

**THIRD-PARTY BILLING COMPANY FRAUD:
ASSESSING THE THREAT POSED TO MEDICARE**

HEARING
BEFORE THE
SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS
OF THE
COMMITTEE ON COMMERCE
HOUSE OF REPRESENTATIVES
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THIRD-PARTY BILLING COMPANY FRAUD: ASSESSING THE THREAT POSED TO MEDICARE

THURSDAY, APRIL 6, 2000

HOUSE OF REPRESENTATIVES,
COMMITTEE ON COMMERCE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2322, Rayburn House Office Building, Hon. Richard Burr (presiding).

Members present: Representatives Burr, Bryant, Stupak, Green, and Strickland.

Staff present: Chuck Clapton, majority counsel; Amy Davidge, legislative clerk; and Chris Knauer, minority investigator.

Mr. BURR. The Chair will call this hearing of the Oversight and Investigations Subcommittee to order.

I would like to take this opportunity to welcome our witnesses today, some of whom have previously been before us.

The purpose of today's hearing is to look at the third-party billing company fraud that exists within the Medicare billing process. We are delighted to have with us a number of witnesses to testify. This hearing will be limited to one panel. I know that we have got members who will be in and out, so please be patient with us as we try to accommodate whatever questions they might have.

For the purposes of an opening statement, the Chair would recognize himself and all members who wish to make one and would also ask unanimous consent that any member who wishes to enter an opening statement that is not here would be permitted to do so.

Without objection, that will be so ordered.

Today's hearing is about determining whether HCFA is doing an adequate job of protecting Medicare from fraud and abuse by third-party billing agencies. Across America, the population of companies that represent medical providers from the standpoint of processing their billing information for the purposes of reimbursement to the Health Care Financing Administration has grown dramatically.

Today we will hear how a woman using one of the third-party billing agencies in Texas was able to submit \$1.3 million in false claims, which was never detected by the Health Care Financing Administration. This raises a great question for this subcommittee, for Congress, and for the American people. The Office of the Inspector General at HHS will also tell us about several cases they

investigated where a third-party billing agency was able to steal millions of dollars from Medicare.

I will take this opportunity to say the purpose of this hearing is not to bash the Health Care Financing Administration. It is to educate us more clearly about this third-party billing industry that has emerged in America, to determine what additional procedures should be in place at the Health Care Financing Administration that have not existed up until this point. We should insure that everybody involved in the process has the comfort level of knowing that gaming the system is not quite as easy as it seems to be right now.

Let me say that even the IRS, which is not known for its efficiency, requires the preparers of tax returns identify themselves with an identifying number. One of the most troubling pieces of this challenge that we have before us today is that we do not currently have any type of identifier that follows a third-party biller. A third-party biller can contract with multiple physicians, yet the identifier that the Health Care Financing Administration sees is, in fact, the physician's, and not the third-party biller's.

One of the questions I hope to get an answer to is how many third-party billers exist in the country today. Clearly, our hope is that, between the members of this committee, we can work to make sure that the right type of procedures are in place at HCFA that assure us that the future is not one where fraud and abuse is such an opportunity. In fact, what we can do is shepherd third-party billing companies to be honest entities providing a very valuable service for the reimbursement process that many health care entities do not have the manpower, the time or the expertise to do.

I would be remiss if I did not take this opportunity to say that third-party billers have been created for a number of reasons, but probably the biggest is because of the confusion and difficulty faced by physicians attempting to understand the rules and regulations that HCFA sets out for them. Congress is partly responsible for that very massive undertaking that each physician is faced with.

I have made the comment many times that physicians in North Carolina, in the absence of being able to understand the constant changes in our health care regulations, turn to the business schools of many universities and hire that MBA student to come in and run their medical practice from the standpoints of the administrative and billing side.

The biggest problem they have today is now that same MBA is walking into the physician's office saying, I can't do this any more, because I can't figure it out. I can't assure you with any degree of confidence that I have kept you out of that gray area that somebody might want to chase that we commonly refer to as fraud and abuse.

I am confident that we can find a satisfactory conclusion to this current problem, but my hope also is that we can in the future build a system that is easier to understand, simpler for all involved, and, more importantly, focuses more on the beneficiaries who are covered under Medicare than the process of paying claims.

At this time, the Chair would recognize Mr. Bryant for an opening statement.

Mr. BRYANT. I thank the chairman, and I thank the chairman for conducting this hearing. I thank the panel of witnesses. My statement will be brief.

I have been in Congress as long as the chairman has, but this is really my first tour of duty on Commerce. It seems to me the short time I have been on Commerce, we have been at this hearing, this type of hearing, over the fraud in Medicare and abuse a couple of times. This may even be the third time we have been up here on some aspect of it.

I fully appreciate the complexity of everything involved in Medicare, the size, the amounts of money we are dealing with, the number of people necessary to handle this, but I would echo what our Chairman has said that we are all wanting the same thing out of this, and it seems to me we ought to be able to get a handle on this. By bringing in third-party payers and intermediaries, I assume that was done to make this process work better, but it appears that, to some extent, we have just added somebody else in the system who can cheat and steal from us.

I appreciate very few of the people in the big picture do this, but the ones that do it do it in significant amounts. It just seems to me we have got to find a way to better account and oversee all the parties involved in this.

I know, in reading some of the materials in preparation for this hearing, it seems we have not done much with this intermediary group of third-party payers, and, of course, we are now starting to see the results, or at least catching some of these folks.

Again, I am going to stop now. I know Mr. Stupak is here and has a statement to make, and I am very interested in hearing what each one of you has to say. If you have got any comments you can make in terms of how Congress can help you do your job, particularly from HCFA, we would appreciate it. But, again, I thank all of you for taking your time to come today. I look forward to your testimony.

Mr. Chairman, I yield back balance of my time.

Mr. BURR. The gentleman from Michigan.

Mr. STUPAK. Thank you, Mr. Chairman. I will be very brief. I don't have an opening statement. I am here interested in hearing the witnesses today.

I am familiar with this third-party payee system and how sometimes innocent doctors get caught in the billing practices where they give to a third-party, who then bills Medicare and then, unfortunately, we have some problems. That is what we are going to get at today and how best to address it. I am not here looking to put blame on anyone but trying to get answers to the serious situation.

Mr. Chairman, with that thought in mind I would like to enter into the record, if I may, a GAO report dated June 2, 1999, to the Honorable John Dingell, ranking minority member on this side of the aisle. This side, as the majority, has been concerned about the third-party billing claims, submitting claims, and if there is fraud and abuse going on in that area. Mr. Dingell has a report from GAO, and I would like to make that part of the record with your acceptance of this report.

Mr. BURR. Without objection, so ordered.

[The information referred to follows:]

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

Health, Education, and
Human Services Division

B-282763

June 2, 1999

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

Subject: Medicare: Identifying Third-Party Billing Companies Submitting Claims

Dear Mr. Dingell:

With annual costs of about \$193 billion and responsibility for financing health services delivered by hundreds of thousands of providers to about 39 million elderly and disabled Americans, Medicare is inherently vulnerable to fraud, waste, and abuse. A recent Department of Health and Human Services (HHS) Office of the Inspector General (OIG) report estimated that in fiscal year 1998, \$12.6 billion of Medicare's \$176.1 billion in fee-for-service payments was for claims that did not comply with Medicare's rules.¹

Third-party billing services are businesses that prepare and submit claims on behalf of health care providers to payers such as Medicare, Medicaid, and private health insurers. Although third-party billing services have been part of the U.S. health care system since the 1950s, large billing companies did not emerge until 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 beneficiaries, increasing providers' billing workload. Many providers have turned to third-party billing companies to assist them in processing claims and to provide advice regarding reimbursement matters, as well as overall business decision-making.

Recently, several cases of alleged Medicare fraud have involved third-party billing companies. 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 agreed to pay the federal government \$1.5 million to settle allegations that it had submitted duplicate claims, claims with incorrect diagnosis codes, and other incorrect claims. As a result of these and similar cases involving third-party billers, you asked us to describe how the Health Care Financing Administration (HCFA) and its contractors monitor third-party billing companies' involvement in the submission of claims to Medicare.

To address these questions, we examined HCFA's methods for identifying claims submitted through third-party billing systems and HCFA's methods for gathering information about Medicare providers' use of third-party billing companies. Specifically, we reviewed applicable laws, HCFA's regulations and program guidance, and the HHS OIG's Compliance Program Guidance for Third Party Medical Billing Companies. We also gathered some limited information about OIG fraud cases involving third-party billing companies. We interviewed OIG and HCFA officials, as well as officials from two Medicare claims-processing contractors, and we reviewed documentation from HCFA and the contractors.

¹HHS, OIG, Improper Fiscal Year 1998 Medicare Fee-for-Service Payments (Washington, D.C.: Feb. 9, 1999).

We also interviewed representatives of an industry association and reviewed documentation from the association. We conducted our work from February through May 1999 in accordance with generally accepted government auditing standards.

In summary, providers are ultimately responsible for the claims that they submit or that are submitted on their behalf. Despite this, HCFA has an interest in tracking claims submitted by third-party billers as one way of targeting its program safeguard resources and determining the source of inappropriate or fraudulent claims. We found that HCFA currently cannot identify when third-party billers were involved in the more than 700 million electronic claims in fiscal year 1998, because its systems identify only one of the many possible entities involved in preparing a claim. Further, paper claims—146 million in 1998—do not have any identifying information that would indicate whether third-party billers submitted them. We also found weaknesses in HCFA's recent efforts to obtain information about third-party billers. HCFA recently issued a new enrollment form for providers first enrolling in Medicare after May 1996. This form obtains, among other things, the identity of third-party billers that the enrolling providers use. However, since 96 percent of Medicare's providers enrolled in Medicare before 1996, HCFA has no information on billing arrangements for most providers. HCFA is proceeding with plans to develop a national system to capture this information on the enrollment form, even though the system would initially contain current data for only a fraction of all Medicare providers. Although HCFA's plans for implementing this system are not final, HCFA officials told us they plan to complete it after addressing computer systems work needed to prepare for year 2000.

BACKGROUND

Established under the Social Security Amendments of 1965, Medicare is a two-part program: (1) "hospital insurance," or part A, which covers inpatient hospital, skilled nursing facility, hospice, and home health care services, and (2) "supplementary medical insurance," or part B, which covers physician and outpatient hospital services, diagnostic tests, and ambulance and other medical services and supplies. Medicare provides benefits through either the traditional fee-for-service program or managed care plans that contract with HCFA to provide health care services.²

In fiscal year 1998, 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 Blue Cross and Blue Shield plans and Mutual of Omaha—that process and pay Medicare claims. Once enrolled in Medicare, physicians, hospitals, and other providers may submit claims for payment, often through third-party billers, to Medicare contractors. Fiscal intermediaries process part A claims, and carriers process part B claims. In fiscal year 1998, Medicare contractors processed 863 million claims.

Officials of an industry trade association estimate that there are about 5,000 third-party billing companies. Third-party billing companies may prepare either paper or electronic claims for submission to Medicare contractors. In fiscal year 1998, 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.

In addition to processing and paying Medicare claims, Medicare's contractors are responsible for payment safeguard activities intended to protect Medicare from paying inappropriately. These activities include analyzing claims data to identify

²Managed care plans participate in Medicare through the Medicare+Choice program established by the Balanced Budget Act of 1997.

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 scarce safeguard 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, knowledge of third-party billers involved in completing and submitting claims could be useful to HCFA's safeguard activities. Currently, HCFA is unable to identify all the claims associated with a problem third-party biller and subject these claims to more extensive review to identify any improper ones.

INCOMPLETE RECORDS ARE NOT USEFUL FOR TRACKING BILLERS OR TARGETING SAFEGUARD EFFORTS

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. In these cases, therefore, HCFA and its contractors are not able to identify entities submitting claims with certainty.

While HCFA has established this process—albeit imperfect—to monitor the source of electronic claims, no such process exists at all for paper claims. Paper claim forms include a section or space to identify the provider but not the biller.³ In general, contractors would know if a third-party biller submitted a paper claim only if the biller or provider specifically informed the contractor when it first enrolled in Medicare 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 the billing companies used paper claims it was difficult for OIG to identify all providers involved. For example, in one case, a third-party billing company was submitting fraudulent claims for surgical dressings on behalf of many nursing homes across the United States. Because there was no indication that the 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 the source of the fraud was the third-party biller.

HCFA HAS OBTAINED SOME INFORMATION ON BILLERS FOR A LIMITED NUMBER OF PROVIDERS

In May 1996, HCFA issued a new enrollment form for all providers entering Medicare. The form requires detailed information, including which third-party billing company a provider will use, if any. However, a HCFA official indicated that only about 4 percent of Medicare providers have enrolled since HCFA began using the enrollment form. Thus, the 96 percent of Medicare providers that enrolled before May 1996 may not have provided this information to HCFA. HCFA officials indicated that they are drafting a regulation to require providers that enrolled in Medicare before May 1996 to complete the new enrollment form to fill this information gap. However, having each of Medicare's nearly one million providers complete this form will be a major undertaking. HCFA officials told us that while they plan to meet with providers to obtain their input while drafting the regulation, the time periods for implementation have not been made final.

³Although paper claims do not include a space to identify third-party billers, one contractor indicated that third-party billers do sometimes identify themselves below the provider's name on the claim form.

Developing a database of accurate information on all Medicare providers—including their use of third-party billers—is a significant undertaking. Despite the major information gaps that currently exist, we learned that HCFA is proceeding with a new automated system to provide contractors access to 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.⁴ Initially, HCFA plans to incorporate currently available provider information into the system. However, the format and completeness of this information varies among contractors. According to HCFA officials, this system will in the future include updated information from all providers. Although PECOS has not yet been tested, HCFA officials told us that they hope to implement the system at fiscal intermediaries in April 2000 and at carriers in January 2002. In the interim, information from the enrollment forms will not be readily accessible to other contractors nor will it have a format useful for monitoring third-party billers' involvement in the submission of Medicare claims.

A limitation in PECOS' design is that it will depend entirely on the accuracy of the third-party biller information that providers submit to contractors. Further, if a provider does not inform the contractor of changes, the information in PECOS will be incorrect. While the provider enrollment instructions direct providers to notify their claims-processing contractors when they change third-party billers, as a practical matter there are no adverse consequences if they do not. According to HCFA officials and the contractors we contacted, providers often do not report changes in billing services.

CONCLUSIONS

Information about those involved in completing claims and submitting them to Medicare for payment would be useful in identifying potentially fraudulent claims for more extensive review. HCFA's process for identifying claims submitted by third-party billers often does not provide this important information. When claims are submitted electronically, contractors cannot always identify third-party billers for claims that pass through another entity before reaching the contractor. When claims are submitted on paper, contractors have no way of identifying the billers. HCFA's recent efforts to collect information on providers' use of third-party billers have limitations and will not result in comprehensive identification of third-party billers. As a result, HCFA will not have the advantage of this information when it conducts its safeguard activities.

AGENCY COMMENTS AND OUR EVALUATION

We provided copies of this report to the Administrator of HCFA for review and comment. Officials from HCFA's Office of Financial Management, Center for Health Plans and Providers, Office of Legislation, and Office of Communications and Operations Support provided oral comments. These officials told us that they agreed that information regarding third-party billers' involvement would be useful in conducting safeguard activities. They also told us that HCFA intends to seek public input regarding possible registration of third-party billing companies while developing the regulation requiring providers to complete the new provider enrollment form. They also provided technical comments, which we incorporated as appropriate.

⁴PECOS' 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 chain information to other processing systems.

We are sending copies of this report to the Secretary of HHS, the Administrator of HCFA, the contractors we contacted, and others who are interested. We will also make copies available to others upon request. Please call me at (312) 220-7600 if you or your staff have any questions about this report. Major contributors to this report are Paul D. Alcocer, Lynn Filla-Clark, and Barbara Mulliken.

Sincerely yours,



Leslie G. Aronovitz
Associate Director, Health
Financing and Public Health Issues

Mr. STUPAK. I yield back my time. Thank you.

Mr. BURR. I thank the gentleman from Michigan.

[Additional statement submitted for the record follows:]

PREPARED STATEMENT OF HON. TOM BLILEY, CHAIRMAN, COMMITTEE ON COMMERCE

Chairman Upton, thank you for holding this hearing today. This hearing builds on the work this Committee has done to reduce fraud in the Medicare program. Serious questions have been raised about what the Health Care Financing Administration is doing about third party billers, and whether HCFA is putting Medicare at unnecessary risk of fraud. I hope that today's hearing will provide answers to these questions.

I should note that I believe that the vast majority of third party billers are honest and reputable small businesses that provide a very valuable service to many health care providers. In fact, third party billers can play a very important role in insuring that claims are submitted in an accurate manner that complies with all of the complex billing requirements associated with the Medicare program. Unfortunately, a very small number of unscrupulous individuals have used third party billing services to take advantage of weaknesses in the current Medicare system to steal millions of scarce program dollars.

At my request, the Office of Special Investigations at the General Accounting Office took a look at a Texas health care provider who was using a third party biller to submit claims to Medicare. The GAO found that Behavioral Medical Systems, of Sugarland Texas, was able to submit \$1.3 million in false claims that went undetected. It was not until GAO shared their findings with the Medicare contractor that the provider number being used to submit these false claims was suspended. Last week we learned that this individual has also been using an old number to submit additional claims to Medicare. How was this individual able to submit all of these false claims and avoid detection? How was she able to continue billing Medicare after her group provider number was suspended?

I was equally shocked to learn of the findings in the report released by the Office of Inspector General at HHS two days ago. The OIG found that many Medicare contractors have no way of knowing who actually submitted a claim to Medicare, or how many claims were submitted by a third party biller. In addition they lack even basic information about who submits a claim. According to the OIG, anyone with a computer, a modem, access to a provider's number and a patient's health insurance number could send false claims to Medicare.

This seems to me to be a recipe for disaster. How can we expect Medicare's front line defenders to fight fraud when they know so little about the claims being submitted by third party billers. These findings all indicate that HCFA is failing to adequately protect Medicare from potential fraud and abuse by third party billers. This is not a hypothetical risk. The case that the GAO has investigated for the Committee, along with the cases identified and prosecuted by the OIG, clearly show that fraud by third party billers costs millions of Medicare dollars.

HCFA has indicated that they are taking steps to address these problems. While any effort to reduce the risk of Medicare fraud is good, I am concerned that these efforts may not do enough to solve the problems that have been identified. HCFA proposes to obtain information from health care providers about their use of third party billers and clearinghouses, but studies show that this information is often out of date and inaccurate. Additionally, in the time that it takes HCFA to gather this information, Medicare will continue to be at risk. How many more millions of Medi-

care dollars do we have to lose before we put in place an adequate system that will address these problems?

I would like to thank all of the witnesses for testifying today, and will look forward to hearing their views on what can be done to prevent the criminal misuse of third party services to defraud Medicare.

Mr. BURR. We are pleased today to have a number of witnesses. We have with us Mr. Robert Hast, Acting Assistant Comptroller General of the United States General Accounting Office. We have Mr. Lew Morris, Counsel of the Office of Inspector General. Mr. Morris is accompanied by Steve Lack, Special Agent. Mr. Robert Burleigh, Vice President, PractiCare. Ms. Leslie Aronovitz, Associate Director for Health Care Financing and Public Health Issues from the General Accounting Office; and Ms. Penny Thompson, from the Health Care Financing Administration.

As I believe most of you are aware, this subcommittee is an investigative subcommittee; and, as such, it has had the practice of taking testimony under oath. Does anyone have an objection to taking testimony under oath?

You also have the right under the House rules to be advised by counsel. Is there anybody who chooses to have counsel advise them?

Hearing none, if I could get all of you to rise.

[Witnesses sworn.]

Mr. BURR. Consider yourselves sworn in and under oath. The Chair would work from your right, my left.

At this time, I would recognize Mr. Hast.

TESTIMONY OF ROBERT H. HAST, ACTING ASSISTANT COMPTROLLER GENERAL, OFFICE OF SPECIAL INVESTIGATIONS, UNITED STATES GENERAL ACCOUNTING OFFICE; LESLIE G. ARONOVITZ, ASSOCIATE DIRECTOR FOR HEALTH FINANCING AND PUBLIC HEALTH ISSUES, UNITED STATES GENERAL ACCOUNTING OFFICE; LEWIS MORRIS, COUNSEL, OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY STEVE LACK, SPECIAL AGENT; PENNY THOMPSON, DIRECTOR, MEDICARE PROGRAM INTEGRITY GROUP, HEALTH CARE FINANCING ADMINISTRATION; AND ROBERT B. BURLEIGH, VICE PRESIDENT, PRACTICARE

Mr. HAST. Mr. Chairman and members of the subcommittee, I am pleased to be here today to discuss the results of our recent investigation in the operations of Behavioral Medical Systems, Incorporated, referred to as BMS. We determined that BMS represented itself to Medicare as a health care provider. However, BMS functioned as a broker of medical services and contracted with a third-party biller for submitting claims to Medicare. In short, BMS prepared claims and had its third-party biller remit them to Medicare on behalf of the health care providers. My testimony today is based on the report of our investigation, which you are releasing.

More specifically, my remarks concern BMS and how it conducted business, its improper billing of Medicare, and our belief that BMS violated the U.S. Code.

In brief, BMS, founded by Sandra Hunter, a Ph.D. and a licensed social worker, consistently caused improper claims to be submitted to Medicare. Those claims involved services by six psychiatrists

contracted to it. Indeed, of the approximately 4,900 Medicare claims that BMS filed in the 20-month period we investigated, 87 percent, or almost 4,300 claims, were for services that were not provided. These improper Medicare claims total \$1.3 million.

In addition, BMS violated the general statutory principle that Medicare payments should be made directly to the beneficiary or the assigned physician who provided the medical service. Neither of these situations fit BMS.

On the basis of our investigation, a Medicare carrier temporarily suspended BMS from the Medicare program on July 9, 1999. To date, BMS remains on suspension.

In addition, we referred the matter to the Inspector General of the Department of Health and Human Services and also to the Justice Department. However, we recently learned that Dr. Hunter is currently submitting Medicare claims under an old provider number issued to her in 1993. That provider number is not related to BMS and we have not conducted an investigation to determine whether or not these claims are proper.

In regard to BMS and its operations, Dr. Hunter applied for and received a group provider number for BMS in 1995. That group provider number allowed her to bill Medicare for services rendered. In the application, Dr. Hunter represented the location of BMS as a suite at a particular address in Sugarland, Texas. This gave the impression that BMS was located in a business environment and that medical services would be provided there. Instead, the stated suite number and business address consisted of a mailbox number at a local Mailbox Express.

In addition, on her application for a group provider number, Dr. Hunter represented BMS as a group practice specializing in psychiatry. We determined, however, that BMS did not directly employ psychiatrists and was thus not a group practice. Instead, in its business, BMS contracted with nursing homes to provide psychiatric and related services to the resident. BMS then contracted with psychiatrists and psychotherapists as independent contractors, not as BMS employees to provide these services. According to the psychiatrists, they were to use BMS as their third-party biller.

These psychiatrists and psychotherapists prepared monthly activity reports providing necessary Medicare billing information. These reports were then forwarded to Dr. Hunter for processing. Dr. Hunter next forwarded them to her contracted third-party biller who, following her directions, submitted them as billings to the fiscal carrier on behalf of BMS. Medicare sent the claim payments back to Dr. Hunter, who paid the contracted psychiatrists and psychotherapists, extracting a 5 percent fee.

Medicare also sent the explanations of benefits detailing these payments for the services to BMS and not to the psychiatrists. These psychiatrists stated they were thus unaware of the additional claims being made on their behalf.

However, BMS billed Medicare for fictional visits to patients. Most, in fact 80 percent, of the claims we analyzed for the period of September 1997 through April 1999 were for services that the psychiatrists had not rendered to these patients.

For example, Medicare paid BMS for 90 visits by one psychiatrist to a patient between September 1, 1997, and February 28, 1998.

According to his records, the psychiatrist had not visited the patient at all during that period. In addition, the same psychiatrist saw a second patient six times between May 23, 1998, and February 16, 1999. Yet carrier records show that BMS billed Medicare for 70 additional visits by the psychiatrist during that timeframe.

According to another psychiatrist, he made five visits to one patient, yet carrier claims records show BMS billed Medicare for 41 more visits by that psychiatrist.

As another matter, we believe BMS violated the U.S. Code concerning direct Medicare payments. BMS should not have billed Medicare because it did not directly employ the psychiatrists and psychotherapists who provided the services to Medicare patients, and it did not provide a facility in which services were rendered. Based on the statute and HCFA's implementing regulations, BMS was not entitled to bill Medicare directly for the services provided by the psychiatrists to nursing home patients.

We believe that the statutory language is clear that BMS could not bill Medicare because it was neither the beneficiary nor the provider of services to the Medicare patients.

Mr. Chairman, this concludes my prepared remarks, and I would be pleased to respond to any questions that you or the other members have. Thank you.

[The prepared statement of Robert H. Hast follows:]

PREPARED STATEMENT OF ROBERT H. HAST, ACTING ASSISTANT COMPTROLLER
GENERAL FOR SPECIAL INVESTIGATIONS, OFFICE OF SPECIAL INVESTIGATIONS, GAO

Mr. Chairman and Members of the Subcommittee: I am pleased to be here today to discuss the results of our recent investigation of the operations of Behavioral Medical Systems, Inc. (BMS) of Sugarland, Texas, which functioned as a broker of medical services and contracted with a third-party biller for submitting claims to Medicare. Third-party billers prepare and remit (electronically or by paper) claims to Medicare contractors on behalf of health care providers.

You had asked that we undertake the investigation because of your concern about fraud and abuse within the Medicare program. Such activities could be involved in a recent estimate, reported by the Office of Inspector General (OIG), Department of Health and Human Services (HHS), that \$12.6 billion of fiscal year 1998 Medicare payments for fee-for-service claims did not comply with Medicare rules. My testimony today is based on our recent report of our investigation, which you are releasing today.¹ More specifically, my remarks concern (1) BMS and how it conducted business, (2) its improper billing of Medicare, and (3) our belief that BMS violated the U.S. Code.

In brief, we determined that although BMS represented itself to Medicare as a health-care provider, in fact it functioned as a broker of medical services and, according to its contracted psychiatrists, a third-party biller. Further, through the services of the third-party biller with which it had contracted, BMS consistently caused improper Medicare claims to be submitted for services by six psychiatrists contracted to it. Indeed, of the approximately 4,900 Medicare claims that BMS filed in the 20-month period we investigated, 87 percent—or almost 4,300 claims—were for services that reportedly were not provided. Those improper Medicare claims totaled \$1.3 million. As another matter, we believe that BMS violated the general statutory principle² that Medicare payments should be made directly to the beneficiary or the assigned physician who provided the medical service. Neither of these situations pertained to BMS.

On the basis of our investigation, the Medicare carrier temporarily suspended BMS from Medicare program participation on July 9, 1999. At this time, BMS remains suspended. Further, we referred the matter to the HHS OIG, and it has been referred to the Department of Justice. However, we recently learned that the found-

¹ See *Medicare: Improper Third-Party Billing of Medicare by Behavioral Medical Systems, Inc.* (GAO/OSI-00-5R, Mar. 30, 2000).

² 42 U.S.C. section 1395u(b)(6).

er of BMS—Sandra J. Hunter, Ph.D., a licensed social worker—is currently submitting Medicare claims under an old provider number issued to her in 1993. That provider number is not related to BMS. We have not conducted an investigation to determine if these claims are improper.

BMS and Its Operations

In February 1995, Dr. Hunter applied to a Texas Medicare Part B carrier for a Medicare billing (provider) number for BMS. Dr. Hunter subsequently received a group provider number that allowed her to bill for Medicare services rendered. In the application, Dr. Hunter represented the location of BMS as a suite at a particular address in Sugarland, Texas. This gave the impression that BMS was located in a business environment and that medical services would be provided there. Instead, the stated suite number and business address consisted of a mailbox number at a local Mail Box Express.

In addition, on her application, Dr. Hunter represented BMS as a group practice specializing in psychiatry. We determined, however, that BMS did not directly employ psychiatrists and was thus not a group practice. Instead, in its business, BMS contracted with nursing homes to provide psychiatric and related services to their residents. BMS also contracted with psychiatrists and psychotherapists—as independent contractors, not BMS employees—to provide those services and, according to the psychiatrists, use BMS as their third-party biller.

Then, as was the BMS process, (1) the psychiatrists and psychotherapists prepared monthly activity reports providing necessary Medicare billing information; (2) the reports were forwarded to Dr. Hunter for processing; and (3) Dr. Hunter forwarded them to her contracted third-party biller for it to submit billings, following her direction, to Medicare on behalf of BMS. Medicare sent the claims payments to Dr. Hunter, who paid the contracted psychiatrists and psychotherapists. Medicare also sent the Explanations of Benefits, detailing the payments for the services, to BMS and not to the psychiatrists.³ These psychiatrists stated that they were thus unaware of the additional claims made on their behalf.

BMS Billed Medicare for Reportedly Fictional Visits to Patients

We compared the service dates that the psychiatrists submitted to Dr. Hunter in their activity reports and the claims that the BMS contractor submitted for reimbursement to Medicare, under Dr. Hunter's direction. Most—87 percent—of the claims that we analyzed from the period September 1997 through April 1999 (the period that we investigated) were for services that the psychiatrists had not rendered to their patients. For example, Medicare paid BMS for 90 visits by one psychiatrist to a patient between September 1, 1997, and February 28, 1998. However, according to his records, the psychiatrist had not visited the patient at all during that period. In addition, the same psychiatrist saw a second patient six times between May 23, 1998, and February 16, 1999. Yet carrier records show that BMS, through its contractor, billed Medicare for 70 additional visits by the psychiatrist during that time frame. According to another psychiatrist, he made five visits to one patient. Yet carrier claims records show that BMS billed Medicare for another 41 visits by that psychiatrist.

We analyzed the 4,922 claims that the BMS contractor submitted to Medicare on behalf of the 6 contract psychiatrists for the September 1997-April 1999 time frame. Of these claims, 4,291—or 87 percent—were reportedly fictitious. According to the 6 psychiatrists and fiscal carrier records, these claims represented 9,854 patient visits that never occurred. Also according to carrier records, the improper claims totaled \$1.3 million for unrendered services. We determined that BMS had received over \$362,000 in Medicare payments for the fictional visits and services. The difference of approximately \$951,000 is attributable to claims that were disallowed/disputed, co-payments, deductibles, or claims that exceeded allowable Medicare reimbursable amounts.

BMS Violated the U.S. Code Concerning Direct Medicare Payments

BMS should not have billed Medicare because it neither (1) directly employed the psychiatrists and psychotherapists who provided the services to the Medicare patients nor (2) provided a facility in which the services were rendered. Based on stat-

³Our analysis did not include a review of psychotherapists because their rate of reimbursement was based on an hourly rate for individual services rendered.

ute⁴ and HCFA's implementing regulations,⁵ BMS was not entitled to bill Medicare directly for the services that the psychiatrists and psychotherapists provided for patients in the nursing homes.

We believe that the statutory language is clear that BMS could not bill Medicare because it was neither the beneficiary nor the provider of the services to the Medicare patients. The subject statute establishes the general principle that Medicare payments are to be made to the beneficiary or, under assignment, to the medical provider who rendered the service. Legislative history indicates that the Congress was concerned about third-party direct billing because, among other points, "[s]uch reassignments have been a source of incorrect and inflated claims for services." (H.R. No. 92-231, at 104 (1971)) Through the subject statute, the Congress sought to eliminate a third party's incentive to submit claims for unprovided services or to engage in abusive billing practices.

Mr. Chairman, this concludes my prepared remarks. We would be pleased to respond to any questions that you or other members of the Committee have.

GAO Contacts and Acknowledgements

For further information regarding this testimony, please contact Robert H. Hast at (202) 512-7455 or Steve Iannucci at (202) 512-6722. Robert Gettings and Harvey Gold made key contributions to this testimony.

Mr. BURR. Thank you, Mr. Hast.

The Chair would recognize Ms. Aronovitz.

TESTIMONY OF LESLIE G. ARONOVITZ

Ms. ARONOVITZ. Thank you, Mr. Burr, Mr. Stupak and Mr. Bryant.

I am very pleased to be here today. I am very pleased to be here today to discuss the effectiveness of HCFA's efforts to detect fraud by third-party billing companies that submit claims to Medicare on behalf of their provider clients.

Mr. Hast has just described to you a case of a broker who supplied erroneous information that was ultimately used to fraudulently bill Medicare. This case involved a different entity than a third-party biller, but our concerns about third-party billers could actually apply to any entity that acts on behalf of providers to facilitate the submission and payment of medical claims. That is not to say that all third-party billers should be suspect. In fact, the vast majority play an important and legitimate role in assisting providers with billing and management services.

HCFA's contractors can only manually review a limited number of claims. Finding fraud among third-party billers is like finding a needle in a haystack.

Knowing that providers are linked to a problematic third-party biller is like giving HCFA a magnet to look for the needle. We found that HCFA's efforts to comprehensively identify and review claims associated with third-party billers fell short in several areas. I would like to briefly discuss some of our concerns.

First, the identity of a third-party biller submitting a claim is lost on many electronic claims when multiple entities are involved,

⁴Title 42 U.S.C. section 1395u(b)(6) states in pertinent part, "No payment under that part [B] for a service provided to any individual shall be made to anyone other than such individual or[,] pursuant to an assignment[,]...[to] the physician or other person who provided the service, except that (A) payment may be made (i) to the employer of such physician or other person...[or] (ii) (where the service was provided in a hospital, rural primary care hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such services...."

⁵HCFA regulations at 42 C.F.R. section 424.73(a) implement the congressional intent by limiting the extent to which Medicare pays individuals or entities that do not directly provide medical care.

while on paper claims such information is not recorded at all. For providers, third-party billers and other entities such as clearinghouses to submit claims to Medicare electronically, they must obtain a submitter number from a Medicare contractor. This number becomes part of each claim's submission. However, when a claim passes through other entities such as one or more clearinghouses before reaching the contractor for payment, the entity may overwrite another's number.

Further, on provider claims, forms only include space to identify the provider and not the biller. It should also be noted that such billers do not register with Medicare nor are they linked systematically to the providers they serve. 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 crucial 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.

We also found that HCFA's efforts to develop comprehensive data on all providers, including their use of third-party billers, is still several years from completion. In May, 1996, HCFA issued a new enrollment form, but HCFA's data indicates only about 15 percent of Medicare providers have enrolled since HCFA began using the new form. Thus, 85 percent of Medicare providers that enrolled before 1996 likely have not provided this information to HCFA.

Further, even if providers that have completed the new enrollment form—even those providers may not have valid information in HCFA's system because HCFA's contractors depend on providers to report any changes.

We heard that providers often do not report changes in their billing arrangements and as a practical matter action would rarely be taken against non-complying providers.

Finally, we are concerned that information HCFA does have about providers' use of third-party billers is not reliable because HCFA's data base is dependent on a provider's self-reporting and does not validate it. HCFA is drafting a regulation effective this October which would require all providers to update their enrollment information, and we think this is a good thing. Here again, however, this process involves self-reported data that typically will not be validated or updated by the contractors.

Mr. Burr, this concludes my statement. I will be happy to answer any questions you or other members of the subcommittee have.

[The prepared statement of Leslie G. Aronovitz follows:]

PREPARED STATEMENT OF LESLIE G. ARONOVITZ, ASSOCIATE DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, GAO

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 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 sub-

¹ GAO/HEHS-99-127R, June 2, 1999.

mitted 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 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.

Mr. BURR. I can assure you we will have some questions. Thank you for your testimony.

The Chair recognizes Mr. Morris for an opening statement.

²PECOS' 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.

TESTIMONY OF LEWIS MORRIS

Mr. MORRIS. Good morning, Mr. Chairman, members of the subcommittee.

Mr. Chairman, as you observed, third-party billing companies that operate ethically can provide great service to both providers and the Federal health care programs. These companies offer expertise in program reimbursement requirements, help assure claims are accurately prepared, and free physicians and other practitioners to devote their energy to the care of their patients. Unfortunately, there are system vulnerabilities which an unethical company can take advantage of and exploit for its financial gain.

While the OIG cannot discuss any ongoing investigations, the following cases and others discussed in my written testimony show easily how dishonest third-party billing companies can generate millions in fraudulent claims.

A criminal investigation from the early 1990's aptly demonstrates the vulnerability to our programs. In this case, a third-party billing company known as Handle With Care performed lost charge audits for over 70 nursing homes in eight States. The company referred nursing home resident medical records for services that supposedly had been provided but not claimed, billed Medicare in the name of the nursing home for these overlooked charges, and kept 50 percent of the proceeds. In actuality, Handle With Care billed for surgical dressings for nursing home patients who had never had surgery and fraudulently caused Medicare to pay approximately \$7.4 million for non-rendered services.

A more recent example of third-party billing fraud can be found in the Emergency Physician Billing Service case, or EPBS. EPBS provided coding, billing and collection services for emergency physician groups in 100 emergency departments in as many as 33 States. The investigation and subsequent trial revealed that EPBS and its principal owner, Dr. J.D. McKean, routinely billed for higher levels of treatment than was provided or supported by medical record documentation.

The operation of EPBS had a number of characteristics common to these type of fraud schemes. First, EPBS was paid by its clients based on a percentage of revenues, either billed or recovered. Coders received a base pay, with bonuses based on the number of charts processed and were required to process 40 emergency room charts per hour or the equivalent of a chart every 90 seconds. By contrast, a competitor of EPBS required 120 charts per day. The coders at EPBS were able to meet the quotas by taking shortcuts and disregarding information in the charts. In addition, no coder at EPBS ever attended training or other informational meetings regarding emergency room decoding requirements other than those provided by the company, and coders never contacted a physician who had questions regarding the charts.

EPBS and its owner, Dr. McKean, were found liable under the False Claims Act and agreed to pay \$15.5 million to resolve their liabilities. In addition, Dr. McKean was excluded from participation in the health care programs for a period of 15 years, and EPBS entered into a comprehensive corporate integrity agreement. We are presently pursuing cases against the physician groups that were clients of the firm.

These investigations, as well as studies by the Inspector General's Office and GAO, highlight the Federal health care program's potential vulnerabilities to fraud by unscrupulous third-party billing companies.

Among the insights gained from our efforts are the following: First, the ability of the Federal health care programs to identify third-party billers is inadequate. There are approximately 5,000 third-party billing companies in the United States. However, recent reports indicate HCFA's ability to identify these companies is limited. Likewise, it is unknown how many of the approximately 700 million claims per year processed by Medicare are submitted by third-party billers. As the case of Handle With Care demonstrates, a scam artist can hide behind the identification of a legitimate health care provider and evade detection.

Another lesson: there are loopholes in the payment reassignment rules. Medicare will only pay a third-party biller on behalf of its clients when the agent has no financial interest in how much is billed or collected. Unfortunately, some billing companies circumvent this rule by having the health care provider agree to automatic transfer of Medicare payments to the billing company's billing account. Under this lockbox arrangement, as it is called, the restrictions-only reassignment of claims do not apply because the initial Medicare payment is made directly to the physician, not the agent.

Given the inability to adequately identify those third-party billers, assessing the qualifications of these companies or their personnel is almost impossible. Currently, the Medicare program lacks any standards or eligibility requirements to allow third-party billing companies to prepare and submit claims to the program.

Based on our experience to date with third-party billers, the IG has formulated some tentative suggestions for reform measures.

First, those who administer the health care programs need an effective mechanism to identify third-party billers when they participate in our programs. This identification system should allow the programs to track the third-party billing company's overall billing paths earnings, to link specific claims to particular billers, and to require claims to be submitted only from authorized sites. This may involve registering third-party billers and clearinghouses so as to provide an audit trail and ensure that claims entering the system are from authorized sources.

Second, Congress should consider measures to expressly prohibit the use of payment incentives in third-party billing companies, no matter how the arrangement is structured. In other words, the lockbox loophole should be closed.

Finally, mandated minimum training as parts of qualification standards must be considered as a way to discourage unscrupulous and ill-informed billers from gaining access to the Federal health care programs and to ensure high-quality participation by honest billers who do participate. In the interim, contractor education efforts should be directed to billing companies, rather than indirectly through providers.

I appreciate the opportunity to share the information and insights of the Office of Inspector General. Special Agent Lack and I would be pleased to try to answer any questions you may have.

[The prepared statement of Lewis Morris follows:]

PREPARED STATEMENT OF LEWIS MORRIS, ASSISTANT INSPECTOR GENERAL FOR LEGAL AFFAIRS, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good Morning, Mr. Chairman and Members of the Committee. I am Lewis Morris, Assistant Inspector General for Legal Affairs in the Office of Inspector General (OIG), U.S. Department of Health and Human Services (HHS). I am accompanied by Special Agent Steve Lack from our San Francisco Regional Office who is familiar with many of the issues and cases I will describe today.

The mission of the OIG is to identify ways to improve HHS programs and operations and protect them against fraud, waste and abuse. We do this by conducting independent and objective audits, evaluations, and investigations, which provide timely, useful, and reliable information and advice to Department officials, the Administration, the Congress, and the public. In carrying out our mission, we work with the Department and its operating divisions, the Department of Justice (DOJ), other Federal and State agencies, and the Congress to bring about systemic improvements in HHS programs and operations, and to prosecute and/or recover funds from those who defraud the Government.

I appreciate the opportunity to testify before you today and provide the Committee with the OIG's perspective on the issues presented by the role of third-party billing companies in the Federal health care programs. My testimony will provide:

- an overview of the role played by third-party billing companies;
- a description of OIG efforts to promote integrity among third-party billers;
- a look at some specific fraud investigations involving third-party billing companies;
- the insights the OIG has gained from these cases; and
- some suggestions for programmatic reforms.

Role of Third-Party Billing Companies

Billing companies are becoming a vital segment of the health care industry. Increasingly, health care providers rely on billing companies to assist them in processing claims in accordance with applicable statutes and regulations. Additionally, health care providers consult with billing companies for advice regarding reimbursement matters, as well as overall business decision-making.

Billing companies provide a variety of types of services. For example, some billing companies only process bills that have already been coded by the provider, while others take on the added responsibility of assigning billing codes based on the client's medical documentation. In addition to claims preparation, some billing companies also offer a spectrum of management services, including accounts receivable management and bad debt collections. Other third-party billing companies specialize in a particular sector of the health care industry, such as physician services provided in emergency rooms.

In fiscal year 1998, the Medicare program processed over 700 million Part B claims and 149 million Part A claims, the vast majority of which under both categories were electronic. Even with its enhanced program integrity functions, the Health Care Financing Administration is able to conduct payment reviews on only 10 percent of these claims. The system must rely on the honesty and good faith of health care providers, as well as those who process and submit claims on their behalf. Third-party billing companies that operate ethically can provide a great service to providers and the Federal health care programs. These companies can offer expertise in program reimbursement requirements, help ensure that claims are accurately prepared, and free physicians and other practitioners to devote their energies to the care of their patients.

OIG Efforts to Promote Integrity among Third-Party Billers

In order to assist honest billers establish internal controls that promote adherence to Federal health care program requirements, the OIG has taken proactive steps to promote integrity among the third-party billing industry.

Compliance Guidance. The primary method by which the OIG has reached out to the billing industry is through the release of the "Compliance Program Guidance for Third-Party Medical Billing Companies," in November 1998. Consistent with other OIG compliance guidance, the Third-Party Billing Compliance Guidance sets forth the benefits of a compliance program, describes the essential elements of a compliance program, discusses general compliance principles and counsels companies on how they might use the Guidance. Most importantly, the OIG formulated the Guidance with the input of the third-party billing industry, as well as other interested parties.

The Third-Party Billing Compliance Guidance also identifies the specific risk areas that should be addressed by all billing companies. Such areas include billing for items or services not actually documented; unbundling and upcoding of claims; computer software programs that encourage billing personnel to enter data in fields indicating services were rendered though not actually performed or documented; knowing misuse of provider identification numbers which results in improper billing in violation of rules governing reassignment of benefits; billing company incentives that violate the anti-kickback statute; and percentage billing arrangements.

In addition, the Guidance describes the risk areas for companies that provide coding services in addition to billing services, including “assumption” coding (the coding of a diagnosis or procedure without supporting clinical documentation); alteration of the documentation; coding without proper documentation of all physician and other professional services; and billing for services provided by unqualified or unlicensed clinical personnel.

The OIG hopes that providing information and recommendations such as contained in the Guidance will help lead third-party billing companies to voluntarily embrace corporate compliance programs that fit their individual needs, and thus, help reduce the level of fraud, waste and abuse in Medicare and Medicaid reimbursement.

Corporate Integrity Agreements (CIAs). Another manner in which the OIG seeks to promote compliance in the third-party billing industry is through the imposition of CIAs on certain billing companies involved in fraud schemes. These agreements are imposed in global settlements in lieu of exclusion from participation in Federal health care programs. CIAs are imposed on companies to help reorient a corporate culture that may have previously been prone to fraud and abuse. In this way, the OIG attempts to directly affect change in third-party billing entities. Such CIAs may also serve as admonitory examples for others within the industry.

CIAs set forth specific requirements that a provider must meet in establishing a compliance program or in maintaining an existing compliance program. For instance, the CIAs imposed on third-party billing companies require them to establish and maintain a compliance officer function, a code of conduct, specific policies and procedures addressing billing and coding issues, a training program, and annual audits and reviews. Moreover, the companies must make annual reports to the OIG on their efforts to comply with the CIAs.

Investigations of Third-Party Billing Companies

Unfortunately, there are system vulnerabilities that an unethical billing company can take advantage of and exploit for its financial gain. The problems associated with dishonest third-party billing companies are as old as the Medicare program itself. As early as 1972, the Congress took action to stop “factoring” arrangements, the practice of physicians and other providers reassigning their Medicare and Medicaid receivables to a collection agency for a percentage of their face value. The agency in turn prepared and submitted the claims to the health care programs and received payment in its name. These reassignments were a significant source of incorrect and inflated claims. Cases of fraudulent billings by collections agencies and payment of substantial overpayments to these “factoring” agencies were also found. In response, Congress prohibited, with limited exceptions, payment for covered services to anyone other than the patient or the person who provided the service.

Despite the effort to stop factoring of Medicare and Medicaid bills, some individuals and billing companies circumvented the intent of the law by the use of a power of attorney, allowing the billing company to receive Federal health care payments in the name of the provider, thus continuing the abuses associated with reassignment of claims. In 1977, the Congress responded by precluding the use of a power of attorney as a device for reassignment of benefits. However, a billing agency could continue collecting Medicare or Medicaid payments on behalf of a health care provider, provided that the agency does so pursuant to an agreement under which the compensation paid to the agency for its services is unrelated to the dollar amount of the billings or payments, and is not dependent upon the actual collection of any such payments.

These Congressional efforts to curb program abuses continue to be thwarted by unethical billing companies. While the OIG cannot discuss any ongoing investigations, the following cases show how easily a dishonest third-party billing company can establish a scheme that generates millions in fraudulent claims.

Physicians on Call. During the 1980’s, the OIG investigated allegations that a billing company called “Physicians on Call” used recent medical school graduates to perpetrate a fraudulent billing scheme. The company hired doctors, obtained Medicare providers numbers in their names, and then contracted with nursing homes for the provision of monthly physician visits to perform examinations of the residents.

Although these monthly examinations generally were brief, the billing company upcoded the physician's visits to reflect extensive, and more highly reimbursed, services. This fraudulent upcoding was done without the knowledge of the doctors, who received payment from the company based on the services actually rendered. The scheme was uncovered by the Medicare contractor during a routine review of claims for physician services. As the named providers of service on the Medicare claims, the physicians were assessed overpayments. They were not able to seek relief from Physicians on Call because it had gone out of business.

Handle With Care, Inc. A criminal investigation from the early 1990's provides another example of how vulnerable the Federal health care programs are to the schemes of dishonest billing companies. In this case, two sisters, Kristina Brambila and Wendy Desalvo, set up a third-party billing company known as Handle With Care, Inc. (HWC) to perform "lost charge" audits for nursing homes. The two sisters persuaded at least 70 nursing homes in 8 states that they would review residents' medical records and accounts for services that had not been billed to Medicare. Using "tricks of the trade" known only to HWC, the company billed Medicare on behalf of the nursing home for these overlooked charges and kept 50 percent of the proceeds. In actuality, HWC billed for surgical dressings for nursing home patients who had not had surgery and fraudulently caused Medicare to pay approximately \$7.4 million for nonrendered services.

Because the billing company submitted the fraudulent claims under the nursing home's provider number, it took OIG investigators a great deal of time and resources to tie what appeared to be unrelated improper billings by different nursing homes back to a single third-party billing company. At the conclusion of the investigation, the two sisters were convicted of Medicare fraud and received prison sentences. Additionally, the Government reached False Claims Act (FCA) settlements with 15 of the involved nursing homes and recovered over \$5 million cumulatively.

Medaphis Corporation. While some third-party billing schemes involve a small group of individuals, they can also involve some of the largest billing agencies. For example, in 1998, the United States investigated allegations brought by a whistleblower that the national third-party medical billing companies, Medaphis and Medaphis Physician Services (Medaphis), was submitting duplicate claims and using incorrect codes on claims submitted on behalf of a client. During the period of 1992 through 1996, a Medaphis subsidiary was alleged to have improperly submitted multiple claims for payment for the same service to the same patient on the same date of service; used incorrect or inapplicable diagnosis codes in resubmitting claims which had been denied based on the diagnosis originally stated; and submitted other improper radiology and cardiology-related claims. Medaphis agreed to pay \$1.5 million to resolve its civil liability and entered into an extensive five year corporate integrity agreement (CIA) that covers its activities throughout the nation.

Gottlieb Financial Services, Inc. In 1999, the United States resolved allegations against another wholly-owned subsidiary of Medaphis Physician Services, Gottlieb Financial Services, Inc. (GFS), that provided emergency department physician billing services. When preparing claims for evaluation and management services, GFS allegedly used an automated coding software system that routinely upcoded emergency room visits. In this instance, based on an inability to pay more, Medaphis agreed to pay \$15 million to settle its liability, \$2.4 million of which went to the whistleblower who brought the case under the *qui tam* provisions of the FCA. Moreover, the Medaphis CIA imposed as part of the earlier settlement was made part of this new settlement, given that GFS's conducted pre-dated the execution of the prior CIA.

Professional Medical Billers d/b/a Professional Radiology Billers. Yet another example of the Medicare program's vulnerability to third-party billing fraud can be found in a recently prosecuted criminal case. Professional Medical Billers d/b/a Professional Radiology Billers (PRB) provided third-party billing services primarily to physicians. From 1994 through 1996, PRB added fabricated services to the physician claims and then submitted the claims to Federal health care programs under the physicians' provider number. PRB would reimburse the physicians for the legitimate claims (less PRB's percentage for providing billing services) and keep all the payments for the fabricated services. The scheme was uncovered when one of the company's clients learned that his year-to-date earning from Medicare were double the amount that had been deposited into his bank account by the billing service.

Nancy Thetford and Tracey Huff, co-owners of PRB, pled guilty to criminal charges and acknowledged that the scheme cost Medicare and Medicaid over \$1 million. Thetford was sentenced to 5 years supervised probation and was excluded from Federal health care programs for 10 years. Huff was sentenced to 21 months imprisonment and is also subject to mandatory exclusion. The company ceased to operate in the course of the investigation and is now defunct.

Emergency Physician Billing Services, Inc. Perhaps the most alarming example of the systematic abuse of the Federal health care programs by a third-party billing company can be found in the recent case of Emergency Physician Billing Services, Inc. (EPBS). At the time of the investigation, EPBS provided coding, billing, and collections services for emergency physician groups in over 100 emergency departments in as many as 33 states. Based upon allegations presented by a qui tam relator, the United States charged that EPBS and its principle owner, Dr. J.D. McKean, routinely billed Federal and state health care programs for higher level of treatment than was provided or supported by medical record documentation.

EPBS was paid based on a percentage of revenues either billed or recovered, depending on the client. EPBS coders received a base pay with bonuses based on the number of charts processed and were required to process 40 emergency room medical charts per hour, or the equivalent of a chart every 90 seconds. By contrast, a competitor of EPBS requires 120 charts per day. The EPBS coders were able to meet these quotas by taking short-cuts and disregarding information in the chart. As the trial court noted, no coder at EPBS ever attended training or any other informational meeting regarding emergency department coding other than in-house EPBS training and no coder ever contacted a physician with questions regarding a chart.

After a trial in which the United States District Court for the Western District of Oklahoma found EPBS and Dr. McKean liable under the FCA, the defendants agreed to pay \$15.5 million to resolve their civil and administrative monetary liabilities. In addition, Dr. McKean agreed to be excluded from participation in the Federal health care programs for 15 years and EPBS entered into a comprehensive CIA. Currently, the Government is pursuing physician groups that benefitted from EPBS's fraudulent practices.

Insights Gained from these Investigations

These investigations, as well as program evaluations by the OIG and GAO, highlight the Federal health care program's potential vulnerability to fraud by unscrupulous third-party billing companies. The insights gained from the investigations include:

- payment incentives such as percentage compensation arrangements can encourage abuse;
- there is a loophole in the prohibition on reassignment rule;
- training of billers and coders may be inadequate;
- the ability to identify and track third-party billers is limited at best; and
- standards for participation (certifications, qualifications or conditions) to act as billing agents for Federal health care programs are non-existent.

Payment incentives can encourage abuse. There can be little doubt that payment arrangements where billing companies are reimbursed on a percentage basis create an environment ripe for abuse. The temptation to upcode or fabricate additional services may be irresistible when the billing company's compensation depends upon the amount of revenue generated or claims submitted. For instance, EPBS was paid by its physician clients based on a percentage of revenues, and in turn EPBS paid its coders a base salary with bonuses based on the number of charts coded. Such payment incentives discouraged coders from paying close attention to the adequacy of documentation in charts to support the claim to Medicare.

Improper incentives appear to have been a factor in several of the cases discussed above. Although we are not certain of the pervasiveness of these types of arrangements, our suspicion is that it characterizes many third-party billing arrangements.

Loophole in prohibition on reassignment rules. Although not addressed specifically by the court in the EPBS case, the Government determined that the manner in which EPBS was compensated by its clients undermined Medicare policy on reassignment. As a general matter, Medicare prohibits the reassignment of the right to payment to persons other than the provider or supplier who delivered the service. However, as an exception to this general rule, payment may be made to an agent who furnishes billing and collection services to the health care provider if certain conditions are satisfied. Among the conditions to be eligible for the reassignment, the agent's compensation may not be related to the dollar amounts billed or collected. In other words, Medicare will only pay a third party biller on behalf of its clients when the agent has no financial interest in how much is billed or collected.

Unfortunately, it appears that some billing companies have constructed payment arrangements that circumvent the intent of the Medicare rule. Rather than comply with the prohibition on incentive payments, billing companies arrange for the Medicare payments to be made to the client for deposit in a bank account in the client's name, usually at the same financial institution where the billing company maintains an account. The money is typically held in the client's account for twenty-four

hours or less, after which the Medicare funds from the individual provider client account are swept into the billing company's general bank account. There often is an agreement between the client and the biller that the former will not remove any funds during the initial twenty-four hour period. Then the billing company remits to the client's account the reimbursement to which the client is entitled, minus its percentage-based billing fee. And in the case of dishonest billing companies, they also withhold the proceeds from fabricated, upcoded or other improper claims submitted in the name of the client. Under this "lockbox" arrangement, as it is often called, the prohibition on reassignment of claims to an incentive compensated billing agent does not apply because the payment is made directly to the physician and not the agent.

Training may be inadequate. The OIG is not aware of any studies examining the quality and extent of training provided by billing companies to their personnel. However, certain facts are clear. First, the Medicare program does not mandate that billing companies ensure that their personnel meet minimal training requirements. While there are certain private organizations that train and certify coders and Medicare contractors can provide certain coding and billing training, such certifications and outside training are not required by Medicare. Moreover, it is the OIG's understanding that to the extent that Medicare contractors issue educational guidance on billing and coding issues, such guidance is only sent to providers and not to billing companies.

Third-party billing companies that choose to abuse the Medicare program can take advantage of these system weaknesses. For example, EPBS did not send its coders to any training or any other informational meeting regarding emergency department coding other than in-house EPBS training. Such in-house training was highly problematic as it was based on an internal coding manual created by Dr. McKean and did not incorporate the CPT manual, the primary tool used by Medicare to determine appropriate billing codes.

Ability to Identify third-party billers is limited. There are approximately 5,000 third-party billers in the United States. However, the OIG has just issued a report¹ on computerized billing systems that incidentally raised the issue that HCFA's ability to identify these companies is limited. Likewise, it is unknown how many of the approximately 700 million claims per year processed by Medicare are submitted by third-party billers. One reason for this uncertainty is that many billing agencies submit claims to Medicare using billing and submitter numbers (unique numbers assigned to billers and providers by HCFA for electronic claim submission) of the providers for whom they bill. As the case of Handled with Care, Inc. demonstrates, a scam artist can hide behind the identification numbers of a legitimate health care provider and evade detection. Even if the billing company uses its own submitter number, the electronic claims often are passed through clearinghouses that reformat the claims and then submit them to Medicare. Under this situation, the initial third-party billing number may no longer appear on the claim.

Standards for participation are non-existent. Given the inability to adequately identify who is doing third-party billing, assessing the qualifications of these companies or their personnel is almost impossible. Currently, the Medicare program lacks any standards or eligibility criteria for allowing third-party billing companies to prepare and submit claims to the program.

The magnitude of this vulnerability is highlighted by a recent advertisement for a "step-by-step" business guide for medical claims processing services found in a complementary airline magazine. For a mere \$69 dollars, "How to Start a Medical Claims Processing Service" promises that your "prescription for a healthy income" involves no more than owning a computer, printer, modem and claims processing software. As the ad also notes: "There's no training needed and . . . with health care reform, the need for processors (and the profits to be made) will only increase." In short, without any type of certification process or minimal standards for third-party billers, Federal health care programs shall remain vulnerable.

Suggestions for Reform

Based on its experience to date with third-party billing in the Federal health care programs, the OIG has formulated some tentative suggestions for reform measures.

First, those who administer the Federal health care programs need an effective mechanism to identify third-party billers when they participate in Federal health care programs. This identification system should allow the programs to track billing companies' overall billing patterns, to link specific claims with particular billers, and to require claims be submitted only from authorized sites. This may involve reg-

¹Medical Billing Software and Processes Used to Prepare Claims, March 2000 (OEI-05-99-00100).

istering third-party billers and clearinghouses so as to provide an audit trail and ensure that claims enter the Medicare system from authorized sources.

Second, Congress should consider measures to expressly prohibit the use of payment incentives in third-party billing contracts, no matter how the arrangement is structured. In other words, the “lockbox loophole” should be closed.

Third, mandated minimal training as part of qualification standards may be a way to discourage unscrupulous and ill-informed billers from gaining access to Federal health care programs and to ensure high quality participation by honest billers who do participate. In the interim, we believe contractor education efforts should be provided directly to billing companies rather than indirectly through providers.

Conclusion

I appreciate the opportunity to share the views of the Office of Inspector General on this important subject. Special Agent Steve Lack and I welcome your questions.

Mr. BURR. Thank you, Mr. Morris.

The Chair would recognize Ms. Thompson for an opening statement and welcome.

TESTIMONY OF PENNY THOMPSON

Ms. THOMPSON. Mr. Burr, Mr. Bryant, good morning. Nice to see you again.

Thank you for inviting us here to talk about this issue. The question of what we should do and what our relationships should be with third-party billers is an area of growing interest and concern to us, and we greatly appreciate this subcommittee’s interest and support, as well as the efforts of the General Accounting Office and the Office of Inspector General.

As has been said here, but bears repeating, third-party billing companies who operate ethically can provide a valuable service in helping providers and suppliers submit claims correctly, and actually they can participate in helping us ensure that those claims are processed in an ethical and appropriate manner. But improper third-party billing practices pose a significant threat to the program.

Under current regulations, we review these arrangements when new providers or suppliers ask that their payments be made directly to an agent. Those reviews have led to an increasing compliance with our requirements around the financial arrangements as delineated in our existing laws and regulations. But these billing companies are not regulated when they do not actually receive the payment for the provider directly and our overall ability to monitor third-party billing practices is quite limited as discussed by both the GAO and the OIG.

I would like to take this opportunity also to clarify one statement in our testimony in our letter to the chairman around paper claims which, as you have said and as the GAO and OIG have said in their testimony, do not contain information on submitters or preparers. We are looking into that now to see what should be done about that. Problems identified by us, by our OIG and GAO colleagues and others make clear we need to do more.

We are now working to strengthen the available safeguards to better protect the Medicare trust funds from potential third-party billing abuses. We are developing new provider enrollment regulations and a new enrollment data base, and these will help us gather information on third-party billing companies. The regulations will require providers to periodically update their billing arrangements; and, in publishing the provider enrollment regulation, we

intend to solicit public comments on what we should do to further strengthen our oversight of third-party billing companies.

In addition to our desire to appropriately collect information on billers so that we can track claims and know who we are doing business with, we also need to understand and assess the costs and benefits of collecting that information, of changing electronic claims submission standards, of setting and enforcing regulatory standards, and of overseeing private contracts. We also need to think through what are the rights and expectations we have with the physician and the suppliers and the providers who are providing the service and contracting with these entities to help them with their business functions and what special issues exist for third-party billers as opposed to billers employed by physicians, suppliers and providers.

We also know that we need to consult with private insurers, who largely treat third-party billers in exactly the same way that Medicare does, and in the interest of administrative simplification understand what changes we want to make to electronic claims transactions so that they apply to all billers and all insurers and not just the Medicare program.

In the meantime, we will increase our efforts to educate providers and billing agents around the legal requirements for their relationships, as well as how to file claims correctly, and we are doing more in that regard every day. We are committed to working with providers, billing agents, our OIG and GAO colleagues and Congress as we proceed.

I thank you again for holding this hearing. I am happy to answer your questions.

[The prepared statement of Penny Thompson follows:]

PREPARED STATEMENT OF PENNY THOMPSON, PROGRAM INTEGRITY DIRECTOR,
HEALTH CARE FINANCING ADMINISTRATION

Chairman Upton, Representative Klink, distinguished Subcommittee members, thank you for inviting us to discuss our efforts to address concerns with third party billing agents. This is an area of growing concern, and we greatly appreciate this subcommittee's interest and support, as well as the efforts of the General Accounting Office and HHS Inspector General.

Third party billing companies who operate ethically can provide a valuable service to providers and suppliers who seek out their help in submitting claims correctly and efficiently. These firms vary greatly, performing a wide variety of services from simply formatting claims for submission to Medicare and private insurance companies to managing the entire "business end" of provider practices.

Improper third party billing practices can pose a significant threat to Medicare. Under current regulations, we review these arrangements only when new Medicare providers or suppliers ask that their payments be made to an agent. These reviews have led to an increase in the number of third party billing contracts that are in compliance with existing laws and regulations.

However, when billing companies assist in preparing bills or coding, but do not actually receive payment, they generally are not regulated. Billing arrangements for providers who entered the program before 1996 are not reviewed, and our overall ability to monitor third party billing practices is quite limited. Problems identified by us, our HHS Inspector General and General Accounting Office colleagues, and others make clear that we need to do more.

We are working to strengthen the available safeguards to better protect the Medicare Trust Fund from waste, fraud and abuse. We are developing new enrollment regulations and a new enrollment database for all providers. This database will gather information on third-party billing companies. The new enrollment regulations will require providers to periodically update information, including their billing arrangements.

And, in publishing the provider enrollment regulation proposal this spring, we intend to invite public comments on how to address challenges in better oversight of third party billing companies. For example, the costs and benefits of collecting additional information, changing electronic claims submission standards, setting and enforcing regulatory standards, overseeing private contracts, and other possible risk mitigation strategies must be weighed. There also may be unintended consequences and marketplace responses to any actions that should be carefully assessed and considered.

Background

Third party billing companies can take on many different forms, structures, operations, functions and relationships with providers. Billing companies vary significantly in both the size and reach of their organizations and functions, from small “mom and pop” organizations who only facilitate the electronic submission of claims to large business organizations providing coding, claims submission and consulting services. As the U.S. Department of Health and Human Services Office of Inspector General noted,

“It is important to note the tremendous variation among billing companies in terms of the types of services and the manner in which these services are provided to their respective clients. For example, some billing companies code the bills for their provider clients, while others only process bills that have already been coded by the provider.

“Some billing companies offer a spectrum of management services, including accounts receivable management and bad debt collections, while others offer only one or none of these services.” (*HHS OIG, “Compliance Program Guidance for Third-Party Medical Billing Companies,” page 3.*)

False Claims

Billing companies that engage in behavior that gives rise to false claims can be held accountable under the False Claims Act. One such case was brought through qui tam or “whistleblower” lawsuits. The firm, Emergency Physicians Billing Service, had promised its clients it would increase their reimbursements by 10 to 25 percent. Unfortunately, it did so by “upcoding,” or filing claims for a higher level of service than was actually delivered. Reassignment violations and misrepresentations on Medicare enrollment applications were also identified.

In a settlement agreement last fall with the federal government and 28 individual states, the firm and its owner, and J. D. McKean, Jr., M.D., agreed to pay \$15.5 million. In addition, McKean is excluded for 15 years from participation in any federal health care program. The firm has entered into a comprehensive Corporate Integrity Agreement with the Inspector General. And the federal government is negotiating additional settlements with approximately 25 emergency physician groups that were clients of the firm.

This case serves as a national example of improper billing perpetrated by third party billers. We, along with staff from five Medicare contractors, participated in this investigation, performing data analysis directed at detecting the improper billing, suspending Medicare payment, and calculating the losses to the program.

In fact, one of the contractor employees received a commendation for their exemplary performance during the investigation from the Department of Justice.

Current Oversight

Our current ability to detect such abuses is limited. Medicare does not have a direct business relationship with such entities, and the only oversight authority we have is to review arrangements for new fee-for-service providers who have entered the Medicare program since 1996 and requested that their payments be made directly to a third party billing agent.

Medicare claims processing contractors conduct reviews for these requests to ensure compliance with the statutory requirement that the provider’s compensation to such an agent not be related in any way to the dollar amounts billed or collected. These reviews have led to an increasing number of such agreements coming into compliance with the statute and regulations. As the health care and billing communities have become more aware of these requirements and our enforcement of them, we see more contracts expressly containing language supporting our requirements.

However, thorough assurance of compliance with the law is hampered by:

- the resource-intensive process for reviewing lengthy, complicated legal documents;
- the capacity of contractors to accurately and fully understand such documents;
- variability in the nature and scope of agreements and the complicated corporate structure reflected in such agreements, where it is not unusual to find a number of subcontractors involved in various functions;

- lack of penalties for failure to inform Medicare when such agreements change; and
- the limited number of providers and suppliers required to submit such information.

Our ability to identify when third party billers have been involved in submitting claims is also limited. Paper claims include a space for listing the “source” or “preparer” of the claim. And electronic claims differentiate whether the claim was sent by a third party agent or directly by a provider. However, we are not able to identify all entities that may have had a role in processing and filing a claim.

For example, if a third party billing company coded the claim and sent it to a clearinghouse that formatted the claim for electronic submission to the Medicare program, only the clearinghouse information would be evident on the claim.

New Enrollment Process

We are taking steps to improve our oversight of third party billing arrangements. We plan to issue this Spring a proposed rule that would, among other things, require periodic verification of provider enrollment data and reporting of changes in third party billing arrangements. Once the proposed rule is finalized, we will begin an “enrollment clean up” process and require providers and suppliers to confirm and update their information, including information on third party billing arrangements.

We also are developing a new national database, the Provider Enrollment, Chain and Ownership System, that will include extensive information on providers, including information on providers’ billing arrangements and any reassignment of benefits. It also will include information on chain ownership and related organization information, which is essential because it allows us to identify when a provider or supplier is part of a larger organization, and to view the entire line of business. This will also allow a local contractor to view national data about an individual or entity rather than simply the data that appears on a local provider file. And it will better identify providers and suppliers who have been denied privileges, or subject to revocations or exclusions.

Even with this new system and our enrollment “clean-up” process, outstanding issues remain. These include:

- identifying common ownership among billing entities or “linking” agencies that might operate in different jurisdictions;
- regulating billing agents to ensure adherence to professional standards; and
- our lack of information on third party billers who do not negotiate checks or submit claims directly to the program.

We are seeking to answer many of these questions through comments to proposed regulations.

In our proposed provider enrollment regulation, we will solicit comments on several approaches to better oversight of third party billing agents. Among the issues we are considering in regulation billing agents:

- Should we register billing companies, and/or set standards for them?
- Would we need additional legislative authority to do so?
- Should such standards apply only to entities that actually submit claims and receive negotiated checks on behalf of providers?
- Should such standards apply to all entities that might advise, consult, prepare, support, staff, or otherwise influence the selection of codes and claims to be submitted to the Medicare program?
- How should such standards reflect the diversity in capability, organization, mission, functions, and relationships in the industry?
- How would we enforce such standards?
- What staffing and skill set needs would we require in order to ensure billing companies met standards and agreements were properly executed?
- How should claims properly reflect the preparer’s identifying information? What if there are multiple preparers or submitters?
- To what extent would providers, suppliers, and physicians support Medicare regulation of their business contracts and partners?
- To what extent is surveillance and assessment of billing patterns a better approach to ensure compliance than registration or standard setting?
- What information would be needed to accurately group claims handled by a common third party billing company?
- If Medicare were to regulate business arrangements with third party billing companies, what impact would such regulation have on the private sector and the arrangements between providers and third party billers in submitting claims to private insurance companies and, overall, would those effects be positive or negative?

Answers to these questions are necessary before we can proceed in taking further action to address third party billing concerns.

Education Efforts

In the meantime, we will increase our efforts to educate providers and billing agents about legal requirements for their relationships, as well as how to file claims correctly. One of the task orders we have for our special new program integrity contractors specifically focuses on developing educational strategies for third party billers.

We want to build on the success we achieved in working to educate billing agents about how to be prepared for the Year 2000 information system challenge. These efforts helped to ensure that these billers were aware of our format requirements, Y2K compliance standards, and testing standards. Our claims processing contractors aggressively pursued testing with these submitters to assure their systems were ready for Y2K. And these billers helped us in setting up a major conference to bring together these organizations and Medicare contractors to discuss testing and implementation strategies and timetables.

We intend to pursue similar avenues of education on other issues of importance to third party billing initiatives. For example, we have already contacted a major association to invite key billers to participate in education sessions for the new outpatient prospective payment system. We will continue dialogue with these organizations on future, significant changes to Medicare's claims processing systems. And these relationships should help contribute to a climate of cooperation in all our efforts, including those related to program integrity.

CONCLUSION

We are making some progress in addressing concerns about third party billing. Our new provider enrollment system and database will help us make additional progress. However, we clearly have much more to do to fully protect program integrity in this area. We are committed to working with providers, billing agents, our IG and GAO colleagues, and Congress as we proceed. I thank you again for holding this hearing, and I am happy to answer your questions.

Mr. BURR. Thank you, Ms. Thompson.

The Chair would recognize Mr. Burleigh for his opening statement.

TESTIMONY OF ROBERT B. BURLEIGH

Mr. BURLEIGH. Chairman Burr, distinguished members, I have the honor of representing the Healthcare Billing and Management Association today as Chairman of HBMA's Ethics and Compliance Committee and consultant to the Association's Board of Directors.

HBMA is a voluntary membership organization and is the only trade association representing third-party billing companies. The Association's primary goals are education, promotion of ethics and compliance and advocacy.

On behalf of HBMA, I would like to thank the committee for the opportunity to appear today to address your interest in developing methods to identify those who submit claims to federally sponsored health care programs. We are pleased that the Commerce Committee, in addition to its responsibilities regarding oversight of Medicare, has some interest in the Small Business Administration, since almost all of our members are small businesses. Our member companies employ nearly 20,000 nationwide processing and an estimated 650 million claims per year, worth an estimated \$55 billion. However, most of our member companies have fewer than 25 employers. We have attached a one-page profile of our membership to our testimony.

HBMA and its members share your commitment to preventing and detecting fraud and abuse in the Medicare program. Indeed, HBMA takes great pride in our compliance activities, putting us in

the forefront of efforts to prevent fraud and abuse in third-party billing. Having said that, it is our view that the potential for the commission of fraud by third-party billers is no greater than the potential for fraud committed by physicians' offices that bill Medicare directly.

Let me begin by emphasizing that HBMA strongly supports the goal of protecting the integrity of the Medicare program and other federally funded health care programs. We have worked for over 4 years with HHS's Department of OIG on the development and promotion of the Model Compliance Guidance for Third-Party Billing Companies.

Beginning in February 1999, HBMA began conducting a compliance education program for its members and non-members to support implementation of the Model Compliance Guidance for Third-Party Billing Companies released the previous November.

We are pleased to report that several hundred third-party billing companies have completed our course, in spite of the fact that our registration fee is seven times higher than the fee charged for national meetings.

Interestingly, had the third-party billing company cited in today's GAO report been a HBMA member or had they attended our compliance course, they might have known that what their client was doing was improper. Our compliance course specifically discusses the need for third-party billing companies to be aware of the potential that criminal enterprises, intent on generating fraudulent Medicare claims, may seek out legitimate third-party billers to serve as a front for their criminal enterprise. It appears that the conduct cited earlier is exactly such a case.

Every Medicare claim, regardless of its origin or mechanisms for delivery to HCFA's contractors, carries with it a risk of either being fraudulent or manipulated in such a way as to cause an overpayment by the Medicare program.

It is also important, as we engage in this dialog on how to prevent Medicare fraud and fraudulent billing, that we do so with an understanding that, no matter how creative we may be in establishing mechanisms for prevention or detection of fraud, we realize that we will never be able to eliminate deliberate billing fraud.

The analysis prepared by the GAO and the OIG made constant reference to third-party billing companies without attempting to define the use of that term. This is important because the issue is far more complex than it would appear to the layman. Certainly a separately incorporated company offering billing services is a billing company. Our full testimony outlines the variations that illustrate the complexity of the issue.

The number of variations in billing service relationships is nearly infinite and they change constantly, usually driven by entrepreneurs, concerns over excess operating costs by billing companies and/or changes in technology. We are concerned that any initiative to register claim submitters would overlook large segments of the industry that regularly handle some part of the claims preparation and/or submission process.

We have considered the list of potential factors that might be involved in the registration of Medicare claims submitters, and our

full testimony outlines 12 potential problematic concerns relating to how a billing company or submitter would be registered.

As we read the OIG's report, it appears the sole basis for concluding that the Medicare program is at risk due to claim submission by third-party billers is that an additional party has been added to the claim's processing chain between the practice and the contractor. The fact that more than 30 billing individual/entities have been excluded from participation in the Medicare and State Medicaid programs seems to be the only thing of evidence that there is a problem.

We noted that the report contains numerous examples of incorrect understanding of how the industry operates, how practices use billing services, how the software industry serves practices and billing companies; and the report reaches a number of inaccurate conclusions regarding the types and levels of risk associated with claims handled by billing companies, clearinghouses and medical practices. HBMA would be willing to itemize these concerns, although it may be unnecessary, as we know that the identity of each and every party involved in presenting a claim for a party would be beneficial to reducing fraud and abuse. This may not be economically or technically practical.

Of the companies identified by the OIG in their data base, we are pleased to report that none of the excluded individuals or companies is or was a HBMA member. What is not clear is whether the potential for fraud is any greater at different points in that chain. In other words, is a claim handled by a third-party biller any more likely be used to commit fraud than a claim submitted directly by a physician's office? We suggest an equally reasonable conclusion, given that we have so few billing entities excluded from the Medicare program. It is that claims submitted by third-party billers are less likely to be erroneous and therefore less likely to be fraudulent.

We have made a number of specific comments regarding our reaction to these proposals.

In the interest of time, I would like to conclude by thanking the committee for inviting us to participate in this very important process, and we look forward to your questions and to further participation in this important matter.

[The prepared statement of Robert B. Burleigh follows:]

PREPARED STATEMENT OF ROBERT B. BURLEIGH, VICE PRESIDENT, PRACTICARE

Chairman Burr and Distinguished Members of the Committee, my name is Robert B. Burleigh and I am Vice President of PractiCare; I direct my company's healthcare consulting practice, known as Brandywine Healthcare Consulting Group, a firm I founded in 1988. Today I have the honor of representing the Healthcare Billing and Management Association (HBMA) as Chairman of the HBMA's Ethics and Compliance Committee and Consultant to the Association's Board of Directors. HBMA is a voluntary membership organization and the only trade association representing third-party medical billing companies. The Association's primary goals are education, the promotion of ethics and compliance and advocacy.

On behalf of HBMA, I would like to thank the Committee for the opportunity to appear today to address your interest in developing methods to identify those who submit claims to federally sponsored healthcare programs. We are pleased that the Commerce Committee, in addition to its responsibilities regarding oversight of Medicare, is also responsible for the Small Business Administration, since almost all of our members are small businesses. Our member companies employ nearly 20,000 nationwide, processing an estimated 650 million claims per year, worth an esti-

mated \$55 billion; however, most of our member companies have fewer than twenty-five employees. A one-page profile of our membership is included at the end of our written testimony.

INTRODUCTION

HBMA and its members share your commitment to preventing and detecting fraud and abuse in the Medicare program. Indeed, HBMA takes great pride in our compliance activities, putting us in the forefront of efforts to prevent fraud and abuse in the third party billing industry. Having said that, it is our view that the potential for the commission of fraud by third party billers is no greater than the potential for fraud to be committed by physician's offices that bill Medicare directly.

Let me begin by emphasizing that the HBMA strongly supports the goal of protecting the integrity of Medicare and other federally funded health care programs. We have a long and well-established record of working with the House and Senate, HCFA, the HHS OIG, the GAO and the OMB and other government agencies on a wide variety of matters, most of which involve Medicare and compliance in some way. We are currently working with HCFA's Office of Program Integrity and OMB on improvements to the provider enrollment form (855) and processes as well as having had meetings last year on the subject of today's hearing; we have worked for over four years with HHS's OIG on the development and promotion of the Model Compliance Guidance for Third Party Billing Companies; we have testified about and submitted comments on Congressional and HCFA proposals regarding patient privacy and confidentiality; and, of course, we intend to carefully review and comment on the upcoming Model Compliance Guidance for Physicians.

Beginning in February 1999, HBMA began conducting a compliance educational program for HBMA members and non-members to support implementation of the OIG's Model Guidance for Third Party Billing Companies released in November 1998. This intense, 3½ day course is based on HCFA's model compliance program guidance for third party billers. HHS's OIG, U.S. Attorney's Office and the FBI have each provided guest speakers for our programs. The response to this program from the third party billing community has been overwhelming. Each of the three conferences presented in 1999 sold-out; the first presentation for 2000 has already shown strong registration. We are pleased to report that several hundred third party billing companies have completed our courses in spite of the fact that the registration fee is more than seven times the fee for our regular educational meetings. Moreover, compliance has been an educational topic at every HBMA National and Chapter meeting since 1995.

Interestingly, had the third party billing company that has been cited in today's GAO's report been an HBMA member or had they attended our compliance course, they would have known that what their client was doing was improper. Furthermore, had the billing company followed our compliance training, it would have "fired" or reported the customer. Indeed, more and more of our members report that they have found it necessary to "fire" customer(s) because the client has refused to cease its (apparently) suspect behavior. Our compliance course specifically discusses the need for third party billing companies to be aware of the potential that criminal enterprises, intent on generating fraudulent Medicare claims, may seek out legitimate third party billers to serve as a front for their criminal enterprise. It appears that the conduct cited earlier is exactly such a case.

Every Medicare claim, regardless of its origin or mechanism(s) for delivery to HCFA's contractors, carries with it a risk of either being fraudulent or manipulated in such a way as to cause an overpayment by the Medicare program. Our goal, and we believe the goal of this Committee, is to *reasonably* reduce the extent to which this can happen and create a mechanism where auditors can more readily detect those instances of fraudulent billing that may occur. We also believe that the Medicare program's best source of protection is the partnership of a medical practice with an effective compliance program and a billing company with an effective compliance program; rather than increasing risks to the program, this relationship would double the program's protection. With two compliance programs at work, the chances of errors, as well as deliberate misconduct are sharply reduced. We are happy to report that such arrangements already exist and are a growing trend as our members encourage their clients to develop and implement their own compliance programs.

It is also important, Mr. Chairman, as we engage in this dialogue on how to prevent fraudulent billing, that we do so with an understanding that no matter how creative we may be in establishing mechanisms for the prevention and detection of fraud, we realize we will never eliminate deliberate billing fraud. The simple reason is that the creativity of the criminal mind knows no bounds. Just as sophisticated

bank vaults do not stop determined bank robbers from their crimes, no system of registration, auditing or oversight, will prevent a criminal from defrauding Medicare.

DEFINITIONS AND CLASSIFICATIONS

The analysis prepared by the GAO and the OIG make constant reference to “third party billing companies” without attempting to define their use of the term. This is important, since the issue is far more complex than it would appear to the layman. Certainly, a separately incorporated company offering billing services is a billing company. But...

1. What about the medical practice that, for tax reasons, has incorporated its own billing office under another identity?
2. What about the claims clearinghouse to whom claims are sent by medical practices and/or billing companies?
3. What about the billing software vendor serving as a “collection station” who then forwards the claims on to a clearinghouse, or the software vendor that serves as a clearinghouse itself.
4. What about the claims editing vendor who edits the claims on their way to the software vendor and/or clearinghouse?
5. What about the collection agency to whom uncollected claims are referred by the practice after the billing process (the practice’s or their billing company’s) has failed?
6. What about hospital-owned practices, billed by the hospital under the identity of its MSO (Management Service Organization)?
7. What about insurers who own practice(s) and provide billing?
8. What about the company that provides off-site printing and mailing of paper claims as a subcontractor to the practice and/or the practice’s billing service?
9. And, of course, what about the Practice Plan providing centralized or de-centralized billing support for medical school faculty?

The number of variations in billing and service relationships is nearly infinite, and they change constantly, usually driven by entrepreneurs, excess operating costs and/or changes in technology. It is impossible to anticipate the number of combinations and variations of claims handling: to register only one party (a billing company, if a clear definition can be constructed) would be unfair and would not achieve the apparent goal of this initiative; to register and track all of the possible combinations could become impossible. We are concerned that any initiative to “register” claims submitters would overlook large segments of the industry that regularly handle some part of the claims preparation and/or submissions process.

THE REGISTRATION PROCESS

We have considered the list of potential factors that might be involved in the registration of Medicare claims submitters. Listed below are some of the aspects of this potential process that we consider potentially problematic:

1. How is a “billing company” defined?
2. By whom would billers be registered? HCFA, the Carrier(s), or another central source?
3. How would “registration” be accomplished? A simple name, address, telephone and FEIN #, or a long, detailed “855-style” form? How could a new “billing company” begin business without a number, and how could it be a “submitter” without one?
4. What would be done when the ownership and/or management of the “billing company” changes? What would be considered a “reportable” change?
5. How many “registration(s)” would be required? One, or one for each type of claim (Physicians, Hospitals, DME Companies, Home Health Agencies, Nursing Homes, Ambulance Services, etc.)?
6. Would “registration” discriminate against billers and discourage their use?
7. How would “billers” with multi-state constituents be affected?
8. Would the practice handling its own billing be registered? If not, why not?
9. Where in the Uniform Data Set would the biller registration number be located?
10. Where on the HCFA 1500 form would the number(s) be printed?
11. How much lead time would be required for Carriers, Intermediaries, software vendors, clearinghouses and others to adapt their systems? (We estimate three to five years.)
12. Is a “submitter” a company or a person?

THE OIG'S REPORT

We have had an opportunity to perform a preliminary review of the recently released Inspector General's report entitled, "Medical Billing Software and Processes Used to Prepare Claims." Before addressing the specific recommendations made by the OIG, I would first like to comment on the information gathering process used to develop these recommendations.

As we read the OIG's report, it appears that the sole basis for concluding that the Medicare program is at risk due to claims submissions by third party billers is that an additional party has been added to the claims processing chain between the practice and the Medicare contractor. We found no information presented in the OIG report to demonstrate that there is direct evidence of a third-party billing company problem. The fact that "more than 30 billing individuals/entities have been excluded from participation in the Medicare and state Medicaid programs" is the only thing approaching evidence of a problem.

We noted that the report contains numerous examples of incomplete or incorrect understanding of how the billing industry operates, how practices utilize billing services, how the commercial billing software industry serves practices and billing companies, and the report reaches a number of inaccurate conclusions regarding the types and levels of risk associated with claims handled by billing companies, clearinghouses and medical practices. HBMA would be willing to itemize these concerns, although it may be unnecessary, since we agree with the broadest conclusion of all—that knowing the identity of EACH AND EVERY party involved in presenting a claim for payment would be beneficial to reducing fraud and abuse. However, this may not be economically or technically practical.

The OIG's Report notes that "it is estimated that there are more than 5,000 third party billing companies. To date, "more than 30" (the OIG's online database reports exactly 30 individuals and/or companies) have been excluded from the Medicare and Medicaid programs. That is six tenths of one percent of the number of companies that may be submitting claims to Medicare or Medicaid. To further put this in context, we noted that according to the OIG's web site, more than 40 federal or state employees have been excluded from participation in the Medicare or Medicaid programs. Finally, in terms of the magnitude of this problem within the overall context of Medicare fraud, only 30 of the nearly 18,000 individuals or entities (or .0016) excluded from the Medicare program are classified as third party medical billers. I am pleased to report that none of the excluded individuals or companies is or was an HBMA member.

Incidentally, the only HBMA member ever adjudicated of a claims-related violation was promptly suspended from membership, pending the court's determination of the penalties to be imposed. That company is now under a Corporate Integrity Agreement, has had its ownership restructured, and we have asked the new President to apply for and justify reinstatement or face termination of its membership.

Mr. Chairman, we believe it is fair to conclude that every individual or organization that "touches" a Medicare claim is in a position to commit fraud with respect to that claim, including the contractors who process them. What is not clear is whether the potential for fraud is any greater at different points in that chain. In other words, is a claim handled by a third party biller any more likely to be used to commit fraud than a claim submitted directly by the physician's office?

We believe that there is little or no clear evidence of a problem and we are troubled by the OIG's conclusion on page 9 of the report that states: "Inability to assess whether a claim came directly from a provider or passed through the hands of a third party represents a vulnerability in Medicare program safeguards." We suggest that an equally reasonable conclusion—given that there have been so few billing entities excluded from the Medicare program—is that claims submitted by third party billers are less likely to be erroneous and therefore less likely to be fraudulent.

Now to the specific recommendations and a preliminary reaction to these proposals: Due to the fact that we only learned of these proposals very recently, the Association leadership has not had an opportunity to discuss these recommendations nor consult with our members. Consequently, the comments I make about these recommendations are the views of someone with over 30 years of experience in health care billing and not those of the Association. We will, however, discuss these proposals with our membership and provide you with an organizational position in the near future.

1. Identification and registration of all clearinghouses and third-party billers.

In concept, we support the idea of identification of clearinghouses and third-party billers. However, we suggest that this should be broadened to include everyone who submits claims to government payers. In other words, the claim should not only

identify whether the claim was submitted by a third party billing company, it should identify whether the claim was submitted by an employee of the practice, and all of the (many) others who may have handled the claim prior to submission.

We would also suggest that because many third party billers handle billing for practices located in multiple states, the identification/registration process should be national and not carrier specific. Some of our members have a national clientele spanning dozens of states; the prospect of securing and keeping track of dozens of submitter numbers is daunting, to say the least.

In addition, the majority of our members utilize commercial billing software. None of the programs currently contain a provision for such an identification number. We predict that it will take the software industry two or more years to accommodate a new data element requirement and the transmission of it. Medicare Carriers may need even more time.

2. *HCFA should only accept electronic claims from authorized sites and terminals.*

Please refer to our comments, above, under **THE REGISTRATION PROCESS**. In addition, we do not understand the report's reference to "terminals."

3. *HCFA should educate the provider community concerning their liability for erroneous claims submitted to Medicare using their provider number.*

Educating the provider community is laudable and we would welcome HCFA's assistance in this area. Our members go to great lengths to educate their clients about their legal responsibilities. These are not the third party billers claims, they are the practices' claims. We are merely acting as the agent for the practice and we are therefore dependent upon the quality of information we receive from them to prepare and submit their claims. The old saying, garbage in, garbage out, is particularly relevant to third party billers.

On all of these issues, Mr. Chairman, the HMBA is eager to work with HCFA and HHS's Office of the Inspector General to develop standards that are fair, equitable and reasonable in view of the scope of the potential problem.

As I mentioned in my description of the third party billing industry, the majority of third party billers are small businesses. For some, this is literally a cottage industry; some third party billers are home-based businesses. If requirements are created that are costly or create an environment that suggests that practices that use third party billers are subject to a higher level of scrutiny, it could reduce the desirability of using a billing company and could put some companies out of business. HCFA staff has indicated that they view third party billing companies as an ally in preventing improper claims rather than being a source of them.

In conclusion, Mr. Chairman, we welcome the support of Congress and the Health Care Financing Administration as the billing industry does its part to prevent fraud and abuse and we appreciate the opportunity to participate in this important matter. Our budget is, of course, more limited than those available to the Medicare program. We believe it is possible to develop a system that provides a higher level of confidence in the third party billing process while at the same time ensuring that a role for billing experts continues to exist. If reforms in this area result in the diminishment or closure of third party billing companies, we believe that the result will be more errors in claims submissions and at least the potential for more fraud and abuse.

I would be happy to answer any questions you may have.

Mr. BURR. Thank you, Mr. Burleigh. Thank you for your reminder to those of us on this committee that when that pendulum on the clock swings from one direction to the other, we have a tendency to let it go too far. I think you raise a good warning to us as it relates to some things I am sure members will ask questions on.

Let me thank all of our witnesses for their testimony.

Let me especially thank the OIG for making Special Agent Lack available. The OIG has a policy that generally prohibits field agents from appearing in congressional hearings, and we very much appreciate their accommodating our request to have Agent Lack here accompanying Mr. Morris. Given that they prefer that special agents do not directly testify, I will let my first question go to Mr. Lack so that he can answer a question versus testifying.

I would ask you, if you would, to share with us anything about the third-party billing cases that you have investigated and also

comment on the vulnerabilities that exist in the Medicare program relating to third-party billing, Agent Lack.

Mr. LACK. Well, the case that was highlighted in Mr. Morris's testimony was Handle With Care. What exemplifies the vulnerability to the program is that Handle With Care billed under the premise of different nursing homes. They would go to a nursing home and they would tell them what appeared to be a legitimate pitch—that they were missing charges that they could legitimately recover. The company said to the nursing homes, "It would be no loss to you, we will bill on your behalf, and the government will pay you, and then you just cut us a check for 50 percent." So, it seemed like no loss to the nursing home. It seemed legitimate, since the check would come from Medicare to the nursing home.

The billing company proceeded to prepare a claim for surgical dressings, using a surgical diagnostic code, and the computer logic went: "Surgical dressing, surgical code, pay," and then paid the nursing home, and eventually ended up paying 70 nursing homes in the same way.

We didn't know that there was a billing company out there. It ended up we had several cases in the United States open on this kind of problem, not realizing we were dealing with one company. One thing about companies that are questionable is they want to get in; they want to get the money; and they want to get out fast; and that is what happened with Handle With Care.

By the time we determined that it wasn't the nursing homes' fault, it was this company, the company ceased to exist. In fact, it had split into two companies. The sisters had a disagreement and each went her way forming her own billing company, now billing other nursing homes. We knew Handle With Care, but were figuring out we got a new company.

We then attempted to find out who this new company was. Our problem was there was no data base with which to determine this. We were lucky in being able to determine what codes were being used and queried the system on those codes. We found, in fact, one of the sisters was actively engaged in this fraud as we were working. We were able to mount an undercover operation and get her to pitch us and find out, one, how this pitch worked; and, two, how the mechanism worked that they got it through.

The highlight of the vulnerability was this billing company was masquerading as nursing homes. That is a particular problem highlighted by that.

Another case called "Physicians on Call" from the late 1980's, that was my first experience with billing companies. In that case, the company recruited brand new medical graduates and said, "We will start you up with a medical practice visiting nursing home patients, because they have to be seen every 30 days. We will get you a Medicare number. We will take care of the hassle for you, because, I think the regulations are somewhat difficult." Both Handle With Care and Physicians on Call oversold the difficulty of it and got people to say, "Well, if it is too difficult, you know what you are doing." These doctors gave permission to use their number or to get a number and use it to bill. What they didn't realize was the usual fee for an intermediate visit was padded by Physicians on Call as an extensive visit. The Medicare contractor sent the check

to Physicians on Call, thinking it was going to the doctor. Physicians on Call cut a check back to the doctor for what should have been billed and kept the remainder, which was the fraudulent portion of it.

The Medicare system actually worked in its analysis of utilization by these physicians. The system found these physicians were billing high for these types of services and did an analysis, finding the payments were not typical. The Medicare contractor called the physician in. The physician said, "I didn't bill you; somebody else billed you." But Medicare said, "This is your number on the check; you are the one we paid; it is an overpayment; and you are eligible to be excluded from the program." This surprised the brand new physicians. They called Physicians on Call, and, like Handle With Care, Physicians on Call said, "We would like to help you, but we are out of business; we have no money; and good luck."

So that also highlighted the masquerading of a billing company.

Mr. BURR. Let me say, for the purposes of the witnesses and members, it is the intent of the Chair not to keep a clock on members and to be a little more informal because of the few number of members that are here. I would just ask all members not to abuse that, including myself.

Ms. Thompson, would you like to comment on what you have just heard from the standpoint of the Health Care Financing Administration?

Ms. THOMPSON. Well, as I mentioned in the testimony, we do believe and agree with all that the GAO and the OIG have said about what we don't know about third-party billers. My question is, what is the right set of solutions to respond to that? As I hear some of the cases described, for example, I wonder to what extent, had we registered billing agents, that that would have really addressed the problem, for example.

In a lot of instances, for example in the case that Mr. Hast talks about, it seems to me there is a person masquerading as a provider that really isn't a provider. That is something that we should be catching and dealing with in our provider enrollment process.

In the cases that Mr. Lack is describing, it seems to me one of the issues is providers or suppliers or physicians basically delegating their responsibilities and saying I am not going to worry about this, I am not going to pay attention to what is going on, I am going to have my contractor deal with all of these issues, not looking at the information that is being submitted, not looking at the kinds of claims that are being submitted, not doing any double-checking, not asking about what are the credentials of the people, what are your quality control procedures, do you have ways of ensuring that claims that are being submitted are correct.

So I worry a little bit about rushing to a false solution that makes it appear as though we have really addressed the problem, but the fundamental vulnerabilities still remain.

Again, that is one of the reasons I raised the question about what is the right set of expectations for the physicians and the suppliers and providers who are doing business with some of these companies. What should they be doing? What are the right set of expectations for us to place on them to say, you can't simply delegate away this responsibility and decide you are not going to worry

about it anymore, you are not going to care about it anymore, you are not going to look at information being submitted to the program on your behalf?

Mr. BURR. Let me share with you a personal frustration on the part of this member. With only 6 years of experience at serving on this committee and looking at our health care delivery system as it is currently designed, I think one of the frustrations that I have is that it seems that the fraud and abuse initiatives of the Health Care Financing Administration are, in fact, the results of congressional hearings and the investigations of GAO and OIG. It is not an internal evaluation of the vulnerabilities that exist in our system and a proactive initiative by the Health Care Financing Administration to make sure that we have a system in place that does not require Special Agent Lack to, in fact, be on the job. I am not trying to put him out of business. I can assure you we have got plenty for him to stay after.

But I share that with you in an open way, to tell you that this is a frustration. It seems that our level of interest in fraud and abuse is driven based upon the threat of a possible congressional hearing on a specific area. I would hope that, in the future, those initiatives are something that can be determined prior to fraud and abuse being committed, to the degree that it can be.

I would also take this opportunity to tell you this is not a member that believes that we will increase the solvency of Medicare by another 50 years because we can squeeze out fraud and abuse. I think that publicly that is sometimes the belief that is conveyed from this institution to the American people. But clearly we have a responsibility for the fiscal integrity of Medicare regarding how the money is being spent.

The Chair would recognize Mr. Bryant for questions.

Mr. BRYANT. Thank you, Mr. Chairman.

I was going to start with Mr. Lack on a question, but I want to start with Ms. Thompson, because I think you hit on a good point, something that I am sitting here thinking about, and you partially answered my question. But in this relationship that is set out, where the health care provider is entitled to be paid, and a lot of these health care providers have actual employees on the payroll where they are responsible for the billing process and getting the right codes, and I assume they take great care to properly train these people and make sure, for instance, that they are not up-coded, that they are coded properly—we will talk about that in a minute. There are those out there like that.

Then we have got this situation where many use the intermediary, the third-party people that Mr. Burleigh represents in his Association.

You talk about the expectation thing. Let's talk about legalities here. What is the legal relationship, in your view, between a health care provider and this third-party person I assume they contract with to handle the administration of their claims?

Ms. THOMPSON. Largely we have treated that as a private transaction, like how any provider or supplier or physician might decide to arrange their practice in a way that makes sense to them in terms of their employment practices or in terms of whether they employ consultants to help them with training, whether they em-

ploy auditors to look at their practices, whether they employ compliance training firms to come in and help them develop compliance programs and so forth.

So we have seen that as sort of a subcontract type of arrangement, where the provider, the supplier, the physician is basically our prime contractor, and they have subcontractors who may specialize in certain areas or assist them in certain areas, but ultimately they are the ones responsible, they are the ones making those selections, they are the ones assessing the qualifications and capabilities of those kinds of entities.

Mr. BRYANT. Okay, you said something at the end that may have answered my question. You said, ultimately, the buck stops there; they are responsible. Do you accept the premise that the providers have legal liability, legal exposure, for the fraud and abuse that person they have contracted with, their subcontractor, perpetrates on the United States Government? Do you take that position? If so, do you go back after the health care providers in a civil fashion to recover the dollars? Does that happen?

Ms. THOMPSON. Yes. But I would offer perhaps Mr. Morris to expound more on that.

Ultimately, yes, the payments are made to the provider, regardless of whether or not they select an agent who helps them collect that payment and post accounts receivables and so forth. If there is an overpayment, it does get taken back from that provider. Whether or not they are legally culpable, of course, in a civil or criminal matter will in some part depend upon whether or not they meet the legal standards for reckless disregard and so forth.

Mr. BRYANT. One angle we are talking about today where it is not the provider cheating, it is the provider's third-party subcontractor, there are all kinds of answers to this; and we can talk about maybe HCFA ought to set some standards and requirements for these third-party payers to come in and be qualified. But it seems to me the simple solution is to look back to the health care provider with whom we have the contract with, who has deep pockets. If they can't be any more careful in who they subcontract with or who they oversee or check, some of the people where they are being cheated, they don't catch that, if they can't be more responsible, then they are the ones that owe us the money.

I am wondering why we are here trying to find a solution at the Federal level in overseeing this, when it is just a simple matter of going back to that provider and saying, I am sorry, but the folks you trusted abused the system and committed fraud or abuse, and we had to overpay them, so therefore you owe us this.

Maybe by making some examples—and I have friends that are health care providers, and I hate to lay it on them, but they are the ones responsible. By letting them know in a clear, visible, financial way that then maybe they will be more careful in who they hire and be more careful in overseeing and making sure that these folks they hired are not cheating. To me, that is the simple solution to this aspect of third-party fraud and abuse.

Mr. BURR. Would the gentleman yield for 1 second? I know Mr. Morris wants to answer the question you asked, but let me turn to Mr. Lack for just a second. Because you got on the inside. You understand—you got pitched.

Mr. LACK. Yes.

Mr. BURR. I guess my question would go right at the heart of what Mr. Bryant is raising. Did you find that the pitch really did feed off of the difficulty that doctors have any assurance that they are in compliance with what the rules and regulations are?

Mr. LACK. Yes. As a matter of fact, with the pitch that we received, we portrayed ourself as a nursing home chain seeking the assistance of Handle With Care. As part of it, we had an agent acting as a medical records technician, saying, "Why can't we do this ourselves? Why do we need you?"

And what we got pitched back was, "Medicare doesn't want you to know how to bill. It is a secret. It is a trade secret. And you know how difficult this is, and we have been at this for years. We used to work for an intermediary." Which was not true. Most of it was puffery and fabrication. But we would not have known that as a company. We would have had to check their references.

And they had very good references, by the way, extremely good references. Because of all the other nursing homes—the nursing homes didn't know they had been defrauded originally. The first one they went to in Seattle, they went to work for a week, and Medicare cut a check to the hospital—the nursing home was owned by a hospital—for half a million dollars. The hospital would say, "This came from Medicare. How can it be fraudulent? It went through the system. Everything is fine."

It wasn't until those claims were reviewed at our request 2 years later that the fraud became evident. Medicare processed those because the computer thought they were fine. It is surgical dressing, surgical diagnosis. The computer didn't ask the critical question: "What are surgeries being done for in a nursing home?" The computer just did what it was told to do.

In that case, it appeared to be a legitimate transaction. This nursing home was very happy. Actually, they enlisted the help of a large law firm, a law firm that specialized in health care matters, and they underwrote Handle With Care for the tune of a couple million dollars, saying this is great. This law firm was then representing Handle With Care and getting clients for it. When they come to us, they come to us with representatives from the Seattle hospital, which is a legitimate major concern, and representatives from this legal firm that was legitimate. So, for all intents and purposes, it appeared legal.

Mr. BRYANT. But it seems to me again we are chasing the wrong horse here. It is a simple matter that the health care provider is liable for the subcontractors, at least in terms of not going to jail, but in terms of paying that money back if we put that onus to pay money back on the provider, that sounds good.

These folks are doctors. They go to medical school. They have MBAs running their hospitals and clinics and so forth. These are smart people. They are going to have to get the message that, yes, if these folks cheat, we are going to ultimately be responsible, as they would be in any such legal relationship. This is not an exceptional case for doctors and hospitals. It seems like, anyway, that would be the simplest solution.

Those people, like the third-party payers who commit fraud, criminal fraud—and my question to you was going to be, do you

ever see any of these people go to jail? Or is it always just they are on a list somewhere and they can't do this for a while or they have to pay the money back? But do any of them go to jail?

Mr. LACK. In the Handle With Care case we were successful in all avenues. One of the sisters went to prison for 3 years. The other went to prison for 5 years. We brought civil actions against the nursing homes because we held them responsible for not looking at nine claims. They should have asked more questions. The main question is, "If I get a check for \$500,000, I don't want to miss that in the future. What did we do wrong?"

So we recovered—of the \$7 million that was offered paid, we recovered \$5 million of it in civil settlements against 15 of the nursing homes.

Mr. BRYANT. Without being abusive, let me just thank you for your answer and commend you for sending some people to jail that need to be in jail for a while, and let Mr. Morris make your comment.

Mr. MORRIS. Although you are correct that both the provider, in this case the nursing home or the physician and the third-party billing company, are responsible for the claim and the False Claims Act specifically addresses those who submit or cause to be submitted a false claim, there are three potential challenges to the solution you proposed.

The first is that oftentimes we cannot find all the providers that a third-party billing company has enlisted, wittingly or unwittingly, in its scheme. As Mr. Lack explained in his case, we did not realize that there was a common thread to separate investigations. So it may be, even when we close down a crooked third-party billing company, we never learn all of those who intentionally or otherwise benefited from its scheme.

The second problem is that, many times, the amount of money that a particular provider receives as a result of these schemes is relatively small. When we are talking about millions of dollars in fraud taking place in our programs, we obviously have to allocate resources. So a \$15,000, \$20,000, \$30,000 fraud, although not insignificant and is money that should come back to the trust fund, may not warrant the sort of attention that a \$1 million fraud has. Even if we know who the health care provider is that benefited from a crooked third-party biller, it may not be an appropriate use of our resources to go after that one. Finally, we are always mindful of providers' ability to pay.

If we take money back from a provider who thought it was receiving legitimate payment for legitimate service, that is money that comes off of their bottom line. Oftentimes we are confronted with the situation of having to ask whether it is better to walk away from a known debt and allow a provider to continue to provide quality services to needed patients or to insist on that money being repaid.

So both the challenge of finding these people in a timely fashion and actually getting the money back in a cost-effective way makes the idea of just going back to the provider and holding them accountable have some challenges to it.

Mr. BRYANT. If I might just respond, I understand the economies of scale on this, and I appreciate that, but I think, again, if we put

the burden on the—where it should be, we could accomplish a great deal. We are not going to get every case, obviously, but issues like small amounts, relatively small amounts like \$30,000, it seems to me if you know that money is owed, send a letter to them, like in overpayments in the past we have done that. Of course, I hear from my hospitals and doctors when you do that. I say, why are you all being so hard on them? But that is what you might need to do, particularly if there is a pattern there.

Again, I think I am interested in sending a message out there that we have to—this is a problem and we have to be careful about this. I am not so sure it is HCFA and those of us sitting in the room that have to be that careful, we should, but the legal burden is on the people in the contract with them, to check them out better and to monitor what they are doing better, and maybe the way to get their attention to do this is through the pocketbook.

Mr. MORRIS. If I could add one last point—and we agree with that approach, we have issued a number of compliance guidelines, one in particular to third-party billing companies. We are now working on a compliance guideline, a voluntary guideline, for physician practices. One of the issues we will be addressing in that set of best practices is the need to make sure they know who they are contracting with, consultants, third-party billing companies and the like.

Mr. BRYANT. We will let Mr. Burleigh speak after a while on this.

Mr. BURR. I think Ms. Aronovitz would like to add something. Let me say as I move to it, I have been sitting here thinking as Mr. Bryant has talked about physicians entering into this agreement and what Mr. Lack said trying to figure out what drives them, with my belief that we do have a very confusing system. I don't quite give the credit to physicians. They are educated, they are intelligent up to a point. I think business is not a course that they teach in medical school, nor was tax preparation.

I sit here waiting for my taxes to come back. I contracted with somebody that I thought was capable, reputable, and the fact is that I am at the mercy of the calculations they come to. They will ask me to look them over. If I was smart enough to catch the mistake, I would have done the damn thing myself. But the fact is that I am not capable of doing it because of the confusion and the difficulty of wading through a Tax Code that I am not educated enough to do.

I don't know that that is necessarily—

Mr. BRYANT. When the IRS comes back and you underpaid, who pays that?

Mr. BURR. They come to me.

Mr. BRYANT. You get a different accountant next year.

Mr. BURR. I am not questioning that fact. But the same way I would look at the Tax Code and say does it have to be this difficult, I would look at your quarterly booklet of new regulations and say, does it really have to be this difficult.

Ms. THOMPSON. If I may make a comment about that, in these cases, as is often the case, because often we hear this, our rules are complex, and some of them are—but these are services that weren't rendered, every claim submitted was submitted at a higher code.

These are things, if anybody had been paying one degree of attention to the claims submitted, they would have known they were wrong.

Mr. BURR. Clearly, you are right. I think my point was more on the motivational factor of the contract being entered into originally. I think when we choose somebody who has the references, who we have the confidence in, we tend, because we are not experts, to trust the conclusions that they come to. I think Mr. Burleigh said it. We will never weed out all the bad apples.

Ms. Aronovitz.

Ms. ARONOVITZ. I think we are talking about an issue that is—this a fundamental issue in terms of the way HCFA uses very limited and valuable safeguard resources to identify problems that arise.

I think Mr. Morris said the key thing when you talked about how we could get HCFA to systematically identify providers that have been either victimized or a part of a situation where one problem third-party biller has engaged in erroneous or fraudulent billing.

The problem right now, and one of the concerns we have, is that HCFA, in identifying a situation where there is a third-party biller and going after one provider, it can do that. But what it cannot do is link that third-party biller with all the other providers who might have been involved and systematically deal with them as one case.

I think Special Agent Lack and Mr. Morris both described the extra resources and intellect it took to finally realize that this one third-party biller was behind quite a few different fraud schemes around the country. That is unacceptable. If there could be a way to link in either a data base or some automated approach which would then get to identifying individual providers or third-party billers in a more systematic and constructive way—

Mr. BURR. Hopefully—we all hope the outcome of this hearing is to stimulate the thought processes as to whether this is a way to design that, and clearly I think we can.

Before I recognize Mr. Stupak, let me just ask one question of Ms. Thompson. You said to Mr. Bryant that you consider this to be one entity, the physician and the contractor as one. We have new proposed regulations as it relates to health care privacy. Do you consider that the third-party billing agent is under the guidelines that you extend to the physician as it relates to health care privacy?

Ms. THOMPSON. I am not the privacy expert, and I know that those are fairly complicated rules. We will get you an answer for the record. I believe that is the case.

[The following was received for the record:]

Yes, the proposed rule, which implements the privacy provisions of the Health Insurance Portability and Accountability Act of 1996, would apply to the third-party billing agent of the physician.

The third-party billing agent, who is under contract to perform services for the physician, is a contractor. While the proposed privacy rule applies to three types of covered entities (e.g., health plans, health care clearinghouses, and health care providers who transmit any health information in electronic form), its provisions also pertain to the business partners of covered entities. Section 160.504 of the regulation describes a business partner as a person to whom the covered entity discloses protected health information to assist in the performance of a function or activity and includes “contractors or other persons who receive protected health information

from the covered entity...including lawyers, auditors, consultants, third-party administrators, health care clearinghouses, data processing firms, billing firms, and other covered entities." Clearly, the third-party billing agent falls within the purview of a business partner.

In section 160.506(e)(1) of the regulation, covered entities are required to have contracts with their business partners to ensure that the business partners appropriately safeguard protected health information. This means that business partners of covered entities are required to comply with the same privacy rule standards for the use and disclosure of protected health information as covered entities.

Therefore, the proposed privacy rule requirements for protecting health information would apply to the physician's third-party billing agent.

Mr. BURR. So wouldn't that really compel you to want to know who that third-party billing agent is?

Ms. THOMPSON. Our instincts are to want to know who the third-party billing agent is. That is why we are collecting that information on our enrollment forms. When we have fully implemented our new enrollment process, it will do it.

Miss Aronovitz has talked about collecting information on third-party billers, to be able to allow us to make some linkages about which providers third-party billers are associated with, for the purposes of looking at claims and doing analysis and supporting investigations and so forth and so on. There are some issues with that. Ms. Aronovitz talks about the fact it is self-reported data. That is true. We are going to be setting out requirements asking for periodic updates of that information. It is also true, though, if someone fails to do that, our recourses are somewhat limited. People will say, well, I overlooked it. I didn't update the information. But it was an oversight.

So I think that there are some issues with that, but I think it is going to provide a lot richer data for us in order to be able to aggregate and analyze claims that are being handled by a third-party source.

Mr. BURR. I just want to make sure I understood you. As director of the Medicare Program Integrity Group, you weren't consulted in an integral way about the privacy regulations that HHS was proposing?

Ms. THOMPSON. Yes, I was, but I am not the privacy expert, and I don't have in front of me all of the answers to who falls under what rubric.

Mr. BURR. Mr. Stupak is on a very tight schedule, I know, and I don't want to take away from that, but I am going to come back to this, because I think the implications of the privacy issue are enormous. I saw Mr. Burleigh start writing. I think I have raised an issue that he should be very interested in, too, in taking your interpretation and understanding of how these two tie together.

Mr. Stupak.

Mr. STUPAK. Ms. Thompson, in response to Mr. Bryant you said something like, this case was very simple. No one was paying attention. They were overpaying false claims. I think 87 percent of the claims filed were false by this BMS. Who should have been paying attention? Who should have been overlooking the data that comes in?

Ms. THOMPSON. Well, clearly, it is one of our responsibilities, in terms of analyzing the claims, that we receive to assess whether or not those claims are correct and appropriate for payment. Obviously, with 1 billion claims, it is very difficult for us to collect a

medical record on each one of those claims or to go out to the providers or the beneficiaries onsite and document that those claims were actually rendered.

Mr. STUPAK. If you have the responsibility, then where is the accountability then? Who do we hold accountable when we get cases like this?

This isn't something that just happened. I entered Mr. Dingell's report from GAO, which was June 1999, but I know this has been on the radar screen for several years now and doesn't seem like we are any closer to a solution to this problem.

So while maybe people are willing to accept responsibility, I guess we are still not getting accountability here. How do we go about implementing this so it doesn't continue to happen?

Ms. THOMPSON. I have to say that I always want to caution people about the idea of how do we fix the problem of people submitting claims that aren't true, and there isn't an easy, silver-bullet answer to that. If there was, we would do it, and we would put the OIG out of business, and they could go home and move on to other areas of fraud.

Mr. STUPAK. That is not realistic. I said it has been going on for a couple of years. The GAO report in June 1999 put forth conclusions that it should be done. What has been done to implement the conclusions of almost 10 months ago? Anything?

Ms. THOMPSON. We have had many conversations about what steps we need to take, and I think that part of my testimony is pointing out that two sentences saying you should register billing agents who collect this data doesn't quite reflect the complexity which Mr. Burleigh discusses, about the kinds of questions we need to answer so we are not imposing a regulation on the industry, that really doesn't accomplish what any of us want it to accomplish and creates administrative burdens and new requirements without really addressing the underlying vulnerability.

Mr. STUPAK. You said you have had some conversations, and the two lines you put out in your statement there, those suggestions have been around even before June 1999, even before that report. So how many more years are we going to have conversations before we actually get some implementation of something?

Ms. THOMPSON. Mr. Stupak, implementation of what? What would you like us to do?

Mr. STUPAK. Just start with the third-party billing. Let's start with the identifications and identify who they are.

Ms. THOMPSON. So what are the answers to the questions that Mr. Burleigh and I have raised in our testimony about who we should classify as a third-party biller, and what standards should be set for them, and what is the registration process so that we can validate the information that we receive?

Mr. STUPAK. Well, the rule of law under HCFA says the person who receives it is the provider, right? You have to have a provider number, right?

Ms. THOMPSON. Right.

Mr. STUPAK. Someone applies to you. They are either a provider or not. So if they are not, I think they would fall into third-party billing.

Ms. THOMPSON. We don't enroll third-party billers. We enroll providers. I think the question is whether or not we should enroll—

Mr. STUPAK. Hasn't the recommendation been for some time now, even before the June 1999 report, that it is time to enroll these third-party billers?

Ms. THOMPSON. Yes.

Mr. STUPAK. So other than just having discussions among yourselves, what have you been doing to get the process off the ground?

Ms. THOMPSON. We are not prepared to say that we agree that that is the right solution.

Mr. STUPAK. If that is not the right solution, then what is your suggestion as the right solution?

Ms. THOMPSON. What we are inclined to do is say, yes, we need to have a process for tracking claims so that we can understand who is associated with the preparation of those claims. Again, the response to that—I think we also need to be clear about what that information is going to give us, and whether or not we can be confident about the reliability of the information—to the extent we have collected information from providers, for example, on who their third-party billers are, as Ms. Aronovitz points out, how confident are we that information is being updated and that information is correct, or in absence of a registration process, how well we link commonly owned, say, third-party billers from one to another.

Mr. STUPAK. To summarize, you are really not sure what you should be doing yet. You haven't made a decision yet.

Ms. THOMPSON. That is one of the reasons we are very happy to have this hearing and work with the committee on what are the proper responses.

Mr. STUPAK. Let me ask Ms. Aronovitz and Mr. Morris. Each of you know the GAO report was completed for Mr. Dingell in June of last year highlights a number of weaknesses regarding the way HCFA tracks third-party billing. Since that report was issued, can you tell me of any material changes HCFA has made to correct these problems?

Ms. ARONOVITZ. I think in our report last June we did not actually take on the idea of registration. We were concerned with some other fundamental problems about activities that HCFA had agreed to do, and that was to update its provider enrollment data base and to develop its automated system. We see that there are some real gaps in reliable and complete and timely information in those two efforts, and our hope is that, at a minimum, HCFA will consider ways to deal with those gaps.

Mr. STUPAK. Those two gaps—

Ms. ARONOVITZ. Those still exist right now.

Mr. MORRIS. In a report we issued earlier this week entitled Medical Billing Software and Processes Used to Prepare Claims, one of our conclusions was there was a need for identifying and registering all clearinghouses and third-party billers, and there was a need for improving safeguards. HCFA agreed with those recommendations. I don't think we are finding resistance from HCFA. As Ms. Thompson indicated, the question is how to do that effectively.

One of the problems we have seen, not just in the third-party billing context but all of the interfaces we have with providers or

their representatives, is how do we know the information is accurate and updated? So one of the balances is, if you get all this information in, can you rely on it and what do you do with it?

We do think there are vulnerabilities. I think Ms. Thompson made it clear she acknowledged that as well. To answer your specific question, I am not aware of any changes from the summer.

Mr. STUPAK. Mr. Burleigh?

Mr. BURLEIGH. Well, I think that this is probably a good point to make several comments on, but to respond specifically to your question, the idea that a third-party billing company is a third-party billing company oversimplifies this.

For example, a medical practice might, for tax reasons—and there are a number of examples of this—incorporate a separate identity to employ all of the staff involved in its billing, and they do that because they can have separate pension funds and so forth. Is that a billing company? Their only customer is the owner of the billing company. It is a different name.

Some of those organizations provide billing services to other practices. Gee, I am having trouble with my billing, and my colleague tells me they are doing pretty well, so I will hire my colleague and their practice to do my billing. They use commercial software. Because of the aggregation and sort of critical mass required for claims submission, it is not unusual for the software vendor that provided the software to become a collection point for the claims. They then forward that to a clearinghouse.

Mr. STUPAK. That may all be true, but, again, if you rely on 42 USC 1395, it says that payments made to a beneficiary or under assignment to the medical provider who provides the service—

Mr. BURLEIGH. That is how it works.

Mr. STUPAK. [continuing] whether they set up a corporation to do their billing or anything else, if it is supposed to be to the provider, if it is not the provider, then I think it is a third-party.

Mr. BURLEIGH. The payments are not made to the third-party. The payments are made to the practice.

Mr. STUPAK. The third party does the billing, right?

Mr. BURLEIGH. That is right.

Mr. STUPAK. So they should have a separate identification number, separate from the doctor or the hospital providing the medical service.

Mr. BURLEIGH. The complication is the number of third parties involved in that process explodes. The practice hires a third-party biller. The biller is a relatively small organization. They transmit the claim that they have prepared to the software company whose software they are using. The software company aggregates them with others, forwards it to a clearinghouse.

Mr. STUPAK. That may be all true. Maybe I am taking a little hardheaded approach here, but this has been going on for some time. I don't think it is that difficult to identify a provider and third-party biller. I mean, we just were talking about our taxes. Most of us probably have someone else do our taxes. That person who prepares our taxes has his identification or her identification number on there. I still have to sign it. I still have to put my John Hancock on there. If there is a problem, I am still responsible.

But, you know what? There is a provider number for that accountant or CPA firm or H&R Block or if Burr is doing my taxes, heaven forbid, he has to have one. The point being, I don't think it is that difficult to identify these third parties if we get at it instead of continue discussions and make up excuses—you know, different scenarios how we could get around it. If we do it with the Tax Code, which everyone says is the worst thing in the world to deal with, why can't we do it with something like this?

Mr. BURLEIGH. We agree conceptually identifying who we are is not a problem. The concern is that, in terms of the practical process, if the billing company has touched a claim, put their number on it, if the software company that they sent it to has touched the claim and could theoretically participate in some fraudulent scheme, put their number on it also, it then goes to a clearinghouse, and they have the same opportunities, you have got to put their number on it as well. There are additional variations of that. There are billing companies and practices alike who subcontract to have their paper claims handled by a third-party, even though they do their own electronic claims, or they have other contractors do that. The industry has become very, very complicated.

Mr. STUPAK. Probably with all the rules, we made it more complicated. Why don't we just call a summit between all the stakeholders next month and have them come in and get a grip on this thing and fix the thing?

Mr. BURLEIGH. We would be happy to do that.

Mr. STUPAK. That is one positive thing I heard. Go ahead, Ed.

Mr. BRYANT. I thank my friend from Michigan.

Before you arrived, we were talking about this issue, and I think it has become even more complicated.

Mr. Burleigh, I appreciate your explanation in terms of the way the system works sometimes. It appears we have got multiple layers now of subcontractors, and that subcontractor is subcontracting, and as many as maybe two or three, which seems to be something of a defense here, that, well, that is part of the problem. That is why there is abuse and fraud. We don't know who is doing it, but we are not doing it. Somebody else is doing it.

I am not saying HCFA doesn't have an obligation and others don't have an obligation at the top end to look down. But, ultimately, all of these layers of subcontractors—the legal responsibility goes back to the provider who hires the first subcontractor. And it seems to me that is—I know it is an oversimplification, but if we start going back against some of my colleagues back home who operate clinics and doctors' offices and hospitals and really letting them know I think they have a legal obligation to the taxpayers to be more responsible in who they bring on and monitoring who they bring on so we don't get hit with this fraud and abuse—this is not to say you don't have a responsibilities, too, but I think we are missing a key component here. I know we are doing it some, but I think we could do a better job of getting that message out.

I yield back.

Mr. STUPAK. Mr. Burleigh, has HCFA contacted you, your business, PractiCare, on your input on the problem?

Mr. BURLEIGH. We have had an ongoing dialog with Ms. Thompson's office and with the Office of the Inspector General and others

in the government. Because, as an association, we viewed this as an obligation that we have to be proactive, to have a clean house, to be a strong advocate for compliance in every respect, to promote it with our members and our members' customers.

You will see in my written comments that we have even advised our members that it may become necessary for them to fire a customer if they have a problematic practice who has asked them to do things that they are not comfortable with. So we are very much in favor of keeping a clean process and supporting compliance, as long as it is realistic and practical, and as long as it really is not a false solution, as Ms. Thompson said. Because you can know who we are, and there are so many others involved in the process that you really have not addressed the issue.

Mr. STUPAK. Well, you know, as I think Ed pointed out in his opening statement, he has only been on here—he is in his first term. Mr. Burr and I have been on here for some time, 6 years at least, and it seems like we are always dealing with the same thing, always getting the answer we are working on it, and nothing gets done. From this end of the dais, it gets frustrating. When I suggested a summit between the stakeholders next month to fix it, I hope HCFA picks that up. Is there any objection to having a summit and getting it resolved?

Ms. THOMPSON. I think that is a wonderful idea. As we noted in our testimony, we plan—our upcoming provider enrollment regulation asks for public comments on what steps we should be taking to strengthen the oversight of third-party billers. That could be, actually, a very helpful sort of precursor to wider opportunity for public comment on what steps we should be taking.

Mr. STUPAK. Thank you, Mr. Chairman.

Mr. BURLEIGH. If I could just add one thing, last year we met—our immediate past president and our current treasurer, two of our board members met with Ms. Thompson and her staff to talk about this specific issue; and we also participated in a conference call with the GAO staff, who were also exploring this on behalf of Congressman Dingell. So we have been active and wish to continue to be active in assisting the committee and developing a solution.

Mr. STUPAK. Active discussions are great, but we want active, concrete action.

Mr. BURR. I thank the gentleman.

I see that we have been joined by several more of our colleagues. The Chair would recognize Mr. Green for the purposes of questions.

Mr. GREEN. Thank you, Mr. Chairman. I ask unanimous consent to have a statement placed in the record.

[The prepared statement of Hon. Gene Green follows:]

PREPARED STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Thank you, Mr. Chairman for scheduling today's hearing. The problems of waste, fraud and abuse in the Medicare program is a continuing one and this Committee must remain vigilant if we are to ever start making progress toward diminishing it.

Today, we are examining the role of third party billers in the Medicare system. Because of their access to billing information from the health care providers and their patients, these companies, should they be inclined, are in a unique position to commit fraud with a low chance of discovery.

Part of the difficulty in tracking this fraud is that HCFA currently has no way to determine whether or not providers are submitting claims themselves, or if they are using a third party billing company.

In the example that the GAO will present to us today, a woman from Sugarland, Texas added a new twist. She operated as a broker between doctors providing mental health services to nursing homes and another, reputable third party billing company, using her access to doctor and patient information to improperly bill Medicare for \$1.3 million dollars.

This case, currently under review by the U.S. Attorney's office in Houston, should serve as a call to action, not just to this Committee, but to HCFA, to implement regulations that will put an end to this type of behavior.

Again, I commend the Chairman for calling this hearing and look forward to the testimony of the witnesses before us today.

Mr. GREEN. Mr. Morris, your office, the OIG, released a report suggesting that HCFA register all claims and clearinghouses and all third-party billers. Following up on my colleague from Michigan, in that report OIG suggested HCFA cannot identify most of the clearinghouses and billing agencies. I think that is what we heard in the last series of questions.

First, what are the implications of this finding; and, second, Ms. Thompson, after Mr. Morris, does HCFA agree with the IG's findings in that it cannot identify most of the clearinghouses and most much the billing agencies and all of the people that may touch those? Mr. Morris?

Mr. MORRIS. The implications of that recommendation are we would have then a data base by which we could draw patterns and identify overarching practices and individuals. I think the analogy of a needle in the haystack, this would allow us to use a magnet to pull that needle out. It would give us another tool to be able to identify problems which are broader than a single provider. So it would be very helpful to us.

Mr. GREEN. Ms. Thompson?

Ms. THOMPSON. We did concur with the OIG recommendation as we have been discussing. We do believe we need to develop more information and have more information on the clearinghouses and third-party billers involved in our process and have some plans and efforts under way to increase the amount of information that we collect on those billers.

Mr. GREEN. Okay. That includes the whole gambit, as Mr. Burleigh talked about, of people who—everyone that may touch that particular claim?

Ms. THOMPSON. I think that is one of the issues that we need to sort out a bit better. Because there is a question, for example, as to whether or not we would want to reach in to, say, a small practice environment in one of our rural States where there is a part-time contractor who comes in perhaps on a weekly basis to prepare a claim. Do we really want to regulate that kind of person and set standards for that kind of person? Does that kind of person need to register? So we do need to have some conversations about where to draw these lines and who we want to define as a third-party biller and who we really want to know about and track.

Mr. GREEN. If that part-time contractor all of a sudden from that rural State that does it part-time all of a sudden started billing three or four times what is expected, you need to have some mechanism to identify that.

Ms. THOMPSON. That is right. There are some available mechanisms where we might be able to see that. In fact, at least in one of the cases that was discussed here today it was a contractor actually performing focused medical review, which is one of our program safeguard activities, that actually identified the vulnerability and identified the improper payments and actually triggered the investigation. So I think, again, the question is, do we—you know, where do we want to draw the line? Is it on everyone who may influence or who may participate in a coding decision? And to what extent, for example, would we want to set standards if we are doing that for employees, say, of a physician's office?

Mr. GREEN. Mr. Morris?

Mr. MORRIS. If I could just add, there is a way of looking at this that expands the analysis beyond just clearinghouse registration. As we note in our written testimony, Congress recognized as early as the early 1970's paying billing companies based on a percentage of the revenues they bring back to the client is an incentive to cheat, because the more you bill the program, the more you can take off the top.

This is what we have seen in Handle With Care. They took 50 percent of the receivables. It is what we see with physician billing practices. If you can inflate claims because you are going to get a percentage of each claim that goes in in dollars, that creates an incentive. Anonymity creates an incentive to cheat, because, if no one knows what you are doing in the dark corners, it is one more temptation. Registering third-party billing companies addresses the issue of anonymity, but we should also be thinking about whether there should be an expressed, clear prohibition against incentive billing.

The way the Congress set the reassignment requirements up, there is such a prohibition. But, as we note in our written testimony, there is a very easy way that one can circumvent that by having the payment first go to the physician who then promptly re-assigns it to the third-party billing company.

What happens is physicians will have all the money come into an account and authorize its third-party billing company to sweep that account every 24 hours. So from the appearance of HCFA, it is making a payment to a physician and thus none of the reassignment rules apply. Yet, in reality, the third-party billing company has swept that account, taken all the money out and, if operating on a percentage basis, has every incentive to inflate the claims that went into that account. So as we think about this, it is not just a question of registering third-party billing companies and facing the challenges of dealing with small providers and the like, but it is also going to the fundamental incentive that anybody has to inflate services in order to get a greater share of the fraud.

Mr. GREEN. Again, from what we have heard today and the suggestion of my colleague, Mr. Stupak, do you think HCFA is moving forward with what they are talking about, just from the little bit of time here?

By the way, Mr. Chairman, I apologize. I was at the telecom hearing downsize. Governor Gilmore was there, and very seldom does a lowly Member of Congress get to question a Governor of a State.

Mr. BURR. My only hope is I can touch you before you go.

Mr. GREEN. But do you think HCFA is on the road to drafting new regulations or addressing the concerns that the OIG has?

Mr. MORRIS. I think so. I think, as Ms. Thompson indicated, this hearing, our reports, the GAO reports, all add logs to that fire. I think certainly they intend to try to address this as best they can.

Mr. GREEN. Do you have any other suggestions that HCFA could do? Obviously, hopefully you communicate with each other more often than when we have these congressional hearings every 6 months.

Mr. MORRIS. One other suggestion we would offer, and it is in our written testimony, is, in addition to knowing who we are dealing with and cutting out the incentive to cheat through these incentive payments, is that there be efforts made to ensure that third-party billing companies are adequately trained and know what they are doing.

In my written testimony I reference an advertisement we came across in an airline magazine, where for \$69 you could get into the business of medical billing company services. It is quite remarkable, if I could read from it.

For a mere \$69 you can pick up a book called "How to Start a Medical Claims Processing Service" that promises that your prescription to a healthy income involves nothing more than owning a computer, a printer, a modem and claims processing software. The ad goes on: "There is no training needed; and with health care reform, the need for processors and the profits to be made will only increase."

We think that kind of inducement to bring people in who don't know what they are talking about to this line of work creates another vulnerability.

Mr. BURR. Would the gentleman yield for a second? I just want to take this opportunity to point out, I am sure this is not an ad that the association took out.

Mr. BURLEIGH. That is right.

Mr. BURR. I don't want there to be any link there. That ad just on its face suggests that you have to have some type of application or ID number or something that eliminates an ad like that from filtering anybody into this business it can.

One real specific question: In your proposals, your No. 1 was you have got to have an ID. I heard Ms. Thompson say we are not convinced that that is a necessity. I understand Mr. Burleigh's reluctance, because sometimes our actions to tighten an opening that is there becomes very onerous, and we are going to stay focused on that as we look for solutions to make sure it is not overburdening on stakeholders.

But there is a distinct difference. You are making a specific proposal with a great deal of confidence that this is one of the things we need to do. You are saying we don't know. I am hearing that you are talking to OIG. I don't think you didn't know that he would make this proposal. I think you have probably shared it with him.

Mr. MORRIS. We talk frequently.

Mr. BURR. Had you ever seen that ad?

Ms. THOMPSON. No, although it was very scary to me, because it was very reminiscent of some ads we used to see for home health

agencies about 15 years ago. We don't see them any more. But it is a very scary kind of ad.

Again, I want to clarify, we do believe conceptually that registering billing agents is something that we should do. The question is less what than how.

Appreciating all the kinds of issues that Mr. Burleigh brings to the table, as we have discussions about how would you react to that and would you be supportive of that kind of an approach—and the general answer again is, conceptually, yes, but now what information are we collecting? Some of this gets down to the details about how onerous is this going to be. How high is the bar going to be? Can you decline to register me? On what basis would you decline to register me and basically then sort of make me unable to do business with providers who are billing the program?

Mr. BURR. Clearly, based upon our reimbursements, if that were a home health ad today, we could bring them up on false advertising. They can't aspire to making a profit being in the business.

Mr. GREEN. I just have one last question.

Mr. Burleigh, you remarked in your testimony that your Association is concerned with, and in the last line of questioning, any initiative to register claim submitters would overlook large segments of the industry that regularly handle some parts of the claims preparation and submission process. Mr. Burleigh, how do you achieve accurate accountability over the entire Medicare payment chain without your having to register each and every participant involved in handling or submitting a Medicare claim? In other words, what is the best solution for tracking ancillary or third-party billers that play some role in preparing these Medicare claims?

Mr. BURLEIGH. The methodology has to be divided, first, between electronic claims and paper claims, because there continues to be claims that require attachments and other documents that have to be go on paper, and there are still insurers who will not accept claims electronically. So on the tracking electronic claims, our view is it would require there be an identification number or an identification mark of some kind that would be attached by each party that handled the claim, and that would require space for probably five or six possible additions to the claim before it got to the payer.

The physical aspects of that, the technological aspects of that—there is a very well-established data set, and the time required to reprogram the contractor's computers to receive the information, the vendor's computers to transmit the information, the practice to keep track of all of that information, would be very time-consuming, and we have to begin wondering to what benefit?

To go back to what Ms. Thompson said about the possibility that we have a false solution, we agree that identifying all the parties that have handled the claim will make the OIG's job easier, and we don't disagree with that. We support that as well. We believe in compliance. Our members are not concerned about having anyone know who they are. Most of the examples that have been discussed today describe a criminal enterprise and not ordinary business being done by billing companies.

So, you know, again, we have no problem with it. We do have concerns about how it would be done and whether it is technically feasible and whether it is economically practical.

Mr. BURR. If the gentleman would yield, let me say it is the hope of this committee that our policy won't be to make Special Agent Lack's job easier. It would be that we discourage people from committing the type of fraudulent claims that Mr. Lack goes out and investigates. I think you just misstated what you meant to—

Mr. BURLEIGH. Thank you for that suggestion. I think, too, that Mr. Lack will never be out of work, just because there are criminals in every walk of life, and some of them decide to come down in the medical billing arena or in health care in general.

Mr. BURR. There seems to be an attraction to that anywhere there is a large pot of money. Clearly, this is one of the largest that we can identify.

Mr. BURLEIGH. Let me just make a comment on an example that Mr. Morris gave related to the \$69 get-into-the-billing business. That ad and others like it, there is an example that \$695, another one at \$895, all of those represent essentially consumer fraud and not billing fraud. What is really going on there is the separation of the unaware from their money. No billing ever occurs.

The people who respond to those ads are buying basically an empty bag, because they get what they think is software that will allow them to be in the billing business, and they are misinformed as to the amount of money that they can get paid by practices to provide those services, and they never get any customers. So really what that describes is a consumer fraud. No one ever really ends up in the billing business as a result of those ads, as far as we know. We have had a number of people who after buying the package contact our association to join, and months later come back saying they can't find any customers. They were told how to do this, and it isn't working. It is because they really don't know.

Mr. BURR. Let me go back to you, Mr. Morris, because I think the Office of Inspector General has done some studies on providers that have identification now. You have looked at those that—you know who some of the third-party billers are now at HCFA. Have you looked at the data that they have got?

Mr. MORRIS. On electronic claims, there is a field for the submitter which could be one of potentially many third-party billers. I don't believe we have done any studies specifically analyzing what that submitter data field means.

Mr. BURR. I was hoping to get a feel for the accuracy of the information that they currently have or that exists about these people.

Mr. MORRIS. I don't believe we have done any work to determine what is on the electronic claim form, if it matches present reality, for example, whether the number on the electronic claim form for a submitter actually represents who is doing the submitting of the claim.

Mr. BURR. Let me go to you, Mr. Burleigh. Prior to my question to Ms. Thompson about privacy, did you know that HCFA considered your members covered under the new proposed privacy legislation exactly in the same way that the doctors are?

Mr. BURLEIGH. We interpreted the proposal differently. We prepared official comments to the proposal and submitted those. Our reading of it was that a billing company would be a business partner, although one of our criticisms of the regulations was that the proposal was left quite confusing as to whether we were a clearing-

house or a business partner or both or neither. So I think that the regulations require considerable effort to clarify that question.

We are quite aware of the confidential nature of the data we possess on a regular basis, and we regularly inform our members on what they have as a responsibility to protect the privacy of the data.

Mr. BURR. Ms. Thompson, who is responsible under the proposed privacy legislation to purge the physician worlds on any breach of medical data?

Ms. THOMPSON. Well, as a general rule, all electronic claims that we are dealing with and that are dealt with within the insurance world in general are going to be subject to the privacy rule protections.

Mr. BURR. If there is a breach by a physician of medical data, is it HCFA's responsibility—

Ms. THOMPSON. There are various penalties laid out, some of which we have responsibility for and some of which may be enforced by law enforcement.

Mr. BURR. That would be also the same penalty that would go to the third-party billers?

Ms. THOMPSON. Correct.

Mr. BURR. How do we enforce that if we don't know who they are? Mr. Burleigh said earlier we will never eliminate all the bad apples. I believe that. Medical data is, I think, an issue that all of us have taken on as a very big responsibility of the Congress for the American people. We have attacked this issue in a way that, though I haven't been in full agreement how we have done it, we have erred on the side of protection, in some cases when some of us thought it limited our capabilities for research and development of future drugs, devices and other things. But with that said, can we take it that seriously and have an entity out there that has full access of medical data that we are not concerned with knowing who it is?

Ms. THOMPSON. One comment that I would make about that is that, in any kind of surveillance or enforcement mechanism, there are going to be various layers of detail and attention. One of the issues that we always face, of course, in program safeguard activity, is figuring out where to place those resources and knowing we are not going to be able, for example, to look underneath every claim that we process to assess the medical record and the necessity of the service and whether the service is coded correctly based on what we see in the medical record, or even then to go below the medical record to say to the beneficiary or to the provider, was this service actually rendered? Was it rendered in the way described in the record?

So the question is always one of balancing how much information do we want to collect and receive and deal with at the Federal level, what do we want to enforce as an ongoing, every-case kind of basis, what do we want to pursue on an exception basis, and what should that entire surveillance network look like.

I think that is one of the issues that we have to face with the Privacy Act issues or the privacy rule issues, as well as many of the other sets of rules that we establish.

Mr. BURR. I remember in the privacy debate—and correct me if I am wrong, because I think you are closer to it than we were. At a point of that debate we discussed whether we should limit what insurance companies got about procedures performed because we were concerned about what could happen to that patient. And we got to the point where we were talking about could it just be one lump sum. And the question that arose is, how can an insurance company pay based upon not knowing what was performed?

So I know how tightly we were in this debate and in the negotiations. This seems to be an area that we have just disregarded any concern about privacy and just said, well, they are covered. I mean, it is an automatic link.

Whether Mr. Burleigh knew it or whether every member of the Association knows it or whether the 5,000 individuals out there know it, I think there is a question and probably an honest effort to make sure that they do. But then we go back around the circle and say, if HCFA is responsible for the integrity and Congress ultimately, I believe, because we go back to our constituents and say you don't have to worry, we have got things in place, can I confidently with 5,000 individuals, or potentially 5,000 individuals, can I go home and tell them that all of the information they are using to bill these Medicare claims, that none of that medical data gets out?

Mr. THOMPSON. One of the issues that we are addressing in developing the proposed regulation actually goes back to HIPAA, which established certain requirements for administrative simplification of electronic claim submission standards, some of which have to do particularly with security, with things like the protection of data at rest, the protection of data in motion, the encryption of data, the possibility for digital signatures to authenticate who actually created or prepared the claim. So some of those issues are being addressed as well through that venue.

Mr. BURR. Let me go back to you, Mr. Morris, because I was trying to work off my memory, which on a Thursday when we are getting ready to adjourn—as you can tell, I am in travel clothes. Nothing matches. I am just trying to reallocate these to the right spot, whether it is North Carolina or Washington. In the OIG report it said this: Studies have shown that information on provider applications concerning billing agencies is often outdated and inaccurate. Can you expand on that at all?

Mr. MORRIS. You are referring to the reports we issued earlier this week?

Mr. BURR. Yes.

Mr. MORRIS. Well, this is a concern that we have that I think Ms. Thompson touched on. If it is the self-reporting obligation with no sanctions associated with failure to keep the information current, you don't know that the data that you have, the data base you developed, has any value to you, because it may be so outdated that you are dealing with companies that no longer exist.

We have come across this in other contexts as well. Ofttimes we will go out to the provider address which payments have been made for and discover it is now a pizza parlor, because we have not, nor has the Health Care Financing Administration nor its con-

tractors, been given updated data about who it is we are dealing with.

So the vulnerability we have—and I think this is what Ms. Thompson was getting at. If we put this data field together, if we compel billing companies to provide us with their identification, how are we going to make sure that it is accurate, updated and reflects all the players? Because it is very easy to put a number in a field. The computers are set up generally to say look for a number in this field. If it is there, move on.

Mr. Lack gave a good demonstration of it in the Handle With Care case. If you put the right procedure code number into the computer, it will say, “Oh, surgical dressing, surgery, fine, I will pay.” The computer doesn’t then ask questions like, “What is a patient in a nursing home doing with surgery?” Unless we have the computers ask, do we know that this biller number is accurate, and when was the last time it was updated, and has someone gone out actually onsite and knocked on a door, that information sits there, but it has no value. So that is the risk you face.

Mr. BURR. We update physician information how often?

Ms. THOMPSON. Our proposed regulation will address that. It is supposed to be updated with any material changes within 30 days. The difficulty, of course, is that, as Mr. Morris and Ms. Aronovitz have talked about, if we find that the information is not updated, what is our response? Sometimes what a physician might say is, well, I just forgot to update the information. It was an oversight on my part. Here is the updated information.

Mr. BURR. Don’t physicians who participate in Medicare as well get an annual notification?

Ms. THOMPSON. No. But that is one of the issues that we are addressing in our proposed rule. How frequently should we go back, even if we haven’t heard—No. 1, a provider, a supplier physician should be updating their information on an ongoing basis. But how often should we ourselves go back and ask them to recertify to what we have currently in our data base? Physician groups basically don’t think that we need to go back to them very frequently. They believe that physicians will update it and fulfill their responsibilities as required.

There may be some higher risk versus lower risk kinds of groups where we want to go back to some folks more frequently than other folks. Maybe you could postulate, for example, that a hospital, a large hospital, would be more apt to keep their information updated, or perhaps even have fewer changes, than some other kinds of providers or suppliers or physicians. But we do believe that we have to have a sort of reasonable process to go back to people where we haven’t heard from them over some period of time and make sure—

Mr. BURR. We might go back to physicians more frequently that use third-party billing as a way to reimburse.

Ms. THOMPSON. Yes.

Mr. BURR. But we wouldn’t know which ones use third-party billing today, would we?

Ms. THOMPSON. In our enrollment form that we instituted in 1996, it contained a space for completing information on third-party billers. When we go back and do our enrollment clean-up

process, we will be getting that information from everyone. I think that is an excellent idea.

One of the things we are looking at is, what are some of the risk triggers or categories that would make us want to go back more frequently to certain providers than others, knowing that we don't necessarily want to go back to 1 million different providers every 6 months or every year to ask them to update their information. Maybe the presence of a third-party biller is sort of an additional risk factor that could trigger more frequent requests for updated certifications.

Mr. BURR. I don't want to put words in your mouth, but did you just tell me you are interested in knowing who the third-party billers are?

Ms. THOMPSON. Yes. We are collecting that information now and collecting that going forward. That is a different question than whether or not you want to register or set standards for third-party billers.

Mr. BURR. Our debate is over how we want to know who they are.

Ms. THOMPSON. Right. And how much information we should collect to know who they are. Right now, we collect information on a company name and address and contact name. We don't collect as we do on providers' and owners', Social Security numbers.

Mr. BURR. You have that on how many third-party billers?

Ms. THOMPSON. We have that on all providers that have come into our system since the institution of the new form, which is since 1996. That is about 15 percent of the providers that we do business with now.

Mr. BURR. That is how many?

Ms. THOMPSON. 150,000.

Ms. ARONOVITZ. 150,000.

Mr. MORRIS. The only drawback or challenge to that approach is all you have to do is put down the name of a third-party billing company. You can create a name of a third-party billing company as quickly as getting lunch. Handle With Care could be Handle with Diligence overnight. All of a sudden we have two different billing companies. Well, no, we don't. We have one billing company with two names.

So, one of the things that it speaks to having a unique identifier, similar to physicians, is to say if you are going to be in business, you are going to have, like an employment identification number, a single number that identifies you, regardless of what you call yourself, so we can then match data based on a common element. Whereas, if you are free to put down whatever the company chooses to call itself this week, you have got a data field completed, but it tells you nothing about the commonality of that named party to others that, in this case, scam artists have set up.

The Handle With Care case demonstrates that once the two scam artists parted ways, two sisters in this case, they set up two different companies with two different names. Neither of those names presumably would have had any linkage to the first company name. So having a field that gives you just a name isn't requesting to help you try to figure out where there is commonality in the third-party billing companies.

Mr. BURR. Does the fact that they are registered, with no degree of confidence as to who they are, bring credibility in any way to their operation?

Mr. MORRIS. The mere fact of registering?

Mr. BURR. Yes.

Mr. MORRIS. I guess you would have to ask what are you registering.

Mr. BURR. What are they registering?

Mr. MORRIS. Well, that is the question. Right now, I think the answer is nothing. For the third-party billing company, nothing is registered. So the provider, the physician, will say, "When I filled out this form, the name of the company that I did my third-party billing through was X. I made no representations about who it is, what they do, what their skill levels are, or who their head is and whether he or she——"

Mr. BURR. So from a standpoint of an investigative agency, what is that worth to you?

Mr. MORRIS. If you are focusing on intent to defraud, not much.

Mr. BURR. Let me go back to Special Agent Lack. I don't want to take anything away from your investigative skills——

Mr. LACK. Sure.

Mr. BURR. [continuing] but the connection that was made between these two companies, as I understand it, was the result of more than one agent getting together, agents working on different cases——

Mr. LACK. Right.

Mr. BURR. [continuing] and through the exchange of what each was doing, a light bulb went off and said this is all connected.

Mr. LACK. Correct. It was the name of one of the sisters. When we had this conference call, I threw out the name, and the others said, "That is the owner of mine. That is the owner of mine. That is the owner of mine." That is what tied it together as a national problem.

Mr. MORRIS. Coincidence.

Mr. BURR. I didn't want to use that.

Mr. LACK. I got the case as an individual case. As a matter of fact, when the nursing home in question found out about it, they went to their legal counsel; and their legal counsel said, "You've got to be careful, because they might hold you responsible. Send a check for the overpayment." This nursing home, to their credit, agreed with that and called us up. I got there, and, sure enough, those claims were false. They said, this company told us they are out at a lot of different places. We don't know how many.

If I had been able to go to a data base and pull up that number, I would have found Massachusetts, Florida, Ohio, and we could have immediately pulled it altogether. But it wasn't until 2 years later that we knew the full extent. We knew when we had that conference call we had maybe four or five nursing homes. We didn't realize the extent was 70 nursing homes, and this all occurred in the space of 10 months. She went from No. 1 to number 70 in 10 months.

Mr. BURR. Ms. Thompson, whose responsibility was it to have caught this?

Ms. THOMPSON. I think there is some shared responsibilities. I mean, I think the program itself has significant responsibility in analyzing the claims that it receives to make sure they are—there is no doubt we consider that to be our responsibility and our job.

I think the nursing homes have responsibility for knowing what has been submitted on their behalf. I think that they had some responsibility for perhaps not being as tempted as perhaps they were for the idea that there was some easy money that was going to require no outlays on their part and that magically some money would show up and it would be good money they were entitled to and they decided to take that money and not ask any questions. So I think there is also some responsibility on the nursing home.

Of course, ultimately, the actual, ultimate accountability lies with the people themselves who decide the way to make some money and be successful in life is to defraud the program.

Mr. BURR. Let me be more specific in how I can ask the question. Where should we have detected it, if it isn't in Special Agent Lack's investigation?

Ms. THOMPSON. I think that we probably should have detected it if we had had some more information on the commonality amongst the claims themselves.

One of the best ways that we use to detect potential fraud or payment errors is by aggregating claims and making comparison among different kinds of sets of claims. For example, if you can look at various kinds of physician specialists, for example, and you can see that in a certain community every physician specialist has a kind of bell curve in their billings, some high coded, some lower—

Mr. BURR. Does that happen at the Medicare carrier level or at HCFA?

Ms. THOMPSON. It happens at the contractor level. But it is under our direction, and we tell them the kinds of things that we want them to do, and we give them the resources.

Mr. BURR. Are there contractors sitting in on these discussions as to how we close this hole?

Ms. THOMPSON. Yes. We discuss with our contractors on an ongoing basis issues of importance to us and how to address potential program vulnerabilities.

Mr. BURR. Let me just stipulate, there is a huge difference between a discussion and an inclusion. If you see the Medicare carrier as the point that we should be catching, detecting, some improprieties, then they should play a substantive role in the design of what it is we are trying to institute to close that. Are they playing such a role?

Ms. THOMPSON. I would characterize it, yes, as a substantive role. We do look to them to help us understand what it is they are seeing as they conduct these activities. But we are also aware that we are the ones that have the responsibility and the contractors have the responsibility to implement our instructions. So, ultimately, we have to be the decisionmakers about where we want to place resources and what expectations we want to place on what we want our contractors to do. We can't, again, delegate that responsibility to the contractors and say, well, this contractor did a

good job, this contractor did a bad job, and it is all the contractors. We have to take that responsibility ourselves.

Mr. BURR. I don't think the intent of this oversight hearing was to reach conclusions today. I think it was clearly to make sure that we provided the correct amount of stimulus so that we could reach some type of conclusion.

Mr. Hast, I want to apologize to you, because we have neglected you at that end of the table. Let me also make the assurance that from a standpoint of an oversight investigative committee, that is a good thing.

I want to take this opportunity to thank each of you for your willingness and openness to discuss this particular issue. The lack of involvement by all of the members of the subcommittee is not a lack of interest in the challenge that we have got before us in finding a solution to this, it is more indicative of its schedule today and the fact that they are probably also trying to book some flights for tonight since we weren't expected to leave.

Let me extend to anybody that would like to, if there is any follow-up comments that you would like to make, anybody that would like to make additional comments? Mr. Burleigh?

Mr. BURLEIGH. Well, once again, we very much appreciate becoming part of this hearing and having the opportunity to contribute to this process. The vast majority—we think 99 percent of, at least, the members of our Association and more billers who may not yet be members are honest and improve the system, and we want to make sure that any changes that are made continue to contribute to strengthening the system and provide a practical solution to these very appropriate concerns that the committee is investigating.

Mr. BURR. As do we. Any other members?

Let me once again thank you and say to you, Mr. Morris, with your comment relative to the incentive that we create on a percentage billing, it has made me also think about my choice of tax preparers and wondering, had somebody been out there and said, you know, I will set your cost based upon how much I save you over last year, I wonder what my reaction would be. Clearly, it would get my attention. Whether it would get a business relation between the two of us, probably as a Member of Congress, it wouldn't. As a member of the private sector, it probably would have an influence on who I chose. I might on the back end be a little more prudent at my review of what they came up with, which I think is something that Mr. Bryant expressed about your members and consequently the physicians that contract with them.

But, clearly, there are some ways that we can set it up or that could be allowed to be set up that create incentives for people to cheat. Health care is the largest challenge that we will deal with for the next decade, and the primary piece of that will be how we pay for it. The work that each one of you has before you will play a very important role in how long or whether in the future we can continue to afford what it is we have in this country. I thank you for your commitment.

This hearing is now adjourned.

[Whereupon, at 12:15 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON COMMERCE
March 14, 2000

Ms. PENNY THOMPSON
Director
Program Integrity Group
Health Care Financing Administration
7500 Security Blvd.
Baltimore, MD 21244

DEAR MS. THOMPSON: I am writing to ascertain what actions the Health Care Financing Administration (HCFA) has taken to respond to the problems associated with third party billing companies, which were identified in a June 2, 1999 General Accounting Office (GAO) letter. The Committee on Commerce is very concerned about possible misconduct by third party billing companies, which may result in the loss of millions of Medicare program dollars due to undetected fraud and abuse. As part of the Committee's ongoing efforts to assess the efforts of HCFA to combat fraud and abuse within the Medicare program, I wish to learn what specific steps have been taken to insure that scarce Medicare dollars are not being wasted due to fraud committed by third party billing companies.

As you know, acts of fraud committed by third party billing companies are an insidious form of health care fraud which is, by many accounts, particularly difficult to detect. It has been estimated that there are currently over five thousand third party billing companies currently operating in the United States, which prepare and submit claims on behalf of health care providers to Medicare, Medicaid and other health insurers. In doing so, they provide a valuable service to many doctors and other health care providers, by freeing them from the sometimes onerous administrative requirements of submitting claims for the health care services they provide. However as third party billing companies often have wide access to the billing information of multiple health care providers and many of the patients they treat, unscrupulous individuals operating such companies are uniquely situated to be able to submit fraudulent medical claims.

Given the threat that such activities could pose, the Committee was particularly disturbed to learn of GAO's findings regarding this issue. The GAO determined that HCFA and its Medicare contractors are unable to determine, when Medicare claims are submitted in a paper format, whether the claim was prepared by a third party billing company. In addition, where claims are submitted electronically, Medicare contractors are still not always able to identify claims submitted by third party billing companies. For the overwhelming majority of providers, HCFA has not sought information about whether they utilize third party billing companies to prepare and submit their claims, nor has HCFA made any effort to gather information about the third party billing companies themselves.

Such a lack of basic safeguards provides an open invitation for fraud. Further, according to the GAO, HCFA has taken only limited steps to address this problem. Since 1996, HCFA's new provider enrollment form has required these new providers to identify which third party billing company, if any, that they will use to prepare their claims. This change has no impact, however, on the 96% of all Medicare providers who enrolled in the program prior to 1996. In addition to modifying the enrollment form, HCFA is also developing a new automated database system, to provide Medicare contractors with provider enrollment data. It has been reported that this data will include the identity of any reported third party billing company used by that provider. This database, the Provider Enrollment Chain and Ownership System (PECOS), will depend upon the information submitted by providers, who often fail to report when they change billing services.

These changes, while individually possessing some merit, fail to address the systemic problems associated with third party billing company fraud. It is imperative that HCFA and its contractors be able to immediately identify all claims submitted by a third party billing company, whether such claims are submitted electronically or in paper format. Additionally, HCFAs should at least obtain basic background information on all persons who are submitting Medicare claims. Failure to do so needlessly exposes the Medicare program to additional risks of fraud and abuse.

In order for the Committee to better assess HCFA's response to this emerging problem, we request pursuant to Rules X and XI of the U.S. House of Representatives, that you provide the following information no later than March 30, 2000.

1. Please identify what actions have been taken to date to enable HCFA and its contractors to identify all paper claims prepared and submitted by third party billing companies. In your answer, please also separately identify all actions that

- HCFA prospectively plans to take relating to this issue, including the specific type of action planned and when such action will occur.
2. Please identify what actions have been taken to date to enable HCFA and its contractors to identify all electronic claims prepared and submitted by third party billing companies. In your answer, please also separately identify all actions that HCFA prospectively plans to take relating to this issue, including the specific type of action planned and when such action will occur.
 3. Please identify what actions have been taken to date to gather basic background information relating to third party billing companies. In your answer, please also separately identify all actions that HCFA prospectively plans to take relating to this issue, including the specific type of action planned and when such action will occur.
 4. Please analyze all actions taken to date by HCFA and its contractors relating to third party billing companies and provide to the Committee your assessment of whether these actions have sufficiently addressed the concerns raised in the June 2, 1999 GAO letter and thereby minimized the risk of third party billing company fraud.
 5. Please identify when the regulation requiring all Medicare providers to complete a new enrollment form, which will identify any third party billing companies they utilize, will be completed.
 6. Please specifically identify when the PECOS system will be made available to Medicare fiscal intermediaries and carriers.
 7. Please provide to the Committee your assessment of whether these additional actions, along with any others HCFA may be planning, sufficiently address the concerns raised in the July 2, 1999 GAO letter and thereby minimize the risk of third party billing company fraud.

If you should have any questions relating to this request, please contact Charles M. Clapton, Committee Counsel at 226-2424. We appreciate your cooperation in this matter.

Sincerely,

TOM BLILEY
Chairman

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
March 30, 2000

The Honorable TOM BLILEY
Chairman
Committee on Commerce
U.S. House of Representatives
Washington, DC 20515-6115

DEAR CHAIRMAN BLILEY: Thank you for your letter of March 14, 2000, asking about our activities with respect to third party billing companies and issues raised by the U.S. General Accounting Office in a June 2, 1999 letter on this subject. We appreciate your interest in this important subject and for giving us the opportunity to express our views.

Third party billing companies who operate ethically can provide a great service to providers, suppliers and physicians who seek out their expertise and help in submitting claims that are consistent with Medicare laws and regulations. However, unethical third party billing practices pose a significant threat to Medicare's program integrity. Our efforts to review third party billing arrangements have led to an increase in the number of third party billing contracts that are in compliance with existing laws and regulations. Though our ability to monitor third party billing practices is now limited, we are working to strengthen the available safeguards to better protect the Medicare Trust Fund from waste, fraud and abuse. We intend to ask for public comments on how to strengthen our oversight of third party billing entities in the proposed provider enrollment regulation that we anticipate issuing this spring. And we look forward to working further with you, as well as our colleagues at the General Accounting Office and HHS Inspector General to address this important issue.

Our efforts involving third party billing practices represent one part of our overall strategy to protect the integrity of Medicare today and for the future. We continue to work to ensure that providers are paid appropriately while we protect beneficiaries and taxpayers from improper payments caused by both honest errors and unscrupulous activity. Our efforts to date have shown real results. As you know, Medicare has reduced its improper payment rate sharply from 14 percent four years

ago to less than 8 percent last year, and we are committed to achieving further reductions in the future.

General Background

As you know, we consider our provider enrollment function central to our program integrity activities. In fact, we focused on provider integrity and enrollment functions in our comprehensive plan for program integrity, which we released last year. Since then, we have accomplished a number of important tasks which have strengthened the Medicare program by ensuring that only qualified entities enter the program and have billing privileges. For example, we have implemented:

- *New standards for testing facilities.* Because of evidence of widespread problems in enrolling qualified entities to perform physiological testing, we implemented new standards for supervisory physicians, technicians and equipment. We required all entities previously enrolled as independent physiological laboratories (IPLs) to reenroll in the program and establish their qualifications to meet the new, enhanced standards as independent diagnostic testing facilities. We verified their status through site visits. Hundreds of IPLs did not even submit new applications or failed their assessments, and are now off our rolls. As a result, we now have much better assurance that the entities doing business with us are legitimate, qualified health care suppliers.
- *New scrutiny of Community Mental Health Centers.* Likewise, we have stepped up our scrutiny of CMHC applicants as part of our 10-point plan for addressing vulnerabilities in this area. We now conduct site visits to all new applicants to verify the representations made in their applications and ensure that they are qualified to enter the program. We have also moved to terminate noncompliant providers, beginning with the most egregious providers, and have clarified to our regional offices and to state survey agencies the statutory and regulatory requirements applicable for participation in the Medicare program.
- *Continued vigilance over durable medical equipment supplies.* We have continued to fund the work of the National Supplier Clearinghouse, which conducts site visits for suppliers. In fiscal year 1999, the NSC completed over 22,000 site visits on new and reenrolling suppliers, resulting in 227 denials of initial applications and 2,848 revocations of existing numbers.
- *Work on new regulations and national database.* We plan to issue this spring a proposed rule on provider enrollment, and are currently developing a national database including extensive information on providers as they enroll in our program. Once the proposed rule is finalized, we will begin an "enrollment clean up" process. As part of this process, we will go back to providers, suppliers and physicians now billing the program and require them to confirm and update their information, including information on third party billing companies they use. Providers and suppliers will be required to periodically update this information, and inform us of any changes to their billing agreements. Information collected will be entered in our new enrollment system, known as the Provider Enrollment, Chain and Ownership System (PECOS). PECOS is integral to our enrollment approach, because it will be a central source of provider/supplier enrollment information. In addition, to chain ownership and related organization information, it will include information on providers' billing arrangements and any reassignment of benefits. The chain organization/related organization information is essential, because it allows contractors to identify when a provider or supplier is part of a larger organization, and to view the entire line of business. PECOS will also allow a local contractor to view national data about an individual or entity rather than simply the data that appears on a local provider file. PECOS will also identify provider/suppliers who have been denied privileges, or subject to revocations or exclusions.

Third Party Billing Companies

Your letter specifically asks about third party billing companies, our efforts to identify them as claims are submitted or as providers are enrolled, and the risks and vulnerabilities we see.

Health care providers look to billing companies to assist them in processing claims in accordance with applicable statutes and regulations, and many claims received by Medicare, Medicaid and private insurance companies involve such companies.

Third party billing companies can take on many different forms, structures, operations, functions and relationships with providers. Billing companies vary significantly in both the size and reach of their organizations and functions, from small "mom and pop" organizations who only facilitate the electronic submission of claims to large business organizations providing coding, claims submission and consulting services. They can be employed by providers, suppliers and physicians to manage

the “business end” of the practice or simply to format claims for submission to insurance companies. As the U.S. Department of Health and Human Services Office of Inspector General noted,

At this juncture, it is important to note the tremendous variation among billing companies in terms of the types of services and the manner in which these services are provided to their respective clients. For example, some billing companies code the bills for their provider clients, while others only process bills that have already been coded by the provider. Some billing companies offer a spectrum of management services, including accounts receivable management and bad debt collections, while others offer only one or none of these services. (HHS OIG, “Compliance Program Guidance for Third-Party Medical Billing Companies.”)

Medicare contractors review billing agreements when Medicare payments are made to a billing agent rather than a provider. However, when billing companies assist in preparing bills or coding, but do not actually receive payment, as a general rule, they are not regulated.

Yet, it is absolutely true that the Medicare program can be inordinately harmed by the poor business practices or unethical or even illegal behavior of such companies, even though the program does not have a direct business relationship with those entities or regulate them in any fashion. If a billing company engages in behavior that gives rise to false claims, however, they can be held accountable under the False Claims Act.

For example, On September 27, 1999, the United States, through the Department of Justice, HHS, TRICARE, and OPM, as well as 28 individual states, entered into a Settlement Agreement with Medical Consultants, Inc., d/b/a Emergency Physicians Billing Service (“EPBS”) and J.D. McKean, Jr., M.D. (“McKean”). EPBS provided billing and coding services to emergency physician practice groups and was owned and operated by McKean.

Emergency Physicians Billing Service (“EPBS”) and its owner, Jack McKean, were the subjects of a qui tam lawsuit. The lawsuit alleged that the parties engaged in deceptive practices resulting in significant Medicare, Medicaid, and CHAMPUS overpayments. The allegations of fraud have now been confirmed by a Federal Judge in Oklahoma City, Oklahoma. On August 10, 1998, EPBS and Mr. McKean were found liable for the submission of false claims to various federal and state health insurance programs.

EPBS and McKean were found liable for upcoding emergency room services, reassignment violations, and misrepresentations on Medicare enrollment applications. EPBS promised its clients it would increase their reimbursements by a range of 10-25 percent and was able to deliver on this promise by upcoding emergency services to higher complexity levels than were provided. Nearly all of EPBS’ clients saw increased billings in the range of 10-25 percent as a result of EPBS’ services.

As part of the settlement McKean and EPBS have agreed to pay \$15.5 million to resolve their civil and administrative liabilities arising out of the allegations in the qui tam lawsuit. In addition, McKean is being excluded for 15 years from participation in the Federal health care programs, and EPBS has entered into a comprehensive Corporate Integrity Agreement with the OIG. In addition to the settlement with EPBS and McKean, the United States is currently negotiating additional settlements with approximately 25 emergency physician groups which were clients of EPBS.

This case was developed by the FBI and HHS OIG, with assistance provided by various Medicare contractors. HCFA and staff from five Medicare contractors participated in the EPBS investigation, performing data analysis directed at detecting the improper billing, suspending Medicare payment and the calculation of the losses (overpayment) to the Trust Fund. One such contractor employee received a commendation for their exemplary performance during the investigation from the Department of Justice’s Assistant U.S. Attorney responsible for the case.

This case served as a national example for improper billing perpetrated by third party billers and was presented at the Department of Justice’s quarterly Health Care Fraud Working Group meeting in February 2000. This working group consists of federal staff from law enforcement agencies, U.S. Attorney’s offices, HCFA, Medicaid State law enforcement offices, and Medicare contractors’ anti-fraud units.

As this case demonstrates, unethical third party billing companies can cause significant damage to the Medicare program.

At the same time, there are challenges and costs involved in stricter oversight of third party billing companies. In addition to the simple resource costs of collecting additional information on companies, changing electronic claims submission standards, setting and enforcing regulatory standards, overseeing private contracts, and

other possible risk mitigation strategies, there may be unintended consequences and marketplace responses that should be carefully assessed and considered.

You asked us to identify actions taken or planned to enable HCFA to identify all paper claims and electronic claims submitted by third party billers.

Ninety-seven percent of claims submitted to intermediaries are submitted electronically and 81% of claims submitted to carriers are submitted electronically.

For electronic claims, we can differentiate whether the claim was sent by a third party agent or directly by a provider. Each of the electronic claims formats we support for Medicare (UB-92 flat file for institutional claims, National Standard format for professional claims, and the X12.837 format for professional and institutional claims) have fields that separately identify the submitter and the provider of the care being billed. A comparison of these fields would clearly indicate when the submitter was other than the provider.

However, this identifying information goes to the submitter only, and may not contain a "history" of all entities who may have contributed to the claims data or information. For example, if a third party billing company coded the claim and sent it to a clearinghouse which formatted the claim for electronic submission to the Medicare program, only the clearinghouse information might be obtainable from the claim.

Paper claims include an item for "source" or "preparer" information.

We believe the new provider enrollment regulations, the enrollment clean-up initiative, and our PECOS database will gather information on third-party billing companies, identify such companies for contractors, and provide significant protections for beneficiaries and taxpayers.

You asked us to identify actions taken to date and those planned to gather basic background information relating to third party billing companies, and to analyze all actions taken to date by HCFA and its contractors relating to third party billing companies. You further asked whether those actions, taken and planned, have addressed the issues raised by the GAO's June 2, 1999 letter and minimized the risk of third party billing company fraud.

Presently the HCFA provider enrollment process collects some information about third party billers for new fee for service providers. The current form collects the name of the billing agency/management service organization, the employer identification number, a contact name, the business street address, telephone and fax numbers. Contractors review billing agent agreements when they involve agents who negotiate checks payable to the provider, supplier or physician.

Current law prescribes who may be paid by the Medicare program for services provided to Medicare beneficiaries, generally stipulating that payment must be made to the individual performing such services, or their employer, facility, or plan. However, the statute also provides for payment to be made to agents under assignment "if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for services for or in connection with the billing or collection of payments due...is unrelated (directly or indirectly) to the amount of such payments or the billings..." (42 U.S.C. 1395g.) Under regulations we established at 42 CFR 424.73 implementing the statute, payments to an agent who furnishes billing and collection services to a provider may be made if:

- the agent receives the payment under an agreement;
- the agent's compensation is not related in any way to the dollar amounts billed or collected;
- the agent's compensation is not dependent on the actual collection of payment;
- the agent acts under payment disposition instructions that the provider may modify or revoke at any time; and
- the agent, in receiving the payment, acts only on behalf of the provider.

Our instructions to Medicare contractors reiterate these requirements, explaining that "the primary purpose...is to permit computer and other billing services to claim and receive Medicare payment in the name of a physician (or other supplier or eligible party). The conditions for payment are designed to ensure that the billing agent has no financial interest in how much is billed or collected and is not acting on behalf of someone who has such an interest, other than the physician himself/herself." (Medicare Carriers Manual 3060.10.)

Medicare contractors' review of billing agreements has led to an increasing number of such agreements coming into compliance with the statute and regulations. As the health care and billing community has become more aware of these requirements and our enforcement of them, we see more contracts expressly containing language supporting our requirements. However, thorough assurance of compliance with these requirements is hampered by:

- the resource intensive process for review of sometimes lengthy and complicated legal documents;

- the capacity of Medicare contractors to accurately and fully understand such documents;
- the variability in the nature and scope of agreements, depending on the size of the third party billing company and the services they perform;
- the complicated corporate structure reflected in such agreements, where it is not unusual to find a number of subcontractors involved in various functions;
- lack of sanctions or intermediate penalties for failure to update the Medicare program when such agreements change or arrangements are altered;
- the limited number of providers, suppliers, or physicians who have been required to submit such information (only those who have newly enrolled in the program since implementation of the new national enrollment form in 1996).

Furthermore, until implementation of our enrollment “clean-up” process, a major undertaking, and the availability of PECOS to all contractors, consistent information on third party billers will not be available for easy search and retrieval. Even then, significant limitations remain (in addition to the first five points identified above, which are not solved by PECOS or enrollment clean up), such as our limited ability to identify common ownership or to “link” agencies which might operate in different jurisdictions, the absence of regulation of such entities to ensure adherence to professional standards, or our lack of information on third party billers who do not negotiate checks or submit claims directly to the program. These information or programmatic gaps are not easily solved. We continue to consider to what extent direct Federal regulatory action should be taken to address these issues.

In our proposed rule to be issued this spring, we will be soliciting comments on the question of whether we should register third party billing agents, and/or set standards for them. Such an approach could significantly strengthen our protection of the Medicare program and address some of the problems cited above. However, there are also significant challenges and costs to be carefully weighed and considered. We discuss these in more detail in response to your last question.

We continue to train Medicare contractor fraud units in identification and analysis of third party billing company fraud. Medicare contractors have also received specific training to combat this problem. During fiscal year 1999, HCFA sponsored Benefit Integrity Training Conferences at which contractor staff were provided with detailed explanations on appropriate billing arrangements and examples of inappropriate arrangements. HCFA is also planning additional contractor training during this year’s training sessions. This year’s training session will focus on the improper billing perpetrated by Emergency Physicians Billing Service and J.D. McKean Jr., M.D.

You asked when regulations requiring all Medicare providers to complete a new enrollment form will be completed. We expect to publish a proposed rule this spring.

You asked when the PECOS system will be made available to Medicare fiscal intermediaries and carriers. Our current schedule calls for PECOS to be running for fiscal intermediaries this summer, with carriers following in January 2002.

You asked us to provide an assessment of whether our actions, taken and planned as a whole, will address the GAO’s concerns and minimize the risk of third party billing company fraud.

While we believe that our “enrollment clean up” and PECOS implementation will address a number of vulnerabilities, we believe that additional threats may remain. We continue to consider how to best to respond to risks posed by third party billing companies while not impeding the activities of ethical companies, in light of the substantial assistance they can provide to providers in submitting proper claims. Among the questions we are considering are:

- Should HCFA register billing companies, and/or set standards for them? As noted above, we plan to pose this question in our proposed rule this spring.
- Would HCFA need additional legislative authority to do so?
- Should such standards apply only to entities who actually submit claims on behalf of providers?
- Should such standards apply only to entities who actually submit claims and receive negotiated checks on behalf of providers?
- Should such standards apply to all entities who might advise, consult, prepare, support, staff, or otherwise influence the selection of codes and claims to be submitted to the Medicare program?
- How should such standards reflect the diversity in capability, organization, mission, functions, and relationships in the industry?
- How would HCFA enforce such standards?
- What staffing and skill set needs would HCFA require in order to ensure billing companies met standards and agreements were properly executed?
- How should claims properly reflect the preparer’s identifying information? What if there are multiple preparers or submitters?

- To what extent would providers, suppliers, and physicians support HCFA regulation of their business contracts and partners?
- To what extent is surveillance and assessment of billing patterns a better approach to ensure compliance than registration or standard setting?
- What information would be needed to accurately group claims handled by a common third party billing company?
- If Medicare were to regulate business arrangements with third party billing companies, what impact would such regulation have on the private sector and the arrangements between providers and third party billers in submitting claims to private insurance companies? Overall, would those effects be positive or negative?

We look forward to working closely with your Committee and the Congress as we consider this important topic. We hope the information and analysis we have supplied is useful. Please feel free to contact me should you have any questions or wish to discuss our responses further.

Sincerely,

PENNY THOMPSON
Director, Program Integrity Group

cc: The Honorable John D. Dingell