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Medicare Claims

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The President of the Senate
The Speaker of the House of Representatives

In 1990, the General Accounting Office began a special effort to review and report on the federal program areas we considered high risk because they were especially vulnerable to waste, fraud, abuse, and mismanagement. This effort, which has been strongly supported by the Senate Committee on Governmental Affairs and the House Committee on Government Reform and Oversight, brought much needed focus to problems that were costing the government billions of dollars.

In December 1992, we issued a series of reports on the fundamental causes of problems in designated high-risk areas. We are updating the status of our high-risk program in this second series. Our Overview report (GAO/HR-95-1) discusses progress made in many areas, stresses the need for further action to address remaining critical problems, and introduces newly designated high-risk areas. This second series also includes a Quick Reference Guide (GAO/HR-95-2) that covers all 18 high-risk areas we have tracked over the past few years, and separate reports that detail continuing significant problems and resolution actions needed in 10 areas.

This report discusses our concerns over Medicare's exposure to losses through waste, fraud, and abuse. Since we reported in 1992, the Health Care Financing

Administration, the agency responsible for administering Medicare, has implemented various measures to improve controls over unnecessary and inappropriate Medicare spending. However, Medicare continues to be highly vulnerable to exploitation. Inadequate funding for contractors' antifraud and antiabuse activities, uneven implementation of payment controls, flawed payment policies and abusive billing practices plague the program. Moreover, Medicare's controls against fraud and abuse have not kept pace with health care's more complicated financial arrangements.

Copies of this report series are being sent to the President, the Republican and Democratic leadership of the Congress, congressional committee chairs and ranking minority members, all other members of the Congress, the Director of the Office of Management and Budget, and the Secretary of Health and Human Services.

Charles A. Bowsher
Comptroller General
of the United States

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Overview

Last fiscal year, federal spending for the Medicare program totaled an estimated $162 billion, or over $440 million a day. The Congressional Budget Office estimates that, in less than a decade, Medicare spending will more than double, exceeding $380 billion in 2003. The portion of Medicare spending attributable to waste, fraud, and abuse cannot be quantified precisely, but health care experts have estimated that as much as 10 percent of national health spending is lost to such practices.

In 1992, GAO reported that Medicare was one of several government programs it considered highly vulnerable to waste, fraud, abuse, and mismanagement.[1] Since then, the Health Care Financing Administration (HCFA), the agency responsible for administering Medicare, has made various regulatory and administrative changes aimed at correcting flawed payment policies, weak billing controls, and deficient program management. However, these worthwhile improvements still are not sufficient to protect Medicare against continued program losses. As the nation's health care delivery system evolves with such changes as consolidations of various provider types and increasingly complex financial

[1]High-Risk Series: Medicare Claims (GAO/HR-93-6, Dec. 1992).

arrangements, the Medicare program remains highly vulnerable to waste, fraud, and abuse.

Problem

In our 1992 report, we noted two problems related to the Medicare claims processing contractors, which are responsible for applying controls against fraud and abuse. First, the funding of contractors' activities to control fraud and abuse has not been commensurate with the growing volume of claims. As a result, today Medicare pays more claims with less scrutiny than at any other time in the last 5 years. Between 1989 and 1994, the requirement for contractors to review a portion of claims in process dropped from 20 percent to 5 percent due to reduced funding. Inadequate funding has also stunted the development of new controls to protect Medicare benefit dollars. Second, Medicare claims administration is a complicated process, with some 80 contractors sharing responsibility for claims processing, payment, and review. Because HCFA's management of contractors' antifraud and antiabuse activities provides these contractors with broad discretion, the implementation of payment controls is uneven across the Medicare program.

In addition, HCFA is aware that flawed payment policies and abusive billing practices plague Medicare, but the exploitation of the program continues. For example, Medicare has been charged rates as high as $600 per hour for speech and occupational therapy, though therapists' salaries range from under $20 to $32 per hour. The extraordinary markup between the cost and charges for services is the result of certain weaknesses in payment rules permitted by Medicare.

As another example, the program overpays health maintenance organizations (HMO) serving Medicare beneficiaries as a result of a flawed payment methodology. Numerous government and independent studies show that Medicare pays more for the treatment of beneficiaries in HMOs than it would have spent if the beneficiaries had remained outside the HMO network.

Progress

HCFA has acted on certain payment and billing control problems and has initiated two broad efforts to deal with fraud and abuse. In 1993, HCFA established a requirement that raised the standards for contractor performance regarding analyses of payment data. In 1994, the agency

awarded a contract for developing a national automated claims processing system intended to replace the several systems currently operating. Through these efforts—promising modern data analysis techniques and greater uniformity in claims processing—HCFA expects to reduce Medicare's inappropriate payments. Initially, unreliable data and inadequate guidance from HCFA impaired the contractors' implementation of the data analysis requirement, making it premature to determine the success of this effort. Similarly, the new automated claims processing system is still in the planning stages and will not be ready for operation for at least 3 years.

Outlook for the Future

Medical service delivery is becoming more complex. Companies as well as independent providers are delivering health care services and billing Medicare. Even some of Medicare's claims processing contractors—which are also private insurers—are investing in provider networks. This means that these contractors, which are responsible for reviewing the appropriateness of Medicare claims are also, in principle, billing Medicare through the medical networks they own.

Medicare's traditional controls against fraud and abuse have not kept pace with health care's more complicated financial arrangements. This situation raises concerns about the government's ability to protect Medicare funds in an increasingly entrepreneurial health care environment.

Background

Medicare is the nation's largest health payer—its outlays are exceeded only by social security, defense, and interest payments on the national debt. Medicare is also the fastest growing program in the budget. In less than a decade, Medicare's expenditures have more than doubled, from $70 billion in 1985 to $162 billion in 1994. Medicare's Hospital Insurance Trust Fund is the source of reimbursements for hospitals and other institutional providers. In 1994, the Board of Trustees estimated that the fund could be depleted by 2001.

Federal Program at Risk

Flawed payment policies, weak billing controls, and inconsistent program management have all contributed to Medicare's vulnerability to waste, fraud, and abuse. For example, in our 1992 high-risk series report we noted the following.

- Because Medicare payments for laboratory services were excessive, laboratories' profit rates from Medicare business substantially exceeded the laboratories' overall profit rates.
- A scam involving mobile physiology labs grew into a multimillion dollar fraud, initially involving Medicare before moving on to other public and private payers. In Medicare,

the scam took advantage of Medicare's weak controls over provider billing numbers.

- Hospitals and other health providers owed Medicare millions of dollars in mistaken payments when, in the absence of HCFA guidance and monitoring, contractors failed to recover the erroneous payments.

What Are Medicare's Controls Over Waste, Fraud, and Abuse?

Controls over waste, fraud, and abuse help ensure that Medicare does not pay for unnecessary or inappropriate services. These controls come in various forms. Some are electronic: they are programmed into computer software for claims processing and trigger the suspension of payment for incomplete or erroneous claims. For example, if the number of digits in a provider's billing number or beneficiary identification number is incomplete or otherwise incorrect, the computer automatically holds the claim until the data are corrected.

Electronic controls can also stop processing when claims do not meet certain conditions for payment. For example, when one contractor found that spending for foot care services increased more than threefold—from about $470,000 to about $1.8 million in a 3-year period—it developed

a payment policy covering foot care under certain conditions. It enforced the policy by developing a computerized control that flagged for further review foot care claims not meeting the conditions stipulated. Within a year, the contractor's payments for foot care procedures dropped to about $620,000, or a third of what it paid the previous year.

Another form of control is the analysis of detailed payment data to establish spending trends. In the example above, contractor staff examined several years of data on spending for foot care procedures and determined that in 1991 the contractor paid significantly more for these services than in prior years.

Another control entails the audit of an individual provider's claims to detect fraudulent or abusive billings. Contractors identify providers whose billing patterns appear irregular. In these cases, they review claims for a sample of the provider's patients to verify that the services were appropriate and billed properly. This can involve reviewing medical records and interviewing providers.

Fraud and abuse controls are applied by Medicare claims processing contractors,

which HCFA hires and is responsible for managing. Medicare's contractors are insurance companies, such as Blue Cross and Blue Shield, Travelers, and Aetna. Contractors each receive an administrative budget to pay for the cost of processing claims and performing antifraud and antiabuse activities.

Recent HCFA Initiatives Intended to Reduce Medicare's Vulnerability

HCFA has taken several steps to address long-standing problems with inappropriate payments. These steps are either very recent or only preliminary to corrective action. Foremost among HCFA's actions are (1) the establishment of a data analysis requirement for contractors to better identify excessive spending and (2) letting a contract to design a single automated claims processing system that promises greater accuracy and efficiency in claims processing. These represent HCFA's major initiatives toward better oversight of Medicare contractors' antifraud and antiabuse activities.

HCFA's Data Analysis Initiative

Since our 1992 high-risk report, HCFA has acted to improve certain antifraud and antiabuse activities of the Medicare contractors. Central to this effort has been HCFA's development of the "focused medical review" requirement, which specifies how contractors should review their payment data for identifying and correcting problems that cause excessive Medicare spending.

Prior to this requirement, contractors were expected only to look for physicians whose claims suggested they might be overbilling or engaged in some other wrongdoing. Under the new requirement, contractors must also

examine spending for medical procedures to identify questionable spending patterns and trends.

For example, when a Medicare contractor in Tennessee compared its payments for selected services with those of other contractors, it found an instance where total payments for a service—pathology consultations—were not in line with other contractors' totals. Specifically, the contractor was paying pathologists for consultations when the test results could have been interpreted by the requesting physician. The contractor revised its payment rule governing pathology consultations, and reimbursements for this service declined from $2.7 million in 1988 to less than $11,000 in 1992.

In first implementing the focused medical review requirement, contractors charged that HCFA's guidance was not specific enough to enable them to carry out certain components of the requirement. HCFA has since updated its guidance to contractors, providing the needed specificity.

HCFA's New Claims Processing System

HCFA has also begun a major systems acquisition effort—the development of a new claims processing system called the Medicare Transaction System (MTS). MTS is intended to replace the 14 different claims processing systems used by Medicare contractors with a single system expected to have improved capabilities. Using the current multiple systems, HCFA has difficulty aggregating information on spending, savings, and workload at the various claims processing contractors. Inadequate management information makes it difficult for HCFA to provide the oversight required of a national program. The new system, which promises to format claims data uniformly and produce comparable payment data, is expected to provide HCFA with prompt, consistent, and accurate management information.

The system is not yet in the design phase, and full implementation is, optimistically, at least 3 years away. HCFA revised its initial planning and acquisition strategy to reduce the risk of cost overruns and failure to achieve intended benefits. However, inherent risks remain due to the size, complexity, and importance of MTS to the administration of the Medicare program. In 1994, we recommended continued top

management and congressional oversight to ensure the system's success.

Other Government Actions

Table 1 highlights other ways in which HCFA, the Office of Management and Budget, and the Congress have addressed certain problems cited in our 1992 report—namely, flawed payment policies, weak billing controls, inconsistent management of Medicare contractors, and inadequate funding for payment safeguard activities.

Table 1: Examples of Government Actions Taken to Address Medicare's Vulnerability

Problems areas cited in 1992 report	Government actions
Contractor management and oversight	To promote consistency in contractor reimbursement and coverage policies, HCFA consolidated processing of durable medical equipment claims within four regional contractors. HCFA modified the Contractor Performance Evaluation Program to broaden the range of activities for which a contractor may be assessed. In 1994 HCFA did not renew the contracts of two poorly performing Medicare contractors and placed a third on notice.

(continued)

Problems areas cited in 1992 report	Government actions
Payment policies	OBRA 1993 implemented a phased reduction in fee schedule amounts for clinical lab tests to a level at which Medicare's contribution to laboratories' profits does not exceed the laboratories' overall profit rates. OBRA 1993 phases in a decrease in reimbursement for anesthesia services performed by nurse anesthetists under the medical direction of a physician anesthesiologist.
Billing controls	OBRA 1993 includes new restrictions on Medicare and Medicaid self-referrals and becomes effective largely in 1995. HCFA established a National Supplier Clearinghouse responsible for certifying suppliers and issuing billing ID numbers as conditions for authorization to bill Medicare. HCFA has identified requirements for a national system of provider numbers to track providers that are reimbursed by multiple health insurance plans.
Funding for safeguard activities	OMB released nearly $20 million in contingency funds to help contractors recover $613 million owed Medicare by other insurers. This was a one-time infusion of funds into the Medicare Secondary Payer program to allow contractors to reduce workload backlogs pertaining to the recovery of the mistaken payments.

Health Care Delivery Expansion Widens Opportunity for Profiteering

Despite some progress in addressing specific payment and management problems, Medicare remains vulnerable. Since Medicare was enacted in 1965, the delivery of health care services has become more complex, but Medicare's fraud and abuse controls have not kept pace. Thirty years ago, providers typically billed Medicare as independent entities—a physician, hospital, or nursing home, for example. More recently, as a greater number of providers deliver and bill for services as large corporate entities, the billing abuses of one "bad apple" can have repercussions nationwide. For example,

- in 1994, a national psychiatric hospital chain, charged with committing fraudulent practices to increase reimbursements, paid over $300 million in the largest settlement to the federal government for health care fraud; and
- from 1988 to 1991, two of the nation's largest clinical laboratory companies systematically overbilled Medicare tens of millions of dollars for lab tests.

In addition, complex billing arrangements have developed through the consolidation and vertical integration of such health care providers as hospitals, physician practices,

diagnostic centers, and home health agencies. These arrangements make it difficult for payers to identify the sources of inflated charges or other billing abuses.

To complicate matters, some of Medicare's claims processing contractors are also moving into the health delivery business. In addition to HMOs, some health insurance companies have begun investing in physician groups, hospitals, and other providers of medical services and supplies. Several Medicare contractors are among those companies actively engaged in diversification. This means that these contractors, which are responsible for reviewing the appropriateness of Medicare claims are also, in principle, billing Medicare through medical care networks they own. In a 1994 memorandum to Medicare contractors, HCFA stated that "...a clear conflict of interest [exists], for example, for a Medicare carrier to process claims submitted by a physician who is employed by a medical group controlled by the carrier, or an intermediary [Medicare contractor for reviewing hospital claims] to audit hospitals in which the intermediary is a major investor." The memo asked that contractors inform HCFA of any providers they may own or in which they have an investment. As of

early November 1994, HCFA was aware of eight contractors for which conflict of interest was a concern due to the contractors' ownership interests in health service delivery.

Rehabilitation Therapy Illustrates Gaming of Traditional Payment Rules

The inability of the government to respond quickly and effectively to profiteering heightens Medicare's vulnerability to exploitation. Medicare's reimbursement of rehabilitation therapy services is a case in point.

An entire industry has grown and flourished out of a federal requirement to assess nursing home residents for their need for rehabilitation therapy services. From 1990 to 1993, claims submitted to Medicare for these services tripled to $3 billion. Some of this cost growth is attributable to the excessive rates Medicare pays for therapy services. For example, Medicare has been charged rates as high as $600 per hour, though physical, occupational, and speech therapists' salaries range from under $20 to $32 per hour.

Medicare's open-ended definition of reimbursable costs and the absence of clear billing rules account for this situation. Combined, these two weaknesses enable

skilled nursing facilities and therapy companies to pad the amount of administrative costs for which they are reimbursed by Medicare. Loose payment and billing rules also allow providers to pass on these inflated charges with little or no scrutiny.

One questionable business practice is that of therapy companies using a skilled nursing home's provider number to bill Medicare. Under such an arrangement, the therapy company bills Medicare as if the patients had received services in that nursing facility, though the patients may be anywhere in the country. This practice benefits therapy companies by enabling them to evade Medicare controls that might flag overbilling. For example, one therapy company divided a Texas patient's $10,950 claim for physical therapy between nursing homes that submitted their claims to two different Medicare processing contractors, one in North Carolina and the other in Florida.

Sometimes shell therapy companies are established to enhance opportunities to overbill. For example, a Georgia Medicare contractor reported that the program authorized a company to bill for therapy services, even though it had no salaried

therapists and was essentially a storefront office operated by one clerical employee. The shell company billed Medicare for services provided to nursing home residents through two therapy agencies with which it subcontracted. The company's contractual relationship with the nursing home entitled it to add to its claims an 80-percent markup over what the company paid the therapy agencies. As a result, a company that appeared to exist solely for the purpose of billing Medicare added in one fiscal year about $135,000 in administrative charges to the costs of the therapy services.

Although aware of these problems since 1990, HCFA did not act until 1993 to advise claims processing contractors of certain irregular billing practices and of actions they could take to minimize billing problems. HCFA is also in the process of establishing certain reimbursable cost guidelines, but drafting and implementing them could take years, judging from similar efforts in the past.

Medicare's HMO Payments Also Result in Losses

Medicare also loses money through its methodology for paying HMOs that participate in the "risk contract" program.[2] Medicare pays these HMOs a flat monthly fee for each beneficiary enrolled. The law sets this fee at 95 percent of the estimated average cost of serving a Medicare beneficiary in the fee-for-service sector. Numerous independent and HCFA-sponsored research studies have demonstrated that HMO enrollees tend to be healthier than beneficiaries who remain in the fee-for-service sector, but HCFA's method of computing rates does not take this into account. As a result, HCFA has paid HM0s more—from 6 percent to 28 percent—for beneficiaries' treatment than it would have spent had those same beneficiaries remained in the fee-for-service sector.

Although the problems in linking HMO and fee-for-service payments are widely acknowledged, there is little agreement over proposed solutions. We identified four alternative risk adjustment mechanisms that—unlike HCFA's current system—would adjust payments based on the health status

[2]Under a risk contract, the HMO provides all necessary medical care in return for a predetermined payment from Medicare for each enrolled beneficiary. Within certain limits, risk HMOs can profit if their cost of providing services is less than the predetermined payment, but the HMOs run the risk of a loss should their cost be higher.

of enrollees. Any of these four risk adjustment methods could reduce favorable selection and allow Medicare to achieve cost savings under the risk contract program. In 1994, we recommended that HCFA conduct research on payment methods that could replace the reliance on fee-for-service reimbursement to determine base payment rates for HMOs.

Funding and Management Problems Leave HCFA Ill-Equipped to Protect Medicare

Physicians, supply companies, or diagnostic laboratories have about 3 chances out of 1,000 of having Medicare audit their billing practices in any given year. Moreover, Medicare pays more claims with less scrutiny today than at any other time over the past 5 years. Government funding of claims review and other fraud and abuse control activities has declined relative to the growing number of Medicare claims. In fiscal year 1993, Medicare processed almost 700 million claims, about 250 million more than it processed 5 years earlier.

Controls Over Medicare Payments Deteriorate Due to Budget Constraints

Despite the rising volume of claims, per-claim funding for antifraud and antiabuse activities declined between 1989 and 1993 by over 20 percent. The largest portion of this funding pays for Medicare contractor staff who develop payment controls, review claims, and investigate suspect providers. Annual per-claim funding reductions have forced HCFA to lower the proportion of claims that contractors must review. In 1989, HCFA set targets for contractors to suspend processing and review 20 percent of all claims; it reduced this target to 15 percent in 1991, 9 percent in 1992 and 1993, and 5 percent in 1994. HCFA also reduced by a third the number of audits

of providers that contractors are required to perform. The purpose of these audits is to identify and recover overpayments.

When claims volume grows but the number of staff remains constant or declines, contractor staff perform fewer or less stringent antifraud and antiabuse activities. In some instances, contractors have curtailed or discontinued reviews of medical services for which there has been evidence of widespread billing abuse and potential for significant savings. For example, a contractor we visited this year temporarily reduced or suspended the use of five electronic controls that triggered further review of the claims by contractor staff. These reviews had previously resulted in the denial of claims submitted and $4 million in savings over a 3-month period. The contractor suspended the use of the controls because the volume of claims they generated overwhelmed the claims review staff.

In other instances, contractors have not pursued claims with high potential for abuse and savings because resources were needed to complete current claims review work. At one contractor we visited in 1994, staff had ranked by potential savings eight claim types as areas warranting further scrutiny. Staff

estimated that, if controls were developed over the eight claim types, the total potential savings would be over $57 million for one quarter. The contractor did not have the resources, however, to develop controls for the eight areas.

The decline in program spending for fraud and abuse controls corresponds in part with the 1990 passage of the Budget Enforcement Act. That act places stringent limits, or caps, on discretionary spending, which covers Medicare administrative costs, including the cost of contractors' fraud and abuse controls. Benefit payments, however, are not subject to these caps. This creates a dual problem. Any increase in spending for Medicare's fraud and abuse controls would require cuts in funding for other programs, such as education or welfare. A decline in benefit costs, however, even if attributable to savings from fraud and abuse activities, cannot be used as an offset. In fact, funding for fraud and abuse activities is in continual jeopardy, since cutting this funding could free up money for other programs.

Reduced antifraud and antiabuse funding, however, translates to greater Medicare costs. HCFA figures indicate that spending for antifraud and antiabuse activities can reduce

Medicare program costs on average by as much as 11 times the amount invested. In effect, by not adequately funding these activities, the federal government is missing a significant opportunity to control Medicare program costs.

Management Deficiencies Compound Funding Problems

Problems in HCFA's management of Medicare's claims processing contractors further weaken the Medicare program. In general, the contractors are responsible for developing payment controls and carrying out antifraud and antiabuse activities. HCFA is responsible for overseeing these efforts, but the lack of information regarding contractors' activities limits its ability to ensure that contractors are adequately protecting Medicare payments from provider exploitation or fraud.

In addition to certain national policies, each contractor has its own coverage policies and its own controls to enforce them. Typically, these prepayment controls are programmed into the contractor's claims processing software so that claims in process not meeting stipulated coverage criteria can be flagged for further review. HCFA has little information on the criteria contractors use to identify claims that may not be eligible for

payment. As a result, HCFA cannot explain why some contractors pay many more claims for certain procedures than do other contractors.

For example, each year Arizona's Medicare contractor pays for about 700 chiropractic manipulations for every 1,000 beneficiaries, whereas Louisiana's contractor pays for about 150 manipulations for the same number of beneficiaries. HCFA has not assessed whether the spending differences between these contractors are related to better payment controls at one contractor or some other factor.

Moreover, HCFA makes little use of the management reports contractors submit that describe their claims review activities. This lack of attention may help explain why HCFA did not probe when, in one year, a contractor reported a 53-percent drop (amounting to $26.9 million) in the amount of savings it achieved through claims review. In its 1992 contractor evaluations, HCFA gave this contractor a maximum score for the relevant segment of its program safeguard activities.

Conclusions

Several significant problems limit HCFA's ability to protect the Medicare program from serious financial losses. Inadequate contractor funding has limited the development of necessary fraud and abuse controls. Also, these controls depend heavily on the analysis of payment data, but HCFA's efforts to enhance contractors' data analysis capabilities are only in the planning or early implementation stages.

Adding to the potential for Medicare losses is the expansion of health care provider types to large, multilayered corporations. The exploitation of Medicare's rehabilitation therapy reimbursement illustrates the ability of an unscrupulous profiteer to shield questionable billings in complicated financial arrangements. In addition, as the trend continues for Medicare contractors to diversify their businesses to involve health care delivery, checks on Medicare payments could be compromised because these checks will increasingly be performed by the same entity that submits the claims.

In essence, HCFA needs to guard a thousand doors but has the resources to guard only a few hundred. This dilemma leaves the Medicare program seriously exposed and vulnerable to losses.

Related GAO Products

Medicare Part B: Regional Variations and Denial Rates for Medical Necessity (GAO/PEMD-95-10, Dec. 19, 1994).

Medicare: Referrals to Physician-Owned Imaging Facilities Warrant HCFA's Scrutiny (GAO/HEHS-95-2, Oct. 20, 1994).

Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs (GAO/HEHS-94-119, Sept. 2, 1994).

Medicare: Shared System Conversion Led to Disruptions in Processing Maryland Claims (GAO/HEHS-94-66, May 23, 1994).

Medicare: Inadequate Review of Claims Payments Limits Ability to Control Spending (GA0/HEHS-94-42, Apr. 28, 1994).

Health Care Reform: How Proposals Address Fraud and Abuse (GAO/T-HEHS-94-124, Mar. 17, 1994).

Medicare: Greater Investment in Claims Review Would Save Millions (GAO/HEHS-94-35, Mar. 2, 1994).

Medicare: New Claims Processing System Benefits and Acquisition Risks (GAO/HEHS/AIMD-94-79, Jan. 25, 1994).

Medicare: Adequate Funding and Better Oversight Needed to Protect Benefit Dollars (GAO/T-HRD-94-59, Nov. 12, 1993).

Psychiatric Fraud and Abuse: Increased Scrutiny of Hospital Stays Is Needed for Federal Health Programs (GAO/HRD-93-92, Sept. 17, 1993).

Health Insurance: Remedies Needed to Reduce Losses From Fraud and Abuse (GAO/T-HRD-93-8, Mar. 8, 1993).

High-Risk Series: Medicare Claims (GAO/HR-93-6, Dec. 1992).

Medicare: One Scheme Illustrates Vulnerabilities to Fraud (GAO/HRD-92-76, Aug. 26, 1992).

Health Insurange: Vulnerable Payers Lose Billions to Fraud and Abuse (GAO/HRD-92-69, May 7, 1992).

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