

March 2001

# MEDICARE FRAUD AND ABUSE

## DOJ Has Improved Oversight of False Claims Act Guidance



GAO

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## Abbreviations

AHA	American Hospital Association
DOJ	Department of Justice
HCFA	Health Care Financing Administration
HHS-OIG	Department of Health and Human Services Office of Inspector General
PPS	prospective payment system



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United States General Accounting Office  
Washington, DC 20548

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March 30, 2001

### Congressional Committees

Payments resulting from improper billing represent a major threat to the fiscal integrity of Medicare—the federal health insurance program serving approximately 39 million elderly and disabled Americans. The Department of Justice (DOJ) places a high priority on identifying improper billing of Medicare and other federally funded health care programs, and it reported recoveries of over \$840 million in fiscal year 2000 related to civil health care fraud. Many of these recoveries are related to the False Claims Act,<sup>1</sup> which provides for substantial damages and penalties against providers who knowingly submit false claims to federal programs—including federally funded health insurance programs.

The use of the False Claims Act against health care providers has been controversial. The hospital industry has criticized DOJ for being overly aggressive in its pursuit of hospitals for improper Medicare billings through a series of nationwide investigations, known as national initiatives or projects. For example, in 1998 many hospitals claimed that DOJ had conducted unwarranted investigations and demanded large penalties for unintentional errors related to billings for outpatient laboratory tests. In response to hospital and congressional concerns, DOJ issued guidance on the fair and responsible use of the act in civil health care matters, including national initiatives, in June 1998. The guidance was intended to emphasize the importance of pursuing False Claims Act cases against health care providers in a fair and even-handed manner and to implement new procedures related to national initiatives.

Congress subsequently required us to monitor DOJ's implementation of the guidance,<sup>2</sup> which has resulted in a series of reports (see app. I). While our initial reviews indicated some problems with DOJ's implementation of

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<sup>1</sup>31 U.S.C. §§ 3729 to 3733: Anyone who “knowingly” presents false claims for payment to the United States may be found to be in violation of the False Claims Act. The act defines “knowingly” to include a person who (1) has actual knowledge of the false claim, (2) acts in deliberate ignorance of the truth or falsity of the claim, or (3) acts in reckless disregard of the truth or falsity of the claim.

<sup>2</sup>These requirements were contained in the Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1999 (P.L. 105-277) and the Consolidated Appropriations Act of 2000 (P.L. 106-113).

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the guidance, our more recent work shows that DOJ had made progress in correcting these problems.

This report continues our ongoing evaluation of DOJ's efforts to ensure compliance with the guidance and focuses on the application of the guidance in two recent DOJ initiatives. The Prospective Payment System (PPS) Transfer initiative identifies hospitals that have incorrectly reported patient transfers between hospitals as discharges. The Pneumonia Upcoding initiative assesses whether Medicare has been billed improperly on behalf of beneficiaries hospitalized with pneumonia. Both initiatives focus on hospitals that may have received greater reimbursement from the Medicare program than they were entitled to receive. Our specific objectives were to (1) review the actions taken by DOJ to improve its oversight of U.S. Attorneys' Offices to ensure compliance with the guidance and (2) determine if the PPS Transfer and Pneumonia Upcoding projects are being conducted in accordance with the guidance.

While DOJ's guidance applies to all civil health care fraud matters, we focused our review, as we have in past reports, on the use of the guidance in national initiatives. To evaluate DOJ's oversight of U.S. Attorneys' Offices, we discussed ongoing monitoring and compliance efforts with DOJ officials, including those responsible for periodic evaluations of the operations of each U.S. Attorney's Office. We also reviewed relevant materials related to these evaluations. To determine if the PPS Transfer and Pneumonia Upcoding projects are being conducted in a manner consistent with the guidance, we interviewed members of DOJ's working groups that coordinate each initiative. We also visited 4 of the 94 U.S. Attorneys' Offices and reviewed files for 11 closed matters and 15 open matters, representing both initiatives. We chose the offices to visit in order to review several examples of matters for each initiative. In addition, we contacted representatives of the American Hospital Association (AHA) and state hospital associations within each of the districts we visited to obtain their views regarding the implementation of the guidance.

We were given access to documents through an agreement with DOJ to ensure that confidentiality of ongoing cases and DOJ's internal review process would not be compromised. This agreement did not materially affect our review because we were able to document compliance with specific elements of the guidance in both open and closed matters. We conducted our work between October 2000 and February 2001. Except for these restrictions on our access, our work was performed in accordance with generally accepted government auditing standards.

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## Results in Brief

DOJ has taken steps to further strengthen its oversight of compliance with its False Claims Act guidance. DOJ's review of each U.S. Attorney's Office's compliance with the guidance now appears to be an integral part of the periodic evaluations it makes of all U.S. Attorneys' Offices. Also, DOJ's annual requirement that all U.S. Attorneys' Offices involved in civil health care fraud control certify their compliance with the guidance appears to have promoted compliance at the offices we visited. We found that these offices had either documented their compliance in case files or instituted a review process under the direction of their office's Civil Chief. Finally, we found that the working groups continue to coordinate national initiatives and maintain ongoing contacts with participating U.S. Attorneys' Offices to determine whether they are complying with the guidance.

Our review also suggests that DOJ is implementing its two most recent and active national initiatives—the PPS Transfer and Pneumonia Upcoding projects—in a manner that is consistent with the guidance. Our review indicated that the working groups had conducted sufficient background research and developed legal and factual bases underlying the initiatives. They also provided U.S. Attorneys' Offices participating in these initiatives with detailed claims data, model contact letters, and other relevant documentation before hospitals were contacted regarding potentially false claims. The offices we visited coordinated their activities with the working groups and, as the guidance requires, took each hospital's unique circumstances into consideration. The hospital association representatives we spoke with continue to express concerns about the appropriateness of DOJ's use of the False Claims Act in civil health care matters, but did not identify specific examples of noncompliance with the guidance among U.S. Attorneys' Offices. Officials from DOJ's Executive Office for U.S. Attorneys and its Civil Division generally concurred with our findings and conclusions.

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## Background

To emphasize fair and responsible use of the False Claims Act, DOJ issued "Guidance on the Use of the False Claims Act in Civil Health Care Matters" on June 3, 1998. The guidance instructs DOJ attorneys and U.S. Attorneys to determine, before they allege violations of the act, that the facts and the law sufficiently establish that the claimant knowingly submitted false claims. The guidance covers all civil health care matters and has specific provisions to address national initiatives. DOJ defines these initiatives as nationwide investigations stemming from an analysis of national claims data, indicating that numerous, similarly situated health care providers have engaged in similar conduct to improperly bill government health care

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programs. Prior to alleging a violation of the act in connection with a national initiative, attorneys shall, in general, use contact letters to notify a provider of a potential liability and give the provider an opportunity to respond before a demand for payment may be made. The guidance contains other safeguards to ensure the fair treatment of hospitals. For example, U.S. Attorneys' Offices must consider alternative remedies to the use of the False Claims Act, including administrative remedies such as recoupment of overpayments, program exclusions, and other civil monetary penalties. In addition, they must also consider a provider's ability to pay; the effect on the community served by the provider, particularly for rural and community hospitals; and the extent of provider cooperation in the matter.

The guidance also requires the formation of a working group to coordinate each national initiative. The working groups, composed of DOJ attorneys and Assistant U.S. Attorneys with expertise in health care fraud control, must develop "initiative-specific guidance" to provide direction and support to the U.S. Attorneys' Offices that are participating in the initiative. For example, working groups may prepare a legal analysis of pertinent issues, provide a summary of Medicare claims data indicating potentially significant billing errors, and develop an investigative plan. The working groups track the participating offices' progress and respond to their questions as each initiative proceeds. Ongoing contacts can help assure the working group that the offices are following the guidance.

The two national initiatives that currently have the most active investigations are the PPS Transfer and Pneumonia Upcoding projects. The PPS Transfer<sup>3</sup> initiative was developed from a series of audits and joint recovery projects by the Department of Health and Human Services Office of Inspector General (HHS-OIG), the Health Care Financing Administration (HCFA)—the agency within HHS that administers the Medicare program—DOJ, and the claims processing contractors to identify improperly coded transfers and recover overpayments from hospitals.<sup>4</sup> The Pneumonia Upcoding initiative targets inappropriate

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<sup>3</sup>Under Medicare's prospective payment system, hospitals are reimbursed a single amount to cover an entire inpatient stay. When a patient is transferred from one inpatient hospital to another, the transferring hospital is only entitled to receive a pro-rated payment based upon the patient's diagnosis and the number of days at that hospital.

<sup>4</sup>See, for example, HHS-OIG, *Medicare Hospital Patient Transfers Incorrectly Paid as Discharges—January 1992-December 1994* (A-06-95-0083), Nov. 1996, and *Medicare Hospital Patient Transfers Improperly Reported and Paid as Hospital Discharges* (A-06-93-00095), Feb. 1995.

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coding of inpatient hospital claims for a relatively rare bacterial form of the disease that is more costly to treat—approximately \$2,500 more per claim—than the more common forms of pneumonia. The initiative assesses whether hospitals submitted claims for a more complex form of the disease than was supported by the patient’s medical records.

This is the fourth report we have issued regarding DOJ’s implementation of its False Claims Act guidance and its efforts to oversee compliance. In February 1999, we issued an early status report on DOJ’s initial efforts to implement the guidance.<sup>5</sup> In August 1999, we reported that DOJ’s process for reviewing implementation of the guidance appeared superficial and that U.S. Attorneys were not consistent in their application of the guidance.<sup>6</sup> However, in March 2000, we reported that DOJ had taken steps to improve compliance with its False Claims Act guidance.<sup>7</sup> We noted that DOJ had strengthened its oversight of U.S. Attorneys’ Offices and that the offices that we had previously found to be slow in implementing the guidance appeared to have addressed their shortcomings. We also found that the working groups were providing legal and factual material on each national initiative for U.S. Attorneys’ Offices to consult prior to contacting hospitals about potential False Claims Act liability.

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## DOJ Continues to Monitor Compliance With False Claims Act Guidance

DOJ has demonstrated its continued commitment to promoting the importance of compliance with the False Claims Act guidance at its U.S. Attorneys’ Offices. In response to our prior recommendations, DOJ revamped its process for periodically evaluating the compliance of these offices and instituted an annual compliance certification requirement for all U.S. Attorneys’ Offices participating in national initiatives. These steps have helped to encourage compliance.

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<sup>5</sup>*Medicare Fraud and Abuse: Early Status of DOJ’s Compliance With False Claims Act Guidance* (GAO/HEHS-99-42R, Feb. 1, 1999).

<sup>6</sup>*Medicare Fraud and Abuse: DOJ’s Implementation of False Claims Act Guidance in National Initiatives Varies* (GAO/HEHS-99-170, Aug. 6, 1999).

<sup>7</sup>*Medicare Fraud and Abuse: DOJ Has Made Progress in Implementing False Claims Act Guidance* (GAO/HEHS-00-73, Mar. 31, 2000).

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## DOJ Evaluation Process Now Provides Meaningful Assessment of Compliance With the Guidance

We found that DOJ's periodic evaluations of the U.S. Attorneys' Offices now incorporate a more substantive examination of compliance with the guidance. The review process, which was instituted in February 1999, initially contained only one interview question relating to the guidance, but DOJ has since expanded its evaluation procedure as it relates to the guidance. By April 2000 the review included a number of questions devoted to the guidance in both the previsit questionnaires and the interviews conducted during on-site visits. Respondents must now describe in detail the activities and procedures each office has in place to ensure that the attorneys are informed of the guidance and that the office is in compliance. Of the 16 full evaluations that took place between April 2000 when the evaluation process was expanded and the end of the calendar year, none resulted in a determination that an office was out of compliance with the guidance.<sup>8</sup> Through our discussions with DOJ officials and our review of relevant materials, we were able to verify that the evaluations provide an effective mechanism for identifying and documenting areas of concern and potential vulnerability, such as the need for additional information on the guidance for attorneys. No such findings were made during reviews of U.S. Attorneys' Offices currently participating in a national initiative. U.S. Attorneys' Offices must respond to weaknesses identified in the review, and the Executive Office for U.S. Attorneys subsequently verifies that, if needed, corrective action is taken. Our review showed that, when weaknesses were identified, this process was followed and implementation of corrective actions was monitored.

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## U.S. Attorneys' Offices Certify Compliance

DOJ's annual requirement that all U.S. Attorneys' Offices involved in national civil health care fraud initiatives certify their compliance with the guidance appears to have promoted compliance at the offices we visited. DOJ officials told us that all U.S. Attorneys' Offices participating in civil health care matters had attested to their compliance for the period ending December 31, 2000. Although DOJ has not required offices to document their compliance with the guidance as part of the certification process, the offices we visited had either documented their compliance in individual case files or instituted a review process under the direction of their office's Civil Chief. For example, every closed case file we reviewed in one office contained a certification that the case had been conducted in accordance

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<sup>8</sup>The evaluations generally take place on a 3-year cycle, with about 31 offices being reviewed each year. DOJ officials informed us that, due to budget constraints, only 22 full reviews took place during calendar year 2000.

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with the guidance. Based on our review of the supporting documentation in these case files, we found no basis to dispute the office's compliance certifications. Another office directed an attorney not involved in the national initiatives to review case files for evidence of compliance. The attorney then prepared a report for the review and approval of the Civil Chief prior to completing the annual compliance certification. We found this report provided detailed support for the attorney's conclusion that the cases were handled in a manner consistent with the guidance.

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## PPS Transfer and Pneumonia Upcoding Initiatives Are Being Conducted in Accordance With the Guidance

Based on our analysis of working group materials and review of case files at four offices, we believe that DOJ is following its guidance as it pursues the PPS Transfer and Pneumonia initiatives. The working groups have prepared material for the U.S. Attorneys' Offices on the legal and factual bases for contacting hospitals about potential False Claims Act liability for each initiative. In addition, the working groups have prepared model contact letters and other documents to ensure that hospitals are contacted in a manner consistent with the guidance. The U.S. Attorneys' Offices we visited consulted the working group materials and conducted independent investigations so that their settlement terms could be adjusted to reflect each hospital's situation. Although the AHA and some state hospital association representatives remain concerned that the False Claims Act is inappropriately being applied to inadvertent billing errors, they did not identify specific instances where a particular U.S. Attorney's Office has acted inconsistently with the guidance in either national initiative.

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## Working Groups Provide Standardized Guidance and Oversight

The working groups prepared extensive initiative-specific guidance and memoranda outlining the relevant legal and regulatory requirements underlying the initiatives. After consulting with the HHS-OIG and HCFA, the working groups analyzed national and hospital-specific claims data. The U.S. Attorneys' Offices were then able to use these data as a starting point to begin investigating whether specific hospitals had knowingly submitted false claims. The PPS Transfer working group conferred with the HHS-OIG regarding its prior audits of PPS hospitals. Similarly, the Pneumonia Upcoding working group obtained extracts of national inpatient claims data from HCFA and reviewed these data with HCFA specialists, the HHS-OIG, and an independent consultant to ensure their validity.

We found that in addition to providing resources and coordinating the initiatives, the working groups play an active role in monitoring the progress of the offices participating in the initiatives. We were able to

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verify that participating districts consult with working group members on an ongoing basis throughout the development and settlement of their cases. This exchange of information allows the working groups to assess compliance with the guidance.

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### U.S. Attorneys' Offices' Interaction With Hospitals Is Consistent With the Guidance

Our review of case files at the four offices we visited suggests the interactions between these offices and the hospitals they investigated were consistent with the guidance. In reviewing records relating to initial contacts from the U.S. Attorneys' Offices and hospitals, the investigations, and settlements, we observed that the offices were attentive to hospitals' individual circumstances and that they varied their actions accordingly, as required by the guidance. For example, our review of correspondence showed that the contact letters used by these four offices were based on the model letters distributed by the working groups. Consistent with the guidance, the letters we reviewed informed hospitals of potential False Claims Act liabilities but did not make demands for payment and gave hospitals the opportunity to meet to discuss the matters further.

We found that U.S. Attorneys' Offices we visited did not pursue hospitals identified by the working group data as a matter of course. Instead, the offices conducted their own reviews of each hospital's billing patterns and circumstances, as the guidance requires. These efforts sometimes revealed other explanations for erroneous billing at specific hospitals, and the hospitals repaid the overpayments with no imposition of damages or administrative sanctions. For example, one Assistant U.S. Attorney reviewed the data supplied by the PPS Transfer working group and found that, while the billing patterns for two hospitals indicated incorrectly coded cases, they did not necessarily reflect "knowing" behavior, as defined by the False Claims Act. Without initiating a formal investigation by sending a contact letter, the office held discussions with management at both hospitals to solicit possible explanations that might account for these billing aberrations. These interviews revealed that the hospitals had not been informed that the facility they were transferring patients to had changed its payment status. The hospitals thought they were discharging patients to a rehabilitation facility—in which case they would have been entitled to receive the full inpatient payment amount—when in fact the facility had become a PPS hospital and the partial-payment rule applied. Because the Assistant U.S. Attorney determined that the improper payments were not knowingly submitted, there was no potential violation of the False Claims Act and no contact letter was sent.

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In another instance, a study conducted for a U.S. Attorney's Office indicated that the claims data for one hospital reflected improper billing. The office's investigation determined that the hospital's inaccurate coding was not the result of deliberate action or recklessness on the part of the hospital, but rather the mistakes of one individual member of the coding staff. This hospital refunded the excess reimbursements to the Medicare program and was not assessed damages.

Offices we visited routinely considered unique factors surrounding the case as well as each hospital's circumstances during the settlement process. In one case, an office settled for lower damages because the hospital had voluntarily disclosed that it had a billing problem. The hospital's cost of performing its own audit was deducted from the settlement amount. In another case, the office reduced its proposed settlement to reflect the hospital's cooperation in voluntarily conducting a self-audit as well as its unique status as the only provider in an area of the state.

While working groups are not authorized to approve or disapprove settlement agreements, we found that the U.S. Attorneys' Offices we visited kept them informed of the status of cases nearing settlement and shared proposed settlement agreements with them. For example, one proposed settlement was accompanied by a detailed analysis documenting how it was handled in accordance with each element of the guidance. Our review of closed cases also showed that the working groups were given an opportunity to comment on the proposed settlement before the agreements were finalized.

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## Hospital Association Representatives Expressed Concerns With National Initiatives

During our review, we contacted representatives from several state hospital associations and the AHA. Most continued to voice concerns over the appropriateness of DOJ's national initiatives. They told us that they generally believe that the vast majority of overpayments made to hospitals reflect the complexity of the Medicare billing system and are not an attempt to defraud the program. Therefore, they suggested that these matters be handled by fiscal intermediaries<sup>9</sup> without the threat of harsh penalties.

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<sup>9</sup>Fiscal intermediaries are insurance companies that contract with the government to process and pay Medicare claims submitted by hospitals.

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Hospital association representatives also raised several concerns. They questioned the use of national normative claims data to target hospitals on the basis that this process fails to take into account each hospital's unique circumstances—such as patient demographics—which may account for discrepancies between a hospital's billing pattern and broader, national trends. This concern is particularly applicable to the Pneumonia Upcoding project, in which hospitals are identified for review following a comparison of hospital and national claims data. While we did not independently analyze the methods used to prepare the claims data for the pneumonia project, information on each hospital's specific billing pattern for complex pneumonia and the national norm for that diagnosis was presented in each of the contact letters we saw. During our site visits we saw evidence that the claims data were used as the starting point for further investigation.

AHA representatives expressed concern that the data used to select hospitals for the investigation of allegedly upcoded pneumonia claims were drawn from a different time period than the period used as the national norm for comparison purposes. DOJ officials stated that this was not the case. Furthermore, the claims data that DOJ relied upon were obtained from the HHS-OIG, and HCFA and an independent claims review consultant were involved with extracting and analyzing the pneumonia claims.

In addition, AHA representatives stated that DOJ is engaging in other projects that have national implications but have not been recognized as national initiatives. DOJ officials explained that they may have multidistrict initiatives underway involving subjects under investigation in multiple jurisdictions, but that these projects do not meet DOJ's definition of a national initiative.<sup>10</sup> DOJ has instituted written guidelines specifically addressing the proper coordination of multidistrict investigations, and, like all civil health care fraud matters, multidistrict initiatives must be conducted in accordance with the guidance. Our work for this report involved no assessment of compliance with the guidance in such cases.

Another concern raised by hospital association representatives was that DOJ often included burdensome corporate integrity agreements in

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<sup>10</sup>We noted in our February 1999 report that DOJ's definition of a national initiative is limited to those multidistrict projects that rely on national claims data.

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national initiative settlements at the insistence of the HHS-OIG.<sup>11</sup> The representatives suggested that DOJ's willingness to accommodate the HHS-OIG violates the part of the guidance that requires that an individual provider's unique circumstances be taken into account when reaching a settlement. They consider the imposition of corporate integrity agreements to be particularly troublesome in cases where hospitals settled for simple repayment without False Claims Act damages and had not demonstrated serious billing problems. However, at the four U.S. Attorneys' Offices we visited, we found that 4 of the 11 closed PPS Transfer and Pneumonia Upcoding cases we reviewed were resolved without the imposition of corporate integrity agreements. Although corporate integrity agreements were imposed in the remaining cases, all of these cases required repayment of the original overpayment and additional damages. The HHS-OIG makes an independent decision whether to require a corporate integrity agreement as part of a settlement; it also has its own guidance addressing participation in national initiatives.

Representatives from the state hospital associations we contacted did not have specific complaints regarding the way U.S. Attorneys' Offices were conducting either the PPS Transfer or the Pneumonia Upcoding initiatives. These associations also did not identify instances of U.S. Attorneys' Offices failing to comply with the guidance. Some associations acknowledged the willingness of the offices to develop an acceptable investigative process. In addition, they noted that some Assistant U.S. Attorneys have developed extensive knowledge about Medicare billing requirements and provide reasonable opportunities to present their positions.

We will continue to solicit the concerns of the hospital community regarding DOJ's implementation of the False Claims Act guidance when we prepare our 2002 mandated report.

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## Concluding Observations

DOJ seems to have made substantive progress in ensuring compliance with the False Claims Act guidance. It has strengthened its oversight of U.S. Attorneys' Offices. The review of each district's compliance now

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<sup>11</sup>A corporate integrity agreement is an obligation imposed on a provider by the HHS-OIG as part of a settlement of a potential fraud matter. In return, the HHS-OIG agrees not to seek further administrative penalties against the provider for the behavior in question. Corporate integrity agreements typically last for 3 years for national initiative cases and require affirmative steps to improve compliance and report periodically to the HHS-OIG.

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appears to be an integral component of the periodic evaluation conducted at all U.S. Attorneys' Offices. These evaluations seem to be effective in identifying areas of vulnerability leading to corrective action taken by the local district. Further, each U.S. Attorney's Office participating in a national initiative is required to certify that it has complied with the guidance on an annual basis.

DOJ's implementation of the two most recent initiatives, the PPS Transfer and Pneumonia Upcoding projects, appears to be consistent with the guidance, based on our visits to a limited number of offices. Each working group has taken the lead in developing the legal and factual basis for its initiative. Their development of detailed claims data and other relevant materials, such as model contact letters, has helped to promote consistency among the districts in their implementation of the initiatives. In our visits to several U.S. Attorneys' Offices, we found that attorneys were conducting their investigations in accordance with the guidance. They coordinated their activities with the working group to ensure consistency, but took into account the unique factors surrounding each hospital's circumstances. This flexibility is in keeping with the principles outlined in the guidance.

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## Agency Comments

We provided a draft of our report to DOJ for comment. Officials from DOJ's Executive Office for U.S. Attorneys and its Civil Division provided oral comments, in which they generally concurred with our findings and conclusions. They also provided several technical comments, which we incorporated as appropriate.

We are sending copies of this report to the Honorable John Ashcroft, Attorney General of the United States, the Honorable Tommy Thompson, Secretary of HHS, and other interested parties. We will make copies available to others upon request.

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If you or your staff have any questions about this report, please call me at (312) 220-7600, or Geraldine Redican-Bigott at (312) 220-7678. Other major contributors were Suzanne Rubins and Frank Putallaz.

A handwritten signature in cursive script that reads "Leslie G. Aronovitz".

Leslie G. Aronovitz, Director  
Health Care—Program Administration  
and Integrity Issues

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# Appendix I: GAO Reports Concerning the Use of the False Claims Act in Civil Health Care Fraud

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Report Mandated by the Consolidated Appropriations Act of 2000 (P.L. 106-113)

*Medicare Fraud and Abuse: DOJ Has Made Progress in Implementing False Claims Act Guidance* ([GAO/HEHS-00-73](#), Mar. 31, 2000).

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Reports Mandated by the Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1999 (P.L. 105-277)

*Medicare Fraud and Abuse: DOJ's Implementation of False Claims Act Guidance in National Initiatives Varies* ([GAO/HEHS-99-170](#), Aug. 6, 1999).

*Medicare Fraud and Abuse: Early Status of DOJ's Compliance With False Claims Act Guidance* ([GAO/HEHS-99-42R](#), Feb. 1, 1999).

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Other Related Reports

*Medicare: Concerns With Physicians at Teaching Hospitals (PATH) Audits* ([GAO/HEHS-98-174](#), July 23, 1998).

Letter to the Committee on Ways and Means, B-278893, July 22, 1998.

*Medicare: Application of the False Claims Act to Hospital Billing Practices* ([GAO/HEHS-98-195](#), July 10, 1998).



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