

## Medical Fraud a Growing Problem

### **Medicare Pays Most Claims Without Review**

By Carrie Johnson - <http://www.washingtonpost.com/wp-dyn/content/article/2008/06/12/AR2008061203915.html?hpid=topnews>

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Friday, June 13, 2008; Page A01

MIAMI -- All it took to bilk the federal government out of \$105 million was a laptop computer.

From her Mediterranean-style townhouse, a high school dropout named Rita Campos Ramirez orchestrated what prosecutors call the largest health-care fraud by one person. Over nearly four years, she electronically submitted more than 140,000 [Medicare](#) claims for unnecessary equipment and services. She used the proceeds to finance big-ticket purchases, including two condominiums and a [Mercedes-Benz](#).

Health-care experts say the simplicity of Campos Ramirez's scheme underscores the scope of the growing fraud problem and the need to devote more resources to theft prevention. Law enforcement authorities estimate that health-care fraud costs taxpayers more than \$60 billion each year.

A critical aspect of the problem is that Medicare, the health program for the elderly and the disabled, automatically pays the vast majority of the bills it receives from companies that possess federally issued supplier numbers. Computer and audit systems now in place to detect problems generally focus on overbilling and unorthodox medical treatment rather than fraud, scholars say.

"You should be able to spot emerging problems quickly and address them before they do much harm," said Malcolm Sparrow, a [Harvard](#) professor and author of "License to Steal," a book about health-care fraud that advocates for greater federal vigilance. "It's a miserable pattern, a cycle of neglect followed by a painful and dramatic intervention."

Fallout from the Campos Ramirez case continues. After pleading guilty to filing false claims, she has helped authorities win indictments against more than half a dozen doctors and patients who allegedly accepted kickbacks for pretending to receive costly HIV drug therapy. With cooperation from Campos Ramirez, [FBI agents](#) this week arrested three Miami-area men who, the government alleges, financed sham clinics that billed the government more than \$100 million.

Daniel R. Levinson, the inspector general of the [Department of Health and Human Services](#), has warned repeatedly that the Medicare program is "highly vulnerable" to fraud, particularly in South Florida, where schemes center on expensive, infusion-based HIV medications and on equipment such as wheelchairs, walkers, canes and hospital beds.

Officials from the Centers for Medicare and Medicaid Services (CMS), which oversees federally funded health programs, say they have stepped up their efforts to combat fraud over the past year by working closely with investigators, removing the requisite billing numbers of nearly 900 companies and imposing new standards in high-fraud areas that would prevent people convicted of felonies from ever receiving a Medicare number.

"There's always more fraud than we have resources to combat," said Kimberly L. Brandt, director of program integrity at CMS. "We have done a much better job of realigning our resources to attack this problem."

Investigators and prosecutors trained their focus on Miami after noticing two troubling patterns:

- HHS investigators discovered that nearly half of 1,581 medical equipment companies they visited in the Miami area did not comply with basic Medicare requirements to be open during scheduled hours and to have a telephone number. The inspector general and the [Government Accountability Office](#) have flagged weak oversight of these kinds of suppliers for a dozen years, according to congressional testimony.
  - The South Florida region bills Medicare more than \$2 billion each year for injectable HIV medications. That figure is 22 times as high as the amount of similar claims in the rest of the country, and is far out of line with demographic data in a population of 2 million people in [Miami-Dade County](#), HHS statistics show.
- [Justice Department](#) officials moved to freeze money in suspicious bank accounts controlled by medical equipment company owners and they created a Washington-based strike force to handle the issue. The strike force, in concert with a small group of U.S. attorney's offices, has in the past year opened nearly 900 criminal investigations and convicted 560 defendants in health-care fraud offenses throughout the country.

Authorities say the strategy is working. They point to a \$1.75 billion drop in Medicare claims in Miami since the operation began a year ago. But even government officials hope for a more comprehensive solution.

Christopher Dennis, the special agent in charge of the HHS inspector general's office in Miami, said fraudulent medical equipment companies appear to have shifted gears since the strike force arrived. After a crackdown in South Florida, at least some corporate owners moved to the north, he said. Investigators dubbed one initiative "Operation Whack-a-Mole," after the carnival game in which a creature pops up in different places after being hit with a hammer.

"The sheer number of zeroes following the dollar sign is irresistible to crooks and con men," [Attorney General Michael B. Mukasey](#) said last month during a Miami visit. "For every crooked company we bust, there is another one to replace it before the ink on the indictment is dry. . . . The money and the temptation are simply too big." The strike force recently established a base in Los Angeles, another area rife with fraud. Prosecutors announced criminal charges last month against two medical equipment company owners who are accused of falsely billing Medicare more than \$2 million. Plans call for a similar rollout this fall in Houston, another potential fraud hot spot.

"You can see how these frauds spread through communities," said Kirk Ogrosky, who is deputy chief in the Justice Department's fraud section and helps lead the strike force. "Family members and friends just get sucked into it. It's really rags to riches on the backs of the American taxpayer."

Officials who oversee the Medicare program say they are vigilant despite time pressure and limited resources. Employees review fewer than 5 percent of the nearly 1 billion claims filed each year. The vast majority of claims shuttle through computer systems that are tweaked when authorities notice fraud patterns. This year, CMS is working to finalize a rule that would prevent convicted felons from obtaining Medicare billing numbers. At present, that regulation applies only in a few high-fraud regions.

"It's a big volume," Brandt said. "No matter how hard we try to get people trained, there's always going to be a margin of error."

Sentenced to 10 years, Campos Ramirez, 60, may yet reduce her prison term by helping authorities unwind "the large web of medical clinics, doctors, nurses, money laundering companies and HIV clinic financiers who participated in this massive fraud," prosecutors wrote earlier this year in court papers. Her lawyer did not return calls seeking comment.

By many accounts, Campos Ramirez was unusually successful. Prosecutors say that corrupt medical clinic owners anticipate that Medicare will cover a quarter of their phony claims. But Campos Ramirez persuaded authorities to cover 60 percent of all the bills she submitted on behalf of 75 HIV clinics in South Florida, according to court filings.

As the owner of R and I Medical Billing, Campos Ramirez advised clinic owners how to justify the costly HIV treatments and manipulated Medicare claims to make sham clinics appear to be legitimate health-care facilities, prosecutors said. She personally collected more than \$5 million with which she bought property and luxury items. Over the past year, however, Campos Ramirez has met repeatedly with law enforcement agents to unravel the scheme, which ran from 2002 to 2006.

At the time of her sentencing in March, Campos Ramirez had amassed a net worth of \$1.5 million, including one of the condominiums where her son, an employee of her billing company, had lived .