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## **THOSE SCAMMING LITTLE RASCALS: POWER WHEELCHAIR FRAUD AND THE FLAW IN THE MEDICARE SYSTEM**

*Sydney Mayer*

### **ABSTRACT**

In the last two decades, power wheelchair fraud has grown into a billion dollar industry. While power wheelchairs have been the most popular choice in recent years, the method of fraud has been around since Medicare's inception. The pay and chase model, in which Medicare receives a claim and pays the claimant before reviewing the actual claim for any fraud, enables a cycle of fraud that moves from one item to another and leads to the loss of billions of dollars. By the time the government catches on to one popular fraudulent item, the fraud has moved to the next one. While the Patient Protection and Affordable Care Act does address the issue of power wheelchair fraud and effectively removes its profitability through its reforms, like other anti-fraud and abuse legislation, it does not address the underlying, consistent problem with the entire system. Instead of continuously applying singular solutions to the greater problem, the government should write legislation that overhauls the Medicare system's payment methods. In addition, if a standardized computer system were implemented in a similar way to what is being done nationally in law enforcement, perhaps the cycle could be broken. Until then, the fraud will continue as it has been for decades, and Medicare will endure massive financial losses.

### **INTRODUCTION**

In March 2010, President Barack Obama signed the Patient Protection and Affordable Care Act ("PPACA") into law.<sup>1</sup> While its main goals are to lower healthcare costs, expand access of coverage to millions, and

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<sup>1</sup> *Affordable Care Act*, Centers for Medicare & Medicaid Services, <http://www.medicare.gov/affordablecareact/affordable-care-act.html> (last visited Dec. 12, 2014).

enhance the quality of healthcare, PPACA also sought to address the numerous fraud and abuse issues that the American healthcare system had endured in the past three decades.<sup>2</sup> The Medicare system loses billions, even trillions, of dollars annually to fraudulent claims and abuse of the system's flaws; the financial losses exceeded \$3 trillion in 2014 according to the FBI.<sup>3</sup> In recent years, the most popular and profitable fraudulent schemes have centered on power wheelchairs and their Medicare reimbursements. Since the federal government discovered it was a remunerative form of fraud in the mid-1990s, power wheelchair scams have become a billion dollar industry, running rampant for over a decade throughout the country.<sup>4</sup> Although PPACA directly addresses the power wheelchair fraud problem, enacting changes to the Medicare system to alleviate the heavy financial losses, it does not address the true problem that power wheelchair fraud demonstrates. Since its creation in 1966, Medicare has been subject to serious and consistent fraud, made possible through the pay and chase payment model, in which the states pay providers for submitted claims and then attempt to recover payments from liable third parties.<sup>5</sup> With a payment model that facilitates schemers fraudulent reimbursements from Medicaid by merely mailing in a claim, simply addressing the symptoms and ignoring the overarching illness, as the government has been doing, does not solve the true flaw in the system.

This Article proceeds in three parts. In Part I, I discuss the pay and chase Medicare model and how it enabled power wheelchair fraud to become a reality. In Part II, I examine the changes made by PPACA and its implications on power wheelchair fraud. Finally, in Part III, I illustrate that the real problem with the Medicare system is that the pay-and-chase reimbursement model enables fraud and abuse and propose two potential solutions: enacting new legislation and creating a standardized computer system to process claims and identify questionable submissions.

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<sup>2</sup> *Program Integrity*, Centers for Medicare & Medicaid Services, <http://www.medicare.gov/affordablecareact/provisions/program-integrity.html> (last visited Dec. 12, 2014).

<sup>3</sup> *Health Care Fraud*, Federal Bureau of Investigation, [http://www.fbi.gov/about-us/investigate/white\\_collar/health-care-fraud](http://www.fbi.gov/about-us/investigate/white_collar/health-care-fraud) (last visited Dec. 12, 2014).

<sup>4</sup> David A. Fahrenthold, *A Medicare Scam that Just Kept Rolling*, WASH. POST (Aug. 16, 2014), available at <http://www.washingtonpost.com/sf/national/2014/08/16/a-medicare-scam-that-just-kept-rolling/>.

<sup>5</sup> OIG, *Medicaid Third-Party Liability Savings Increased, But Challenges Remain*, OEI -05-11-00130 (Jan. 2013), <http://oig.hhs.gov/oei/reports/oei-05-11-00130.pdf>, at 3.

### I. THE PAY AND CHASE MODEL AND THE POWER WHEELCHAIR SCHEME

By law, Medicare must pay its 4.9 million claims per day within thirty days of receiving the claim.<sup>6</sup> Theoretically, during that short period of time, the claim reviewers should read each claim in order to identify and filter out the fraudulent claims.<sup>7</sup> However, the Medicare system does not have the manpower to properly identify these bogus claims. A Medicare Administrative Contractor (MAC) reviews only a small percentage of claims, likely less than three percent, before the reimbursement is provided to the claimant.<sup>8</sup> The rest of the claims are reviewed after the reimbursement has been provided to the claimant.<sup>9</sup> If the claim is identified as fraudulent after the money has been reimbursed to the claimant, the government must pursue the fraud in the hopes that the money can be recovered. This is the “pay and chase” model.

In essence, Medicare is an honor system, hopeful that its participants would be honest and forward with the costs and services rendered. However, such an honor system made it easier for individuals to take advantage of the system, and they have done so continuously. The system allows the claim to be made and paid, without a fact check of what a physician is claiming to have done. In addition, the outside contractors employed by the government to deal with claims are poorly managed; authority and responsibilities are confusing, and little governmental oversight is given once duties are assigned.<sup>10</sup>

Before power wheelchairs became the most popular item of fraudulent claims, diabetic supplies and home electro-shock kits dominated the fraud system. Diabetes supplies were a popular choice because a patient did not need to go to the doctor.<sup>11</sup> Fraudsters would place a phone call to the patient, claiming to be Medicare or a diabetes organization, and inform the patient that he or she is eligible for “free” diabetic supplies in exchange for their Medicare identification number or personal financial informa-

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<sup>6</sup> Fahrenthold, *supra* note 4.

<sup>7</sup> *Id.*

<sup>8</sup> *Id.*

<sup>9</sup> *Id.*

<sup>10</sup> Reed Abelson and Eric Lichtblau, *Pervasive Medicare Fraud Proves Hard to Stop*, NY TIMES (Aug. 15, 2014), available at [http://www.nytimes.com/2014/08/16/business/uncovering-health-care-fraud-proves-elusive.html?\\_r=0](http://www.nytimes.com/2014/08/16/business/uncovering-health-care-fraud-proves-elusive.html?_r=0).

<sup>11</sup> OIG, *Fraud Alert for People with Diabetes*, available at <https://oig.hhs.gov/newsroom/news-releases/2012/alert20120309.asp>.

tion.<sup>12</sup> The fraudsters would then file the claim with Medicare and be reimbursed within a month. It was an intelligent scheme, one that required little work outside of identifying diabetic Medicare patients, but the profit margin was not large. The government soon identified the problem and addressed it with changes to how Medicare dealt with diabetic supplies. As a result, individuals seeking to take advantage of the pay and chase model had to find a new product to exploit.

As far as Medicare fraud goes, before PPACA, power wheelchairs were the most popular and most profitable durable medical equipment (DME) for exploitation. The wheelchair itself is worth \$1,000 to \$4,000, depending on whether it is a standard or complex rehabilitation wheelchair.<sup>13</sup> A standard wheelchair is much less bulky than its complex counterpart and is made for basic, daily mobility.<sup>14</sup> In contrast, a complex wheelchair should be more difficult to acquire because it requires that the “beneficiary’s mobility limitation” be extensive as a result of “a neurological condition, muscle disease, or skeletal deformity.”<sup>15</sup> Despite the heightened standard required for an individual to be prescribed a complex wheelchair, complex wheelchairs were reimbursed significantly more often than standard wheelchairs. Power wheelchairs, specifically complex wheelchairs, yielded a very high profit margin; of its \$1,000 to \$4,000 price range, Medicare reimbursed eighty percent to the physician’s office or the medical supply company. Its profitability coupled with the minimal effort it took to bill the fraudulent claim made complex power wheelchairs an excellent option with which to commit Medicare fraud.

The scheme is simple. The first step is to find the patients.<sup>16</sup> Fraudsters used professional recruiters, often referred to as “cappers,” to either find the Medicare patient or buy Medicare numbers from a third party.<sup>17</sup> The capper coerced seniors to hand over their Medicare identification number by: 1) bribing the senior, or 2) telling the elderly patient that the government was giving away free wheelchairs for a limited time, and the patient must give the capper their number in order to participate.<sup>18</sup> The recruiting business was lucrative, with cappers being paid up to \$900 per pa-

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<sup>12</sup> OIG, *Fraud Alert for People with Diabetes*, available at <https://oig.hhs.gov/newsroom/news-releases/2012/alert20120309.asp>.

<sup>13</sup> OIG, *Medicare Power Wheelchair Claims Frequently Did Not Meet Documentation Requirements*, OEI-04-07-00401 (Dec. 2009), available at <http://oig.hhs.gov/oei/reports/oei-04-07-00401.pdf>.

<sup>14</sup> *Id.*

<sup>15</sup> *Id.*

<sup>16</sup> Fahrenthold, *supra*, note 4.

<sup>17</sup> *Id.*

<sup>18</sup> *Id.*

tient as a finder's fee.<sup>19</sup> Seniors have reported being pressured by cappers to divulge their personal Medicare information and accept the wheelchair. During the 2014 Los Angeles trial of Olufunke Fadojutimi, a registered nurse and former owner of Lutemi Medical Supply<sup>20</sup>, 71-year-old Rodolfo Fernandez testified that Fadojutimi pestered him until he finally accepted her offer of a free wheelchair.<sup>21</sup> Fadojutimi picked up Fernandez in a van along with other seniors and took him for examination and fulfillment of her promise of a free wheelchair in exchange for his Medicare ID number.<sup>22</sup> Fadojutimi used this method to file \$8.3 million worth of false and fraudulent claims, almost \$4.3 million of which was paid by Medicare.<sup>23</sup>

Next, either a doctor is bribed to certify the fraudulent prescription, the fraudsters buy a non-participatory doctor's signature, or acquire a dead doctor's signature for certification, which is the cheapest method of the three.<sup>24</sup> In order to use the dead physician's signature in the scheme, a fraudster will search through the obituaries to find a doctor who has died.<sup>25</sup> The individual then writes to Medicare as the dead physician, saying that he has changed his address and to send any further correspondents to the new address.<sup>26</sup> Finally, once a physician has certified the claim, Medicare receives the bill, and within thirty days, the state sends back the reimbursement.

The pay and chase model enables the fraud to occur at the final step of the fraud scheme. Once Medicare received the claim, it was highly unlikely that anyone would read it fully to identify fraud. With 4.9 million claims received by Medicare daily and too little manpower to review each individually, fraudsters had little fear of getting caught. In addition, power wheelchair fraud was easier than other types of fraud because unlike other Medicare-approved equipment, it was not necessary for a physician's office or hospital to file the claim.<sup>27</sup> Before PPACA, an individual could become a DME provider by complying with the Medicare program's supplier

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<sup>19</sup> Fahrenthold, *supra*, note 4.

<sup>20</sup> Press Release, *Former Owner of Southern California Medical Supply Company Found Guilty in a 10-Year, \$8.3 Million Medicare Fraud Scheme*, Federal Bureau of Investigation (Aug. 1, 2014), <http://www.fbi.gov/losangeles/press-releases/2014/former-owner-of-southern-california-medical-supply-company-found-guilty-in-a-10-year-8.3-million-medicare-fraud-scheme>.

<sup>21</sup> *Id.*

<sup>22</sup> *Id.*

<sup>23</sup> Fahrenthold, *supra* note 4.

<sup>24</sup> *Id.*

<sup>25</sup> *Id.*

<sup>26</sup> *Id.*

<sup>27</sup> *Id.*

standards (42 CFR §424.57 (c)) and quality standards.<sup>28</sup> Once approved, a non-medical professional could provide approved medical supplies and equipment and receive a Medicare or Medicaid reimbursement.<sup>29</sup>

One of the most popular examples of this type of fraud scheme involved The Scooter Store, a Texas-based power and standard wheelchair company, famous for its television ads promising freedom of mobility and independence to seniors.<sup>30</sup> It was also the largest power wheelchair supplier in the country.<sup>31</sup> About eighty percent of The Scooter Store's revenue came from Medicare patients.<sup>32</sup> The company's strategy, according to former salesmen, was to push and bully doctors to write prescriptions for power wheelchairs for needy and non-needy patients.<sup>33</sup> In addition, its famous television ads manipulated the elderly into thinking not only did they need a power wheelchair to live a normal, active life, but they were entitled to one, and any doctor who did not write them a prescription for it was denying them their privilege.<sup>34</sup> This created an adversarial relationship between the elderly patient and his or her physician, and put The Scooter Store in a powerful position to manipulate the elderly to seek a prescription until they were successful. In 2005, the United States Justice Department sued The Scooter Store for using false advertising to entice seniors to obtain power scooters that they did not want or need while Medicare absorbed the cost.<sup>35</sup> The Scooter Store settled the initial Justice Department suit for \$4 million in 2007.<sup>36</sup> From 2009 to 2012, The Scooter Store overbilled Medicare by over \$100 million.<sup>37</sup> However, in the ensuing years, the federal government audited the company, resulting in The Scooter Store paying the government another \$19.5 million, this time for overpayments.<sup>38</sup> In 2013, after numerous other lawsuits and filing for bankruptcy as a result losing its Medicare DME supplier approval, the company closed.<sup>39</sup>

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<sup>28</sup> *DMEPOS Accreditation*, Centers of Medicare & Medicaid Services, (Aug. 24, 2012), available at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/DMEPOS Accreditation.html>.

<sup>29</sup> *Id.*

<sup>30</sup> *The Scooter Store shutting down after federal scrutiny*, *CBS Probe*, CBS News (Sept. 14, 2013), <http://www.cbsnews.com/news/the-scooter-store-shutting-down-after-federal-scrutiny-cbs-probe/>.

<sup>31</sup> Jeff Glor & Ben Eisler, *Are power wheelchair companies ripping off the government?*, CBS News (Jan. 7, 2013), <http://www.cbsnews.com/news/are-power-wheelchair-companies-ripping-off-the-government/>.

<sup>32</sup> *Id.*

<sup>33</sup> *Id.*

<sup>34</sup> *Id.*

<sup>35</sup> *The Scooter Store shutting down after federal scrutiny*, *supra* note 30.

<sup>36</sup> *Id.*

<sup>37</sup> *Id.*

<sup>38</sup> *Id.*

<sup>39</sup> *Id.*

In addition, litigation has become more prevalent in the last ten years as the government has begun to identify the fraud more frequently. In *United States v. Miller*, Miller owned AA Better Medical Supply in Houston, Texas.<sup>40</sup> Miller and her co-conspirator, physician Dr. Walter Long, defrauded Medicare and Medicaid by submitting claims of scooters and wheelchairs that were either never supplied or more costly than the equipment actually supplied.<sup>41</sup> Dr. Long provided pre-authorized blank certifications of medical necessity (CMNs); Miller and her employees would complete the information once they found a patient, very few of whom had a legitimate and pressing need for a power wheelchair.<sup>42</sup> At Miller's sentencing hearing, she stated that one reason she felt confident in the scheme was that she knew that CMS would "assume the truthfulness of information contained in her claim submissions."<sup>43</sup> She was correct; the government assumed the truthfulness of the information and paid over \$1 million to Miller during her tenure as a power wheelchair fraudster.<sup>44</sup>

In another similar case, *United States v. Metoyer*, Metoyer, a Houston-area patient recruiter for a DME company, was convicted of one count of conspiring to receive illegal kickbacks for referring Medicare beneficiaries, and two counts of receiving illegal kickbacks for referring Medicare beneficiaries.<sup>45</sup> Metoyer and her employers used the standard Medicare fraud scheme as described above, but in this particular case, Metoyer billed the government using a special code that designated the power wheelchairs as replacements for wheelchairs lost during hurricanes that hit the area in 2008.<sup>46</sup> She faced the maximum sentencing penalties – ten years in prison for health care fraud conspiracy, ten years for committing health care fraud, five years for conspiring to receive illegal kickbacks and five years for receiving an illegal kickback.<sup>47</sup>

The power wheelchair fraud structure was successful for nearly two decades. After schemers realized how easy it was to exploit the system, the industry grew into the billions of dollars, leaving seniors with pointless pieces of equipment and taxpayers footing the bill. In 2010, as

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<sup>40</sup> U.S. v. Miller, 607 F.3d 144, 147 (5th Cir. 2010).

<sup>41</sup> *Id.*

<sup>42</sup> *Id.*

<sup>43</sup> *Id.* at 149.

<sup>44</sup> *Id.* at 147.

<sup>45</sup> *Houston Federal Jury Convicts Patient Recruiter of Medicare Fraud Involving Claims of Hurricane Damage to Power Wheelchairs*, Department of Justice (May 26, 2011), <http://www.justice.gov/opa/pr/houston-federal-jury-convicts-patient-recruiter-medicare-fraud-involving-claims-hurricane>.

<sup>46</sup> *Id.*

<sup>47</sup> *Id.*

the federal government moved forward with the new healthcare system plan, PPACA, it recognized this issue of fraudulent claims and directly addressed it in the legislation. While it mitigated power wheelchair claims issues, PPACA fails to address the overarching problem: the fact that the system itself allows for a cycle of abuse, always leaving Medicare a step behind fraudsters.

## II. PPACA: Changes and Implications

Section 3136 of PPACA directly addresses the power wheelchair fraud issue. Three major changes to the system were made. Firstly, PPACA eliminated lump sum purchase payments for standard power wheelchairs.<sup>48</sup> Lump sum payments are still available for complex, rehabilitative power wheelchairs, but standard power wheelchairs are only available on a rent-to-own basis.<sup>49</sup> Suppliers must provide these items on a monthly rental basis like other capped rental DME not subject to a lump sum purchase option.<sup>50</sup> PPACA also modified rental payment amounts for power wheelchairs; specifically, “payment is set at 15% (rather than 10%) of the purchase price for each of the first three months, and at 6% (rather than 7.5%) of the purchase price for each of the remaining 10 months.”<sup>51</sup> By doing so, PPACA reduced the profitability of the power wheelchair system.

Without the availability of lump-sum payments, fraudsters were not making as large a profit as quickly as they had before PPACA enacted its changes. More importantly, the rent-to-own system allows Medicare time to investigate claims further.<sup>52</sup> The hope is that the system can more easily detect fraud through this systemic change. Since its enactment, this program has proven somewhat effective. Only about 124,000 beneficiaries received power wheelchairs from Medicare in 2014, the lowest total since 2001.<sup>53</sup>

Additionally, PPACA adjusted the flawed method of orders and documentation. In order to receive a reimbursement, the patient notes submitted with the claim must acknowledge that a named physician, phy-

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<sup>48</sup> Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 3136(a)(2)(A)–(B)(2010).

<sup>49</sup> 42 U.S.C. § 3136(a)(2)(A)–(B).

<sup>50</sup> See generally CMS, *FISS System Changes for Elimination of Lump Sum Purchase Payment for Standard Power Wheelchairs Furnished on or After January 1, 2011 Due to the Affordable Care Act* (Jan. 28, 2011), <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R848OTN.pdf>.

<sup>51</sup> 42 U.S.C. § 3136(a)(1)(B).

<sup>52</sup> Fahrenthold, *supra* note 4.

<sup>53</sup> *Id.*

sician assistant, nurse practitioner, or clinical nurse specialist has had a face-to-face encounter with the patient at least six months prior to the submitted DME order.<sup>54</sup> If the physician does not adhere to the documentation requirements, the Secretary of the Department of Health and Human Services (HHS) can revoke the physician's enrollment for up to a year or longer depending on the number of infractions.<sup>55</sup>

Furthermore, a competitive DME bidding program has been implemented to limit consumers' wheelchair choices.<sup>56</sup> Under the competitive bidding program, suppliers submit bids to provide certain medical equipment and other supplies at a lower price than what Medicare currently pays for these items.<sup>57</sup> Medicare uses the bids to set the amount it will pay for equipment and supplies.<sup>58</sup> Qualified suppliers with winning bids are chosen as Medicare-contract suppliers.<sup>59</sup> The program is meant to limit fraud by lowering equipment prices and limiting Medicare-contracted suppliers within the system.<sup>60</sup> The competitive bidding program has already been successful since its implementation in 2011; the total spending on power wheelchairs, which had reached \$964 million in 2003, fell to \$190 million in 2012.<sup>61</sup>

Although these changes have been successful in the years following their 2011 enactment, they only address power wheelchair fraud specifically. The overall fraud problem is not being properly addressed by these continuous one-off, pointed solutions. The government needs to look at the system as a whole and enact change because the model is allowing abusers to steal millions of dollars from the already financially-strapped system.

Power wheelchair fraud and the greater issue that it demonstrates is an important issue to be considered by the consumer and the government. Not only are the government and its public healthcare system being taken advantage of, but also the citizens are being used and abused as a result. The elderly and the indigent are being targeted, their Medicare identification numbers stolen, and groups of criminals are making money from other's misfortunes. Every taxpayer is paying for this flaw in the system

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<sup>54</sup> 42 U.S.C. § 6407(b)(2)(ii).

<sup>55</sup> *Id.*

<sup>56</sup> 42 U.S.C. § 3136(c)(2).

<sup>57</sup> *Durable Medical Equipment Competitive Bidding Program*, Centers for Medicare & Medicaid Services, <http://www.medicare.gov/what-medicare-covers/part-b/durable-medical-equipment-bidding.html> (last visited Dec. 12, 2014).

<sup>58</sup> *Id.*

<sup>59</sup> *Id.*

<sup>60</sup> *Id.*

<sup>61</sup> Fahrenthold, *supra* note 4.

because on average, Medicare fraud costs an estimated \$60 billion annually.<sup>62</sup> Power wheelchair fraud accounts for a large amount of those costs; therefore, everyone should be aware and concerned about this type of fraud and why it keeps occurring. To end this continuous rotation of fraud, the federal government needs to overhaul the Medicare system in a comprehensive manner instead of dealing with each vulnerability individually over time.

### III. The Real Problem and Proposed Solutions

The PPACA changes to the power wheelchair system will likely continue to reduce fraud and abuse in the ensuing years. However, as history has proven, the fraud will merely switch to another Medicare-covered product. Legislation has continuously addressed individual forms of fraud instead of the principal issue, namely the ease in which fraudulent Medicare reimbursement claims can be filed. For example, Medicare implemented a national mail-order program for diabetic supplies in which a beneficiary either had to participate in the mail-order program or use the pick-up option at a Medicare-approved pharmacy.<sup>63</sup> This solution was specific to diabetic supply fraud, but the government has failed to the glaring overarching issue.

The current remedy – to address a specific fraud after it becomes a serious issue for the system – does not have the long-term effects that are necessary to stop the cycle of fraud from occurring with other medical supplies. The real issue is that the pay and chase model is extremely flawed and has remained the Medicare reimbursement system model despite its obvious issues. It enables fraud to occur by sending people large amounts of money with no review of their claims; by the time fraud is detected, more often than not, the system has already lost thousands of dollars. Medicare does not have the proper resources to have strict enough oversight to detect fraud before the reimbursement is provided. Due to budget constraints, it is not a plausible option to suggest that Medicare needs to hire more people to handle the large amount of claims that come through the system. Medicare is going through a financial crisis. Although PPACA will reduce Medicare spending by \$850 billion over the next decade, the 2012 Medicare trustees report anticipates the Hospital Insurance

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<sup>62</sup> Glor & Eisler, *supra* note 31.

<sup>63</sup> *Medicare's National Mail-Order Program for Diabetic Supplies*, Centers for Medicare & Medicaid Services, <http://www.medicare.gov/what-medicare-covers/part-b/dme-diabetes-national-mail-order-program.html>.

Trust Fund will be depleted by 2024.<sup>64</sup> This fiscal crisis and Medicare's inability to remedy its consistent issues like understaffing demonstrates a serious issue with the Medicare system that the government must eradicate.

While it may not be fiscally possible to increase the manpower to review claims, the federal government and the Medicare system need to work together to make a financially responsible decision as to how to remedy this serious fraud issue. There are several possible solutions that Medicare could pursue. First, the government should process claims in a way that identifies questionable and improper claims before they are paid. Because there are improper resources to deal with the claims, a standardized fraud identification software program would help Medicare have a more accurate level of oversight over potential fraudulent claims. Medicare has continuously implemented programs to address fraud ex post facto. These methods include the Health Care Fraud Prevention and Enforcement Action Team (HEAT) and the Senior Medical Patrol (SMP). SMP volunteers to teach others about health care fraud and show Medicare and Medicaid recipients how to protect against, detect, and report fraud.<sup>65</sup> HEAT's purpose is to crack down on the people and organizations that abuse the system and to reduce health care costs and improve quality of care by preventing fraudsters from taking advantage of the system.<sup>66</sup> These forces against fraud have been effective in raising fraud awareness to Medicare beneficiaries and prosecuting fraudsters, but again, it has focused on dealing with the issue after the fraud has already occurred. With this standardized fraud identification software program, it would be possible to spot patterns within the claim that flag potential abuse. A fraud-spotting program could also flag physicians or medical equipment companies with questionable histories for additional review.

Moreover, such a program might relieve the heavy workload of Medicare claim reviewers. Reviewers would become more diligent in their claim processing and could spend more time reviewing each individual claim. A standardized software program could alleviate more pressures, reduce workloads, and spot fraud before the individual is reimbursed for his or her fraudulent claim.

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<sup>64</sup> Joseph Antos, *Medicare's Fiscal Crisis and Options for Reform*, American Enterprise Institute (May 1, 2012), <http://www.aei.org/publication/medicares-fiscal-crisis-and-options-for-reform/>.

<sup>65</sup> *About the Senior Medical Patrol*, stopmedicarefraud.gov (June 2012), <http://www.stopmedicarefraud.gov/preventfraud/smp/index.html>.

<sup>66</sup> *About HEAT Task Force*, stopmedicarefraud.gov (June 2012), <http://www.stopmedicarefraud.gov/aboutfraud/heattaskforce/>.

This Medicare fraud identification system could be modeled after the New York Police Department's ("NYPD") management software, CompStat. CompStat is a computer system that "synthesizes analysis of crime and disorder data, strategic problem solving, and a clear accountability structure."<sup>67</sup> The NYPD uses the program to address current issues in the department, collect and provide data analysis of input information, and increase efficiency in solving crimes.<sup>68</sup> Furthermore, CompStat "facilitates accurate and timely analysis of crime and disorder data, which is used to identify crime patterns and problems."<sup>69</sup> The Medicare fraud identification program must be able to identify patterns in a similar fashion, so CompStat would be a useful guide for how an analytical system should work. Through a similar pattern recognition method and by identifying red flag variables within those patterns, a computer program dedicated to identifying fraud would be greatly beneficial to the fight against fraud.

CompStat, and its Baltimore counterpart, CitiStat, individually cost only \$20,000 to set up.<sup>70</sup> The system costs about \$350,000 to \$400,000 to run per year; these costs are mainly the employment of analysts and an investigator.<sup>71</sup> This means that the bulk of the costs is employee salaries; once the system is set up, little extra expense is required.<sup>72</sup> Instead of using expensive software and technology, CompStat and CitiStat use Microsoft Excel and PowerPoint to analyze the data, so it is easily teachable, as most individuals know how to use Excel and PowerPoint to some degree.<sup>73</sup> While costs are low for the smaller scale CompStat system in major U.S. cities, for a massive agency like CMS, the costs would be noticeably higher in terms of set up and running the program each year. Budgetary concerns may mean that if this system were implemented, the number of analysts and investigators would be fairly low. CMS is already understaffed, and it is unlikely that the agency would want to hire a large number of analysts because that means a larger number of new salaries and benefits. But, over time, if the program proves as successful as CompStat has been in the ten cities that use it, CMS will likely be spurred to increase the number of analysts and investigators to improve the program's effectiveness. If the program meets any of its goals – to develop strategies to

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<sup>67</sup> *Implementing and Institutionalizing CompStat in Maryland*, University of Maryland, [http://www.compstat.umd.edu/what\\_is\\_cs.php](http://www.compstat.umd.edu/what_is_cs.php) (last visited Dec. 12, 2014).

<sup>68</sup> *Id.*

<sup>69</sup> *Id.*

<sup>70</sup> Tina Rosenberg, *Armed With Data, Fighting More Than Crime*, NY TIMES (May 2, 2012), available at [http://opinionator.blogs.nytimes.com/2012/05/02/armed-with-data-fighting-more-than-crime/?\\_r=0](http://opinionator.blogs.nytimes.com/2012/05/02/armed-with-data-fighting-more-than-crime/?_r=0).

<sup>71</sup> *Id.*

<sup>72</sup> *Id.*

<sup>73</sup> *Id.*

solve problems, reduce crime, and ultimately, improve the quality of Medicare and Medicaid's claims system – the amount defrauded from the Medicare and Medicaid system will be noticeably lower. The amount of savings would justify increasing the number of CMS analysts and investigators.

Additionally, Medicare should re-review all Medicare-approved physicians, hospitals, and suppliers to ensure that there is no history of fraud and abuse with the individual or organization. Along with HEAT and SMP, HHS should organize a special commission or task force dedicated to dealing with the reevaluation of these individuals and organizations. Forming this commission would not be as costly as hiring more MACs to review claims since the task force would be temporary and would derive from HHS. By requiring a reevaluation process that is run by a dedicated task force, the government can identify individuals who have a questionable history. Also, a more detailed analysis of past records may uncover unique tactics previously unknown. This plan could address the issue of fraudsters using deceased physician's Medicare identification numbers because each physician will be reviewed in depth. This part of the review process must continue after the task force is disbanded to discourage fraudsters from initiating new schemes. HEAT is currently going through records as part of their investigation and prosecution, but instituting a task force would allow for earlier detection and would help HEAT in its efforts as well.

The task force could be a pre-cursor to a Medicare CompStat system. In a way, the task force's job would be to weed out the approved Medicare medical professionals before the system goes into place. Through reevaluation, the task force would spot abusers using its knowledge of standard fraud tactics and strategies. If deemed suspicious enough, that individual or organization would be reported for further investigation to the Department of Justice and investigators within HHS, and if proven guilty of fraud and abuse, would be promptly removed from the program. In that intermittent period of investigation, the individual or organization would be put on probation and their activity as a Medicare DME frozen until the investigation was complete. This would be a deterrent to others who are considering or have participated in fraud.

Lastly, Congress should enact legislation that handles the issues with the pay and chase Medicare model. PPACA works diligently to reduce fraud and prevent the Medicare system from losing money. But, as previous legislation has often done, PPACA deals more with specific types of fraud than the underlying reasons for the occurrence of fraud in the

Medicare system. The system allows fraud to occur at high rates because it places too much trust in the individual claimant and too little emphasis on claims review prior to reimbursement. The government needs take the initiative to fix this broken scheme instead of continuing to make one-off fixes that do not address the overarching issue.

This legislation should implement a system that requires greater oversight and Medicare protection. The legislation should deal with specific types of fraud, propose remedies to deal with fraud that is currently occurring, and, most importantly, it should propose an overhaul of the pay and chase Medicare model. The legislation could encompass the first two recommendations and improve on the way the Medicare system is run.

Legislation should identify and prioritize transactions that are at high risk for potential fraud or abuse, like power wheelchairs and prosthetics, and provide additional review before payment. CMS has data and predictions of what items are fraught with fraud and abuse, so this should be a simple process of gathering information and identifying the most at-risk products. In addition, once identified, the product could be limited to only a number of Medicare-approved individuals and organizations. These individuals would need to go through an extensive review process of their backgrounds and experiences with Medicare and Medicaid. Once determined eligible to sell the high-risk products, the individual will be subject to periodic reviews in their facility. Since the products they are selling are prioritized, all claims will be subject to additional review. This plan will lower the potential for major fraud and limit the number of sellers, both making fraud more identifiable and disincentivizing fraud because the potential to get caught is much higher with a smaller group of sellers.

While short-term costs are inevitable in order to implement and successfully run these changes, the long-term gains are invaluable. Fraud and abuse rates would greatly decrease by the increase in oversight and the creation of programs that restrict potential and current suppliers from easily exploiting the system's vulnerabilities.

## CONCLUSION

Medicare fraud has been in the spotlight in recent years as PPACA overhauled the system and vowed to eliminate Medicare fraud. Specifically, power wheelchair fraud has been one of the most profitable fraud industries in the last twenty years. The government has lost billions to individuals who prey on the elderly and indigent in order to receive reimbursements from the Medicare system, made possible by the pay and chase Medicare model. While PPACA addressed power wheelchair fraud

Medicare model. While PPACA addressed power wheelchair fraud specifically and made successful changes to the system, PPACA fails to address the real flaw with Medicare reimbursement. History illustrates that legislation has only dealt with the parts of the issue, not with the underlying problem that has allowed for product after product to be manipulated by schemers who want to make quick money off the system.

If the government wants to stop the massive amounts of fraud in the Medicare system, legislation must be enacted to change the pay and chase model to one that does not sustain and allow fraud so easily. A task force dedicated to reevaluating previously approved physicians, hospitals, and medical equipment companies would put these individuals and their histories with Medicare under scrutiny and would allow for further fraud protection. In addition, a standardized computer software program that detects fraudulent activities through pattern recognition and identifying red flag variables before fraud occurs would prevent further financial losses.

Medicare is an important and essential part of the American healthcare system, but it is fraught with fraudulent claims and consistent abuse. Senator Bob Corker of the Special Committee on Aging sufficiently sums up the issue: "Just think about [it]. We have people within the bowels of government here, that know we have an eighty percent error rate, and [the fraud and abuse] just continues."<sup>74</sup> A serious change must be made to the entire system to prevent the fraud from moving from power wheelchairs to another product, as it has done in the past. It is in the hands of the government to make these changes and deal with the true problem—the Medicare reimbursement system is broken and must be fixed.

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<sup>74</sup> Glor & Eisler, *supra* note 31.



