GAO

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

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

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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. 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 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,

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

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.

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

[3]Although 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.

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

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

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.

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
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