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Report to Congressional Requesters

January 2016

HEALTH CARE FRAUD

Information on Most Common Schemes and the Likely Effect of Smart Cards

GAO-16-216

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GAO Highlights

Highlights of GAO-16-216, a report to congressional requesters

Why GAO Did This Study

While there have been convictions for multimillion dollar schemes that defrauded federal health care programs, there are no reliable estimates of the magnitude of fraud within these programs or across the health care industry. In some fraud cases, individuals have billed federal health care programs or private health insurance by using a beneficiary's or provider's identification information without the beneficiary's or provider's knowledge. One idea to reduce the ability of individuals to commit this type of fraud is to use electronically readable card technology, such as smart cards. Proponents say that these cards could reduce fraud by verifying that the beneficiary and the provider were present at the point of care.

GAO was asked to identify and categorize schemes found in health care fraud cases. This report describes (1) health care fraud schemes and their prevalence among cases resolved in 2010 and (2) the extent to which health care fraud schemes could have been affected by the use of smart card technology. GAO reviewed reports on health care fraud and smart card technology and reviewed court documents for 739 fraud cases resolved in 2010 obtained for a related 2012 GAO report on health care fraud. GAO is not making any recommendations.

The Department of Health and Human Services and the Department of Justice provided technical comments on a draft of this report, which GAO incorporated as appropriate.

View GAO-16-216. For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov.

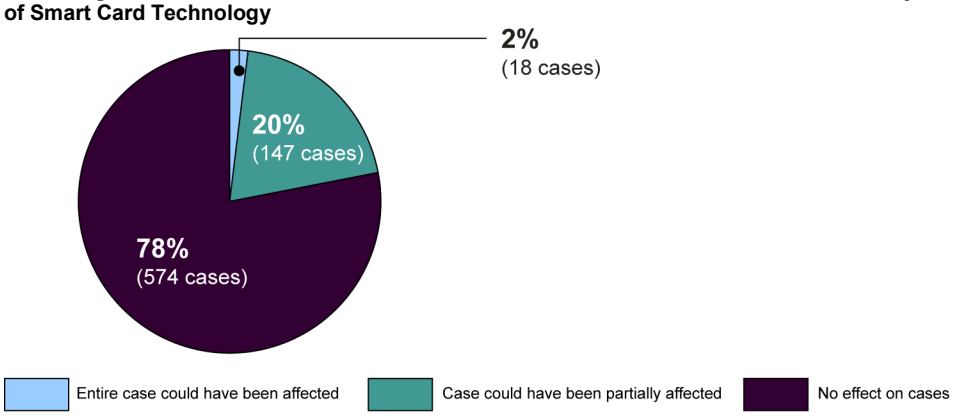
What GAO Found

GAO's review of 739 health care fraud cases that were resolved in 2010 showed the following:

- About 68 percent of the cases included more than one scheme with 61 percent including two to four schemes and 7 percent including five or more schemes.
- The most common health care fraud schemes were related to fraudulent billing, such as billing for services that were not provided (about 43 percent of cases) and billing for services that were not medically necessary (about 25 percent).
- Other common schemes included falsifying records to support the fraud scheme (about 25 percent), paying kickbacks to participants in the scheme (about 21 percent), and fraudulently obtaining controlled substances or misbranding prescription drugs (about 21 percent).
- Providers were complicit in 62 percent of the cases, and beneficiaries were complicit in 14 percent of the cases.

GAO's analysis found that the use of smart cards could have affected about 22 percent (165 cases) of cases GAO reviewed in which the entire or part of the case could have been affected because they included schemes that involved the lack of verification of the beneficiary or provider at the point of care. However, in the majority of cases (78 percent), smart card use likely would not have affected the cases because either beneficiaries or providers were complicit in the schemes, or for other reasons. For example, the use of cards would not have affected cases in which the provider misrepresented the service (as in billing for services not medically necessary), or when the beneficiary and provider were not directly involved in the scheme (as in illegal marketing of prescription drugs).

Percentage of 2010 Health Care Fraud Cases Reviewed That Could Have Been Affected by Use of Smart Card Technology



Source: GAO analysis of health care fraud cases resolved in 2010. | GAO-16-216

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Abbreviations

CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
DME	durable medical equipment
DOJ	Department of Justice
FBI	Federal Bureau of Investigation
FEHBP	Federal Employees Health Benefits Program
HHS	Department of Health and Human Services
HHS OIG	Department of Health and Human Services Office of Inspector General
PACER	Public Access to Court Electronic Records
VA	Department of Veterans Affairs

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Congressional Requesters:

We have designated Medicare and Medicaid as high-risk programs because their size, scope, and complexity make them particularly vulnerable to fraud and abuse.[1] Although there have been convictions for multimillion dollar schemes that defrauded federal health care programs, the extent of the problem is unknown as there are no reliable estimates of the magnitude of fraud within these programs or across the health care industry generally. According to the Department of Health and Human Services' (HHS) Office of Inspector General (OIG), there are several types of health care fraud schemes, including those in which providers bill for services or supplies not provided or not medically necessary, and those in which providers' or beneficiaries' identities are stolen. However, little is known about which schemes are the most common or most costly.

To help reduce fraud and abuse in federal health care programs, including Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), HHS OIG, the Centers for Medicare & Medicaid Services (CMS)—an agency within HHS—and the Department of Justice (DOJ) were provided $571.7 million in budgetary resources for fiscal year 2014 to identify, investigate, and prosecute health care fraud. During fiscal year 2014, about $3.3 billion in health care fraud judgments and settlements were collected (including from cases that occurred before fiscal year 2014) as a result of the HHS OIG's and DOJ's investigations and prosecutions.

Many different types of providers and suppliers are the subjects of fraud cases.[2] In 2012, we examined the types of providers and suppliers

[1]GAO, *High-Risk Series: An Update*, GAO-15-290 (Washington, D.C.: February 2015). Fraud represents intentional acts of deception with knowledge that the action or representation results in obtaining something of value through willful misrepresentation. Abuse represents actions deficient or improper with acceptable business or medical practices.

[2]For this report, the term "providers" includes individuals and entities that provide medical care (such as physicians, medical centers, hospitals, pharmacies, and medical clinics). The term "suppliers" includes companies that provide medical supplies (such as durable medical equipment (DME) suppliers).

involved in criminal and civil health care fraud cases and found that for cases resolved in 2010, medical facilities and durable medical equipment (DME) suppliers were the most common provider or supplier types that were subjects of criminal fraud investigations and in which subjects were found or pled guilty.[3] Hospitals and medical facilities were the most common subjects of civil fraud investigations and the cases that resulted in judgments or settlements.

In some fraud cases, the subjects of the case are able to bill federal health care programs or private health insurance for payment by stealing a beneficiary's or provider's identification information and using it without the beneficiary's or provider's knowledge. Proposals have been put forward to reduce the ability of individuals to commit this type of fraud. Proponents of one proposal—to use electronically readable card technology, such as smart cards that use microprocessor chips to store and process data—say that using these cards would bring a number of benefits, including reducing fraud.[4] In a March 2015 report, we examined the benefits and limitations associated with the use of electronically readable cards in Medicare.[5] We reported that the use of electronically readable cards to verify that the beneficiary and provider were present at the point of care could curtail certain types of fraud (such as when providers misuse beneficiary identification information to bill fraudulently) but would have a limited effect on other types of fraud. Because little is known about the prevalence of even the most common types of fraud, it is difficult to assess the extent to which smart card technology would affect fraud.

[3]GAO, *Health Care Fraud: Types of Providers Involved in Medicare, Medicaid, and the Children's Health Insurance Program Cases*, GAO-12-820 (Washington, D.C.: Sept. 7, 2012). In this report, we use the terms criminal or civil fraud to represent the disposition of the fraud case by its criminal or civil penalties. In addition, while criminal cases are prosecuted and civil cases are litigated, our report describes both types of cases as being prosecuted for simplicity.

[4]Electronically readable cards include cards with magnetic stripes, cards with bar codes, and smart cards.

[5]See GAO, *Medicare: Potential Uses of Electronically Readable Cards for Beneficiaries and Providers*, GAO-15-319 (Washington, D.C.: Mar. 25, 2015). The March 2015 report focused on electronically readable cards, including smart cards. Our current study is focused on smart cards.

You asked us to identify and categorize schemes found in health care fraud cases. In this report we describe

1. health care fraud schemes and their prevalence among cases resolved in 2010 and
2. the extent to which health care fraud schemes could have been affected by the use of smart card technology.

To describe health care fraud schemes and their prevalence among cases resolved in 2010, we reviewed government reports (such as reports produced by HHS and DOJ regarding the Health Care Fraud and Abuse Control Program), and DOJ and HHS OIG press releases to develop a list of definitions for schemes related to health care fraud. To determine the prevalence of health care fraud schemes, we reviewed court documents for fraud cases resolved in 2010 that were obtained during our work for our 2012 report on the types of providers involved in health care fraud.[6] Although the cases obtained for our 2012 report included investigations as well as prosecutions, judgments, and settlements, for this study, we included only cases that had been adjudicated favorably for the United States.[7] The cases we obtained involved both federal health care programs and private health insurance. In total, we reviewed court documents for 739 cases from HHS OIG and DOJ to determine the prevalence of health care fraud schemes by type.[8] These documents were associated with the charging stage of the case (such as an indictment, information, or complaint) unless the charging document for a case was not available. If the charging document was not available, we reviewed case details as described in a DOJ or Federal

[6]The data we obtained for GAO-12-820 were investigations and prosecutions from HHS OIG and DOJ's U.S. Attorneys' Offices and Civil Division, which included information such as the subjects of the investigations and the outcomes of the case (such as civil penalties for civil cases or prison or probation for criminal cases). We obtained data on criminal and civil health care fraud cases from both agencies because HHS OIG conducts investigations, but DOJ does not prosecute all of the cases investigated.

[7]By "favorable for the United States," we mean criminal cases in which the subjects were found guilty, pled guilty, or pled no contest to at least one of the charges, and civil cases that resulted in a judgment for the United States or a settlement.

[8]There were 834 cases that resulted in a favorable outcome for the United States. However, we did not review 95 of those cases for a variety of reasons including that they were duplicative of another case or because we could not determine the fraud schemes used based on the information contained in the charging documents.

Bureau of Investigation (FBI) press release. For several HHS OIG cases, we were unable to locate a charging document or a press release. For these cases, HHS OIG provided us with other court documents, such as settlement agreements and plea agreements. For each case, we also categorized information on the beneficiary's role, the provider's role, the programs affected by the fraud (such as Medicare, Medicaid, or private health insurance), and any monetary amounts associated with the fraud schemes (such as the amount paid).[9] For each case we reviewed, two reviewers independently categorized the case into the relevant health care fraud schemes and resolved any differences in the categorization. To assess the reliability of the data, we reviewed relevant documentation and examined the data for reasonableness and internal consistency. We found these data were sufficiently reliable for the purposes of our report. (See app. I for additional information about our methodology.)

To describe the extent to which types of health care fraud schemes could have been affected by the use of smart card technology, we reviewed literature on the benefits, uses, technical capabilities, and potential effects of smart cards, including our March 2015 report on electronically readable cards, and analyzed data on health care fraud schemes from our review of court cases resolved in 2010. Our analysis of the potential effect of smart cards on the cases we reviewed is based on the assumption that the smart cards would have the capability to correctly identify both the beneficiary and provider at the point of care (e.g., physician office or hospital).[10] We did not assume any other changes in information technology that some smart card advocates have suggested could

[9]We use the term beneficiary to describe individuals who receive medical care and supplies from providers and who are beneficiaries of federal health care programs (such as Medicare or Medicaid) or enrollees or covered individuals of private health insurance plans.

For our review, we defined providers as those who actually deliver care and services directly to beneficiaries (such as physicians) or those who provide supplies to beneficiaries ordered by the provider (such as pharmacies). Additionally, we collected information separately on whether a DME supplier was involved in the case.

[10]Our analysis of the effect of smart cards focused on the use of smart cards to verify beneficiary and provider identities and did not include the use of the smart cards for other purposes, such as to store and convey medical information or to verify the provider's credentials.

accompany the adoption of smart cards in some circumstances.[11] For this analysis, we first identified schemes that could be affected by the smart cards based on the nature of the scheme and the beneficiary and provider roles.[12] We then determined the number and percentage of cases with these particular schemes. For purposes of our analysis, we defined the term "affected" to mean that the use of smart cards to verify the beneficiary and provider identities could have potentially reduced the risk of fraud.[13] We determined whether the smart cards could affect the entire case (if the scheme was the only one used or was used in conjunction only with other schemes that could have been affected by smart cards) or part of the case (if the schemes were used in combination with other schemes that would not have been affected by smart cards). In some cases, we were unable to determine if smart cards would have had an effect because there was insufficient information.

Our analysis has several limitations. First, it is based on cases we received from DOJ and HHS OIG that had been resolved in 2010. Although the cases were resolved in 2010, the fraud schemes and investigations could have occurred in prior years. The types of fraud schemes used during those years may be different from the schemes prevalent now, as schemes can be influenced by various factors, such as changes to payment policies and program integrity efforts in Medicare and Medicaid. To mitigate this limitation, we discussed the schemes identified and our analysis with officials from HHS OIG and DOJ, who confirmed that while there may be geographic or provider type differences in fraud cases, the schemes we identified are still relevant today because they are similar to the common fraud schemes that have been used since

[11]According to reports from smart card advocates, there is a range of potential uses and capabilities of smart cards. For example, some advocates maintain that smart cards could be used to track a beneficiary's presence for each service rendered or the duration of the service.

[12]Specifically, we analyzed whether (1) the scheme was related to misusing the beneficiary's or provider's identification information to fraudulently bill, such as when the beneficiary's identification is stolen for use in the fraud case; (2) the scheme did not involve the provider or beneficiary; (3) the beneficiary was present at the point of care; and (4) the beneficiary or provider was complicit in the scheme.

[13]However, we cannot conclude that the use of the smart card technology would have prevented the fraud schemes in these cases because it is not possible to account for the various factors that may have contributed to the fraud occurring. Also, individuals may circumvent the smart card technology to still carry out the fraud schemes, and smart cards may introduce new fraud schemes.

2010. A second limitation of our analysis is that we generally reviewed charging documents, which represent allegations of fraudulent conduct and may or may not have been the basis on which the case was adjudicated or settled. We chose to use charging documents (when available) as these documents generally tend to provide a more complete description of all of the alleged fraud schemes compared to schemes that were adjudicated. Third, the cases we reviewed were prosecuted and resulted in a favorable outcome. These cases represent a fraction of the potential fraud cases that could have occurred or that were identified by DOJ and HHS OIG for possible investigation and prosecution.[14] As a result, our findings are not generalizable to all fraud cases. Fourth, our analysis of the potential effects of smart cards assumed a particular set of smart card characteristics—specifically, that the identity of both providers and beneficiaries would be verified—and our findings could be different if we had made different assumptions about the capabilities or implementation of smart cards. We believe our assumptions are reasonable given the challenges associated with implementing smart card technology.[15]

We conducted this performance audit from December 2014 to January 2016 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[14]As we have previously reported, not all health care fraud investigations are pursued and not all subjects of the fraud cases are prosecuted. GAO-12-820.

[15]See GAO-15-319 for additional information on the challenges associated with implementing smart cards.

Background

Health Care Fraud Statutes

There are multiple statutes that concern health care fraud, including the following:[16]

- The False Claims Act is often used by the federal government in health care fraud cases and prohibits certain actions, including the knowing presentation of a false claim for payment by the federal government.[17]
- Civil monetary penalty provisions of the Social Security Act apply to certain activities, such as knowingly presenting a claim for medical services that is known to be false and fraudulent.[18] In addition, the Social Security Act also provides for criminal penalties for knowing and willful false statements in applications for payment.[19]
- The Anti-Kickback statute makes it a criminal offense for anyone to knowingly and willfully solicit, receive, offer, or pay any remuneration in return for or to induce referrals of items or services reimbursable under a federal health care program, subject to statutory exceptions and regulatory safe harbors.[20]
- The Stark law and its implementing regulations generally prohibit physicians from making "self-referrals"—certain referrals for "designated health services" paid for by Medicare to entities with

[16]The statutes included here provide examples of those that may be relevant to health care fraud cases. Other statutory provisions, including those located in title 18 of the United States Code, may also be relevant to such cases. *See*, e.g., 18 U.S.C. §§ 669 (concerning theft or embezzlement in connection with health care), 1035 (concerning false statements relating to health care matters), and 1347 (concerning health care fraud).

[17]31 U.S.C. §§ 3729-3733.

[18]42 U.S.C. § 1320a-7a.

[19]42 U.S.C. § 1320a-7b.

[20]42 U.S.C. § 1320a-7b(b).

Kickbacks are a type of illegal remuneration under the statute. Examples of kickbacks include providing identifying information to a provider allowing the provider to bill for services not provided, receiving services in exchange for cash, or compensating individuals for recruiting beneficiaries to receive treatment at a specific clinic.

which the physician (or an immediate family member) has a financial relationship—nor may the entities that perform the "designated health services" present claims to Medicare or bill for these services.[21] These prohibitions also extend to payments for Medicaid-covered services to the same extent and under the same terms and conditions as if Medicare had covered them.[22]

- The Federal Food, Drug, and Cosmetic Act, as amended, makes it unlawful to, among other things, introduce an adulterated or misbranded pharmaceutical product or device into interstate commerce.[23]

Types of Health Care Fraud and Provider and Beneficiary Involvement

Health care fraud takes many forms, and a single case can involve more than one fraud scheme. Schemes may include fraudulent billing for services not provided, services provided that were not medically necessary; and services intentionally billed at a higher level than appropriate for the services that were provided, called upcoding. Other fraud schemes include providing compensation—kickbacks—to beneficiaries or providers or others for participating in the fraud scheme and schemes involving prescription drugs (including prescription drugs that contain controlled substances), such as the submission of false claims for prescription drugs that have been improperly marketed for non-FDA-approved uses and the illicit diversion of prescription drugs for profit or abuse.[24] Fraud cases may involve more than one scheme; for

[21]42 U.S.C. § 1395nn(a)(1).

[22]The statutory provisions commonly known as the Stark law are applicable to Medicare under section 1877 of the Social Security Act, and to Medicaid under section 1903(s) of the Social Security Act (codified at 42 U.S.C. § 1396b(s)).

[23]21 U.S.C. § 331(a). Those who misbrand or promote drugs for non-FDA approved indications may be subject to penalties under the Federal Food, Drug, and Cosmetic Act. 21 U.S.C. § 333. Such conduct may also involve health care fraud if, for example, it results in a false claim to a federal health care program under the False Claims Act.

[24]A controlled substance is one that is included in one of five schedules under the Controlled Substances Act. A controlled substance is placed in a respective schedule based on whether it has a currently accepted medical use in the United States and its potential for abuse and physical or psychological dependence. 21 U.S.C. §§ 802(6), 812. Types of prescription drugs that contain controlled substances that play an important role in health care and could be involved in health care fraud cases include narcotics, stimulants, and sedatives. In this report, we use the term controlled substances when referring to such prescription drugs.

example, an infusion clinic may pay kickbacks to a beneficiary for receiving care at the clinic, and the care that was provided and billed for may not have been medically necessary.

Providers may be complicit in the schemes or unaware of the schemes.[25] For example, providers who are complicit may willingly use their provider identification information to bill fraudulently, misrepresent services provided to receive higher payment, or receive kickbacks to provide their identification information for others to bill fraudulently. In other cases, providers may be unaware that their identification information has been stolen and used in various fraud schemes. Similarly, beneficiaries can be either complicit in or unaware of the fraud. Beneficiaries who are complicit may willingly provide their identification information to a provider for the purposes of committing fraud or receive kickbacks in exchange for providing their information to or receiving services from a provider. In contrast, they also may be unaware of fraud schemes in which the provider bills for services not medically necessary or uses beneficiaries' identification information without their knowledge. Additionally, both beneficiaries and some providers may not be involved in the fraud scheme, in the sense that the fraud schemes involved circumstances other than a provider giving care to a beneficiary. For example, a pharmaceutical manufacturing company that marketed prescription drugs for non-FDA approved uses does not involve a provider giving care directly to a beneficiary. Individuals and entities that commit fraud do so in federal health care programs and private insurance programs, and may commit fraud in more than one program simultaneously.

Agencies That Investigate and Prosecute Health Care Fraud

Several agencies are involved in investigating and prosecuting health care fraud cases, including CMS; HHS OIG; DOJ's U.S. Attorneys' Offices, Civil and Criminal Divisions; and the FBI. HHS OIG and the FBI primarily conduct investigations of health care fraud, and DOJ's divisions

[25]Providers can include those who actually deliver care and services directly to beneficiaries (such as physicians) or those who provide supplies to beneficiaries ordered by the provider (such as pharmacies).

typically prosecute or litigate the cases.[26] DOJ prosecutes fraud cases that affect both federal health programs and private health insurance.

Use of Smart Cards

Amid concerns about identify theft, proposals have been put forward to replace Medicare's paper identification cards that contain the beneficiary's Social Security numbers with electronically readable cards, such as smart cards.[27] Some proposals have suggested that such cards should be issued to providers as well. Electronically readable cards include those that store information on magnetic stripes and bar codes and cards called smart cards that use microprocessor chips to store and process data. In March 2015, we identified three key uses for electronically readable cards: (1) authenticating beneficiary and provider presence at the point of care, (2) electronically exchanging beneficiary medical information, and (3) electronically conveying beneficiary identity and insurance information to providers.[28] We also found that smart cards could provide more rigorous authentication of beneficiaries and providers at the point of care than cards with magnetic stripes and bar codes, though all three types of cards can electronically convey identity and insurance information. Proponents of smart cards have suggested that, among other benefits, using smart cards may reduce health care fraud in the Medicare program. For example, some proponents claim that the use of smart cards to identify the beneficiary and provider at the point of care could potentially curtail certain types of fraud such as schemes in which providers misuse another provider's information to bill fraudulently.

[26]CMS and its contractors, such as the Zone Program Integrity Contractors, conduct activities related to health care fraud, including investigating potential fraud in Medicare fee-for-service in specific geographic areas. These contractors identify suspect claims and provider billing patterns, investigate fraud leads, and refer suspected fraud cases to HHS OIG.

[27]The Medicare Access and CHIP Reauthorization Act of 2015, enacted into law in April 2015, included a provision requiring and providing funding for the Secretary of Health and Human Services, in consultation with the Commissioner of Social Security, to establish procedures to ensure that a Social Security account number is not displayed, coded, or embedded on Medicare beneficiary cards and that any identifier displayed on such cards is not identifiable as a Social Security account number. Pub. L. No. 114-10, § 501, 129 Stat. 87, 163 (Apr. 16, 2015).

In July 2015, CMS started an initiative in response to this law and was in the process of establishing a program to plan and implement system changes to remove the Social Security numbers from Medicare cards.

[28]GAO-15-319.

However, our March 2015 report also found that there are several limitations associated with the use of smart cards. Specifically, it is possible that individuals may still be able to commit fraud by adapting and altering the schemes they use to account for the use of smart card technology. In addition, the use of smart card technology could introduce new types of fraud and ways for individuals to illegally access beneficiary information. For example, malicious software could be written onto a smart card and used to compromise provider IT systems. Further, various factors may limit the implementation of smart card technology in the Medicare program. As we found in our March 2015 report, while the use of smart cards to verify the beneficiary identity at the point of care could reduce certain types of fraud, it would have limited effect on Medicare fraud since CMS policy is to pay claims for Medicare beneficiaries even if they do not have a Medicare identification card at the time of care.[29] CMS officials noted that it would not be feasible to require the use of smart cards because of concerns that this would limit beneficiaries' access to care given that there may be legitimate reasons why a card might not be present at the point of care. For example, beneficiaries who experience a health care emergency may not have their Medicare cards with them at the time care is rendered. Additionally, we concluded that the use of smart cards to verify the beneficiary and provider presence at the point of care would require addressing costs and implementation challenges associated with card management and information technology system enhancements. These enhancements would be needed to update both CMS's and providers' claims processing and card management systems in order to achieve a high level of provider and beneficiary authentication as well as meet security requirements.[30]

Fraudulent Billing Schemes Were Most Common Schemes in Cases Reviewed

The majority of the 739 cases resolved in 2010 that we reviewed had more than one fraud scheme. Fraudulent billing schemes, such as billing for services that were not provided and billing for services that were not medically necessary, were the most common fraud schemes. Over 20 percent of the cases included kickbacks to providers, beneficiaries, or other individuals. Providers were complicit in the fraud schemes in over half of the cases. In contrast with providers, only about 14 percent of the

[29]See GAO-15-319.

[30]For additional information on the costs and challenges associated with implementing electronically readable cards in Medicare, see GAO-15-319.

739 cases we reviewed had beneficiaries who were complicit in the schemes.

Most Cases Had More than One Scheme, and Fraudulent Billing Schemes Were the Most Common

Using cases from 2010, we identified 1,679 fraud schemes in the 739 cases that we reviewed. The majority of the 739 cases (about 68 percent) included more than one scheme; 61 percent of the cases had 2 to 4 schemes, about 7 percent had 5 or more schemes. Thirty-two percent had only one scheme. The most common schemes used in the cases we reviewed were related to fraudulent billing, such as billing for services that were not provided (42.6 percent of cases), billing for services that were not medically necessary (24.5 percent), and upcoding, which is billing for a higher level of service than the service actually provided (17.5 percent). Additionally, schemes used to support other fraud were also common, such as falsifying a substantial portion of records to support the fraud scheme (25.2 percent) and paying kickbacks to participants in the scheme (20.6 percent). Schemes related to prescription drugs (including prescription drugs that contained controlled substances), such as fraudulently obtaining or distributing prescription drugs or marketing prescription drugs for non-FDA approved uses in order to commit fraud, were found in about 21 percent of the cases we reviewed. (See table 1 for the number and percentage of cases in which these schemes were used and app. II, table 6, for additional details on schemes we identified in cases.)

Table 1: Number and Percentage of Health Care Fraud Cases Reviewed, by Fraud Scheme

Scheme	Number of cases in which scheme was used	Percentage of all cases
Fraudulent billing schemes		
Billing for services or supplies that were not provided	315	42.6
• Billing for services or supplies that were not provided, along with services that were provided	54	7.3
• Billing for services or supplies that were never provided, and no legitimate services were provided	94	12.7
• Billing for services or supplies that were not provided, and we were unable to determine whether other services were provided	167	22.6
Billing for services that were not medically necessary	181	24.5
Upcoding services to be paid at a higher rate than the services that were actually provided	129	17.5
Billing for services not prescribed or referred by a physician	104	14.1

Scheme	Number of cases in which scheme was used	Percentage of all cases
Billing for services provided by an unqualified, uncertified, unlicensed, or ineligible provider	83	11.3
Unbundling of services to receive higher total payment when billed separately	31	4.2
Billing for services provided to an individual who was not eligible to receive them	24	3.3
Billing for prescription drugs that were not provided to beneficiaries	24	3.2
Lying about eligibility to obtain benefits or services	19	2.6
Billing for services as if they were provided by a physician, which are paid at higher rate, though services were provided by another provider, such as a nurse practitioner, who would be paid at a lower rate	15	2.0
Schemes that generally support other fraud schemes		
Falsifying a substantial portion of records to support fraudulent claims	186	25.2
Receiving or paying kickbacks	152	20.6
Misusing a beneficiary's or provider's identification information to fraudulently bill (such as for a deceased beneficiary or under the name of a retired physician)	39	5.3
Fraud schemes related to prescription drugs		
Fraudulently obtaining, distributing, or prescribing drugs containing controlled substances	79	10.8
Fraudulently obtaining, distributing, or misbranding prescription drugs	43	5.8
Marketing of prescription drugs for non-FDA-approved uses	30	4.1
Other schemes		
Self-referral of certain health services by providers in violation of the Stark law	17	2.3
Billing for services provided by an excluded provider or employing an excluded provider	17	2.3
Miscellaneous schemes[a]	66	9.0
Other health care fraud-related schemes[b]	125	16.9
Total	**1,679**	**—**

Source: GAO analysis of court and other documents. | GAO-16-216

Notes: We reviewed 739 health care fraud cases that were resolved in 2010.

Percentages add to more than 100 because each case can have more than one scheme. Percentages were calculated using the total number of cases reviewed (739 cases).

[a]Miscellaneous includes the remaining schemes identified in our review that each represented less than 2 percent of the cases. These include schemes such as billing for services as if they were provided in a setting for a higher level of care than actually provided, inappropriately waiving copayments for beneficiaries to receive care or services, and inflating prescription drug prices.

[b]These health care fraud-related schemes included a large variety found in the cases we reviewed but that did not fall within the categories of identified schemes, such as violating Medicare policy requirements by failing to document care provided, billing for services that did not meet standard-of-care requirements, and inflating or misreporting costs on cost reports submitted to Medicare.

Many different combinations of schemes were present in the 68 percent of cases with more than one scheme. The most common schemes were

also the ones that were most often used together: billing for services not provided along with billing for services that were not medically necessary, billing for services or supplies that were not prescribed by a physician and falsifying a substantial portion of records in order to support the fraud scheme. (See app. II, table 7, for additional analysis of the number of schemes per case.) For example, according to the indictment in a fraud case we reviewed, a DME supplier used two schemes to commit fraud: (1) billing Medicare for medical equipment, such as orthotic braces, that were not provided to Medicare beneficiaries and (2) billing for supplies that had not been prescribed by physicians for these beneficiaries.

Many different federal programs and private insurers were affected by fraud schemes in the cases we reviewed. In one-quarter of the cases, more than one program was affected. Medicare was affected in about 63 percent of the 739 cases reviewed, Medicaid and/or CHIP in about 32 percent, TRICARE in about 5 percent, and the Federal Employees Health Benefits Program (FEHBP) in 3 percent of the cases.[31] In over 11 percent of the cases, private health insurers were affected. Other programs affected included Department of Veterans Affairs programs, Social Security programs, worker's compensation programs, and other benefit plans.[32]

Among the fraud cases we reviewed, one-third—262 cases—had information in the documents we reviewed about the amount of fraudulent payments made by the programs and insurers. For the 262 cases, the total paid was $801.5 million. The amounts of the fraudulent payments in these cases typically ranged from $10,000 to $1.5 million.

[31]TRICARE is health coverage offered by the Department of Defense's military health system for eligible beneficiaries including active duty personnel and their dependents, Reserve and National Guard personnel and their dependents, and retirees and their dependents and survivors. FEHBP provides health care coverage to millions of federal employees, retirees, and their dependents through health insurance carriers that contract with the Office of Personnel Management.

[32]Additionally, for 66 cases (about 9 percent), we could not determine the program or programs affected, as the document reviewed did not provide this information.

About 20 Percent of Cases Reviewed Included Kickbacks to Providers, Beneficiaries, or Other Individuals

In about 20 percent of the 739 cases we reviewed, kickbacks were paid to providers, beneficiaries, or other individuals. The most common schemes used in cases where providers were paid kickbacks were marketing prescription drugs for non-FDA-approved uses, billing for services that were not medically necessary, upcoding, and self-referring. Many different types of providers received or provided kickbacks in these cases; the most common provider types were DME suppliers, hospitals, and pharmaceutical manufacturers. The most common schemes used in cases where beneficiaries were paid kickbacks were billing for services that were not medically necessary and billing for services that were not provided. In addition, kickbacks were paid to both beneficiaries and providers for their involvement in a fraud case or to other individuals, such as "recruiters," who connect providers and beneficiaries in exchange for a fee. For 23 of the cases we reviewed, there was information in the documents we reviewed about the amount of kickbacks paid to beneficiaries, providers, and other individuals, which totaled $69.7 million.

Examples of health care fraud cases in which kickbacks were used

According to a complaint in a civil fraud case we reviewed, a prescription drug manufacturer paid millions of dollars in kickbacks to a nursing home pharmacy to encourage the pharmacy to purchase and recommend prescription drugs from that manufacturer. As a result of these kickbacks, false claims were submitted to and paid by Medicaid in violation of the Anti-Kickback Statute.

An indictment in a criminal fraud case we reviewed stated that a medical clinic that provided injection and infusion treatments paid kickbacks to individuals who recruited Medicare beneficiaries to provide their identification information so that the clinic could bill Medicare for treatments, which the clinic did not provide to these beneficiaries. The beneficiaries who provided their information also received kickbacks. The clinic also paid kickbacks to the physicians who signed the required documentation to support billing Medicare for these services.

Source: GAO analysis of court documents. | GAO-16-216

Providers Were Complicit in Fraud Schemes in More than Half of the Cases Reviewed

In about 62 percent of the 739 cases we reviewed, providers were complicit in the cases, either by submitting fraudulent claims or by supporting the fraud schemes.[33] (See table 2 and app. II, table 8, for additional information on the role of the provider, by fraud scheme.) For example, a physician would be complicit when billing for higher level services than those actually provided in order to receive a higher payment rate (upcoding). A physician may also be complicit in a case by receiving kickbacks for referring beneficiaries to a particular clinic, even though the physician did not bill for the services provided by that clinic.

Table 2: Number and Percentage of Health Care Fraud Cases Reviewed, by Provider's Role

Provider role	Number of cases	Percentage
Provider was complicit		
Provider was biller	425	57.5
Provider was not biller but was complicit in fraud scheme	31	4.2
Provider was not complicit		
Provider's information was stolen, sold, or used without his or her knowledge	55	7.4
Provider's information was obtained under false pretenses (such as through a telemarketer)	17	2.3
Provider was not involved in the fraud scheme (including where no care was provided directly to the beneficiary)	72	9.7
Fictitious provider information was used in fraud scheme	2	0.3
Unknown (insufficient information to determine the role of the provider)	137	18.5
Total	**739**	**99.9**

Source: GAO analysis of court and other documents. | GAO-16-216

Notes: We reviewed 739 health care fraud cases that were resolved in 2010.

Percentages do not add to 100 due to rounding.

Among the cases in which providers were complicit, the most common fraud schemes were billing for services that were not medically necessary, falsifying records to support the fraud schemes, upcoding services to receive a higher payment, and billing for services that were not provided. For these cases, medical centers, clinics, and practices as

[33]For our analysis, we considered the provider to be the individual who gives the actual care or would have provided care, such as a physician. If at least one provider was complicit in the scheme, we considered the provider to be complicit even if other providers within the same case were not complicit. We collected information on whether a DME supplier was involved in the case separately from whether the provider was complicit.

well as hospitals, other clinics, home health agencies, and pharmacies were the most common types of providers that were complicit.

Providers were not complicit in about 10 percent of the cases we reviewed. In those cases, providers' information had been stolen or used without their knowledge to carry out the fraud schemes. The most common schemes in these cases were falsifying records and billing for services or supplies that were not prescribed by the physicians. Additionally, in two cases, a fictitious provider was created to support the fraud schemes.

No provider was involved in another 10 percent of the cases that we reviewed. For example, no provider gave care directly or billed for services provided to a beneficiary in cases where a prescription drug manufacturer marketed prescription drugs for non-FDA-approved uses. In the remaining 18.5 percent of cases, we were unable to determine how the provider was involved as the court documents did not include this information.

Example of health care fraud case in which providers were complicit

According to an indictment in one of the cases we reviewed, a physician conspired with the owner of a medical testing company that performed diagnostic ultrasound tests to bill Medicare and private insurance companies for tests that were either never provided or were not medically necessary. The physician signed orders for these ultrasound tests for beneficiaries that he had not actually treated and received kickbacks from the medical testing company for the orders.

Source: GAO analysis of court document. | GAO-16-216

Example of health care fraud case in which provider was not complicit

According to a complaint, a DME supplier billed Medicare for supplies prescribed by a physician. However, those supplies were not prescribed by the physician the DME supplier had listed on the claims. During an interview with investigators, the physician indicated his practice was not to prescribe DME supplies to his patients and instead to refer them to a specialist. When reviewing a list of 200 Medicare beneficiaries for whom the DME supplier had listed him as the prescribing physician on the claims, the physician identified that only 12 of those listed had ever been his patients. In this case, the DME supplier was using the physician's information without his knowledge to bill for DME supplies that were not provided.

Source: GAO analysis of court document. | GAO-16-216

Beneficiaries Were Complicit in about 14 Percent of Cases Reviewed

In contrast with providers, only about 14 percent of the 739 cases we reviewed had beneficiaries that were complicit in the schemes. For example, there were cases in which the beneficiary willingly provided identification information so a provider could fraudulently bill, or the beneficiary received kickbacks for receiving treatment at a specific clinic. Among the cases in which the beneficiary was complicit, the most common schemes were billing for services that were not medically necessary, billing for services that were not provided, and falsifying records to support the fraud schemes.

Example of health care fraud case in which beneficiary was complicit

According to an information document filed by prosecutors in one case we reviewed, an employee of a medical clinic asked a beneficiary to visit the clinic complaining of ailments that the beneficiary did not have in order to receive prescriptions for drugs containing controlled substances. The beneficiary visited the clinic complaining of a toothache and obtained a prescription for a controlled substance. The employee then purchased that medication from the beneficiary.

Source: GAO analysis of court document. | GAO-16-216

In about 62 percent of the 739 cases we reviewed, beneficiaries were not complicit in the schemes. Among beneficiaries that were not complicit, most received services from the provider, but there was no evidence that the beneficiary was aware of the fraud (54.8 percent). For example, beneficiaries who were not complicit in the schemes received services from the provider but were unaware that the provider billed for upcoded services or that they received services that were not medically necessary. In 39 cases (5.3 percent), court documents we reviewed indicated that the beneficiaries' information was stolen or sold without their knowledge. In an additional 12 cases (1.6 percent) we reviewed, the beneficiaries' information was obtained through false pretenses, such as through a telemarketer. (See table 3 and app. II, table 9, for additional information on the role of the beneficiary, by fraud scheme.)

Table 3: Number and Percentage of Health Care Fraud Cases Reviewed, by Beneficiary's Role

Beneficiary role	Number of cases	Percentage
Beneficiary was not complicit		
Beneficiary received services from provider, but there was no evidence that beneficiary was involved in fraud scheme	405	54.8
Beneficiary's information was stolen or sold without his or her knowledge	39	5.3
Beneficiary's information was obtained under false pretenses (such as through a telemarketer)	12	1.6
Beneficiary was complicit	105	14.2
Beneficiary was not involved (including where no care was provided directly)	97	13.1
Unknown (insufficient information to determine the role of the beneficiary)	80	10.8
Fictitious beneficiary's information used in the fraud scheme	1	0.1
Total	**739**	**99.9**

Source: GAO analysis of court and other documents. | GAO-16-216

Notes: We reviewed 739 health care fraud cases that were resolved in 2010.

Percentages do not add to 100 due to rounding.

Example of health care fraud case in which beneficiary was not complicit

According to an information document filed by prosecutors in one case we reviewed, an individual obtained names and dates of birth for two individuals enrolled in Federal Employees Health Benefits Program (FEHBP) who had flexible spending accounts. The individual created counterfeit prescriptions for drugs containing controlled substances for these beneficiaries, submitted them to a pharmacy to fill, and received the controlled substances.

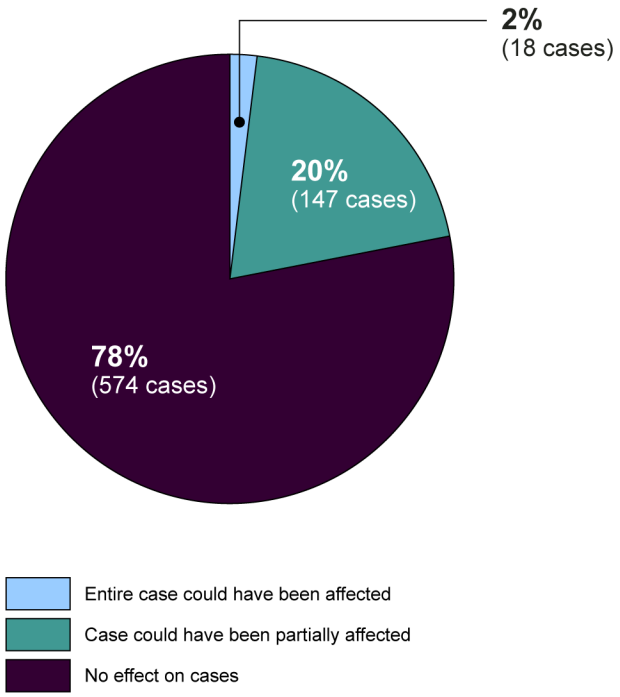
Source: GAO analysis of court document. | GAO-16-216

Additionally, the beneficiary was not involved in about 13 percent of the 739 cases we reviewed. The beneficiary may not have been involved in the fraud schemes because the schemes did not involve billing for care provided to a beneficiary. For instance, in one case, a pharmaceutical drug manufacturer marketed drugs for non-FDA-approved uses and paid kickbacks to providers for prescribing those drugs to beneficiaries. This scheme did not involve billing for care provided to the beneficiary. For the remaining 11 percent of cases we reviewed, we were unable to determine whether the beneficiary was complicit or not, and in 1 case, a fictitious beneficiary's information was created to support the fraud scheme.

Smart Cards Likely Would Not Have Affected the Majority of Cases Reviewed

Among the 739 cases, we found 165 cases (22 percent) in which the entire case (2 percent) or part of the case (20 percent) could have been affected by the use of smart cards. The remaining 574 cases (78 percent) had schemes that would not have been affected by smart cards. (See fig. 1.)

Figure 1: Percentage of 2010 Health Care Fraud Cases Reviewed That Could Have Been Affected by Use of Smart Card Technology



Source: GAO analysis of health care fraud cases resolved in 2010. | GAO-16-216

Health Care Fraud Schemes That Could Have Been Affected by the Use of Smart Cards

Example of health care fraud case in which the provider was complicit but the beneficiary was not

According to a complaint document in one case we reviewed, the provider submitted duplicate claims for the same service provided to a beneficiary. The beneficiary received the service from the provider the first time but was unaware that a second claim had been submitted as if the service had been provided a second time when it had not.

Example of health care fraud case in which neither the beneficiary nor the provider was complicit

According to a complaint document in one fraud case we reviewed, a DME supplier used the identification information for several beneficiaries to submit a bill for DME supplies. The DME supplier also used a physician's identification information to allege that the supplies had been prescribed when that physician had not prescribed the DME supplies. In this case, neither the beneficiaries nor the provider were aware of the fraud schemes.

Source: GAO analysis of court documents. | GAO-16-216

Among the 739 cases we reviewed, we found 165 cases in which the entire or part of the case could have been affected by the use of smart cards. These cases included at least one of six schemes smart cards could have affected as the schemes involved the lack of verification of the beneficiary or the provider at the point of care. These six schemes were (1) billing for services that were never actually provided and no legitimate services were provided; (2) misusing a provider's identification information to bill fraudulently (such as using a retired provider's identification information); (3) misusing a beneficiary's identification information to bill fraudulently (such as using a deceased beneficiary's identification information or stealing a beneficiary's information); (4) billing more than once for the same service (known as duplicate billing) by altering a small portion of the claim, such as the date, and resubmitting it for payment; (5) providing services to ineligible individuals; and (6) falsifying a substantial part of the records to indicate that beneficiaries or providers were present at the point of care.[34]

In 18 cases (2.4 percent of all cases resolved in 2010 that we reviewed), the entire case could have been affected because all of the schemes on those cases involved the lack of verification of the beneficiary or provider at the point of care. For these 18 cases, either the beneficiary or the provider was complicit in the scheme, while the other was not, or neither the beneficiary nor the provider was complicit in the scheme. The use of smart cards could have had an effect because the card would have been able to verify at least one identity.

[34]For our analysis of the falsified records scheme, we determined that smart cards would have an effect in cases in which the falsification of records was used to document the beneficiary's and provider's presence at the point of care. All other cases that included the falsified records scheme were included in the schemes that would not have been affected by smart cards as discussed in the next section.

Example of health care fraud case that may have been partially affected by the use of smart cards

According to a complaint in one case we reviewed, a physical therapy provider was billing for services that were not medically necessary and was submitting duplicate bills for the same service. This case could have been partially affected by the use of smart cards, as the smart card would have verified that the beneficiary was present for only one service in which a duplicate bill was submitted but would not have affected the ability of the provider to bill for services that were not medically necessary.

Source: GAO analysis of court documents. | GAO-16-216

Smart cards could have partially affected an additional 147 cases (19.9 percent) in which at least one of the six schemes was present. However, because other fraud schemes were used, the entire case would not have been affected. (See table 4.)

Table 4: Number of Health Care Fraud Cases GAO Reviewed in Which Schemes Could Have Been Affected by Use of Smart Cards, by Scheme

	Entire case could have been affected	Case could have been partially affected
Billing for services that were never provided, and no legitimate services were provided	6	34
Misusing a provider's identification information to bill fraudulently (such as using a retired physician's information)	0	15
Misusing a beneficiary's identification information to bill fraudulently (such as using a deceased beneficiary's information)	2	8
Duplicate billing	1	8
Billing for services provided to an individual who was not eligible to receive care	8	2
Falsifying records to support any of the schemes listed above[a]	2	111
Total	**18**[b]	**147**[c]
Percentage of all 739 cases reviewed	**2.4 %**	**19.9%**

Source: GAO analysis of health care fraud cases resolved in 2010. | GAO-16-216

Note: This table includes cases in which neither the beneficiary nor the provider was complicit in the scheme and cases in which either the beneficiary or provider was complicit while the other was not. Additionally, we determined that the entire case could have been affected if the schemes listed were the only scheme in the fraud case or were only used in conjunction with at least one of the other schemes that could have been affected by smart cards. We also determined that a case could have been partially affected by the use of smart cards if the schemes listed were used in conjunction with other schemes that would not have been affected by smart cards.

[a]We determined that the smart cards could have an effect on cases in which the falsification of records was used to document the beneficiary's and provider's presence at the point of care.

[b]In 1 case, several of the six schemes were used. The total reflects the unique number of cases in which these schemes were present.

[c]In 31 cases, several of the six schemes were used in the same case. The total reflects the unique number of cases in which these schemes were present.

Health Care Fraud Schemes That Likely Would Not Have Been Affected by the Use of Smart Cards

Smart card technology would not have affected the majority of fraud schemes we identified, which represented 574 of the 739 cases that we reviewed (78 percent).[35] In these instances, the schemes would not have been affected by the smart cards because although the beneficiary and provider were present at the point of care, the provider misrepresented the services rendered after the smart cards would have registered their identities. These schemes included the following:

- billing for services that were not provided along with services that were provided legitimately,
- billing for services that were not medically necessary,
- upcoding,
- unbundling of services,
- billing for services that were not prescribed or not referred by a physician, and
- billing for services as if they were provided by a physician to receive a higher payment rate when they were actually provided by another provider in which the payment rate would have been lower.

In these schemes, smart cards would not be able to detect that the provider misrepresented the actual services provided even if the cards verified the beneficiary's and provider's presence. Similarly, schemes that involved a provider misrepresenting eligibility to provide services would not have been affected by smart cards, including schemes in which bills were submitted for services provided by an excluded provider or by an unlicensed, uncertified, or ineligible provider. Many of these schemes involved health care entities that billed for services provided by

[35]For five of these cases, we could not determine whether smart cards could have had an effect. These cases involved only the scheme of billing for services that were not provided, and there was insufficient information to determine whether legitimate services were actually provided. As a result, we were unable to determine if smart cards could have had an effect on the scheme in these cases.

employees or contractors that were not licensed or were excluded from providing care.[36]

In addition, smart card technology would not have affected schemes in which the beneficiary was not present or the verification of the beneficiary and provider was not relevant to the scheme. These fraud schemes involved improper marketing of prescription drugs, including drugs for non-FDA-approved uses; misbranding prescription drugs; inflating prescription drug prices; and physician self-referrals. In addition, smart cards would not have affected schemes related to improperly obtaining or distributing prescription drugs (including drugs that contained controlled substances), regardless of whether the beneficiary's or provider's identity was verified, such as cases in which individuals visited multiple providers complaining about pain to obtain prescriptions.

Further, smart cards would not have had an effect on cases in which the beneficiary and provider were complicit in the scheme, regardless of the schemes used on the case. For instance, smart cards would not have an effect on the billing for services never provided if both the beneficiary and provider were willing participants in the scheme. Similarly, smart cards would not have an effect on cases in which kickbacks were paid to a beneficiary or to a provider that allowed his or her smart card to be used for fraud.

Agency Comments

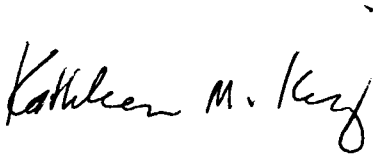
HHS and DOJ provided technical comments on a draft of this report, which we have incorporated as appropriate. In its comments, HHS reiterated that it would be difficult for CMS to implement smart cards in the Medicare program because implementation would require significant changes. For example, CMS stated that it would need to require that Medicare beneficiaries present smart cards at the point of care, which is contrary to current CMS policy and which CMS believes could create access to care issues. Additionally, CMS officials noted that implementing smart cards in Medicare would be a significant business process change,

[36]For example, in one case we reviewed, a hospital contracted with a physical therapy group to provide physical therapy services, but the physical therapists that provided these services were not licensed. In cases similar to this, it is not clear which provider may have a smart card and whether cards would be given to any provider that gives care (such as physical therapists or nurses) or only those providers who directly submit bills (such as physicians).

requiring substantial resources and time to implement. This report, as well as our past work on smart cards in Medicare, recognizes the concerns raised by CMS.[37]

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services, the Attorney General, and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or kingk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Major contributors to this report are listed in appendix III.



Kathleen M. King
Director, Health Care

[37]See GAO-15-319.

List of Requesters

The Honorable Orrin G. Hatch
Chairman
The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

The Honorable Ron Johnson
Chairman
The Honorable Thomas R. Carper
Ranking Member
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Charles E. Grassley
Chairman
Committee on the Judiciary
United States Senate

The Honorable Sander Levin
Ranking Member
Committee on Ways and Means
House of Representatives

The Honorable Earl Blumenauer
House of Representatives

The Honorable Peter J. Roskam
House of Representatives

Appendix I: Methodology for Describing the Types of Health Care Fraud and Their Prevalence

This appendix provides details on the methodology we used to describe the types of health care fraud and their prevalence among cases resolved in 2010 that we reviewed.

To describe types of health care fraud, we reviewed our prior reports, as well as reports from the Department of Health and Human Services (HHS) Office of Inspector General (OIG) and the Department of Justice (DOJ) to develop a list of schemes and definitions for these schemes, and then reviewed cases resolved in 2010 that we obtained through the course of work for our 2012 report.[1] Specifically, we reviewed several government reports, such as reports produced by HHS and DOJ on the Health Care Fraud and Abuse Control Program, and DOJ and HHS OIG press releases to identify fraud schemes that were commonly included in the reports and to develop definitions for these schemes. See table 5 for the health care fraud schemes developed for our case review.

Table 5: Health Care Fraud Schemes by Category and Description, for Cases Reviewed

Category	Description
Fraudulent billing schemes	
Billing for services or supplies that were not provided	This scheme includes three subtypes: (1) services or supplies were provided along with fraudulent services or supplies; (2) services or supplies were never provided despite billing for those services or supplies; and (3) services or supplies were not provided and it is unknown whether other services or supplies were actually provided.
Billing for services that were not medically necessary	Billing for services or supplies provided that were not medically necessary or for services that were excessive (such as extending a hospital stay when not medically necessary).
Upcoding services to be paid at a higher rate than the services that were actually provided	Upcoding for services or supplies, including time-based upcoding (e.g., billing for 60 minutes instead of the 30 minutes actually provided) or service-based upcoding (e.g., billing for evaluation and management services when a lower level of service was provided).
Billing for services not prescribed or referred by a physician	Submitting a claim for services or supplies when a physician had not prescribed or completed a necessary referral.
Billing for services provided by an unqualified, uncertified, unlicensed, or ineligible provider	Submitting a claim for services provided by an uncertified, unqualified, unlicensed, or ineligible provider.
Unbundling of services to receive higher total payment when billed separately	Billing separately for services that should be in a bundled payment.

[1]See GAO, *Health Care Fraud: Types of Providers Involved in Medicare, Medicaid, and the Children's Health Insurance Program Cases*, GAO-12-820 (Washington, D.C.: Sept. 7, 2012).

Category	Description
Billing for prescription drugs that were not provided to beneficiaries	Billing by a pharmacy for a prescription drug that a physician never prescribed or a beneficiary never received.
Billing for services provided to an individual not eligible to receive services or supplies	Submitting a claim for services or supplies provided to an individual (who is not a beneficiary) under a beneficiary's name.
Lying about eligibility to obtain benefits or services	Schemes that involve misrepresenting information to obtain services, lying on application for benefits, not reporting information that would affect benefit status, etc.
Billing for services as if they were provided by a physician but were actually provided by another provider	Schemes that involve billing for services as if they were provided by a physician in order to receive a higher payment when they were provided by another provider (such as a nurse practitioner or physician's assistant), who would have been paid at a lower rate.
Duplicate billing	Altering a small portion of a claim to submit it again for payment.
Double billing	Billing for a claim to more than one payer (such as Medicare and Medicaid for the same service).
Billing for services as if they were provided in higher-care setting	Billing for services as if they were provided in a higher level-of-care setting (such as an inpatient hospital) for higher payment even though service was provided in lower level-of-care setting (such as an outpatient facility).
Schemes that generally support other fraud schemes	
Falsifying a substantial portion of records in order to support fraudulent claims	Creating falsified medical records, invoices, orders, and prescriptions, etc., to support fraud scheme.
Receiving or paying kickbacks	Kickbacks—financial compensation for participating in the fraud scheme, such as receiving services in exchange for cash—to beneficiaries, providers, or other individuals.
Misusing a provider's identification information to bill fraudulently	Includes misusing another provider's identification, stealing a provider's identification, and using a retired or deceased provider's identification to bill fraudulently.
Misusing a beneficiary's identification information to bill fraudulently	Misusing a beneficiary's health information and identification, for example, to bill for services, including using identification of a deceased beneficiary.
Fraud schemes related to prescription drugs	
Fraudulently obtaining, distributing, or prescribing drugs containing controlled substances	Schemes involve drugs containing controlled substances and include stealing, writing fake prescriptions, distributing, and diluting. Additionally, these schemes include situations where those involved obtain large quantities of controlled substances to sell illegally and where a beneficiary or individual visits multiple providers to obtain prescriptions for controlled substances (more than are medically necessary).
Fraudulently obtaining, distributing, and misbranding prescription drugs	Schemes involve prescription drugs (not controlled substances) including wholesale issues, pricing issues, prescribing drugs, misbranding, and adulterating.
Marketing of prescription drugs for off-label or unapproved uses	Marketing drugs for off-label uses (i.e., uses not approved by the FDA); also known as false or misleading labeling or misbranded prescription drugs.
Inflating prescription drug prices	Misrepresenting the manufacturer's actual cost or the number of doses in a container.
Pharmacy shorting	Pharmacy manipulates the quantity or price of a prescription that was billed, such as filling a lower quantity than what was billed, charging the beneficiary the full price of the drug instead of only the copayment, and submitting a bill for a more expensive version of prescription than what was filled.

Category	Description
Other schemes	
Self-referral of certain health services by providers in violation of the Stark law	Self-referral of services or facilities in which the provider had a financial interest (often referred to as a Stark law violation).
Stealing of funds or products by employees	Schemes involve employees stealing, misappropriating, or embezzling bank funds, funds, and premium refunds, etc.
Inappropriately waiving copayments for services or supplies provided	Schemes include waiving copayments for services provided and providing free supplies.
Provider exclusions - lying on application about exclusion status, billing for services provided by or employing an excluded provider	Schemes involve providers that are excluded from participating in health care programs. Schemes include lying on applications, concealing exclusion status, and working with excluded providers.
Other health care fraud-related schemes	Schemes do not fall into other categories but are health care-related.

Source: GAO analysis of information from the Department of Health and Human Services and Department of Justice. | GAO-16-216

Using the list of fraud schemes identified, we reviewed court documents for the health care fraud cases resolved in 2010 to determine the prevalence of health care fraud schemes. The data we obtained for the 2012 report were for fraud cases, including investigations and prosecutions, from HHS OIG and DOJ's U.S. Attorneys' Offices and Civil Division and included a variety of information such as information on the subjects of the fraud case and outcomes of the case (such as prison or probation). We obtained data from both HHS OIG and DOJ, as HHS OIG conducts investigations but DOJ does not prosecute all of the cases that are investigated. Also, because HHS OIG often works jointly with DOJ on fraud cases, for our 2012 report, we reduced duplication of fraud cases from the data we received from HHS OIG and DOJ by comparing subjects of the fraud cases that were in more than one data set we received.

Although the cases we obtained for the 2012 report included investigations as well as prosecutions, judgments, and settlements, for this engagement, we included only cases that had been adjudicated favorably for the United States, meaning criminal cases in which the subjects were found guilty, pled guilty, or pled no contest to at least one of the charges, and civil cases that resulted in a judgment for the United States or a settlement. There were 834 cases that resulted in a favorable outcome for the United States, though we only reviewed 739 of these cases. We excluded 95 cases because they were duplicative of another case in our data set (18 cases), they were not health care fraud cases (21 cases), the data were insufficient to determine the fraud schemes used on the cases (15 cases), the cases were administrative actions rather than criminal or civil cases (9 cases), or we could not locate information

on the cases, such as a court document or a press release, to determine the fraud schemes involved in the cases (32 cases).

To determine the health care fraud schemes used in the 739 cases included in our report, we reviewed court documents associated with the charging stage of the case (such as indictment, information, or complaint) unless the charging document for a case was not available. We used court documents that we had previously obtained through our work on the 2012 report. For that report, we obtained court documents from the Public Access to Court Electronic Records (PACER) database for the DOJ cases. However, we did not have a charging document for all of the DOJ cases and did not have a charging document for any of the HHS OIG cases. As a result, we searched in PACER for charging documents for any cases for which we were missing a charging document. If the charging document was not available, we reviewed case details as described in a DOJ or Federal Bureau of Investigation (FBI) press release. For several HHS OIG cases, we were unable to locate a charging document or a press release and obtained other court documents, such as settlement agreements and plea agreements, from HHS OIG.

When reviewing the court documents, we collected information on the health care fraud schemes that were used in the cases along with information about the beneficiary's role, the provider's role, whether a durable medical equipment supplier was involved, the programs that were affected by the fraud, and any monetary amounts associated with the fraud schemes (such as the amounts paid). For each case we reviewed, two reviewers independently categorized all information obtained for the case, including the relevant health care fraud schemes used on the case, and resolved any differences in the categorization. To assess the reliability of the data, we reviewed relevant documentation and examined the data for reasonableness and internal consistency. We found these data were sufficiently reliable for the purposes of our report.

Appendix II: Additional Details on Health Care Fraud Schemes in Cases GAO Reviewed

Tables 6 through 9 provide detailed information on health care fraud schemes for cases we reviewed, including whether the scheme was the only scheme in the case or used in combination with other schemes, the number of schemes used in cases, the role of the provider, and the role of the beneficiary.

Table 6: Number and Percentage of Health Care Fraud Cases Reviewed, by Fraud Scheme

	Number of cases in which			
Scheme	**Scheme was the only one used in the case**	**Scheme was used in combination with other schemes**	**Scheme was used**	**Percentage of all cases**
Billing for services or supplies that were not provided	29	286	315	42.6
• Billing for services or supplies that were not provided along with services that were provided	2	52	54	7.3
• Billing for services or supplies that were never provided, and no legitimate services were provided	22	72	94	12.7
• Billing for services or supplies that were not provided, and we were unable to determine whether other services were provided	5	162	167	22.6
Falsifying records in order to support fraudulent claims	5	181	186	25.2
Billing for services that were not medically necessary	9	172	181	24.5
Receiving or paying kickbacks	20	132	152	20.6
Upcoding to be paid at a higher rate than the services that were actually provided	21	108	129	17.5
Billing for services not prescribed or referred by a physician	1	103	104	14.1
Billing for services provided by an unqualified, uncertified, unlicensed, or ineligible provider	13	70	83	11.3
Fraudulently obtaining, distributing, or prescribing drugs containing controlled substances	31	48	79	10.8
Fraudulently obtaining, distributing, or misbranding prescription drugs	20	23	43	5.8
Misusing a beneficiary's or provider's identification information to fraudulently bill (such as billing under a deceased beneficiary's name or billing under a retired physician's identification)	7	32	39	5.3
Unbundling of services to receive higher total payment when billed separately	3	28	31	4.2
Marketing of prescription drugs for non-FDA-approved uses	6	24	30	4.1
Billing for services provided to an individual who was not eligible to receive services	0	24	24	3.3
Billing for prescription drugs that were not provided to beneficiaries	2	22	24	3.2
Lying about eligibility to obtain benefits or services	3	16	19	2.6

Scheme	Number of cases in which: Scheme was the only one used in the case	Scheme was used in combination with other schemes	Scheme was used	Percentage of all cases
Self-referring by providers	2	15	17	2.3
Billing for services provided by or employing an excluded provider	6	11	17	2.3
Billing for services as if they were provided by a physician to be paid at a higher rate when the services were actually provided by another provider (such as a nurse practitioner), which would have been paid at a lower rate	0	15	15	2.0
Miscellaneous schemes[a]	16	42	58	7.9
Other health care fraud-related schemes[b]	45	80	125	16.9
Total	**239 schemes**	**1,440 schemes**	**1,679 schemes in 739 cases**	**—**

Source: GAO analysis of court and other documents. | GAO-16-216

Notes: We reviewed 739 health care fraud cases that were resolved in 2010.

Percentages add to more than 100 because each case can have more than one scheme.

[a]Miscellaneous schemes include the remaining schemes that were identified in our review but each individual scheme represented less than 2 percent of the cases and thus is not included in the table. These schemes include billing for services as if they were provided in a higher level-of-care setting than actually provided, waiving copayments for beneficiaries to receive care or services, and inflating prescription drug prices.

[b]These health care fraud-related schemes included a variety of schemes, such as violating Medicare policy requirements by failing to document care provided, billing for services that did not meet standard-of-care requirements, and inflating or misreporting costs on cost reports submitted to Medicare.

Table 7: Number and Percentage of Health Care Fraud Cases Reviewed, by Number of Fraud Schemes Used

Number of schemes	Number of cases	Percentage
1 scheme	239	32.3
2 schemes	246	33.3
3 schemes	146	19.8
4 schemes	57	7.7
5 schemes	35	4.7
6 schemes	11	1.5
7 schemes	1	0.1
8 schemes	2	0.3
9 schemes	1	0.1
10 schemes	1	0.1

Number of schemes	Number of cases	Percentage
Total	**739**	**99.9**

Source: GAO analysis of court and other documents. | GAO-16-216

Notes: We reviewed 739 health care fraud cases that were resolved in 2010.

Percentages do not add to 100 due to rounding.

Table 8: Number and Percentage of Health Care Fraud Cases Reviewed, by Role of Provider

	Provider was complicit					
Scheme	**Provider was the biller and complicit**	**Provider was not the biller but was complicit**	**Provider's information was stolen or sold without his or her knowledge or was obtained under false pretenses**	**Provider was not involved**	**Unknown how provider's information was obtained**	**Total cases with this scheme**
Billing for services or supplies that were not provided	186	12	41	3	71	**315**
• Billing for services or supplies that were not provided along with services that were provided	44	2	6	0	2	**54**
• Billing for services or supplies that were never provided, and no legitimate services were provided	53	7	15	2	15	**94**[a]
• Billing for services or supplies that were not provided, and we were unable to determine if other services were actually provided or not	89	3	20	1	54	**167**
Falsifying a substantial portion of records in order to support fraudulent claims	112	13	32	12	15	**186**[a]
Billing for services that were not medically necessary	117	10	18	1	35	**181**
Receiving or paying kickbacks	105	21	7	9	9	**152**[a]
Upcoding services to be paid at a higher rate than the services that were actually provided	111	6	5	0	7	**129**
Billing for services not prescribed or not referred by a physician	26	2	25	0	51	**104**

Scheme	Provider was complicit: Provider was the biller and complicit	Provider was complicit: Provider was not the biller but was complicit	Provider's information was stolen or sold without his or her knowledge or was obtained under false pretenses	Provider was not involved	Unknown how provider's information was obtained	Total cases with this scheme
Billing for services provided by an unqualified, uncertified, unlicensed, or ineligible provider	73	1	7	0	2	**83**
Fraudulently obtaining, distributing, or prescribing drugs containing controlled substances	31	1	15	8	24	**79**
Fraudulently obtaining, distributing, or misbranding prescription drugs	9	1	3	21	9	**43**
Misusing a beneficiary's or provider's identification information to fraudulently bill (such as billing under a deceased beneficiary's name or billing under a retired physician's identification)	22	1	6	3	7	**39**
Unbundling of services to receive higher total payment when billed separately	31	0	0	0	0	**31**
Marketing of prescription drugs for non-FDA-approved uses	10	10	1	9	0	**30**
Billing for services provided to an individual who was not eligible to receive care	11	0	4	5	4	**24**
Billing for prescription drugs that were not provided to beneficiaries	13	0	6	1	4	**24**
Lying about eligibility to obtain benefits or services	3	0	2	9	5	**19**
Self-referral of certain health services by providers in violation of the Stark law	17	0	0	0	0	**17**
Billing for services provided by or employing an excluded provider	14	0	2	0	1	**17**

Scheme	Provider was complicit: Provider was the biller and complicit	Provider was complicit: Provider was not the biller but was complicit	Provider's information was stolen or sold without his or her knowledge or was obtained under false pretenses	Provider was not involved	Unknown how provider's information was obtained	Total cases with this scheme
Billing for services as if they were provided by a physician to be paid at a higher rate when the services were actually provided by another provider (such as a nurse practitioner) that would have been paid at a lower rate	13	0	2	0	0	**15**
Miscellaneous schemes[b]	43	0	3	13	6	**66**[a]
Other health care fraud-related schemes[c]	90	2	2	13	18	**125**
Total	**1,037**	**80**	**181**	**107**	**268**	**1,679**

Source: GAO analysis of court and other documents. | GAO-16-216

Note: We reviewed 739 health care fraud cases that were resolved in 2010.

[a]For these schemes, there were cases in which a fictitious provider was created to commit fraud. For the schemes of billing for services or supplies that were never provided, and no legitimate services were provided and falsifying records in order to support the fraud scheme, there were two cases that had fictitious providers created to commit the fraud. For the schemes of kickbacks and one miscellaneous scheme, there was one case that had fictitious providers created to commit the fraud.

[b]Miscellaneous schemes include the remaining schemes that were identified in our review but each individual scheme represented less than 1 percent of the cases and thus is not included in the table. These schemes include billing for services as if they were provided in a higher level-of-care setting than actually provided, waiving copayments for beneficiaries to receive care or services, and inflating prescription drug prices.

[c]These health care fraud-related schemes included a variety of schemes, such as violating Medicare policy requirements by failing to document care provided, billing for services that did not meet standard-of-care requirements, and inflating or misreporting costs on cost reports submitted to Medicare.

Table 9: Number and Percentage of Health Care Fraud Cases Reviewed, by Role of Beneficiary

Scheme	Beneficiary was complicit in scheme	Beneficiary was not complicit		Beneficiary was not involved	Unknown how beneficiary's information was obtained	Total cases with this scheme
		Beneficiary's information was stolen or sold without his or her knowledge or was obtained under false pretenses	Beneficiary received service or supply from provider, but there was no evidence to indicate that the beneficiary was aware of the fraud			
Billing for services or supplies that were not provided	52	28	193	8	34	**315**
• Billing for services or supplies that were not provided along with services that were provided	4	0	50	0	0	**54**
• Billing for services or supplies that were never provided, and no legitimate services were provided	17	17	31	6	23	**94**
• Billing for services or supplies that were not provided, and we were unable to determine if other services were actually provided or not	31	11	112	2	11	**167**
Falsifying a substantial portion of records in order to support fraudulent claims	41	18	99	15	12	**186**
Billing for services that were not medically necessary	43	11	117	5	5	**181**
Receiving or paying kickbacks	60	14	55	21	2	**152**
Upcoding services to be paid at a higher rate than the services that were actually provided	5	4	119	1	0	**129**
Billing for services not prescribed or referred by a physician	6	15	74	2	7	**104**

		Beneficiary was not complicit				
Scheme	**Beneficiary was complicit in scheme**	**Beneficiary's information was stolen or sold without his or her knowledge or was obtained under false pretenses**	**Beneficiary received service or supply from provider, but there was no evidence to indicate that the beneficiary was aware of the fraud**	**Beneficiary was not involved**	**Unknown how beneficiary's information was obtained**	**Total cases with this scheme**
Billing for services provided by an unqualified, uncertified, unlicensed, or ineligible provider	5	1	72	2	3	**83**
Fraudulently obtaining, distributing, or prescribing drugs containing controlled substances	26	6	11	13	22	**78**[a]
Fraudulently obtaining, distributing, or misbranding prescription drugs	4	2	10	24	3	**43**
Misusing a beneficiary's or provider's identification information to fraudulently bill (such as billing under a deceased beneficiary's name or billing under a retired physician's identification)	4	14	14	2	5	**39**
Unbundling of services to bill separately for services that were bundled to be billed as a bundle	0	0	31	0	0	**31**
Marketing of prescription drugs for non-FDA-approved uses	1	0	12	17	0	**30**
Billing for services provided to an individual who was not eligible to receive care	14	1	8	0	1	**24**
Billing for prescription drugs that were not provided to beneficiaries	5	5	11	1	1	**24**[a]
Lying about eligibility to obtain benefits or services	14	1	2	0	2	**19**
Self-referral of certain health services by providers in violation of the Stark law	0	0	17	0	0	**17**
Billing for services provided by or employing an excluded provider	0	0	16	1	0	**17**

Scheme	Beneficiary was complicit in scheme	Beneficiary was not complicit: Beneficiary's information was stolen or sold without his or her knowledge or was obtained under false pretenses	Beneficiary was not complicit: Beneficiary received service or supply from provider, but there was no evidence to indicate that the beneficiary was aware of the fraud	Beneficiary was not involved	Unknown how beneficiary's information was obtained	Total cases with this scheme
Billing for services as if they were provided by a physician to be paid at a higher rate when the services were actually provided by another provider (such as a nurse practitioner), which would have been paid at a lower rate	0	0	15	0	0	**15**
Miscellaneous schemes[b]	2	1	46	13	4	**66**
Other health care fraud-related schemes[c]	6	4	77	24	14	**125**
Total	**288**	**125**	**999**	**149**	**115**	**1,679**

Source: GAO analysis of court and other documents. | GAO-16-216

Note: We reviewed 739 health care fraud cases that were resolved in 2010.

[a]For these schemes, there was one case in which a fictitious beneficiary was created to commit fraud.

[b]Miscellaneous schemes include the remaining schemes that were identified in our review but each individual scheme represented less than 1 percent of the cases and thus is not included in the table. These schemes include schemes, such as billing for services as if they were provided in a higher level-of-care setting than actually provided, waiving copayments for beneficiaries to receive care or services, and inflating prescription drug prices.

[c]These health care fraud-related schemes included a variety of schemes, such as violating Medicare policy requirements by failing to document care provided, billing for services that did not meet standard-of-care requirements, and inflating or misreporting costs on cost reports submitted to Medicare.

Appendix III: GAO Contact and Staff Acknowledgments

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Staff Acknowledgments

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