the President unveiled more initiatives to fight against fraud and abuse.

- o Beginning next month, the HHS Inspector General's toll-free hotline number for beneficiaries to report suspected fraud will appear on every statement Medicare sends out to our beneficiaries.
- o A package of legislative proposals will seek authority to:
  - charge providers a fee so we can do more audits,
  - eliminate excessive payments for certain drugs,
  - curtail abuse of outpatient mental health benefits, and
  - prevent providers from using bankruptcy to avoid paying money back to Medicare.
  - use competitive bidding so Medicare does business with those equipment suppliers who provide the best price and quality,
  - eliminate loopholes that allow abuse of outpatient mental health services,
  - create monetary penalties for false certification of the need for care,
  - take action to end illegal provider "kickback" schemes,
  - ensure Medicare does not pay for claims owed by private insurers.

# # #

December 29, 1997

RECEIVED JAN 10 1998

The Honorable Susan M. Collins  
United States Senate  
Senate Dirksen Office Building-B-40-4  
Washington, D.C. 20510

Dear Senator Collins:

The purpose of this letter is to express my concern over the increased scrutiny of healthcare billing issues and the automatic assumption that all billing errors are attempts to defraud the government. I respectfully request that you and your staff gather all of the facts surrounding a specific government investigation before agreeing that fraud has been committed. I would also like to take this opportunity to outline the steps this institution has taken to avoid billing errors and ensure against anyone in the billing office committing fraud.

Maine Medical Center is a not-for-profit teaching hospital established to provide health care services through its acute care and specialty care facilities. We have 606 licensed beds, and during our most recent fiscal year, ended September 30, 1997, we had 28,243 patient discharges, 38% of these discharges were for Medicare patients. We also saw 64,819 patients in our emergency and urgent care departments. Maine Medical Center employs over 3,500 people and we are strongly committed to serving our community.

As Vice President for Finance and Treasurer, I believe very strongly in maintaining the highest professional ethics. This includes keeping current with all that is happening in the world of healthcare finance. To assist me in this goal, I am a member of the Healthcare Financial Management Association (HFMA). HFMA is the professional membership organization for individuals involved in the financial management of health care. HFMA's more than 35,000 members work in a variety of healthcare settings – hospitals, long-term care facilities, managed care organizations, and physician groups – as well as public accounting and consulting firms and other organizations.

We are providing educational opportunities for all hospital employees involved in patient billing related areas. Within the context of a larger organizational ethics initiative, we are in the process of developing corporate compliance programs in a variety of areas to ensure continued compliance with regulations. As an institution, and as individuals, we make every effort to remain compliant with the multitude of regulations promulgated relating to Medicare and Medicaid.

Healthcare finance is an extremely complex field. This complexity often causes news reports of alleged fraud to be misleading. Sometimes "the rest of the story" is missing. However, that "rest of the story" is often the very essence of how errors occur.

Maine Medical Center has had some direct experience with the "rest of the story". In May, 1997, the United States Attorney for Maine said "apparently it was common practice in Maine and elsewhere for many hospitals to double bill for these tests". This was in reference to a settlement regarding alleged 72 hour window violations. Due to human error and inadequate guidance from governmental agencies, MMC incorrectly billed approximately 0.01% of its Medicare bills. Given the complexity of the Medicare billing system and the number of claims we process, I feel this is an indication of how good our performance is and not in any way an attempt to submit false claims. I hope you agree.

Senator Susan M. Collins  
Page 2  
December 29, 1997

To help you navigate through this complex environment, I invite you to call me if you have questions about any healthcare billing issue. Alternatively, HFMA's Knowledge Network<sup>SM</sup>, located in the Association's Washington, D.C., office is available to answer technical questions about healthcare reimbursement or other healthcare finance policy issues. Network staff can be reached at (800)252-4362, extension 3.

I share your concern that the "bad apples" should be removed from our profession. However, I am concerned that we are all being viewed in this same negative light. Most of us, and especially Maine Medical Center, constantly work to ensure that our billing processes are above reproach and that we are part of a system that delivers quality care at an affordable price to all of our patients. Therefore, I respectfully request that you look beyond the news media and review the facts of each particular case. This will enable you to form an informed opinion about the practice of healthcare finance as it relates to alleged fraudulent practices.

Thank you for this opportunity to share with you my concerns about healthcare fraud and abuse issues and my profession. If I can be of assistance to you or your staff, please do not hesitate to call me at (207)871-2654.

Sincerely,



John E. Heye  
Vice President for Finance and Treasurer

JEH/dg

C: Robbi-Lynn, Watnik, JD  
Healthcare Financial Management Association  
Washington, D.C., Office



20 Middle Street, Augusta, Maine 04330  
207-623-0345 FAX 207-623-7141

Senate Permanent Subcommittee  
on Investigations

EXHIBIT # 16

**MEDICARE FRAUD & ABUSE**  
**POSITION STATEMENT**

The Home Care Alliance of Maine membership has a long-standing commitment to provide the highest quality of care to the elderly and infirm of our state. Even one unscrupulous home health provider that fails to maintain the values and ethics that are at the core of home care jeopardizes the viability of ongoing access to appropriate home health services.

We recognize that the responsibility for resolving concerns of fraud and abuse lies with the government, the home health industry, and individual providers. We further believe that different strategies are needed to clearly distinguish deliberately fraudulent practice from unintentional errors that can occur in the interpretation of the complex and often vague rules and regulations in the Medicare home health care benefit.

The Home Care Alliance of Maine firmly believes that fraud and abuse can be eliminated and errors corrected when addressed by comprehensive and concerted efforts among the industry, government, individual providers, and consumers. This partnership is critical to achieve the mutually beneficial goal of assuring integrity in administration of the Medicare home health care benefit.

We further believe that education of consumers and advocacy groups is central to ensuring trust in legitimate providers of home health services. It is only through open and public discussion about the basic structure of changes in the Medicare home health care benefit that consumers and others can confidently distinguish blatant fraud and abuse from innocent errors in interpretation and provision of services. Informed consumers and their advocates can then be reassured by their choice of licensed and certified home health agencies.

The Home Care Alliance of Maine supports:

1. Zero tolerance for fraud and abuse of the Medicare home health care benefit.
2. Total cooperation with prompt and responsible investigation and resolution of any errors in interpretation and application of the Medicare home health care benefit.
3. Medicare coverage and reimbursement standards in language that is understandable and readily accessible to providers and consumers through various means, e.g. federal depository libraries, state regulatory agencies, trade associations, fiscal intermediaries, and the Internet.
4. Enhancement of education and training of home health agencies through joint efforts with regulators.
5. Credentialing and competency testing standards for government contractors and federal regulators responsible for issuing Medicare determinations.
6. Mandatory screening and background checks on all applicants for Medicare certification as a home health agency.
7. Development and provision of a summary of program coverage requirements for consumers and prospective consumers of Medicare home health care benefits.
8. Enhancement and increased accessibility of the consumer reporting hotline for suspected fraud and abuse.

The Home Care Alliance of Maine is committed to working with its membership, state and federal regulatory bodies, and consumer advocacy groups to ensure the integrity of the Medicare home health care benefit in Maine.

Senate Permanent Subcommittee  
on Investigations

EXHIBIT # 17

Florida Department of  
Law EnforcementP.O. Box 1489  
Tallahassee, Florida 32302  
(904) 488-8771James T. "Tim" Moore  
CommissionerLawton Chiles, *Governor*  
Sandra B. Mortham, *Secretary of State*  
Robert A. Butterworth, *Attorney General*  
Robert F. Milligan, *Comptroller*  
Bill Nelson, *Treasurer*  
Bob Crawford, *Commissioner of Agriculture*  
Frank T. Brogan, *Commissioner of Education*

February 3, 1998

The Honorable Susan Collins, Chairman  
Permanent Subcommittee on Investigations  
The United States Senate  
340 Dirksen Senate Office Building  
Washington, D.C. 20510

Senator Collins:

I viewed with great interest your appearance last week on ABC News regarding your Committee's efforts at stemming Medicare fraud. As your Committee's summary of ongoing investigations points out, health care comprises about 17<sup>th</sup> of the nation's economy and is subject to a tremendous amount of fraud, waste, abuse, and mismanagement. The Florida Department of Law Enforcement's recent experience in investigating Medicaid fraud in Florida has demonstrated that health care fraud frequently is orchestrated by organized criminal enterprises. I commend you and the Committee in making health care fraud, and particularly Medicare fraud a major focus of your efforts. I write to suggest a strategy that is very useful in providing law enforcement, government regulators and honest health care providers a powerful tool in reducing fraud. We have found that better screening of health care providers before they are approved to handle public funds can, and has, helped to reduce the likelihood of illegal activity. You mentioned a similar concern in your ABC news appearance.

To facilitate "pre-approval" background screenings, the screenings must be done in a timely fashion. This requires an ability to utilize **name-based criminal history inquiries** as a preliminary step to a more formal fingerprint-based inquiry. Our experience in Florida in allowing name-based criminal history inquiries on Florida's criminal history files as the first step in background investigation efforts has been promising. A licensing entity can submit names of prospective health care providers by name and a very quick response can be provided indicating whether there appears to be a Florida criminal history under the name provided. Of course, a fingerprint-based inquiry is the only true means of avoiding the use of aliases or other attempts to avoid the identification of one's criminal past, but this can be done as a follow-up inquiry. Name based searches provide a good balance between the needs of licensing agencies and providers to obtain a prompt review of applications and the needs of government to assure that those approved to provide health care services meet the essential qualifications under law.

While Florida is able to facilitate name-based searches using our state criminal records, the FBI does not allow the same for federal records in the NCIC system. Over the last several years, I have attempted to encourage the FBI to make a policy change to allow name-based federal criminal history searches, but the FBI has resisted such a change. FDLE's current experience with the FBI on fingerprint-based background criminal history checks for these purposes suggests that it will take several months for a response to be received.

Committed to  
Service • Integrity • Respect • Quality

Honorable Susan Collins  
February 3, 1998  
Page 2 of 2

The Department's experience suggests that perpetrators of fraud move from state to state, often after having a conviction of record in a previous state. Without a name-based search of NCIC records, perpetrators can obtain initial approval to operate in a new state and can practice their well-defined fraud skills with little fear of discovery at least until a fingerprint background check response is returned. In short, under the current FBI policy, criminals have a window of three to four months in which they may conduct fraud in a new state with little fear of discovery. I am firmly convinced that the FBI, like FDLE, could allow name-based inquiries and still continue to assure the overall integrity of the NCIC system. What is needed is a change of policy within the FBI to facilitate this approach.

It has also been our experience in Florida that health care licensing entities can effectively utilize the talents of private data management firms to compile information from numerous sources in a comprehensive report that allows the licensing entity to make a more-informed decision. Private sector expertise can be valuable to government, too. For example, in Florida, the Agency For Health Care Administration (AHCA), the entity which licenses Medicaid providers in Florida, has entered into a contract with a private entity, Data Base Technologies ("DBT") to allow DBT to provide to AHCA a complete report on a prospective provider, including bankruptcies, civil judgments, problems with associates of the provider, as well as a report based on the public version of Florida's state criminal history database. To facilitate AHCA's mission, FDLE has entered into a contract with DBT in which we make available for the sole use by DBT in preparing its reports to AHCA, our complete public criminal history database. DBT "runs" by name-based checks, every prospective Medicaid provider, and then continues to "run" by name on a regular basis all previously-approved providers to determine whether, after approval, a provider has been convicted of a crime. This innovative public/private cooperation is another means of better equipping government to ferret out fraud.

When we approach the FBI with similar ideas, we are told that existing federal law will not allow the FBI criminal history files to pass to private entities, even if the entity is operating under contract with a law enforcement agency with appropriate restrictions on the use of the NCIC data. Under current federal law, it would be impossible to expand our AHCA-DBT-FDLE concept to include NCIC criminal history checks. Clearly, if more information at the time when one is seeking approval to provide health services is important to preventing fraud and abuse, changes in federal law and policy are needed. Florida's Senator Bob Graham is drafting a proposal (copy of draft is attached) that would begin to move the NCIC system toward name-based checks. I ask you to support Senator Graham's effort in this regard. I will be glad to expand my ideas and concerns upon your request. Please feel free to contact me at (850) 488-8771 to engage in more discussion. I wish you and your committee the greatest of success in your efforts.

Sincerely,



James T. Moore  
Commissioner

JTM/mr

cc: Honorable Fred Thompson, Chairman  
Senate Government Affairs Committee  
Timothy J. Shea, Director  
Permanent Subcommittee on Investigations  
Honorable Bob Graham, Senator

105TH CONGRESS  
1ST SESSION

**S.** \_\_\_\_\_

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IN THE SENATE OF THE UNITED STATES

Mr. GRAHAM introduced the following bill; which was read twice and referred to the Committee on \_\_\_\_\_

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**A BILL**

To provide States access to certain information in the National Crime Information Center of the Department of Justice.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. USE OF NATIONAL CRIME INFORMATION CEN-**  
4 **TER FOR EMPLOYMENT AND LICENSURE.**

5 (a) IN GENERAL.—As soon as practicable after the  
6 date of enactment of this Act, the Attorney General shall  
7 issue regulations to establish a program under which the  
8 appropriate official of a State agency may request the At-  
9 torney General to provide information from the National  
10 Crime Information Center of the Department of Justice

1 concerning the identity of an individual (without regard  
2 to whether that individual has a criminal history). The in-  
3 formation requested under this subsection may be used  
4 only for the purpose of obtaining background information  
5 concerning the identity of an individual in connection with  
6 the employment or licensing of that individual.

7 (b) REQUIREMENTS.—Under the program estab-  
8 lished under this section—

9 (1) the Attorney General may provide informa-  
10 tion only to the appropriate official of a State—

11 (A) that has in effect a law that requires  
12 that a criminal history check (including check-  
13 ing the identity and fingerprints of an individ-  
14 ual) be conducted for the employment or licens-  
15 ing of an individual; and

16 (B) with respect to which a single State  
17 agency has the primary responsibility for carry-  
18 ing out a criminal history check referred to in  
19 paragraph (1);

20 (2) the checking of the identity of an individual  
21 shall be considered to be a preliminary step in a  
22 criminal history check referred to in paragraph  
23 (1)(A);

1           (3) the Attorney General shall specify restric-  
2           tions designed to protect the privacy of individuals;  
3           and

4           (4) a State that violates an applicable require-  
5           ment of this section (including any regulation issued  
6           under this section) may be denied access to the in-  
7           formation described in subsection (a).



## **MEDICARE FRAUD**

*The Symptoms and the Cure*



1301 Connecticut Ave., NW, Suite 400, Washington, D.C., 20036 (202) 467-5300  
Internet Address: [www.cagw.org](http://www.cagw.org)

### **CITIZENS AGAINST GOVERNMENT WASTE**

Citizens Against Government Waste (CAGW) is a private, nonprofit, nonpartisan organization dedicated to educating the American public about waste, mismanagement and inefficiency in the federal government.

CAGW was founded in 1984 by J. Peter Grace and nationally-syndicated columnist Jack Anderson to build public support for implementation of the Grace Commission recommendations and other waste-cutting proposals. Since its inception, CAGW has been at the forefront of the fight for efficiency, economy and accountability in government.

CAGW has a national membership of more than 600,000. Since 1986, CAGW and its members have helped save taxpayers more than \$486 billion.

CAGW publishes a quarterly newsletter, *Government WasteWatch*, and produces special reports, monographs, and television documentaries examining government waste and what citizens can do to stop it.

CAGW is classified as a Section 501(c)(3) organization under the Internal Revenue Code of 1954 and is recognized as a publicly-supported organization described in Section 509(a)(1) and 170(b)(A)(vi) of the code. Individuals, corporations, companies, associations and foundations are eligible to support the work of CAGW through tax-deductible gifts.

**Thomas A. Schatz, President**  
**Leslie K. Paige, Vice President of Policy and Communications**  
**Elizabeth L. Wright, Director of Health and Science**  
**David E. Williams, Research Director**

1301 Connecticut Avenue, NW  
Suite 400  
Washington, DC 20036  
(202) 467-5300

## MEDICARE FRAUD: THE SYMPTOMS AND THE CURE

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### Executive Summary

Citizens Against Government Waste's (CAGW) 1995 *Medicare Fraud: Tales From the Gyped* exposed and detailed many avenues of Medicare fraud. Since then, numerous hearings have been held, and legislation, the Health Insurance Portability and Accountability Act (HIPAA), was passed in 1996 to further expose and punish those responsible for gaming the system by giving the Department of Health and Human Services (HHS) Inspector General's (IG) office additional resources to aggressively combat Medicare fraud. CAGW's new report, *Medicare Fraud: The Symptoms and the Cure*, not only documents new and unsavory examples of fraud and abuse, but offers long-term solutions to improve the Medicare system itself.

The report addresses major questions surrounding Medicare, including: Who's at fault for the waste, fraud, and abuse – the system itself, those who use it, or both? Who are the real victims – the taxpayers, the seniors who rely on Medicare, or those who are expecting to draw down benefits in the future? What is the best way to cure Medicare's afflictions in the long run? Should the current course of treatment be continued; i.e., attacking fraud, reducing payments to hospitals and doctors, and marginally increasing choices for seniors in Medicare services? Or, is the country ready to embrace more innovative approaches that will allow seniors to regain control of their healthcare choices, rather than deferring to third parties and the federal government?

This report identifies dozens of examples of waste, fraud, and abuse, which can be characterized as: civil penalties, criminal penalties, kickbacks, home healthcare, nursing-home fraud, laboratory fraud, durable medical equipment fraud, hospital fraud, and program exclusions. These examples are further graphic proof that, as long as funds flow generously and indiscriminately from this impersonal and nebulous source called the government, Medicare will continue to be plagued by scam artists and crooks, as well as garden variety bureaucratic snafus and misunderstandings.

In 1995, HHS IG June Gibbs Brown estimated that up to \$17 billion, or 10 percent of Medicare funds, were lost each year because of waste, fraud, abuse and mismanagement.<sup>1</sup> In 1996, following the first comprehensive audit of Medicare since its inception 32 years ago, the IG was forced to revise that staggering figure *upward*, estimating that the true losses due to fraud, waste, and abuse were closer to \$23.2 billion a year. That is \$63 million per day, or about 14 percent of total

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<sup>1</sup> Congressional Quarterly, *Congressional Monitor*, August 1, 1995, p. 7.

program costs, in net overpayments by Medicare in FY 1996.<sup>2</sup> Almost half (46 percent) of the \$23 billion was the result of insufficient or absent documentation. The IG admitted that her staff was unable to determine exactly how many of the improper payments occurred as a result of outright fraud and how many were simply honest human errors.<sup>3</sup>

Recent high-profile Medicare investigations indicate that the system may be as much, if not more, to blame as healthcare providers. While there are certainly plenty of unscrupulous individuals bilking Medicare – and the examples offered in this report will rightly outrage the public – there are genuine disagreements between the Health Care Financing Administration (HCFA) and providers, and a significant number of these discrepancies grow directly out of misinterpretation of vague and sometimes conflicting HCFA guidelines.

HCFA has admitted that “the best hospitals can do is to be paid for their costs of furnishing services; they can also be paid less than costs, but they cannot make a profit even if they are extremely efficient.”<sup>4</sup> This no-win situation naturally drives Medicare providers to seek the highest possible reimbursements and encourages even the most law-abiding among them to stretch the rules as far as possible. Some providers conjure up ever more creative techniques to fraudulently squeeze out additional dollars. Further, Medicare’s price control system is ineffective and may reduce the quality of healthcare services available to beneficiaries. In fact, the Balanced Budget Act of 1997, with its short-term “fix” of further lowering reimbursement rates for providers, will only exacerbate this problem.

This helps explain why attacking fraud alone, although a laudable goal and the government’s only bulwark against the appalling abuses of the system, will never solve Medicare’s problems entirely. Medicare needs much more than a vigilant IG to ensure its long-term viability.

Seniors are not the only players in the Medicare debate. Legislators, law enforcement officials, lawyers, healthcare providers, healthcare consultants, accountants, and bureaucrats all have a stake in the outcome. Ironically, two groups – members of Congress and HCFA employees – wield a disproportionate percentage of power over which healthcare procedures will be covered by Medicare and at what cost, despite the fact that few of them are healthcare professionals.

Their decisions are heavily influenced by the well-organized and well-financed lobbying efforts of hundreds of special interest groups. Members of Congress are under a constant barrage from groups demanding changes to the Medicare laws

<sup>2</sup> Department of Health and Human Services (HHS), Office of the Inspector General (OIG), *Report on the Financial Audit of Health Care Financing Administration for Fiscal Year 1996 (HCFA Financial Audit)*, July 1997, p. 5.

<sup>3</sup> June Gibbs Brown, Inspector General, Department of HHS, *Audit of HCFA Financial Statements – Testimony before House Committee on Ways and Means, Subcommittee on Health*, June 17, 1997.

<sup>4</sup> Susan Horn and Robert Goldberg, “A Sickly Approach to Medicare,” *The Washington Post*, July 1994.

that address their special causes, diseases, or constituencies. Expensive legal advisors must, in turn, be retained by hospitals, healthcare professional associations, trade groups and other organizations to interpret the impact of these new laws on their ability to deliver quality healthcare to their patients. And finally, accountants, consultants and healthcare insurers must also pore over the 45,000 pages of convoluted Medicare regulations to determine which medical procedures they can bill for and for how much.

Medicare not only encourages providers to stretch the limits of reimbursement to recapture as many of their costs as possible, it also offers patients little incentive to question excessive costs or report overpayments. Because there are no rewards for delivering high quality healthcare or improving efficiency, there are no "up front" incentives for providers to control costs. Instead, there are "back-end" investigations and billing disputes, well after the money has disappeared, and lack of attention to the root causes of the problems. In this insidious cycle, more dollars are reprogrammed and committed to investigations, and regulations are constantly made more complex and vulnerable to misinterpretation, abuse, and litigation. This, in turn, leads to still more insistent calls for crackdowns and investigations.

These problems will multiply as technology and advances in medicine continue to outpace the government's ability to write and enforce new rules and regulations. Many of the newest and most innovative medical techniques are not even recognized or covered by Medicare, which means that seniors do not have access to all of the same high quality treatments under Medicare as patients under the age of 65. Medicare trails the private sector in using both managed care and healthcare outcomes to control unnecessary medical spending. The only way to control expenditures in this type of entitlement program is to specify in advance exactly what price the government will pay for each and every service rendered. A lumbering, monopolistic bureaucracy like Medicare is simply not nimble enough to keep up with a rapidly evolving industry that offers many different types of services, products, and treatments.

Real change in Medicare will only come about when the power to make healthcare decisions is taken away from politicians, bureaucrats, lawyers, consultants, and accountants, and placed into the hands of those who depend upon the program. The Balanced Budget Act of 1997 was a good start in providing seniors with more choices and more control. But it does not address the core problem: Medicare will begin to slide into bankruptcy in 10 years, as the baby boomers begin flooding the program. The commission created by the Balanced Budget Act must confront this immediate crisis head-on by taking bold steps. CAGW concurs with U.S. Rep. Pete Stark (D-Calif.), who recently wrote "Medicare beneficiaries deserve the best we can offer – quality care at an affordable price with strong protections against unscrupulous providers."<sup>5</sup>

<sup>5</sup> Congressman Pete Stark, "Letter to the Editor," *The Wall Street Journal*, September 11, 1997.

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**Waste, Fraud and Abuse - The Continuing Saga**

Medicare was created in 1965 to provide healthcare insurance benefits to the aged and other eligible populations who might not otherwise be able to afford decent health insurance coverage in the event of injury or illness.

Medicare Part A provides hospital and other institutional coverage for eligible disabled persons and persons 65 or older. This coverage is premium-free and is financed through mandatory payroll taxes. Part A is commonly referred to as the hospital insurance program.

Medicare Part B, Supplementary Medical Insurance (SMI), is an optional program that covers most of the costs of medically necessary physician and other services. All persons 65 years or older can choose to enroll in the SMI program by paying a monthly premium. Even though this is a voluntary program, non-participating taxpayers finance approximately 75 percent of the spending.

HCFA administers Medicare through more than 70 private claims processing contractors (who are really in control of the system). Healthcare providers and beneficiaries are paid by these companies, which also receive tax dollars to cover administrative expenses (approximately \$1.2 billion in 1996). According to the General Accounting Office (GAO), HCFA processed more than 800 million claims in 1996.<sup>6</sup> The sheer volume of the claims processed allows incidents like the following to occur:

- After unsuccessfully pleading insanity (claiming psychotic delusions caused him to overbill), a Boston, Massachusetts, psychiatrist was sentenced to 46 months imprisonment and fined \$1 million for Medicare and private insurer fraud, obstructing justice, and intimidating a witness. The psychiatrist attempted to get patients to lie for him and even threatened to make public the medical records of a family member of one of the patients if she didn't lie to the government. The witness refused to be intimidated and testified against him.<sup>7</sup>

In 1995, the GAO warned that, "Medicare pays more claims with less scrutiny than at any other time over the past five years."<sup>8</sup> Two years later the situation is not much better:

[P]roblems in funding program safeguards and HCFA's limited oversight of contractors continue to contribute to fee-for-service program losses. While HCFA expects a major system acquisition project to reduce certain

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<sup>6</sup> GAO, *High Risk Series: Medicare (GAO/HR-97-10)*, February, 1997, p. 15.

<sup>7</sup> Department of Health and Human Services (HHS), Office of Inspector General (OIG), *Semiannual Report*, April 1, 1996 - September 30, 1996, p. 15.

<sup>8</sup> GAO, *High Risk Series: Medicare Claims*, February, 1995, p. 7.

weaknesses, the project itself has several risks that may keep HCFA from attaining its goals. In addition, the managed care program suffers from excessive payment rates to HMOs and weak HCFA oversight of the HMOs it contracts with.<sup>9</sup>

The 1996 HHS audit identified HCFA's four internal control weaknesses that hinder Medicare from tracking its money: there is no process to estimate a national error rate for improper payments; no acceptable method for estimating Medicare accounts payable; no integrated financial reporting system to properly account for Medicare accounts receivable or other financial management and reporting issues; and deficient electronic data processing and controls relating to security access, system application development, and service continuity.<sup>10</sup>

The anti-fraud provisions passed by Congress in FY 1996 made significant changes in the oversight of Medicare fraud. HIPAA (also referred to as Kassebaum-Kennedy, after its Senate co-sponsors) contained increased funding for IG activities, along with provisions that will enable the government to recoup more of its losses. The Balanced Budget Act also contained measures to stave off Medicare's financial failure until 2007. Congress chose to carve out the bulk of the savings over the next five years, \$115 billion, by once again reducing payments to doctors, hospitals, and other healthcare providers.

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### Combating Health Care Fraud

Since 1995, the HHS IG's office has stepped up its attacks on Medicare fraud. That year, the department established Operation Restore Trust in California, Florida, Illinois, New York, and Texas, to target areas of waste, fraud, and abuse. HHS joined forces with multiple federal and state agencies to examine the activities of home healthcare agencies, nursing homes, and durable medical equipment suppliers. According to Michael Mangano, HHS's principal deputy inspector general, the IG eventually expects to recover about \$1.1 billion through criminal cases and civil settlements.<sup>11</sup> This is an enormous increase over last year's collections, which totaled \$205 million (the IG collected \$69.8 million five years ago). That figure does not include any collections that may accrue as a result of the IG's ongoing investigation of Columbia/HCA, the largest tax-paying hospital chain in the country.<sup>12</sup>

In May 1997, the IG's office reported that for every dollar spent on Operation Restore Trust, \$23 was recovered. It identified more than \$187.5 million in fines, recoveries, settlements, audit disallowances, and civil monetary penalties. There are still hundreds of pending cases. Because of the program's success, HIPAA

<sup>9</sup> GAO, *High Risk Series: Medicare*, February, 1997, p. 8.

<sup>10</sup> Department of HHS, OIG, *HCFA Financial Audit 1996*, July 1997, p. 2.

<sup>11</sup> David S. Hilzenrath, "Bold Scams Bilk Medicare of Billions," *The Washington Post*, August 8, 1997.

<sup>12</sup> Greg Jaffe and Eva Rodriguez, "In Hospital Probes, a New Focus on Bottom Line," *The Wall Street Journal*, September 12, 1997.

will double the IG's appropriation over the next seven years and the operation will be expanded to include specific targets in all 50 states. Eventually, it will be applied in all 50 states and throughout all Medicare program areas.

Tracking and punishing fraud, of course, are vital parts of administering any government program. And, as a result of some of new laws governing Medicare, they have also become more lucrative. But there are risks. Recent congressional hearings on the Internal Revenue Service (IRS) should serve as a cautionary tale about what can happen when federal law enforcement officials exceed their authority in response to financial or other incentives.

According to *The Wall Street Journal*, almost all 187 hospitals in Ohio recently received letters from federal officials accusing them of overbilling Medicare for blood and urinalysis tests. The letters then offered settlements in lieu of prosecution.<sup>13</sup> Investigations and audits must not become institutionalized government shakedowns.

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#### Civil Penalties for False Claims

Congress enacted the Civil Monetary Penalties Act to empower the IG to impose penalties and assessments against healthcare providers who submit false or improper claims to Medicare and state healthcare programs. The law allows the government to try to recover money lost through illegitimate claims and to impose additional penalties, if necessary. The IG may now also direct companies found to have engaged in improper billing or other transgressions to enter a corporate integrity program and submit to increased scrutiny in order to remain in Medicare.

The IG is currently monitoring 70 such corporate integrity programs, from small physician offices to large laboratory corporations. Most supervision lasts for 5 years and compels active participation by the provider to certify that it is operating within HCFA regulations and the parameters established by the plan. Failure to comply may result in lengthy, or permanent, exclusion from participation in Medicare.

The following are recent examples of civil cases and their settlements:

- A Massachusetts laboratory agreed to pay \$6.67 million to settle charges that it overbilled Medicare. According to the IG, the laboratory routinely billed Medicare for a serum iron test whenever a physician requested a standard panel of tests, even though the iron test was not specifically requested. The laboratory improperly collected more than \$3.35 million from Medicare for the unnecessary tests.<sup>14</sup>

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<sup>13</sup> *Idem*.

<sup>14</sup> HHS, OIG, *Semiannual Report*, April 1, 1996 - September 30, 1996, p. 12.

- A New Jersey corporation performing X-ray and electrocardiographic services used subsidiaries in Massachusetts and Pennsylvania to illegally bill in regions where reimbursement rates were higher. The corporation agreed to pay \$2.1 million to settle the case, and the president and vice president of one subsidiary pled guilty for their involvement in the scheme.<sup>15</sup>
- After submitting false claims to the Medicare and Medicaid programs for experimental cardiac devices that were not FDA-approved, a California hospital paid nearly \$1.3 million to resolve its civil liability.<sup>16</sup>
- In early 1997, four Georgia healthcare providers agreed to pay \$2 million to settle allegations of Medicare fraud. According to the Justice Department, California-based Apria Healthcare Group Inc. used sham consulting contracts to give kickbacks to physicians in exchange for referrals of Medicare patients. Apria, one of the nation's largest suppliers of medical equipment and oxygen, agreed to pay \$1.65 million. The other companies involved were Georgia Lung Associates, which agreed to pay \$346,000; Pasa del Norte Health Foundation of El Paso, Texas, which agreed to pay \$20,000; and Physicians Pharmacy Inc. of Georgia, which agreed to pay \$4,000.<sup>17</sup>
- Between 1991 and 1993, a Philadelphia psychiatrist and his wife filed numerous false Medicare and Medicaid claims by billing for therapy that was not provided, for unsupervised treatments, and for more therapy units than were provided. The psychiatrist attempted to destroy records when federal investigators searched his office. The couple agreed to pay a \$500,000 settlement and entered a corporate integrity program.<sup>18</sup>
- A New Jersey medical supply company paid \$330,000 to settle charges that it billed Medicare for expensive, custom-fitted "spinal body jackets" that were actually little more than seat cushions provided to nursing home residents.<sup>19</sup>
- Pennsylvania-based Mediq Inc. and its subsidiary, ATS Inc., agreed to a settlement in which ATS and its president pled guilty to concealing a felony and ATS agreed to pay \$2.1 million in fines. The settlement was the result of a whistleblower lawsuit, which exposed illegal cross-billing of portable EKGs and portable X-rays. ATS billed services performed in

<sup>15</sup> HHS, OIG, *Semiannual Report*, October 1, 1995 – March 31, 1996, p. 14.

<sup>16</sup> *Idem*.

<sup>17</sup> Bill Rankin, "Medicare Fraud Case Settled for \$2 million," *Atlanta Journal-Constitution*, February 6, 1997.

<sup>18</sup> HHS, OIG, *Semiannual Report*, October 1, 1995 – March 31, 1996, p. 15.

<sup>19</sup> Alice Ann Love, "Medicare Crackdown to Target 12 New States," *The Orange County Register*, May 21, 1997.

one carrier's jurisdiction to a carrier in another jurisdiction where reimbursement rates were higher.<sup>20</sup>

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### Criminal Penalties

Medicare fraud is often tried as a criminal offense, and a conviction can lead to jail time for the perpetrators. Recent criminal convictions for Medicare fraud include the following cases:

- A former Colorado heart surgeon was convicted of Medicare and Medicaid fraud for billing for heart bypasses he never performed. The surgeon was sentenced to 30 days' incarceration, 3 years' probation, and 200 hours of community service. Total restitution, fines, and damages recovered totaled \$30,000.<sup>21</sup>
- An Oregon ophthalmologist pled guilty and was sentenced to 2 years' probation and fined \$10,370 for submitting false claims for medically unnecessary cataract surgeries. Though his patients had near-perfect vision prior to surgery, the ophthalmologist gave the hospital false information about the patients' true visual abilities. He subsequently surrendered his medical license and declared bankruptcy.<sup>22</sup>
- The owner and chief executive officer of Georgia's largest home healthcare agency pled guilty to charging Medicare and Medicaid for campaign contributions, phantom employees, and personal vacations. She was sentenced to 33 months in prison, followed by 3 years' supervised work release, including 200 hours of community service. She was fined \$25 million and ordered to pay \$11.5 million in restitution. The company's former vice president was fined \$75,000, had to repay \$710,000, and was sentenced to 151 months incarceration followed by 3 years' probation. The agency's former risk manager was ordered to repay \$710,000 and received 97 months' incarceration and 3 subsequent years of probation.<sup>23</sup>
- A joint audit and investigation revealed that a California nursing home owner had billed Medicare for nonexistent medical supplies and filed false cost reports. The former owner was sentenced to more than 11 years in prison and was ordered to pay more than \$3.5 million in fines, restitution, and special assessments. Two former Medicare carriers and two former employees also pled guilty and were sentenced after they testified against the owner.<sup>24</sup>

<sup>20</sup> U.S. Department of Justice, *Department of Justice Health Care Fraud Report: Fiscal Years 1995 - 1996*, p. 25.

<sup>21</sup> HHS, OIG, *Semiannual Report*, April 1, 1996 - September 30, 1996, p. 16.

<sup>22</sup> *Idem*.

<sup>23</sup> HHS, OIG, *Semiannual Report*, October 1, 1995 - March 31, 1996, p. 19.

<sup>24</sup> *Ibid.*, pp. 19-20.

- A laboratory clerk and her husband (the president of the laboratory) used a fraudulent passport to set up a laboratory. The clerk and her husband submitted more than 700 claims for 416 beneficiaries (many of whom were already dead) and collected \$330,000 over a 60-day period. One of the "referring physicians" had been dead for 2 years. The wife was sentenced in Florida to 9 months in prison, 2 years' supervised release, and ordered to pay a \$50 special assessment. The husband was arrested after trying to withdraw \$200,000 from the corporate account and was sentenced to 10 months in prison, 3 years probation, and ordered to make restitution of \$115,800.<sup>25</sup>
- After pleading guilty to submitting false claims for complex procedures that he did not perform, a California urologist was sentenced to 24 months in prison. Before the sentencing, he agreed to pay \$440,000 in damages and penalties. The urologist will be barred from participation in Medicare for 10 years due to the egregious nature of his crimes. For example, he performed invasive procedures that he admitted were not medically necessary. He has also surrendered his medical license.<sup>26</sup>
- While employed by a doctor as an office manager, a Texas woman submitted false claims for a personal friend, even though no services were performed. The two split the proceeds when the checks came in. The office manager was sentenced to a year and a day in prison and ordered to make restitution of \$41,500. The friend was sentenced to one year probation and fined \$2,550.<sup>27</sup>
- A former IRS mail clerk was sentenced to five months in prison and five months' home confinement with electronic monitoring, followed by one year supervised release, for impersonating a federal officer, intimidating a witness, and obstructing a Medicare fraud investigation. Before becoming an IRS employee, he had worked for an ambulance company that was being investigated for fraudulent Medicare billing. During that investigation, several company employees revealed that the man had claimed to be an IRS agent and had threatened at least one of them with a tax audit if he cooperated with authorities.<sup>28</sup>
- A psychologist in Pennsylvania was sentenced to 6 months' home detention, 12 months' probation, and 300 hours of community service for mail fraud. Over a 4-year period, she billed Medicare for more than 700

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<sup>25</sup> *Ibid.*, p. 21.

<sup>26</sup> HHS, OIG, *Semiannual Report*, October 1, 1996 – March 31, 1997, pp. 21-22.

<sup>27</sup> HHS, OIG, *Semiannual Report*, October 1, 1996 – March 31, 1997, p. 23.

<sup>28</sup> *Idem.*

services that were never provided. The Medicare loss was estimated at \$113,000.<sup>29</sup>

- Blake Alan Wimpee was sentenced to 18 months in prison for submitting false claims to Medicare. Between 1994 and 1996, Mr. Wimpee billed Medicare for 28 power wheelchairs when he actually provided electric scooters instead. As a result, Medicare overpaid the San Angelo, Texas businessman by more than \$82,000.<sup>30</sup>
- In 1996, Ronald W. Nemeroff pled guilty in U.S. District Court in Newark, New Jersey, to paying kickbacks of \$36,000 to get \$145,000 worth of Medicare-funded orders for equipment.<sup>31</sup>

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### Kickbacks

Many businesses use referrals as an integral part of their day-to-day operations to meet customer needs and provide specialized medical services that are not part of their expertise. The healthcare system is especially dependent on referrals because there are so many medical specialty areas. A referral becomes a kickback when patients are referred in exchange for anything of value. Both parties, the giver and the receiver, share culpability under the law. Medicare requires that referrals be made in the best interest of the patient and without financial gain by either party.

Medicare's anti-kickback statute "penalizes anyone who knowingly and willfully solicits, receives, offers or pays remuneration in cash or in kind to induce or in return for:

- referring an individual to a person or entity for the furnishing, or arranging for the furnishing, of any item or service payable under the Medicare or Medicaid programs; or
- purchasing, leasing or ordering, or arranging for or recommending the purchasing, leasing, or ordering of any good, facility, service or item payable under the Medicare or Medicaid programs."<sup>32</sup>

The following are recent examples of Medicare kickback schemes:

- In the first case initiated under the anti-kickback law, a group of cardiologists in a Massachusetts hospital, who are not permitted to bill Medicare for interpreting coronary angiograms and ventriculograms, gained the illicit cooperation of a group of radiologists, who agreed to pass

<sup>29</sup> Idem.

<sup>30</sup> Associated Press, "Medicare Supplier Gets Prison Time for Fraud," *San Antonio Express-News*, June 8, 1997.

<sup>31</sup> Jerry DeMarco, "Guilty Plea in Kickback Scheme," *The Record*, September 25, 1996.

<sup>32</sup> HHS, OIG, *Semiannual Report*, April 1, 1996 – September 30, 1996, p. 17.

the bills through to Medicare. The hospital paid agreed to pay \$177,000 in restitution.<sup>33</sup>

- Tony Abad, a 43-year-old Florida X-ray and ultrasound technician who owned and operated Physicians Choice Diagnostic Service Inc., was charged with 24 counts of paying illegal kickbacks for Medicare business.<sup>34</sup>
- Two brothers were found guilty by a New York jury for conspiracy related to fraudulent Medicare claims. The brothers visited senior citizen highrises and conducted health fairs where they coaxed Medicare beneficiaries into revealing their Medicare identification numbers. The brothers then used the numbers to forge certificates of medical necessity to two durable medical equipment (DME) companies. The companies then billed for equipment, much of which was never supplied, costing Medicare \$750,000. The brothers received "commissions" based upon the cost of each piece of equipment.<sup>35</sup>
- Five owners of licensed branches of the Florida Impotence Clinic Inc. were indicted for receiving kickbacks for referring Medicare patients to medical equipment manufacturers and service providers.<sup>36</sup>
- A former salesman for a New York DME company was sentenced to four months in prison, followed by 2 years' probation, and \$13,500 in restitution fines for Medicare fraud conspiracy. The salesman recruited patients for his father, a semi-retired podiatrist, in return for the patients' Medicare identification numbers and signed certificates of medical necessity. The salesman then turned around and sold the certificates to his employer. The father was sentenced to three years probation and four months home confinement for billing Medicare and private health insurance for treatments not done and visits not made.<sup>37</sup>
- Physicians First Choice and Somed Company, both owned by Frank J. Lopez of Clearwater, Florida, are accused of paying clinics for Medicare patient referrals and then including the payments in their charges to Medicare. The government is seeking triple damages on 17,000 false claims that Lopez's companies submitted, for a total of \$170 million in punitive damages.<sup>38</sup>

<sup>33</sup> *Idem*.

<sup>34</sup> Mark Albright, "Medicare Fraud Inquiry Spreads," *St. Petersburg Times*, August 1, 1997.

<sup>35</sup> HHS, OIG, *Semiannual Report*, October 1, 1995 - March 31, 1996, p. 22.

<sup>36</sup> Mark Albright, "Medicare Fraud Inquiry Spreads," *St. Petersburg Times*, August 1, 1997.

<sup>37</sup> HHS, OIG, *Semiannual Report*, October 1, 1995 - March 31, 1996, p. 23.

<sup>38</sup> Mark Albright, "Medicare Fraud Inquiry Spreads," *St. Petersburg Times*, August 1, 1997.

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### Home Healthcare

Home healthcare is a rapidly growing industry that allows seniors to receive care in their own homes for less than the cost of hospitalization or nursing home care. Unfortunately, it has become rife with fraud and abuse. A recent government audit found that 40 percent of home healthcare visits reimbursed by Medicare in California, Illinois, New York, and Texas do not qualify for reimbursement. Another IG report uncovered the fact that 25 percent of home healthcare agencies certified to participate in Medicare have defrauded or exploited the program at one time or another. Medicare spends \$17 billion per year on home healthcare services.<sup>39</sup>

Ironically, it was Medicare's policies that helped spawn the huge explosion into home healthcare spending. Much of the technology that has been developed in recent years allows many medical procedures to be performed at home, often by patients themselves. Medicare deliberately offered generous payments for home healthcare, based upon the fact that caring for someone at home is less expensive and more desirable for seniors than admitting them to a hospital. But in the process, Medicare allowed for unlimited payments for a wide variety of home healthcare services instead of capping prices as it has for in-hospital care.

The Balanced Budget Act passed this year by Congress will require home healthcare agencies and other post-acute healthcare providers to move from Medicare's current cost-based reimbursement system to the prospective payment system (PPS) by 1999. It is believed that under PPS, hospitals will no longer have the incentive to shift acute-care costs to home healthcare operations.<sup>40</sup>

After years of promoting the expansion of home health care agencies and then failing to exercise oversight, the Clinton Administration has finally taken steps to address the problem by announcing a moratorium on the acceptance of new home healthcare agencies and by a doubling of the number of investigators assigned to examine agencies' activities. This is the first time since Medicare was implemented that a whole section of the healthcare industry has been barred from admission to the program. The moratorium will put the brakes on what has been one of the fastest growing segments of the healthcare industry -- Medicare was accepting an average of 100 new home healthcare companies each month. Furthermore, currently certified home healthcare companies will be required to reapply for admittance to remain eligible to receive Medicare reimbursements.<sup>41</sup>

In Florida alone, the IG found that:

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<sup>39</sup> Testimony of George F. Grob, Deputy Inspector General for Evaluation and Inspections HHS Office of Inspector General, Hearing before the Senate Special Committee on Aging, July 28, 1997, p. 1.

<sup>40</sup> Charlotte Snow, "Home Health Heats Up," *Modern Healthcare*, August 18, 1997, p. 30.

<sup>41</sup> Amy Goldstein, "President Acts to Curb Home Health Care Fraud," *The Washington Post*, September 16, 1997.

- In Miami Lakes, 24 percent of claims did not meet guidelines: 11 percent were for 145 services that were not reasonable or necessary, 9 percent were for 177 services that physicians either denied authorizing or authorized improperly, and 4 percent were for 24 services that were not provided.<sup>42</sup>
- In Miami, 40 percent of claims did not meet Medicare guidelines: 25 percent of the claims were for 466 services made to individuals who were not homebound; 8 percent of the claims were for 200 services that were not reasonable or necessary; 5 percent of the claims were for 127 services that were not provided; and 2 percent of the claims were for 53 services that physicians denied authorizing.<sup>43</sup>
- In Dade County, 32 percent of claims did not meet Medicare guidelines: 16 percent were for 208 services that were not reasonable or necessary; 9 percent of the claims for 129 services were provided to beneficiaries who were not homebound; 4 percent were for 18 services that were not provided; and 3 percent were for 48 services that physicians either denied authorizing or authorized improperly.<sup>44</sup>
- In one Florida home healthcare agency (HHA), 32 percent of claims did not meet Medicare guidelines: 23 percent were for 262 services that were not reasonable or necessary; 5 percent were for 69 services provided to beneficiaries who were not homebound; 3 percent were for 17 services that physicians did not authorize; and 1 percent were for 5 services that were not provided. During this fiscal year period, the HHA claimed \$12 million in 8,700 claims representing 151,015 services.<sup>45</sup>

Other examples of home healthcare fraud include:

- Some people in the home healthcare business are very generous to their relatives. One HHA hired the owner's nephew to maintain its computer system. The nephew was a full-time college student and was paid \$250,000 for the work.<sup>46</sup>
- The former owner of a Michigan HHA was sentenced to 5 months house arrest and ordered to pay \$18,000 for his participation in Medicare fraud. He sold his agency in December 1994 to a Georgia agency but backdated the sale to November 12, 1994. This sleight-of-hand allowed the corporation to bill Medicare for all the services provided by the former owner's HHA, thereby covering nearly all of the corporation's acquisition

<sup>42</sup> HHS, OIG, *Semiannual Report*, April 1, 1996 – September 30, 1996, p. 18.

<sup>43</sup> *Idem*.

<sup>44</sup> *Idem*.

<sup>45</sup> HHS, OIG, *Semiannual Report*, October 1, 1996 – March 31, 1997, pp. 24-25.

<sup>46</sup> HHS, OIG, *Home Health: Problems and Their Impact on Medicare*, July 1997, p. 9.

costs. Although the former owner provided no services, he received a \$5,000 a month salary from December 1994 to June 1995.<sup>47</sup>

- The former owner of a Texas HHA was handed a sentence of 27 months after he pled guilty to filing false Medicare claims totaling more than \$49,000 in only 6 months. The harsh sentence was partly due to a previous state conviction for embezzlement.<sup>48</sup>
- Two brothers in Texas conspired to include phony expenses for medical supplies, office supplies, and automobile leases on Medicare claims forms. One brother was the president of a medical supply company, which sold equipment to the other brother's agency at a 100 percent markup. The two then altered invoices for supplies not purchased and fabricated automobile lease contracts from vendors who never leased vehicles. They agreed to pay \$30,000 to resolve their civil liabilities.<sup>49</sup>
- In 1996, John Watts, Jr. pled guilty to defrauding Medicare of at least \$1.5 million. He started his company, United Care Home Health Services Inc., just 13 months after finishing a prison term for dealing cocaine. Watts paid kickbacks to local doctors to get his first patients, but later decided it was easier just to bill for services never provided, in some cases using the names of dead people. Watts sent his claims via computer. When investigators asked for documentation of the services, Watts and his partner forged the documents, hoodwinking investigators for several months. Watts made so much money with the scam that he was able to put a \$1.2 million cash down payment on a \$2.5 million house.<sup>50</sup>
- In less than one year, Urgent Home Health Care of Washington, D.C., billed for 1,450 visits its nurses never made, often leaving patients waiting for needed care. The owners of the company, Pauline Bapack and Pierre Yopa, collected about \$100,000 for those fraudulent billings. Bapack was sentenced to three years in jail. Yopa is wanted for failing to show up for sentencing.<sup>51</sup>

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### Nursing Home Fraud

Most nursing home staffs are trustworthy providers of care and comfort for seniors who are unable to care for themselves. When nursing home doctors, nurses, suppliers, or staffs defraud the Medicare system for personal gain, they

<sup>47</sup> HHS, OIG, *Semiannual Report*, April 1, 1996 – September 30, 1996, p. 19.

<sup>48</sup> HHS, OIG, *Semiannual Report*, October 1, 1996 – March 31, 1997, pp. 26-27.

<sup>49</sup> *Ibid.*, p. 27.

<sup>50</sup> Peter Eisler, "Fraud On the Rise," *USA Today*, November 12, 1996.

<sup>51</sup> Brooke A. Masters, "Investigators Try to Keep up with Growing Problem of Health Care Fraud," *The Washington Post*, April 6, 1997.

break that trust. The GAO identified two reasons why nursing homes are so vulnerable to fraud:

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 direct care of the patient, contrary to federal regulations that prohibit such inappropriate access.<sup>52</sup>

As the baby-boom generation matures and more seniors enter the nursing home system, the potential for fraud will explode. The following cases are recent examples of fraudulent schemes involving nursing home facilities:

- An Ohio hospital agreed to pay the federal government \$1.45 million to settle charges of defrauding the Medicare and Medicaid programs. False claims for geriatric psychiatric services that were non-therapeutic or unnecessary were submitted while the hospital was operating an outpatient clinic for nursing home patients. Many of the patients suffered organic brain disorders that did not call for psychiatric treatments, resulting in an overpayment to the hospital of more than \$600,000. The hospital agreed to enter a corporate integrity program.<sup>53</sup>
- A company in New Jersey that employed psychologists to provide services to nursing home residents agreed to pay \$700,000 to settle allegations it submitted false Medicare claims. The company billed for 45 to 50 minutes of psychotherapy to nursing home residents when only 20 to 30 minute sessions were held. Some of the company's psychologists billed for more than 14 hours of therapy a day, and one billed for the equivalent of more than 24 hours in one day. The company has entered a corporate integrity program.<sup>54</sup>
- An Illinois ambulance company owner and one of his employees pled guilty to Medicare and Medicaid fraud for filing false and inflated claims for same-day, round-trip transfers of nursing home patients, many of whom were in fact bed-confined. The company owner was sentenced to 5 months' incarceration, ordered to sell his business, and fined \$10,000. He had previously agreed to a \$367,000 civil settlement. The employee was given two years probation and fined \$500.<sup>55</sup>

<sup>52</sup> GAO, *Fraud and Abuse: Providers Target Medicare Patients in Nursing Homes* (GAO/HEHS-96-18), January, 1996, p. 2.

<sup>53</sup> HHS, OIG, *Semiannual Report*, April 1, 1996 – September 30, 1996, pp. 22-23.

<sup>54</sup> HHS, OIG, *Semiannual Report*, October 1, 1996 – March 31, 1997, pp. 29-30.

<sup>55</sup> *Ibid.*, pp. 30-31.

- A podiatrist received \$143,580 for performing unneeded surgical procedures on at least 4,400 nursing home patients during a six-month period. A doctor would have to operate on at least 34 patients per day, five days a week in order to perform surgery at that volume.<sup>56</sup>
- A Florida therapy company provided free services to nursing homes, then billed group activities such as sing-alongs and arts-and-crafts classes as individual therapy for each patient. The sing-alongs were billed as speech therapy. The arts-and-crafts classes were billed as occupational therapy. The company offered the services to the nursing homes in exchange for information from the patients' charts, which they then used to bill Medicare.<sup>57</sup>

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### Laboratory Fraud

HHS determined in 1993 that many independent clinical laboratories were billing Medicare for millions of tests that were medically unnecessary. Many individual lab tests are included in a routine screen, or panel, of tests. Some laboratories, however, were leading physicians to believe that the tests were free of charge and then billed Medicare for them anyway. The government ordered a national investigation involving the HHS IG auditors, HCFA staff, U.S. attorneys, and federal law enforcement agencies to examine clinical laboratories.<sup>58</sup> What follows are some examples of fraud uncovered during those investigations:

- In one of the biggest financial settlements involving healthcare fraud in the history of the False Claims Act, one laboratory agreed to a \$325 million settlement and entered a corporate integrity agreement to ensure stringent compliance in its future billing practices.<sup>59</sup>
- A laboratory owned by SmithKline Beecham allegedly programmed computers to fabricate information for Medicare claims when missing or incomplete data would have delayed payment and, in some cases, substituted a false diagnosis that would assure payment instead of submitting one that would be rejected. The company has also been accused of unbundling tests, charging for tests that doctors never ordered, and offering physicians kickbacks for patient referrals.<sup>60</sup>
- Another major clinical laboratory agreed to pay \$187 million to resolve its civil liabilities and to enter a corporate integrity program with comprehensive training and monitoring. One of its constituent

<sup>56</sup> GAO, *Fraud and Abuse in Nursing Homes*, p. 4.

<sup>57</sup> Lindsay Peterson, "Medicare Swindlers Exposed," *The Tampa Tribune*, June 23, 1996.

<sup>58</sup> U.S. Department of Justice, *Health Care Fraud Report, Fiscal Years 1995 - 1996*, p. 7.

<sup>59</sup> HHS, OIG, *Semiannual Report*, October 1, 1996 - March 31, 1997, p. 32.

<sup>60</sup> David S. Hilzenrath, "Medicare Scams Easy, Officials Say," *The Florida Times Union*, August 10, 1997.

laboratories also pled guilty to fraud, paid a \$5 million criminal fine, and was excluded from participation in federal and state healthcare programs.<sup>61</sup>

- A fourth major independent laboratory fell victim to "successor liability" for the conduct of laboratory companies that it had purchased during its growth in the early 1990s. Two settlements were reached amounting to \$130 million, bringing the total amount recouped in this case thus far to \$185 million.<sup>62</sup>
- In early 1997, Medicalab Inc. and its owners agreed to pay \$1.3 million to settle allegations that it defrauded Medicare by overbilling for mileage traveled by workers and charging for duplicate radiology services.<sup>63</sup>

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### Durable Medical Equipment

DME is one of the more prevalent and long-standing areas of fraud. Medicare is often billed for higher-cost equipment than that which is actually delivered, equipment that never arrives at all, medically unnecessary equipment and supplies, or equipment delivered in one state but billed in a state where the reimbursement rates are more generous. The HHS IG's office has made investigating DME scams one of its highest priorities. There are a number of ingenious scams used by unscrupulous companies and individuals in order to squeeze more money out of Medicare, including the following cases:

- A New York physician, who was sentenced to 12 months' imprisonment and ordered to pay \$87,000 in restitution, was one of 19 people participating in a scam involving a medical supply company which ended up costing Medicare more than \$13 million over an 18-month period. Without ever seeing patients, the physician signed medical necessity forms, then falsified medical charts to indicate treatment.<sup>64</sup>
- Ben Carroll, owner of Bulldog Medical of Kissimmee Inc. and MLC-Geriatric Health Services, was sentenced to 10 years in prison for overbilling Medicare by \$71 million. Mr. Carroll billed Medicare for urinary-collection pouches costing \$8.45 each, when what he actually supplied were adult diapers costing only 35 cents each. He also pled guilty to defrauding Medicare of \$2.3 million in Kansas City, Kansas.<sup>65</sup>

<sup>61</sup> HHS, OIG, *Semiannual Report*, October 1, 1996 – March 31, 1997, p. 32.

<sup>62</sup> *Idem*.

<sup>63</sup> Associated Press, "Lab Settles Medicare Fraud Allegations with Feds for \$1.3 Million," *The Boston Globe*, July 1, 1997.

<sup>64</sup> HHS, OIG, *Semiannual Report*, April 1, 1996 – September 30, 1996, pp. 24-25.

<sup>65</sup> Maya Bell, "Medicare Easy Target for Thieves," *Orlando Sentinel*, June 15, 1997; and Associated Press, "\$71 Million Medicare Overbilling Alleged Against Medical Supplier," *The Washington Post*, October 13, 1996.

- Alfredo Lazaro Borges of Miami set up two phony DME supply companies and, using the Medicare identification numbers of patients and the names and identification numbers of several licensed physicians, filed falsified Medicare claims between August 1993 and June 1994. He stole \$2.6 million in the course of one year. He never saw a patient, nor did he ever provide anyone with any medical equipment.<sup>66</sup>
- The FBI is investigating complaints that several companies in the Tampa Bay area offered free motorized wheelchairs to residents of a seniors' housing complex, but delivered motor scooters instead. The scooters sell for around \$1,700 each; Medicare was billed and paid nearly \$5,000 each for what it thought were wheelchairs.<sup>67</sup>
- In Charlotte, North Carolina, federal prosecutors have charged five men and one woman with filing more than 11,000 fraudulent Medicare claims for medical supplies and equipment.<sup>68</sup>
- On December 13, 1996, Arthur Schinitzky, a supplier of medical equipment based in Bradenton, Florida, pled guilty to charges that he defrauded Medicare by submitting claims for services he never delivered. On some of the claim forms, he used the Social Security numbers of dead people. His network of transactions involved at least 15 real or fictitious businesses in three states, and relied heavily on mail services, which helped delay his capture. Two of his employees have also been charged with complicity in the scams. In all, Mr. Schinitzky is accused of stealing \$9 million from the government.<sup>69</sup>
- As part of a plea bargain agreement, a Texas DME company paid restitution of \$450,000 and was sentenced to one year probation for supplying wheel chair pads to nursing home patients and then fraudulently billing Medicare for a more expensive lumbar sacral support system.<sup>70</sup>
- A physician fled to the Dominican Republic and his cohort in crime fled to Sierra Leone for preparing and signing fraudulent certificates of medical necessity for DME. A New York judge sentenced the Dominican refugee in absentia to 78 months in prison and ordered him to pay \$3.5 million. His partner waived extradition to return to the United States.<sup>71</sup>
- A New York DME company used a sham subsidiary to submit claims in Pennsylvania for equipment sold in Western New York. In addition to a

<sup>66</sup> "Man Sentenced for Fraud," *Fort Lauderdale Sun-Sentinel*, March 22, 1997.

<sup>67</sup> Lindsey Peterson, "Scooter Bills Spur Probe," *Tampa Tribune*, July 27, 1997.

<sup>68</sup> Harvey Burgess, "Fraud Suspect Strikes Deal," *The Herald Rock Hill*, April 25, 1997.

<sup>69</sup> Sara Langenberg, "Medicare Fraud Charges Spread," *Sarasota Herald-Tribune*, April 16, 1997.

<sup>70</sup> HHS, OIG, *Semiannual Report*, October 1, 1995 - March 31, 1996, p. 26.

<sup>71</sup> HHS, OIG, *Semiannual Report*, October 1, 1996 - March 31, 1997, p. 34.

criminal fine of \$300,000, the subsidiary also pled guilty and agreed to make full restitution of \$1.1 million and to pay a civil penalty of \$2.5 million.<sup>72</sup>

- A Pennsylvania DME company agreed to pay \$110,000 to settle criminal and civil liabilities for submitting false claims to Medicare for marketing and distributing lower-quality body jackets to long-term care facilities than those actually delivered. The company and its president were barred for life from participation in any HHS programs.<sup>73</sup>

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### Lymphedema Pumps – A Special Look

A significant area of abuse in DME has been the purchase of lymphedema pumps. Lymphedema is the swelling of an arm, leg, or other part of the body, a condition that can occur when lymph nodes and vessels in the armpit or the groin have been removed or damaged by surgery, radiotherapy, or blocked by a tumor. This condition is most common in cancer patients whose lymph nodes have been removed. Although there is no cure for lymphedema, several treatments are available to control swelling, including pumps. These pumps vary in complexity and range in price from \$600 to \$6,000 each. HCFA recognizes the pumps as a treatment of last resort.<sup>74</sup>

Several medical supply companies have settled charges that they defrauded Medicare for marketing and selling lymphedema pumps for \$500 while billing Medicare \$5,000 each. The allegations of fraud were first made by Ron Wells, the owner of a medical supply company. In 1991, Wells was approached by Huntleigh Technology Inc., an American subsidiary of Huntleigh Technology of Great Britain, and asked to participate in a network of retailers offering the pumps for the marked-up price. Wells realized that the pumps were identical to a version that cost only \$600 and reported the company's improprieties to authorities. The government's investigation led to a settlement with Huntleigh in which the company agreed to repay \$4.9 million.<sup>75</sup>

Many of the medical supply companies that purchased the pumps from Huntleigh have also reached settlements with the government. The latest settlement came in May 1997, when Mediserv Inc. of Texas agreed to pay \$1.35 million and Medico International Inc. of New Jersey agreed to pay \$150,000. In all, the federal government has garnered \$15 million from settlements of such charges. None of the companies were required to admit wrongdoing, however. Between 1990 and

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<sup>72</sup> *Ibid.*, p. 35.

<sup>73</sup> *Ibid.*, p. 36.

<sup>74</sup> *Idem.*

<sup>75</sup> Robert Rudolph, "U.S. To Reward Whistleblower for Diagnosing Medi-Fraud," *The Star-Ledger*, May 24, 1997, p. 1.

1992, Medicare claims for the pumps jumped from \$4.8 million to \$49.1 million.<sup>76</sup> A few specific examples:

- The former owner of New Jersey's largest Medicare supplier of lymphedema pumps was sentenced to 35 months in prison followed by 3 years supervised release, fined \$7,500, and ordered to pay a total of \$220,100 in restitution for a scheme involving beneficiaries in Florida and New Jersey. The owner billed Medicare for pumps reimbursable at \$4,000 per pump when cheaper quality pumps were actually delivered. In addition, many of the pumps were medically unnecessary, and overpayments totaled more than \$200,000.<sup>77</sup>
- A Maryland DME company agreed to pay \$1.5 million and enter a corporate integrity program to prevent future incorrect billing after submitting claims for lymphedema pumps under an improper code. The company was overpaid approximately \$690,000.<sup>78</sup>
- Bernice Tambascia, owner of MedFast Inc., forged physicians' signatures for prescriptions of lymphedema pumps and billed Medicare in New Jersey and Florida for the equipment. She was sentenced to 2 years and 11 months in jail, and ordered to make immediate restitution of nearly \$200,000 to Medicare carriers and to a private insurance company.<sup>79</sup>
- In October 1995, National Medical Systems agreed to a \$1.5 million settlement for billing the government for 200 top-of-the-line lymphedema pumps when it provided much cheaper equipment. Public Integrity Inc., a watchdog group for the medical equipment industry, received \$225,000 for bringing the qui tam suit that led to the settlement.<sup>80</sup>
- The former owner/operator of a DME company in the state of Washington was sentenced to a year and a day in prison, 3 years' supervised release, and ordered to pay \$294,860 in restitution, fines, and penalties. He billed Medicare and private insurance companies for lymphedema pumps at \$4,500 each, but delivered pumps that were only worth \$600 and pocketed the difference.<sup>81</sup>

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### Hospital Fraud

Recent headlines demonstrate that Medicare fraud is also occurring in some of the nation's most prestigious hospitals. The chief executive officer of the largest

<sup>76</sup> Idem.

<sup>77</sup> HHS, OIG, *Semiannual Report*, October 1, 1996 – March 31, 1997, p. 37.

<sup>78</sup> HHS, OIG, *Semiannual Report*, October 1, 1995 – March 31, 1996, p. 25.

<sup>79</sup> Joseph D. McCaffrey, "Cherry Hill Woman Gets Prison in Med-Fraud," *The Star-Ledger*, September 20, 1996.

<sup>80</sup> John Rivera, "Health Care Fraud Cases on the Rise," *The Baltimore Sun*, August 19, 1996.

<sup>81</sup> HHS, OIG, *Semiannual Report*, October 1, 1996 – March 31, 1997, p. 37.

investor-owned hospital chain in the U.S., Columbia/HCA, was forced to resign after three employees at a Columbia hospital in Florida were indicted for Medicare fraud. Now, the government has expanded its investigations and says the entire company has become a target of the probe. Investigators want to know whether Columbia illegally passed on to Medicare the costs it incurred during the acquisition of hospitals and other healthcare facilities. The government is also investigating Columbia's home healthcare division to determine if the company engaged in cost-shifting of non-reimbursable items such as gift shop merchandise and cafeteria expenses. The investigation could ultimately cost Columbia a record \$1 billion.<sup>12</sup>

HHS officials are also examining the billing practices of many of the nation's 125 teaching hospitals. These audits, commonly referred to as PATH audits (Physicians at Teaching Hospitals), aim to find out if some hospitals billed Medicare for the treatment of patients by senior doctors when medical records show the work was actually performed by residents. Not surprisingly, politics are seeping into the act. Several members of Congress, under heavy pressure from teaching hospital lobbyists, are trying to persuade HHS to suspend the audits pending the release of a congressional study that will try to determine whether the complexity and vagueness of HCFA's regulations contribute to the problem.

While many of Medicare's billing foul-ups certainly occur as a direct result of confusion, it is also clear that some teaching hospitals have erroneously billed for a senior physician's services even when the physician was not physically in the hospital at the time. HHS IG June Gibbs Brown recently explained in a letter to CAGW that:

In order to claim reimbursement from Medicare Part B for a service rendered to a patient, the teaching physician must have personally provided the service or have been present when the intern or resident furnished the care. Physicians claiming reimbursement for services only provided by the intern or the resident are making a duplicate claim – since that service has already been paid for under Part A through the Graduate Medical Education Program.

The following recent incidents are only the tip of the iceberg. More are sure to be uncovered as HHS auditors go forward.

- A former controller and vice president of finance at a New Jersey medical center was ordered to make restitution of more than \$1 million to the hospital and \$24,870 to Medicare after he was sentenced to 25 months in prison for tax evasion, embezzlement, and fraud. The official agreed to aid in the investigation of other hospital officials accused of kickbacks and

<sup>12</sup> Greg Jaffe and Eva Rodriguez, "In Hospital Probes, a New Focus on Bottom Line," *The Wall Street Journal*, September 12, 1997.

false billing schemes that cost the hospital nearly \$3.8 million. The executive vice president was also sentenced to 55 months in prison and ordered to repay \$21,000. Three others executives who pled guilty await sentencing.<sup>83</sup>

- Part of a Pennsylvania university healthcare system agreed to pay \$30 million to settle charges of defrauding Medicare. An audit and investigation revealed that false Medicare bills (totaling approximately \$10 million) were submitted for physician services, and that many of the claims improperly reported the level of care provided or falsely reported the involvement of attending physicians.<sup>84</sup>
- The FBI and the Justice Department are currently investigating whether 4,600 hospitals have been routinely billing twice for blood tests, X-rays, and other outpatient services performed during pre-admission workups. Those services are supposed to be included in the fee Medicare pays for a related inpatient stay.<sup>85</sup>

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### Program Exclusions

One method of deterring fraud is to bar perpetrators from participation in the Medicare program, temporarily or permanently.

According to the IG, such program exclusions can be imposed for "conviction of fraud against a private health insurer, obstruction of an investigation, distribution of a controlled substance, revocation or surrender of a healthcare license, or failure to repay health education assistance loans." The following are only a few of the thousands of program exclusions issued by HHS over the past several years:

- The owner and operator of eight Florida DME companies was excluded from Medicare for 30 years after being convicted of conspiracy to defraud, filing false and fraudulent claims, and paying kickbacks for the referral of Medicare patients. One employee was also convicted of conspiracy and excluded from Medicare for 10 years.<sup>86</sup>
- Two officers in two different Florida DME companies were excluded from Medicare for 20 years each after selling liquid nutritional supplements to beneficiaries who didn't need them. The companies paid fees to several doctors to sign certificates of medical necessity authorizing the supplements, even though the doctors never examined the patients. Once the companies had the certificates, they billed Medicare about \$400 each

<sup>83</sup> HHS, OIG, *Semiannual Report*, October 1, 1996 – March 31, 1997, pp. 7-8.

<sup>84</sup> HHS, OIG, *Semiannual Report*, October 1, 1995 – March 31, 1996, p. 13.

<sup>85</sup> David S. Hilzenrath, "Medicare Scams Easy, Officials Say," *The Florida Times Union*, August 10, 1997.

<sup>86</sup> HHS, OIG, *Semiannual Report*, October 1, 1995 – March 31, 1996, p. 12-13.

month for the supplements and an additional \$250 each month for tubal feedings.<sup>87</sup>

- After convictions for defrauding Medicare of more than \$108,000, a Florida DME company owner and its sales manager were both barred from the program for 10 years. The two had submitted false claims for X-ray tests that had not been ordered or were determined to be medically unnecessary, and for equipment that had never been provided.<sup>88</sup>

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### Time for Real Change

The current crusade against Medicare fraud is long overdue. Unscrupulous providers who game the system must be punished. However, it is striking to note that the \$23 billion in losses identified by the IG are referred to as "improper payments" rather than "fraud," and that more than half of that estimate is based on insufficient or total lack of documentation. Criminalizing and exacting restitution for paperwork snafus and honest misunderstandings will certainly replenish government coffers. The real question is: Will it improve the quality of healthcare for Medicare beneficiaries?

Under the current system, greedy providers motivated to prey on Medicare's inherent vulnerabilities have shown almost limitless creativity in ripping off the system, sometimes repeatedly and for long periods of time. At the same time, law-abiding healthcare providers must engage in expensive anti-fraud education and retain professionals to help them constantly retool their billing systems, as well as to figure out how to recoup some of their costs. As Congress reflexively returns again and again to providers, squeezing them as a short-term fix for Medicare's financial problems, it is almost inevitable that they will, at times, skirt the bounds of "proper" reimbursements.

The Clinton Administration recently suspended a contract for the design of an advanced computer system that would have accelerated payments, improved service, and reduced fraud. The idea was to create a single national database, which would pay all doctors and healthcare facilities that serve Medicare beneficiaries. Government officials finally concluded that Medicare's payment system was far more anachronistic and impenetrable than they had anticipated. They were unable to even reconcile the current system. Estimates on how much this fiasco cost taxpayers vary between \$30 to \$43 million.<sup>89</sup>

Medicare teems with perverse incentives that drive both providers and beneficiaries to spend money that contributes nothing to individual health. Many of the features designed to control costs actually compromise well-being, force seniors to spend billions out-of-pocket, and encourage wasteful spending. The

<sup>87</sup> HHS, OIG, *Semiannual Report*, April 1, 1996 – September 30, 1996, p. 10.

<sup>88</sup> HHS, OIG, *Semiannual Report*, October 1, 1996 – March 31, 1997, p. 16.

<sup>89</sup> Robert Pear, "Modernization for Medicare Grinds to a Halt," *The New York Times*, September 16, 1997.

new wave of price controls included in the Balanced Budget Act passed by Congress is yet another politically facile, stop-gap measure that will simply compound Medicare's problems.

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### Medicare's Price Controls

Medicare was initially an open-ended entitlement program that promised to pay for every medical service and procedure for every eligible beneficiary on a reasonable cost basis. By 1982, the explosive costs of this approach became politically and financially unsustainable. So Congress and President Reagan agreed to squeeze the "fat" out of Medicare by instituting strict price controls, known today as the prospective payment system (PPS).

The PPS established fixed prices for hospitals for treatment of different types of illnesses. In 1989, Congress went a step further and created the Resource-Based Relative Value Scale (RBRVS) for doctors serving Medicare patients. Supporters at the time, including CAGW, argued that price controls would force hospitals and doctors to be more efficient. But, instead, price controls in Medicare actually increased costs and barriers to healthcare.

In the 1980s, healthcare costs in the private sector rates exceeded Medicare's rates. For example, in 1996 Medicare costs grew at a rate of 8.5 percent per year, while private sector costs increased at an annual rate of only 3.2 percent. According to the January 1997 Congressional Budget Office (CBO) baseline budget estimates, Medicare is projected to continue to grow at 8.5 percent per year over the next 5 years, while federal budget outlays will grow at an average annual rate of 5.2 percent and the gross domestic product at an average of 4.8 percent.<sup>90</sup>

Indeed, rather than promoting efficiency, price controls have only led to rationing of healthcare services as a way of reducing costs. As health analyst J.D. Kleinke points out, "Medicare's prospective payment system effectively rewards the rapid discharge of patients, many of whom are not well enough, relapse, are re-admitted – and the meter starts running all over again."<sup>91</sup> In other words, Medicare gets people out of hospitals quicker, but sicker.

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### How Price Controls Promote Waste, Fraud, and Abuse

The causes of fraud and waste in Medicare are deeply rooted in the program's structure itself. The absence of any incentives to deliver high-quality, low-cost healthcare greatly contributes to the problem. First, price controls have encouraged doctors and hospitals to "cost shift," or recoup their losses by increasing their prices to unregulated, or privately insured, patients. Second,

<sup>90</sup> Gail Wilensky, Ph.D., Testimony before Senate Finance Subcommittee on Health Care, February 12, 1997, p. 3.

<sup>91</sup> Susan Horn and Robert Goldberg, "A Sickly Approach to Medicare," *The Washington Post*, September 17, 1995.

providers have resorted to “unbundling” medical procedures, separating a course of treatment into individual, more expensive elements. Third, they will often “upcode” a diagnosis to maximize reimbursement. Fourth, even though Medicare caps the price it will pay for a medical procedure, it will also pay for any procedure for which a claim is filed. It is common to hear seniors complain about their Medicare bills being loaded up with lots of unnecessary procedures. Fifth, a whole new industry has sprung up to educate physicians and other healthcare providers on how to understand, and work around, Medicare’s labyrinthine payment systems.<sup>92</sup> Of the \$23 billion in improper payments uncovered by the HHS IG, 36 percent were for services deemed medically unnecessary after the fact. This steady increase in losses attributable to improper billing is not surprising when the system is set up to reward quantity of care, rather than quality of care.

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### Enforcement Alone Will Never Eliminate Fraud and Waste

Will more aggressive oversight make a difference? Yes, but it will come at a tremendous cost, both in dollars and in further corrosion of the doctor-patient relationship. Every action taken by a doctor or hospital will increasingly be subject to second-guessing and third-party monitoring. Medical judgments made and services rendered will become, in retrospect, grounds for civil and criminal action. Even today, doctors and hospitals practice the art of medicine with the knowledge that even an honest billing error could set off chain of events that could threaten their livelihoods and even land them in prison. It remains to be seen, for example, how much of this is true and the government’s unprecedented investigation of Columbia/HCA. These unfavorable trends will only continue and grow under the current system.

This *post hoc* criminalization of medicine is a direct outgrowth of Medicare’s archaic system. Because it is an entitlement, the Medicare bureaucracy in Washington, D.C., has only the most tenuous control over the program as a whole. Hence, no amount of enforcement will have an impact on the real reason providers inflate medical bills. Medicare cannot capture quality-based savings, because it cannot measure quality, and it will pay for any healthcare, regardless of whether it is good, bad, or indifferent.

Even now, despite a push to improve the quality of the healthcare purchased through Medicare, the program lacks accurate information on how the treatments it pays for relate to the patient’s true medical needs or the patient’s ultimate well-being. Until recently, even private insurers did not demand, and did not receive, up-to-date medical information. However, under the lash of market competition, private healthcare providers have begun to recognize the value of fresh, accurate

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<sup>92</sup>Edmund Haislmaier, “Why Global Budgets and Price Controls Will Not Curb Health Costs,” *Heritage Foundation Backgrounder*, No. 929, March 8, 1993, pp. 18-19.

data and are spending more money to capture, store, and analyze the information needed to generate quality healthcare. Medicare has no such market forces to reward quality.

In fact, Medicare lags so far behind the private sector in the inevitable rush toward the information age that a recent GAO report stated:

HCFA's efforts in distributing comparative performance data lag behind those of state agencies and many employers in the private sector. Furthermore, GAO's analysis of HCFA's previous implementation efforts raises concerns about how well HCFA will implement comprehensive programs to deal effectively with poorly performing providers and improve all providers' performance.<sup>93</sup>

Even if Medicare tried to improve quality, spending money on anything other than Medicare's benefits package must first be approved by HCFA, a process that takes years. As a result, Medicare is also unable to compete with the private sector in using both managed care and healthcare outcomes to measure and control unnecessary medical spending.

Similarly, Medicare has been notoriously slow to recognize and adopt new medical treatments and innovative technologies that provide better healthcare. For example, cochlear implants, which are widely accepted as a superior treatment for hearing loss, are not reimbursed under Medicare. Consequently, patients must pay between \$3,000 and \$5,000 out-of-pocket for this state-of-the-art technology, and physicians may be reluctant to recommend the treatment to low-income patients. Overall, the Medicare bureaucracy conducted only 10 assessments of new technologies and innovations for coverage under Medicare in 1991, and only eight in 1992. Some ongoing assessments have been under consideration for over three years.<sup>94</sup>

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### The Impact on the Elderly

Medicare's antiquated approach to medicine does more than compromise patient care. Seniors tend to spend more on healthcare than the general population and they also spend more on co-payments and deductibles. But studies show that seniors who purchase Medigap insurance (in addition to Parts A and B) to cover these costs spend 70 percent more on healthcare than those who do not, with little measurable increase in their well-being.<sup>95</sup>

<sup>93</sup> GAO, *Medicare: Federal Efforts to Enhance Patient Quality of Care*, April 10, 1996.

<sup>94</sup> Peter Ferrara, "A Proposal for Reform: Resolving the Medicare Crisis," United Seniors Association, Fairfax, Virginia, 1996.

<sup>95</sup> Michael Morrissey, "Retiree Health Benefits," *Annual Review of Public Health*, 1993, Volume 14, pp. 271-292.

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### The Impact on Future Beneficiaries

In spite of the reforms made to Medicare in the 1997 Balanced Budget Act, Medicare will only remain solvent for 10 years. The program will begin to accrue losses just as the baby boomers begin to retire.

For the last 15 years, Medicare has grown faster than any other federal program. The Medicare tax has increased from 0.7 percent of the first \$6,000 in wages to 2.9 percent of every dollar in wages. In 1965, there were 5.5 workers for every beneficiary. Today, there are 3.9 workers for the current number of beneficiaries. The number of retirees will increase by 800 percent in the next 15 years, leaving only 2.2 workers to support every beneficiary.<sup>96</sup> The system foments intergenerational competition for resources and will, if left unchecked, rob future workers – along with their children and grandchildren – of their livelihoods.

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### Reducing Fraud by Reforming Medicare

To paraphrase Friedrich Hayek, the Nobel Prize-winning economist, there are only two ways of holding men accountable: prices and prisons. Enforcing price controls requires throwing people in jail. Unfortunately, some of the people who get thrown in jail may have honestly misunderstood the regulation they needed to follow. But, when prices are set by free-market forces, overcharging for a product is simply punished by the loss of market share.

Eliminating fraud in Medicare calls for reducing the incentives and opportunities to profiteer. Medicare is currently rife with such enticements. Only the discipline of the free market and the creation of a patient-centered healthcare market will allow Medicare patients to choose care based on cost and quality. Providers will then have to compete for patients based upon their ability to provide a variety of quality medical outcomes.

The following changes would go a long way toward establishing such a system:

1. Medicare would be changed from a government-run, fee-for-service health insurance plan to a system in which Medicare beneficiaries would choose among publicly available private health insurance plans. The government would subsidize insurance purchases through individual premium allowances, at an amount set by the average price of competing plans, keyed to a benchmark benefit package.
2. Healthcare plans, physician groups, and health insurers would have to provide consumers with information on the quality of their care. Recent studies show that beneficiaries value such information because they want

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<sup>96</sup> Senator Phil Gramm, "How to Avoid Medicare's Implosion," *The Wall Street Journal*, February 4, 1997.

to be informed, cost-conscious consumers of healthcare services, rather than passive recipients.

3. Direct competition between provider systems would be based on quality and cost. Providers would no longer go to Medicare for their payments. How much money to spend and what to spend it on would be the responsibility of Medicare program participants. The Medicare bureaucracy would simply serve to collect and disseminate up-to-date, patient-friendly healthcare information and stimulate the universal adoption of the best available medical practices. Rooting out and eradicating fraud would be the responsibility of the private sector.

Leaders in healthcare policy from all sides of the political spectrum are now providing sound ideas and solutions for transforming Medicare into a program that responds to the needs of the elderly by providing the best possible healthcare at a reasonable price. Many of these ideas have originated in think tanks and public policy organizations.<sup>97</sup> The Medicare commission, which will be established pursuant to the Balanced Budget Act, should give careful consideration to these proposals, and be bold in its final recommendations. The future health of Medicare, our economy, and our people depends upon true reform.

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<sup>97</sup> Senator Phil Gramm, "How to Avoid Medicare's Implosion," *The Wall Street Journal*, February 4, 1997; Dowd, Feldman, and Christianson, "Competitive Pricing for Medicare," *American Enterprise Institute*, July 1996; Butler and Moffit, "Congress's Own Health Plan as a Model for Medicare Reform," *Heritage Foundation Backgrounders*, June 1997; Dave Kendall, "The Phony Medicare Debate," *The Progressive Policy Institute*, April 1996.

Testimony submitted to the Senate Permanent Subcommittee on Investigations EXHIBIT # 19

Investigations  
Subject: Institutionalized Medicare Fraud

Submitted by Bill Menke  
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My name is Bill Menke. I am the Chief Fraud Investigator for the law firm of Levin, Middlebrooks, Thomas, Mitchell, Green, Echsner, Proctor & Papantonio in Pensacola, Florida. Our mission is to develop Medicare and Medicaid fraud cases under the Federal False Claims Act.

Levin Middlebrooks has five investigators, plus support staff. The individuals working for us have clinical, administrative, general health care, clerical and criminal investigation backgrounds. I previously was an executive with one of America's largest health care corporations. To be perfectly honest, I left because I got tired of working for the "bad guys." I now help Levin Middlebrooks develop evidence to present to federal agents and prosecutors.

As you know, Medicare and Medicaid were born of the "Great Society" programs of the 1960s. They were meant to help *people*. But fraud has turned them into entitlements for *corporations*, not patients. We see blatant health care fraud on a daily basis. It is pervasive; it affects every sector of the health care industry, including durable medical equipment, suppliers, psychiatric hospitals, hospital corporations, and pharmaceutical companies.

The government is unequipped to handle \$90 to \$100 billion a year in fraud. Fraud squads such as ours, who assist in developing qui tam suits, are an additional and important line of defense. We act as consumer advocates to put money back into the taxpayers pockets by bringing these fraudulent companies to justice.

There are 18,000 pages of Medicare regulations. The states also have separate administrative codes. The rules are so complex and ambiguous that crooks try to excuse their behavior by saying they didn't understand the rules. Part of my job is to find the exact rule or law that's been broken, and then take that information to

federal agents, investigators and inspectors. The Federal False Claims Act is the best and perhaps only way to change the “corporate culture” that encourages fraud.

The Health Care Financing Administration, which administers Medicare, says 88% of claims in 1995 were reduced by almost 50 percent as a result of fraud that was detected during claim reviews. There were 600 million false claims submitted in 1995. Those figures suggest that three billion false claims were submitted in the past six years.

I have seen firsthand that many doctors and hospitals routinely overcharge because they know the government will not pay the whole bill. The “bad guys” jack up the costs as high as possible. They collect what Medicare & Medicaid gives them. Then they count the unreimbursed amount as a loss, and write it off on their taxes.

Scams such as upcoding, bundling and unbundling are costing taxpayers billions of dollars a year. You may be familiar with Bundling and Unbundling. Hospitals are supposed to “bundle” charges for each patient. For instance, if someone comes into the emergency room for chest pain, gets tests, and is admitted for treatment, the hospital is supposed to submit all those charges at the same time. But the hospital makes more money by “unbundling” the charges; for instance it would submit the ER charges separately from those incurred after the patient’s admitted. Some charges could be submitted twice without anyone knowing.

I would like to share with you the story of a man named John Perry. He is from St. Petersburg, Florida. He worked in a radiology lab as an ultrasound technician. When Medicare patients came in, his boss told him to do as many tests as possible. The idea was to bilk Medicare out of every penny it could. Perry told federal investigators, and they brought charges. But they waited until the last minute to tell him that if he had pursued the action under the Federal False Claims Act, he would get a financial reward. By the time he contacted us, it was too late.

We hope that in public forums such as this one we can alert people to the fact that they do not have to lose everything if they blow the whistle on corporate criminals. We applaud Congress for strengthening the False Claims Act in recent years. But we also ask you to help spread the word that becoming a whistle-blower does not mean becoming a martyr to justice. Right now the system is so full of fraud that it makes it hard for medical workers who care about patients to do their jobs. It is time to make health care a noble profession again.

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**Testimony submitted to the Senate Permanent Subcommittee on  
Investigations****Subject: Fighting Medicare Fraud****Submitted by Mike Papantonio  
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My name is Mike Papantonio, and I am an attorney in Pensacola, Florida. I am here to share information with you my firm (Levin, Middlebrooks, Thomas, Mitchell, Green, Echsner, Proctor & Papantonio) has uncovered while pursuing whistleblower claims under the federal False Claims Act.

This law is the best tool America has to fight government fraud and waste. I strongly urge you to keep the federal False Claims Act strong. The law must not be weakened. If anything, it should be made stronger. Fighting Medicare fraud without the False Claims Act would be like fighting the Persian Gulf War without fighter jets and tanks.

In January this committee heard testimony from a convicted felon, who said stealing from Medicare is easy. A man with no health care experience got a Medicare provider number, and cheated the federal government out of half million dollars a month.

I am here to tell you, this is not unusual. Medicare fraud is not just easy, it is institutionalized. The ease with which crooks can take money from the pockets of America's citizens has created a culture of corporate crime. It's not just individuals who are stealing from Medicare. It is also the largest health care corporations in America.

Let me share a few figures with you.

Fraud swallows up \$90 to \$100 billion taxpayer dollars each year. Those of you who struggle with the national budget may be immune to figures such as this. Allow me to put them into perspective.

- The amount of money lost to fraud yearly totals the 1994 combined general revenue of Texas, Pennsylvania and Florida.
- If the government simply gave this money away, each family of four would get more than \$1400.
- The amount lost to fraud yearly would pay for 3.3 million American students to attend Yale University for a year -- room and board included.

But this money is not being given away. It is not being spent on reducing crime or improving education. It is going directly into the pockets of corporate criminals, many of whom may never be caught. Most of those who are being caught are being targeted by whistleblowers using the False Claims Act.

Medicare cheats are not just stealing from the government; they are stealing from taxpayers. That includes the young parents in Pensacola struggling to raise their children. They are stealing from newlyweds in Cincinnati just starting their lives together. They are stealing from students in Sacramento working their way through school. They are stealing from the families all across America who are living paycheck to paycheck, while trying to put away a little something for retirement. Medicare cheats are stealing from you and from me.

Normally in a white collar crime investigation, investigators could follow a paper trail. But in Medicare fraud, there is virtually no paper. Many of the crimes occur inside corporate computer systems. Computer records are easy to change. If Medicare cheats know you are on to them, they can "cook the books" with just a few keyboard strokes. Many of America's largest health care companies have programs that automatically "upcode" a diagnosis to the one with the highest amount billable to Medicare. Investigating bank robberies and drug dealers is easy in comparison. Nobody actually looks at individual claims. Even computer systems specifically designed to **catch** fraud can't find everything.

For reasons such as this, it is virtually impossible to detect Medicare fraud without someone on the inside to blow the whistle. The False Claims Act allows whistleblowers to be financially rewarded for turning in corporate criminals. My firm, Levin Middlebrooks, has its own fraud squad. We get 50 to 60 calls each day from potential whistleblowers. These are people for whom honesty pays, partly because this law allows them to keep 15% to 30% of the amount the government recovers. I applaud Congress for its foresight in strengthening this law. We must hold firm.

Our cases are secret, and we cannot discuss specifics. But I can share with you hair-raising stories uncovered by our investigative staff. One reason it is so easy to steal from Medicare is that there are 18,000 pages of regulations. The states also have separate administrative codes. The rules are so complex and ambiguous that crooks try to excuse their behavior by saying they didn't understand. Efforts are underway to clarify some of these rules. We applaud those efforts. But we ask you to be wary of those who would blame their criminal behavior on ignorance of the law.

Here is one example of the calibre of fraud we have seen which is not covered by the secrecy requirements of the whistleblower statute.

An elderly South Florida nursing home resident is judged -- for virtually no reason -- to be a danger to herself. She is transferred to a mental institution, where she is locked away for weeks, supposedly for evaluation. When her Medicare benefits run out, the staff decides she is perfectly fine to return to her nursing home. The reason she is found to be all right is that she was perfectly sane the whole time. What is "insane" is the way institutions are allowed to commit people for the sole purpose of collecting their Medicare benefits.

Anyone who assumes doctors are largely to blame for Medicare fraud would be sadly mistaken. While doctors make good salaries, they work long hours. Some are fighting Medicare fraud on the front lines as whistleblowers. The problem is not with the doctor community; it is with the corporate community which has learned to place the value of money above the value of honesty.

How do we know this? Because people call us. We get dozens of calls every week from people who are tired of working for crooks. Doctors, nurses, administrators, billing clerks, accountants -- they all call with incredible stories to tell about health care fraud.

When did the extensive fraud begin? In the late 70's and early 80's, many small doctors' hospitals were gobbled up by large, profit-oriented hospital corporations. The dramatic increase in qui tam suits can be traced to that same period of time. Filings under the False Claims Act jumped from 33 in 1987 to 530 in 1997. Companies settling these claims have returned billions of dollars to the US Treasury. Hitting these companies in the wallet is the most effective way of changing their behavior. Even fining and imprisoning top executives will not necessarily change the corporate culture.

An intense lobbying effort is underway to convince Congress to weaken the Federal False Claims Act. Many hospitals say they are being targeted unfairly. While no one should be treated unjustly, the truth is that the Medicare fraud is institutionalized. We must examine the system that allows cheaters to prosper. The False Claims Act is the most powerful weapon the government has to fight Medicare fraud. This weapon must not be taken away. The truth is hospital corporations that play fairly with American taxpayers' money have nothing to worry about.

One final word. Some who would weaken the law that is doing so much good say it is promoting a nation of whistleblowers. But if that's what it takes to ferret out the crime, then so be it.

Songwriters Woody Guthrie and Bob Dylan share a song lyric that is most appropriate in this case. "Some rob with you with a six-gun, some with a fountain pen." Those lyrics have never been more true in regard to health care fraud. The Federal False Claims Act must remain strong in order for the corporate criminals to be brought to justice. It must remain strong in order to protect American taxpayers from corporate greed.

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*Papantonio heads the Medicare fraud squad of the Pensacola law firm of Levin, Middlebrooks, Thomas, Mitchell, Green, Echsner, Proctor & Papantonio.*

255

