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MEDICARE

Concerns About HCFA's Efforts to Prevent Fraud by Third-Party Billers

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Medicare: Concerns About HCFA's Efforts to Prevent Fraud by Third-Party Billers

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the effectiveness of HCFA's efforts to prevent fraud by third-party billing companies that submit claims to Medicare on behalf of providers. With 1999 payments of about $208 billion and responsibility for financing health services delivered by hundreds of thousands of providers to almost 40 million elderly and disabled Americans, Medicare is inherently vulnerable to fraud, waste, and abuse. We, and the Department of Health and Human Services (HHS) Office of Inspector General (OIG) have issued several reports addressing the need for sophisticated program safeguards to identify and detect potentially fraudulent billing practices.

In fiscal year 1999, Medicare's fee-for-service program covered about 83 percent of Medicare's beneficiaries. HCFA administers Medicare's fee-for-service program largely through a network of more than 50 claims processing contractors–insurance companies such as Mutual of Omaha and Blue Cross and Blue Shield plans–that process and pay Medicare claims. Once enrolled in Medicare, physicians, hospitals, and other providers may submit claims for payment, sometimes through third-party billers, to Medicare contractors. Third-party billing companies are businesses that prepare and submit claims on behalf of health care providers to payers such as Medicare, Medicaid, and private health insurers. In the first 7 months of fiscal year 1999, Medicare contractors processed over 508 million claims–averaging more than 72 million claims per month.

HCFA's contractors can only review a limited number of claims. Finding fraud among third-party billing companies is like looking for a needle in a haystack. Knowing that providers are linked to problematic third-party billers is like giving HCFA a magnet to look for those needles. In a GAO report issued last June, we found that HCFA's efforts to comprehensively identify and review claims associated with third-party billers fell short for several reasons.[1] First, the identity of a third-party biller submitting a claim is lost on many electronic claims when multiple entities are involved, while on paper claims, such information is not recorded at all. Second, such billers do not register with Medicare, nor are they linked systematically to the providers they serve. Third, HCFA's efforts to develop comprehensive data on all providers, including their use of third-party billers, are still several years from completion. Finally, information

[1] GAO/HEHS-99-127R, June 2, 1999.

HCFA does have about providers' use of third-party billers is not reliable because HCFA's database is dependent on provider self-reporting and is not validated.

Background

Although third-party billing services have been part of the U.S. health care system since the 1950s, large billing companies emerged in the 1980s, when Medicare required that hospital-based physicians' services be separately billed. In 1990, Medicare required physicians and other providers to submit claims to Medicare on behalf of all beneficiaries, increasing providers' billing workloads. Many providers have turned to third-party billing companies to assist them in submitting claims and to provide advice regarding reimbursement matters, as well as overall business decision-making. Officials of an industry trade association estimate that there are currently about 5,000 active third-party billing companies in the United States.

Third-party billing companies prepare either paper or electronic claims for submission to Medicare contractors. In fiscal year 1999, about 83 percent of Medicare claims were submitted electronically. Electronic claims may be submitted directly to a contractor or may be sent through one or more other entities, known as clearinghouses, before reaching the Medicare contractor. Third-party billers, and even providers, contract with clearinghouses to reformat claims to meet Medicare's requirements.

Medicare claims administration contractors are responsible for processing and paying Medicare claims. In addition, they are responsible for payment safeguard activities intended to protect Medicare from paying inappropriately. These activities include analyzing claims data to identify potentially inappropriate claims, performing medical review of claims to determine whether the services provided were medically necessary and covered by Medicare, and investigating potential cases of fraud and abuse. To target program integrity resources, contractors attempt to identify aberrant patterns of claims submitted by providers to determine whether the claims should be subjected to greater scrutiny. In this connection, the ability to scrutinize the claims being submitted by individual third-party billing companies might allow HCFA to identify aberrant patterns indicative of fraud and abuse in their submissions.

HCFA Cannot Identify Claims Submitted By Third-Party Billers

Third-party billing companies often have access to billing information about multiple health care providers and many of their patients. As a result, unscrupulous operators of such businesses have an opportunity to submit false claims. For example, in 1997, a billing company agreed to pay

the government $7.75 million to settle allegations that it had violated the federal False Claims Act when it filed improperly coded claims. In 1998, a different third-party biller was found to have submitted duplicate claims and claims with incorrect diagnosis codes. Although it did not admit guilt, it agreed to pay the federal government $1.5 million to settle these allegations. In a third case, a third-party billing company agreed to pay the government almost $415,000 to settle allegations that it improperly filed medical supply claims with Medicare on behalf of a provider. The provider denied that it knew of, or participated in, any fraudulent conduct with respect to the submission of the claims.

Even when HCFA or its contractors suspect that providers' claims are abusive, they are often unable to tell that the claims were submitted by a third-party biller. This is due to limitations in both the systems for processing electronic claims and the complete lack of identifying information on paper claims. For providers, third-party billers, and clearinghouses to submit claims to Medicare contractors electronically, they must obtain a submitter number from a Medicare contractor. This number becomes part of each claim submission. Electronic claim submissions contain only one submitter number. If a third-party biller submits a claim directly to a contractor, the number identifies the claim as coming from that biller. However, when a claim passes through other entities, such as one or more clearinghouses, before reaching the contractor for payment, the third-party biller's number is not always present. In some cases, one entity may overwrite another's number, or entities may decide among themselves whose number to use.

While HCFA has established this process—albeit imperfect—to monitor the source of electronic claims, no such process exists for paper claims. Paper claim forms include a section or space to identify the provider but not the biller. In general, contractors would know if a third-party biller submitted a paper claim only if the provider specifically informed the contractor when it first enrolled in Medicare of its intention to use a third-party biller, or if the contractor identified a biller while investigating a provider. An OIG official who has investigated several cases of Medicare fraud by third-party billing companies told us that when billing companies used paper claims, it was difficult for the OIG to identify all providers using a given biller. In the case where a third-party billing company was submitting fraudulent claims for surgical dressings on behalf of many nursing homes across the United States, there was no indication that the same third-party biller was involved. The OIG agents pursued the case against one nursing home as an individual fraudulent provider, when in fact 70 nursing homes were involved. After additional cases were opened by other OIG offices targeting other individual nursing homes, the agents

met to share lessons learned and realized that all the nursing homes used the same billing company and that a single company was, in fact, the source of the fraud.

HCFA's Efforts Show Limited Results

HCFA has no routine registration process to collect comprehensive information about third-party billers. Although the enrollment process requires providers to identify the name of the billing company, its address, phone number, and a contact person, there is no registration process for third-party billers that would allow HCFA to identify critical information on the company's owners, criminal history record, or other identifiers. Without this information, HCFA might have difficulty identifying an officer or officers of the company if problems should occur. In addition, although providers indicating that they plan to use a billing company must provide a copy of their contract with the biller, the information in the contract may be minimal. For example, we reviewed one contract that identified the services the biller would provide but included no identifying information about the biller other than its name and a signature. Even if HCFA did have complete information on third-party billers, it has limited recourse if problems arise. Although HCFA can refer the biller to the HHS OIG or the Department of Justice, it does not have the ability to take intermediate administrative actions. According to a HCFA official, whereas the agency would like to be able to exclude third-party billers from submitting claims to Medicare, it cannot do so because third-party billers do not have to enroll with Medicare to participate in the program.

HCFA has made efforts to obtain information on third-party billers, but it still cannot routinely match a third-party biller with all of the providers it represents. In May 1996, HCFA issued a new enrollment form for providers entering Medicare. The form requires detailed information, including an identification of the third-party billing company a provider plans to use, if any. While the enrollment form provides information about billers that HCFA and its contractors previously did not have, HCFA data indicate that only about 15 percent of Medicare providers have enrolled since HCFA began using the new form. Thus, the 85 percent of Medicare providers that enrolled before May 1996 likely have not provided this information to HCFA. Further, even providers that have completed the new enrollment form may not have valid information in HCFA's system. This is due to the fact that HCFA and the contractors depend on providers to report any changes. Providers often do not comply with the requirement in enrollment instructions to notify their claims processing contractors when they change or add third-party billers, according to HCFA and contractor officials we talked with. Although notification is legally required, it is

unlikely as a practical matter that any action would be taken against a non-complying provider.

In an attempt to gather updated and comprehensive information about providers, HCFA is drafting a regulation to require providers that enrolled in Medicare before May 1996 to complete the new enrollment form to fill this information gap. Providers would also be required to recertify the information on their enrollment form every 3 years. HCFA plans to have the regulation in effect by October 1, 2000, and begin requiring providers to update their enrollment information shortly thereafter. Here again, this process involves self-reported data that typically will not be validated or updated by the contractors.

To make provider and third-party biller information more accessible to the contractors, HCFA is developing a new automated system to access the provider enrollment database. HCFA intends that the system, known as the Provider Enrollment, Chain and Ownership System (PECOS) will provide a complete history of a Medicare provider based on the information in the provider enrollment application.[2] Initially, HCFA plans to incorporate currently available provider information into the system, and, according to HCFA officials, will include updated information from all providers in the future. HCFA plans to implement PECOS for institutional providers, such as hospitals and nursing homes, by June 2000. HCFA's timeline currently indicates that PECOS will be operational for providers of outpatient services in January 2002. According to a HCFA official, this timeline was developed prior to addressing all Y2K concerns ; due to a smooth transition, however, it may be able to move implementation up to August 2001. Finally, HCFA expects that comprehensive data on durable medical equipment suppliers will be brought into PECOS about 12 months after these other efforts are completed. The system will depend entirely on providers submitting information to the contractors, without subsequent validation. As a result, PECOS will only be as useful as the accuracy of the information it receives.

Conclusions

In an effort to ensure the integrity of Medicare, HCFA and its contractors need to develop reliable and sophisticated approaches to identifying potentially fraudulent billing practices. In this regard, contractors should

[2] PECOS' functions include capturing enrollment data, logging and tracking provider enrollment forms, identifying and profiling provider chains, tracking associations of Medicare providers to these chains, providing inquiry and reporting capability, and providing a data exchange process that forwards enrollment and claim information to other processing systems.

be able to easily access information about third-party billers that complete and submit claims to Medicare for payment. It is especially important to be able to match up third-party billers with the providers they represent, so that contractors can identify potentially questionable billing patterns and subject these claims to more extensive review. Although HCFA has various efforts underway to better identify providers' questionable claims and their associated third-party billers, there continue to be gaps in its safeguard program. It is important that HCFA complete its provider recertification program as soon as possible so that it will have available comprehensive information about all Medicare providers and their billers. Further, we are concerned about problems with data reliability inherent in any type of self-reporting program.

Mr. Chairman, this concludes my statement. I will be happy to answer any questions you or the Subcommittee Members may have.

GAO Contact and Acknowledgements

For future contacts regarding this testimony, please call Leslie G. Aronovitz, Associate Director, Health Financing and Public Health Issues, at (312) 220-7767. Other individuals who made key contributions include Shaunessye Curry and Lynn Filla-Clark.

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