

FRAUD AND ABUSE AMONG
CLINICAL LABORATORIES

A REPORT

PREPARED BY THE
SUBCOMMITTEE ON LONG-TERM CARE
OF THE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE



JUNE 15, 1976

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

SPECIAL COMMITTEE ON AGING

FRANK CHURCH, Idaho, *Chairman*

| | |
|---------------------------------------|---------------------------------|
| HARRISON A. WILLIAMS, Jr., New Jersey | HIRAM L. FONG, Hawaii |
| JENNINGS RANDOLPH, West Virginia | CLIFFORD P. HANSEN, Wyoming |
| EDMUND S. MUSKIE, Maine | EDWARD W. BROOKE, Massachusetts |
| FRANK E. MOSS, Utah | CHARLES H. PERCY, Illinois |
| EDWARD M. KENNEDY, Massachusetts | ROBERT T. STAFFORD, Vermont |
| WALTER F. MONDALE, Minnesota | J. GLENN BEALL, Jr., Maryland |
| VANCE HARTKE, Indiana | PETE V. DOMENICI, New Mexico |
| CLAIBORNE PELL, Rhode Island | BILL BROCK, Tennessee |
| THOMAS F. EAGLETON, Missouri | DEWEY F. BARTLETT, Oklahoma |
| JOHN V. TUNNEY, California | |
| LAWTON CHILES, Florida | |
| DICK CLARK, Iowa | |
| JOHN A. DURKIN, New Hampshire | |

WILLIAM E. ORIOL, *Staff Director*

DAVID A. AFFELDT, *Chief Counsel*

VAL J. HALAMANDARIS, *Associate Counsel*

JOHN GUY MILLER, *Minority Staff Director*

SUBCOMMITTEE ON LONG-TERM CARE

FRANK E. MOSS, Utah, *Chairman*

| | |
|---------------------------------------|---------------------------------|
| HARRISON A. WILLIAMS, Jr., New Jersey | CHARLES H. PERCY, Illinois |
| FRANK CHURCH, Idaho | HIRAM L. FONG, Hawaii |
| EDMUND S. MUSKIE, Maine | EDWARD W. BROOKE, Massachusetts |
| EDWARD M. KENNEDY, Massachusetts | J. GLENN BEALL, Jr., Maryland |
| CLAIBORNE PELL, Rhode Island | PETE V. DOMENICI, New Mexico |
| THOMAS F. EAGLETON, Missouri | BILL BROCK, Tennessee |
| JOHN V. TUNNEY, California | DEWEY F. BARTLETT, Oklahoma |
| WALTER F. MONDALE, Minnesota | |
| LAWTON CHILES, Florida | |
| DICK CLARK, Iowa | |

PREFACE

MAY 18, 1976.

Eleven years ago, when the Congress enacted the Medicare and Medicaid programs, our primary concern was to make needed health services available to the poor, aged, blind, and disabled. The Congress, in general, gave comparatively little thought to the need to police or protect these new Government health care programs against those who would steal Government funds by perpetrating fraud and assorted other abuses.

In the intervening years, we have seen Medicare and Medicaid grow from million dollar programs to billion dollar programs. This year the combined Government outlays under these two programs will reach \$30 billion and are projected to reach the \$40 billion mark within 2 years.

There is no question that these programs are providing valuable services to a great number of needy Americans. No serious legislator would suggest for a moment that they be repealed or crippled. In fact, there is meritorious argument in favor of broadening the scope of both Medicare and Medicaid to include other benefits, such as expanded home health services, which are in great demand.

Many of us have been struggling with the fiscal constraints necessarily imposed by the current state of the economy, trying to find some way—some avenue—to provide the needed health care services. Of necessity, we have had to make hard choices and assign spending priorities. The Senate Budget Committee, of which I am a member, has carried the balance of this burden.

Ironically, it is in my capacity as chairman of the Subcommittee on Long-Term Care that I believe I have found the greatest opportunity for both budget-cutting and extending benefits to the needy. For more years than I care to remember, we have been investigating nursing home abuses and enacting legislation to reform the reprehensible conditions that we have found. Unfortunately, our legislation has not always been implemented or enforced by the Department of Health, Education, and Welfare. And then, too, we have discovered unanticipated loopholes in the laws.

In January of last year, we conducted oversight hearings in New York City to determine the effectiveness of current laws and regulations. We issued more than 60 subpoenas. We were astounded at what we found. Profiteering and abuse were widespread. Inspection and enforcement activities by both the States and the Federal Government were lackluster, if not nonexistent.

After examining the records we received under subpoena from nursing home operators and other providers, I became convinced that the Medicaid program in general is poorly administered and fraught with widespread abuse. To prove or disprove this thesis, I broadened the

scope of the investigations of my Subcommittee on Long-Term Care to include other providers associated in one way or another with long-term care. Last September, we began looking at pharmacists who serve nursing homes, clinical laboratories, factoring companies, physicians, and hospitals that specialize in welfare patients. Experts at our hearings testified that as much as \$3 billion out of the \$30 billion combined total of Medicare and Medicaid is being ripped off. With the exception of a few States, such as New Jersey, Michigan, and California, there were virtually no controls by the States or HEW to prevent fraud and abuse.

In reply, some State and HEW officials ridiculed the notion that our health care programs are riddled with fraud and abuse. Many insisted that there was very little fraud and that only "isolated instances" of abuse existed. My response was to ask Associate Counsel Val J. Halamandaris and the staff of the Committee on Aging to conduct an in-depth study of generic abuses allegedly perpetrated by a provider group other than nursing home operators and to quantify the abuse and fraud that they found. This report is the result of that request; its focus is primarily on clinical laboratories participating in Medicaid. It was first presented as a staff report at our February 16 hearing on this subject. I am pleased to make it available today as a Subcommittee report.

This report is important for several reasons. First, lawbreakers have been brought to justice. Second, several of the report's recommendations have already been enacted into law. Third, it documents once and for all that fraud and abuse in Government health care programs is massive and widespread. There can no longer be any question about this fact. Even conservative administration spokesmen are projecting that 8 percent of Medicaid expenditures are fraudulent.

Above all, this report demonstrates that the Congress and the administration must quickly work together to eliminate waste, fraud, and inefficiency. The resulting billions that can be saved by even a modest surveillance effort (virtually none exist at the moment) can then be redistributed to the aged, blind, poor, and disabled. It is my hope that this can be done quickly. I pledge my best efforts to see that it happens.

FRANK E. MOSS, *Chairman,*
Subcommittee on Long-Term Care.

LETTER OF TRANSMITTAL

FEBRUARY 16, 1976.

HON. FRANK CHURCH, *Chairman*, and HON. FRANK E. MOSS, *Chairman, Subcommittee on Long-Term Care, U.S. Senate Special Committee on Aging, Washington, D.C.*

DEAR MESSRS. CHAIRMEN: In response to a directive from the subcommittee chairman at the hearing of September 26, 1975, Committee staff and temporary investigators on behalf of the Subcommittee on Long-Term Care began an investigation of clinical laboratories in the State of Illinois. In cooperation with the Better Government Association of Chicago, 21 medical laboratories receiving the great majority of Medicaid business in the State of Illinois were investigated. Some 50 medical clinics were visited and 50 or more physicians were interviewed. In addition, the Subcommittee staff obtained relevant information with respect to investigation of fraud and abuse concerning clinical laboratories in other States.

This report is the result of an intensive investigation. The good work apparent in this report would not have been possible without the assistance of the BGA, and specifically those employees whose names appear throughout this report. Mr. J. Terrence Brunner, the Executive Director of the BGA, should also be credited since his role in planning and policy was substantial.

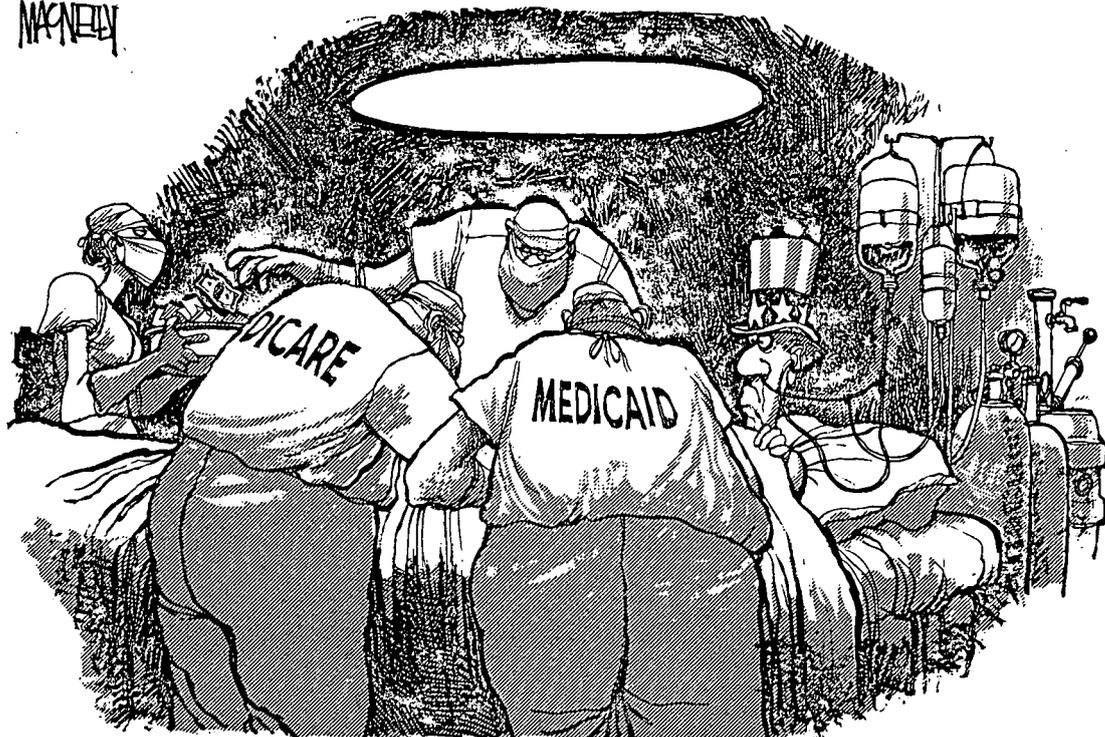
Members of the Committee staff also gave freely of their time and experience. Mr. William E. Oriol, Staff Director of the Committee on Aging, provided guidance and direction. Investigators David Holton, William Halamandaris, and William Recktenwald deserve much credit. I commend Mr. Recktenwald to you in particular for his leadership role in this investigation; we are fortunate to have had his services for 6 months.

As was directed, galley proofs of this report were presented to Mr. Richard L. Thornburgh, Assistant Attorney General, Criminal Division, U.S. Department of Justice, on February 11, 1976, asking him to take appropriate legal action. Copies of the report will be made available to State law enforcement personnel and all pertinent Federal and State officials.

With best wishes,
Sincerely,

VAL J. HALAMANDARIS,
Associate Counsel.

MAGNELY



" THERE! I THINK WE GOT IT ALL.... CLOSE THE WALLET, DOCTOR."

—THE RICHMOND NEWSLEADER,
COPYRIGHT 1976, THE CHICAGO TRIBUNE.

CONTENTS

| | Page |
|---|-----------------|
| Preface..... | ii ¹ |
| Letter of transmittal..... | v |
| Introduction..... | 1 |
| Part 1. The numbers: | |
| Medicare and Medicaid..... | 3 |
| Part 2. Evidence of fraud and abuse: | |
| A. Testimony of Edmond L. Morgan, executive secretary, Illinois Clinical Laboratory Association..... | 5 |
| B. Dr. Herbert Meyer..... | 6 |
| October 20, 1975, meeting with Mr. Trivedi..... | 9 |
| C. The storefront clinic..... | 11 |
| The double pricelist..... | 14 |
| D. Interviews with physicians..... | 19 |
| Part 3. Billing: Techniques of fraud and abuse: | |
| A. Labs charging Medicaid for tests not authorized by the physician..... | 23 |
| B. Labs charging Medicaid for questionable tests: Tests inappropriate for the disease diagnosed..... | 25 |
| C. Charging Medicaid more than private patients..... | 25 |
| D. Billing Medicaid for component parts of automated profile tests..... | 28 |
| E. Brokering: Subcontracting laboratory tests..... | 31 |
| F. The use of forms which encourage overutilization..... | 34 |
| Part 4. Widely varying fee schedules..... | 35 |
| Part 5. Evidence of similar practices in other States: | |
| A. New Jersey..... | 37 |
| B. New York..... | 39 |
| C. Michigan..... | 39 |
| D. Pennsylvania..... | 40 |
| E. California..... | 41 |
| Part 6. Concerns about the quality of laboratory services..... | 43 |
| Part 7. Summary and conclusions..... | 47 |
| Part 8. Recommendations: | |
| To the Congress..... | 49 |
| To the Department of Health, Education, and Welfare..... | 49 |
| To the Department of Justice..... | 50 |

APPENDIXES

| | |
|--|----|
| Appendix 1. Statements by members of the Subcommittee on Long-Term Care at hearing on February 16, 1976: | |
| Opening statement by Senator Frank E. Moss, chairman..... | 51 |
| Statement by Senator Charles H. Percy..... | 55 |
| Statement by Senator Pete V. Domenici..... | 56 |
| Appendix 2. Twenty bills, chosen at random, presented for payment by D. J. Medical Laboratory in Chicago, Ill., purportedly on behalf of Dr. R. Bascon, 4809 West Madison. In 12 of the 20 cases, the physician has no record of seeing the patient. The aggregate total paid by Medicaid for these 20 bills was \$885. According to Dr. Bascon's records, only \$119 of this amount was actually ordered by him. Following each individual bill is a caption with specific details..... | 60 |
| Appendix 3. Comparison of the highest paid laboratories in Illinois in terms of Medicaid reimbursement..... | 80 |

FRAUD AND ABUSE AMONG CLINICAL LABORATORIES

JUNE 15, 1976.—Ordered to be printed

Mr. Moss, from the Special Committee on Aging,
submitted the following

R E P O R T

INTRODUCTION

Americans of all ages are becoming increasingly dependent upon the services of clinical or medical laboratories, which play an important part in helping physicians to determine the presence or extent of disease by carrying out tests on specimens from the human body.

Last year, 4½ billion such tests were conducted. More than 12 million tests were conducted each day of the year at a total cost of \$12 billion. This is equal to roughly 10 percent of the Nation's entire cost of health in 1975.¹

In September of last year, hearings by Senator Edward Kennedy's Subcommittee on Health, Senate Committee on Labor and Public Welfare, raised serious questions about the quality of many of these services. Witnesses testified that 24 States have no legislation with respect to clinical laboratories and that the statutes in the remaining 26 States were largely ineffective.^{1a} Studies were offered indicating that from 7 to 26 percent of all lab tests may be in error. These disclosures prompted Senator Jacob Javits and Senator Kennedy to introduce the Clinical Laboratory Improvement Act of 1975 (S. 1737), which is being considered before the Health Subcommittee.²

Later in September the Subcommittee on Long-Term Care of the Senate Committee on Aging received evidence of widespread fraud and abuse perpetrated by clinical lab firms.³ Witnesses asserted that as much as \$1 out of every \$6 in Medicare or Medicaid payments to clinical labs is fraudulent or at least questionable. Senator Frank E. Moss,

¹ Clinical Laboratories Improvement Act of 1975, hearings before the Subcommittee on Health, Committee on Labor and Public Welfare, U.S. Senate, Sept. 8 and 9, 1975, Washington, D.C., unpublished.

^{1a} As noted later, New Jersey has the most up-to-date laboratory statute of any State.
² S. 1737 passed the Senate on April 29, 1976. Several recommendations from this report (originally presented February 16, 1976) have been incorporated as noted below. Hearings have been held in the House of Representatives on the companion bill, H.R. 11341, introduced by Representative Paul Rogers, of Florida. Action is expected in the near future.

³ Medicare and Medicaid Frauds, hearings by the Subcommittee on Long-Term Care and the Subcommittee on Health of the Elderly, U.S. Senate Special Committee on Aging, Sept. 26, 1975, Washington, D.C.

Subcommittee Chairman, asked the staff to conduct a full investigation of which this staff summary is a part.

As this report indicates, fraud and abuse among clinical laboratories is widespread and it is massive. Immediate action must be taken by the Congress and by HEW to stop the hemorrhage of Federal funds, to insure fiscal accountability, and to improve the quality of services offered to the American public.

Part 1

THE NUMBERS

In 1975 there were some 14,000 independent and hospital-based clinical laboratories in the United States. In addition there were some 50,000 to 80,000 medical labs in physicians' offices.⁴

Some 6,000 medical laboratories in this country are located in hospitals. These labs need meet only standards applicable to hospitals in general. Accreditation of hospitals in general, and of clinical labs in particular, by the Joint Commission on Accreditation of Hospitals, has been criticized as being inadequate and ineffective. Some 3,048 labs are participating in Medicare and Medicaid and thus must comply with Medicare's standards, called the conditions of participation. Another 2,000 labs serve physicians in group practice and do not accept any specimens from outside physicians. These labs may (optional) be accredited by the College of American Pathologists.

Under the provisions of the Clinical Laboratory Improvement Act of 1967, some 900 labs which participate in interstate commerce must be licensed by the Department of Health, Education, and Welfare.

Twenty-six States, the District of Columbia, and Puerto Rico have laws regulating clinical laboratories.

Some 97 percent of all U.S. independent clinical labs are privately owned.

About 164,000 employees worked in medical laboratories at the end of 1975, roughly double the number who worked at such professions in 1965.

As has already been indicated, approximately 10 percent, or \$12 billion out of the \$120 billion spent for health in 1975 went for clinical lab services.

While general expenditures for health have been increasing at the rate of 11 percent a year, lab services (and lab fees) have been expanding at the rate of 15 percent a year.

MEDICARE AND MEDICAID

In fiscal year 1976, taxpayers will pay an estimated \$213 million for clinical laboratory services under Medicare and Medicaid. Actually, the figure is a great deal higher but it is impossible to separate lab services from fees paid to hospitals or physicians. Labs participating in either Medicare or Medicaid must meet the conditions of participation (the Medicare standards).

Medicare's payments to clinical laboratories have increased some 504 percent since 1968.

⁴Testimony of Dr. Theodore Cooper, Assistant Secretary for Health, Department of Health, Education, and Welfare, at the hearings cited in footnote 1.

In that year Medicare paid 434,000 bills from independent clinical labs or almost \$6.5 million on behalf of Medicare beneficiaries. In 1975, Medicare paid \$32.5 million on 2,250,000 submitted bills.⁵

Medicaid's payments for laboratory services have also skyrocketed, increasing by about 15 percent a year—the highest rate of increase for any of the Medicaid authorized services. By the best estimates available, about \$181 million will be spent for Medicaid lab services in fiscal year 1976.⁶ Medicaid expenditures for this year will reach about \$15 billion, of which about \$8.3 billion is Federal and the remainder State and local funds.

⁵ The Schechter Report, Aug. 21, 1975, published by Mal Schechter.

⁶ "Numbers of Recipients and Amounts of Payments Under Medicaid, Fiscal Year 1973," U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, Office of Information Systems, National Center for Health Statistics, November 1975, p. 22. Fiscal year 1973 figures are projected forward to fiscal year 1976 at the rate of 15 percent a year. See also "Medical Care Expenditures, Prices, and Costs: Background Book," Department of Health, Education, and Welfare, Social Security Administration, Office of Research and Statistics.

Part 2

EVIDENCE OF FRAUD AND ABUSE

In the past 2 years an increasing number of State officials have indicated concern about the potential for fraud and abuse among clinical labs participating in Medicaid. Major investigations have been conducted in New Jersey and New York. Providers have been accused of abusing the program in several other States including Michigan, California, and Pennsylvania. The Committee's investigation focused on the State of Illinois.

A. TESTIMONY OF EDMOND L. MORGAN, EXECUTIVE SECRETARY, ILLINOIS CLINICAL LABORATORY ASSOCIATION

At the September 26, 1975 Subcommittee hearing, Mr. Morgan testified that members of the Illinois Clinical Laboratory Association (ICLA) were "distressed" about the "practices of many unethical laboratory facilities which tend to question the integrity of all clinical laboratories in Illinois."

He said that kickbacks and other abuses were common nationwide, citing there has been a major fraud investigation underway in New York by the U.S. Attorney's office.

He added:

It has recently come to our attention that certain criminal elements are involved in the purchase of laboratories and also involved in establishing factoring agencies.

Our Association estimates that approximately \$10 to \$12 million are annually being siphoned out of the health care dollar in Illinois through the padding of laboratory bills and overutilization.

Of the \$600 million annually spent in Illinois for health care through public aid for all services, it is estimated that approximately \$100 to \$125 million is being siphoned out through some form of fraud and unethical billing practices.⁷

In addition, Mr. Morgan stated:

Most of the Medicare and Medicaid patients for which laboratories perform services reside in nursing homes or convalescent and rest homes.

Mr. Morgan asserted that overutilization had become the rule rather than the exception in inner city facilities. He said that in such areas a pharmacy and a clinical lab will make joint arrangement with a clinic of medical doctors for a flow of tests. More often than not, according to Mr. Morgan, the physicians work for clinic owners. (There are few requirements in any State with respect to ownership

⁷ Excerpts taken from hearings cited in footnote 3.

of a laboratory; most laws focus on the qualifications of the operator.) Clinic owners often hire physicians under contracts and "encourage" them to order unnecessary tests to generate income for a lab in which they might have an interest or in order to maximize the amount of the kickback they might receive from a laboratory (in exchange for sending them all the lab business of the clinic).

Mr. Morgan provided a detailed memorandum dated October 23, 1974, which he stated he presented to the Illinois Medical Payments Task Force and to other authorities in Illinois. The memo contains a number of specific charges against several laboratories operating in Illinois. It states that ICLA had investigated the charges and found instances of kickbacks in the form of cash, free employees (salaries of physician's assistants were paid for by the lab), the rental of closets or chairs at exorbitant rental fees, the payment of the physician's personal bills, the payment for medical supplies or the payment for a leased automobile for the use of the physician (or the clinic owner). In addition, Morgan testified:

In 1974 myself and my administrative assistant along with two special investigators assigned to the Legislative Advisory Commission to the Illinois Department of Public Aid inspected and investigated six laboratories chosen at random of whom we suspected of engaging in kickbacks and overutilization patterns in order to reap substantial sums of money.

1. Norven Medical Laboratory, a very small laboratory was billing for numerous tests not performed in this facility. This laboratory was also billing for large sums of money without adequate facilities to perform these services.

2. D. J. Laboratory-Monticello Laboratory, also was billing for substantial sums of money without adequate facilities or personnel.

3. Chicago Medical Laboratory, same pattern existed in this facility and had no proper directors or supervisors.

4. Division Medical Laboratory, also heavily involved in gross utilization with suspected kickbacks to physicians clients.

5. Ridgeland Medical Laboratory, involved in gross utilization, suspected of kickbacks and had no verification records that these tests were even performed.

These are a few of the instances which we have actually investigated and have proven our suspicions were correct.

Senator Moss characterized these revelations as "incredible." He [Moss] directed the Subcommittee staff to follow up and to conduct an in-depth investigation.

B. DR. HERBERT MEYER

In the wake of publicity resulting from Mr. Morgan's appearance before the Subcommittee, the Committee received a complaint from a Chicago physician who reported that he had been offered a substantial kickback by a clinical lab. At the suggestion of the Committee on Aging staff, the physician, Dr. Herbert Meyer, of 3430 South King Drive in Chicago, Ill., asked the representative from the clinical lab to return to the physician's office to talk over the offer.

On October 14, 1975, at about 1:20 p.m., Investigator William Recktenwald was present in the office of Dr. Meyer when the physician was visited by a man who identified himself as a sales representative for a Chicago clinical laboratory. Sitting in an adjacent room (a closet) Mr. Recktenwald was able to overhear Mr. Raiz Khan, sales representative, Westlawn Clinical Laboratory, Chicago, Ill., offer Dr. Meyer a return of 30 percent of each month's gross billings submitted to the Illinois Department of Public Aid (Medicaid).

Mr. Khan said that the kickback could take one of several forms. It could be paid either as a rental to the physician, or perhaps could be disguised as payment toward the salary of one of the physician's employees. The following dialog is excerpted from Mr. Recktenwald's sworn statements which were constructed from notes he made on this occasion:

Mr. Khan. "It is good to see you, Dr. Meyer. I am glad to see that you are considering our services."

Dr. Meyer. "Well, I can't make anything definite until I talk with my lawyer, who won't be back until next week."

(Dr. Meyer then asked some questions about how soon the work would be completed and how many pickups per day there would be.)

Dr. Meyer. "Will you go over your incentive plan, you mentioned to me last time again?"

Mr. Khan. "Yes, it is 30 percent. There are several ways to handle it. We can pay your rent, or cover your overhead."

Dr. Meyer. "Well, my rent here is not very high."

Mr. Khan. "Don't worry about a thing. There are a number of ways that this can be done. We can pay your rent. Or cover part of your overhead or cash. My chief can give you all the details. I would like to set up a meeting with the two of you."

Dr. Meyer. "Well, anything that I get . . . anything coming in here goes on the books."

Mr. Khan. "Don't worry; this is all legal. There are loopholes to every law. We do this with doctors and clinics all over town."

(Mr. Khan explained that they had a similar arrangement with a number of other clinics. And that with 3 clinics alone, they had almost 24 doctors plus about 15 other individual doctors.)

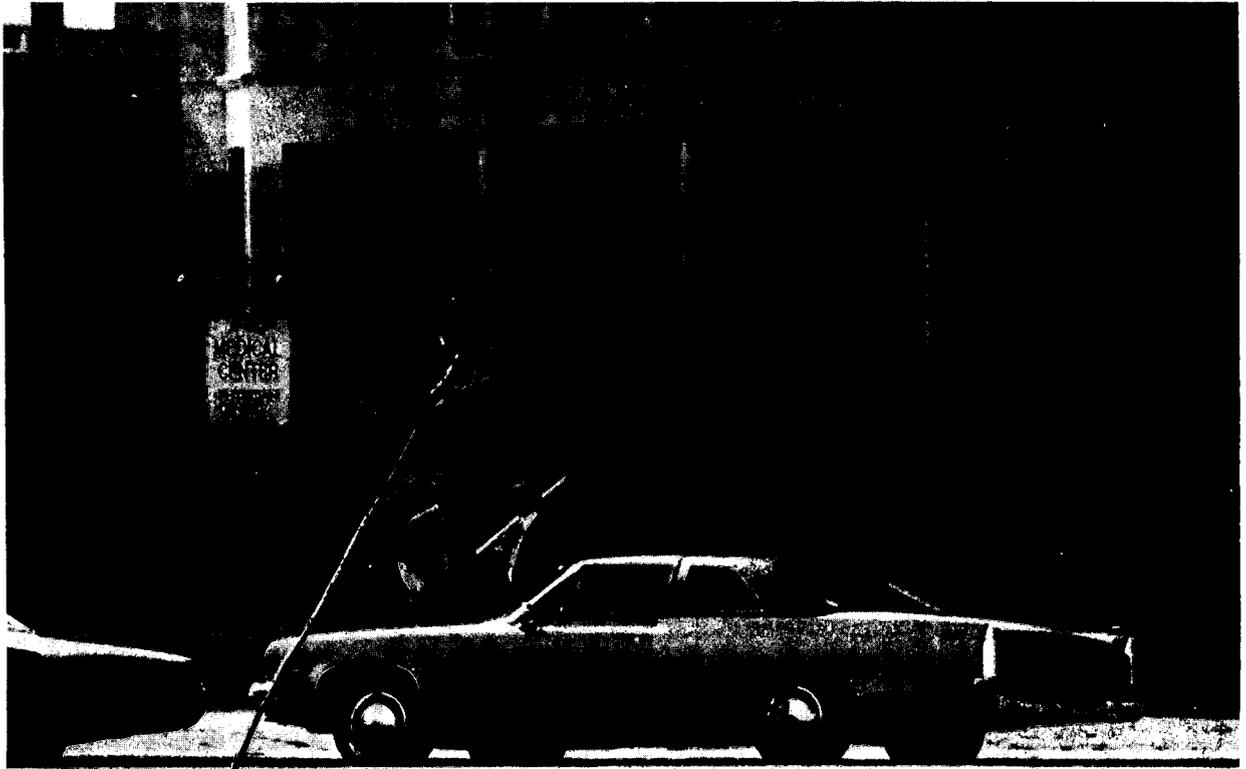
Dr. Meyer. "Now this 30 percent: is that gross or is that net?"

Mr. Khan. "It is 30 percent of all your public aid business."

Subsequent to this discussion, Mr. Khan discussed the details of the kickback with Investigator Recktenwald who Dr. Meyer introduced as an associate. Mr. Khan is shown speaking to Recktenwald in front of Dr. Meyer's office. (See picture, page 8.) In the first 6 months of fiscal year 1976, this laboratory received \$448,369.50 from the Illinois Department of Public Aid in Medicaid funds. At this rate, billings will approach \$900,000 in 1976.⁸

⁸ Source: BGA, and Illinois Comptrollers Office.

NOTE: Names of persons described in this report were provided to the Committee under oath by BGA and Committee staff investigators at its February 16 hearing. Those whose names appear were given the opportunity to be present and to offer testimony rebutting these allegations at this same hearing. These names, in the form of sworn affidavits, were also presented to the U.S. Department of Justice for possible criminal prosecution.



—Photo by James Huenink, BGA

Mr. Raiz Khan, sales representative, Westlawn Clinical Laboratory, Chicago, Ill., discusses possible rebates with Investigator Bill Recktenwald

The following conversation (reconstructed from notes) then took place between Mr. Recktenwald, Mr. Khan, and Dr. Meyer:

Mr. Recktenwald. "Herb, is this the fellow you were telling me about last week?"

Dr. Meyer. "Yes."

Mr. Recktenwald. "Well, I hope you got things made clear (motioning to Mr. Khan). Herb thought you were offering him some sort of a kickback."

Mr. Khan. "Oh, no. Just help with your overhead."

Parties walked out of the building. Recktenwald stated he was going across the street to get cigarettes. Outside the building the conversation continued:

Mr. Recktenwald. "You know, you really had Dr. Meyer worried. He thought he might get into some trouble if he got involved with your rebate program."

Mr. Kahn. "There is nothing wrong with it. Nothing illegal. We just pay part of his overhead, part of the rent or however he would like it. It just works out to 30 percent of his public aid business. Everyone does it. There is nothing wrong with it."

OCTOBER 20, 1975, MEETING WITH MR. TRIVEDI

With Dr. Meyer's cooperation and at the suggestion of Mr. Khan, a meeting was arranged with Mr. Bharat Trivedi, director, Westlawn Clinical Laboratory. Present with Dr. Meyer was William Hood, introduced as a replacement for Dr. Meyer's regular attorney, who was said to be out of town. (Mr. Hood is an attorney who until December 1975 served as an investigator with Chicago's Better Government Association. He had served as an investigator (consultant) with the Senate Committee on Aging since March of 1971.)

Under questioning from Mr. Hood, Mr. Trivedi confirmed the offer extended by his associate. Mr. Trivedi said the arrangement would allow the doctor to get back from the lab 25 to 30 percent of the gross monthly Medicaid billing sent to the lab. Mr. Trivedi concluded: "My personal feeling is that the best way is for us to pay your rent or to pay an employee. It works simplest that way."

Mr. Khan, who was also present at this meeting, expressed amazement, as did Mr. Trivedi, that Meyer had any doubts about the legality of procedures they proposed. They said he was the first doctor who had ever raised any questions with them.

These statements, together with the number of physicians allegedly involved in a similar practice, the fact that no one apparently had ever questioned the legality of the practice, led the Committee staff to again question how widespread the practice of offering kickbacks was in the Illinois Medicaid program.

Moreover, the flat insistence by Mr. Khan and Mr. Trivedi as to the legality of this practice caused the staff to recheck the pertinent Medicare and Medicaid statutes relating to kickbacks. The law is explicit. The law is reprinted on page 10. The identical language can be found in both Medicare and Medicaid.

In addition to this specific provision, there are other applicable fraud provisions in the U.S. Code. For example, see 18 U.S. Code 286 and 287, 1001, and 1341 relating to the making of claims that are known to be false or fictitious against the United States.

§ 1395nn. Offenses and penalties

(a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under this subchapter,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to any such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$10,000 or imprisoned for not more than one year, or both.

(b) Whoever furnishes items or services to an individual for which payment is or may be made under this subchapter and who solicits, offers, or receives any—

(1) kickback or bribe in connection with the furnishing of such items or services or the making or receipt of such payment, or

(2) rebate of any fee or charge for referring any such individual to another person for the furnishing of such items or services,

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$10,000 or imprisoned for not more than one year, or both.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, or home health agency (as those terms are defined in section 1395x of this title), shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$2,000 or imprisoned for not more than 6 months or both.

Also applicable in section 162(c)(3) of the Internal Revenue Code which mandates that no deductions shall be allowed (for expenses incurred in a trade or business) for any kickbacks, rebates, or bribes or rebates paid under the Medicare and Medicaid programs. The pertinent statutory language reads:

(3) Kickbacks, rebates, and bribes under medicare and medicaid. No deduction shall be allowed under subsection (a) for any kickback, rebate, or bribe made by any provider of services, supplier, physician, or other person who furnishes items or services for which payment is or may be made under the Social Security Act, or in whole or in part out of Federal funds under a State plan approved under such Act, if such kickback, rebate, or bribe is made in connection with the furnishing of such items or services or the making or receipt of such payments. For purposes of this paragraph, a kickback includes a payment in consideration of the referral of a client, or customer.

C. THE STOREFRONT CLINIC

Satisfied that the practice was clearly illegal, committee investigators set out to find an answer to an essential question: how common was the practice? An extensive discussion among the staff of the Committee on Aging led to the conclusion that the best way to test the extent of such practices would be to simulate the actions that would be taken by an independent physician beginning a practice specializing in public aid (welfare) patients. To this purpose, it was decided that a storefront clinic would be opened in an appropriate area. Only from the perspective of the practitioner, at street level, could the Committee gain information on the mechanics of these highly questionable operations. And only through understanding the mechanics of the operation could effective corrective legislation be proposed.

A decision was made to go ahead with this plan in conjunction with the Better Government Association (BGA) of Chicago, Ill., a non-profit, nonpartisan civic organization which has cooperated with the Committee on Aging for more than 6 years in a number of areas of investigation. Subsequently, due to considerations of time and money, the BGA assumed primary responsibility for setting up and operating the storefront clinic with Committee staff present only as observers. Two Illinois physicians cooperated with investigators to the extent of allowing their names to be used.

A small storefront was rented at 1520 West Morse in the Rogers Park area of Chicago. This neighborhood has the highest proportion of aged in any area in Chicago . . . and possibly one of the highest in the Nation. A sign announcing the opening of the clinic was placed in the window. A number was listed with the statement: PROFESSIONAL INQUIRIES INVITED. (See photograph, page 12.) Mr. Douglas Longhini, a BGA investigator, posed as a business representative of the two doctors. Working with the BGA personnel was Producer Barry Lando and other individuals from the CBS television program "60 Minutes," who modified the storefront clinic. They installed special lighting and a one-way mirror, hoping to film those who entered the clinic offering kickbacks to the disguised BGA investigators.



—Photo by George Quinn, *Chicago Tribune*

The storefront clinic, located at 1520 W. Morse Ave., Chicago, Ill.

Over the next 3 weeks, business representatives from more than 12 laboratories doing more than 65 percent of the Medicaid business in the State of Illinois visited the storefront clinic. All but two offered some form of inducement or kickback. The offers ranged from an "educational program" for physicians in billing procedures, to maximize return from public aid, to cash rebates of more than 50 percent of gross payments received from Illinois Department of Public Aid.

In addition to Mr. Longhini, Mrs. GERALYN Delaney, a BGA secretary, was present during each of the interviews which took place, recording the conversations that took place in shorthand.⁹ At times, BGA Investigator Patrick Riordan was present. Mr. Recktenwald and David Holton, temporary investigators for the Senate Committee on Aging, were present on several occasions, posing as maintenance men. As an example of what transpired in these visits the following exchange between Mr. William Footlick, owner of Division Medical Laboratory, said to be the largest lab in terms of public aid business in the State of Illinois, and Douglas Longhini is reprinted below as taken from Mrs. Delaney's sworn statement:

(Mr. Longhini asked what arrangements were made.)

Mr. Footlick. "A percentage of the volume of business in dealing with public aid."

Mr. Longhini asked Mr. Footlick how many square feet the lab would need to draw the blood.

Mr. Footlick. "A blood drawer, chair, and cabinet."

Mr. Longhini stated the clinic's rent is \$450 a month. If the clinic's business is brisk in the beginning the clinic could get that \$450 back in rent.

Mr. Footlick. "Oh sure, \$5,000 to \$6,000 a month."

Mr. Longhini asked whether the clinic would get \$5,000 to \$6,000 a month for rent.

Mr. Footlick. "Sure. . . . volume of people."

Mr. Longhini asked if the clinic would sign a lease.

Mr. Footlick. "Sure. . . . wouldn't be able to refer to rent until we look at volume. We would have to renegotiate the lease."

Mr. Riordan asked whether the clinic's rent would change four times a year.

Mr. Footlick. "I don't think it would be fair to do once or twice and get good idea of volume."

Mr. Riordan asked whether Mr. Footlick's firm provides a technician to draw the blood.

Mr. Footlick. "Depends on volume."

Mr. Longhini asked Mr. Footlick if the clinic gets a rebate off of the volume.

Mr. Footlick. "A rose, is a rose, is a rose. I look at it as a rental."

Mr. Longhini asked whether the clinic was safe from the FBI.

Mr. Footlick. "FBI frowns upon an incentive for the doctor to draw in a lot of . . . on kickback system. . . . I justify it would cost more to bring these patients to the lab than if I were to do the work here."

⁹ Particular care was taken to make sure that no Federal or State laws were broken in this effort. Illinois has a statute which prohibits electronic recording of conversations unless all parties consent to it. Accordingly, the best alternative available was stenographic recording. The CBS cameras did not record sound unless all parties consented.

THE DOUBLE PRICELIST

Another common arrangement was the double price list as spelled out in Mrs. Delaney's sworn statement. Mr. Joeslito C. Espino, president, D. J. Medical Laboratory Inc., told Mr. Longhini and the BGA that his clinic had two price lists, one for private paying patients and one for public aid patients. (This is clearly a violation of HEW, Medicare, and Medicaid regulations which prohibit a rate payment for public patients higher than that customarily paid by the general public.) The double price list offered by Mr. Espino is as follows:

| Test | Prices charged for private | Prices charged for State (medicaid) |
|-------------------|----------------------------|-------------------------------------|
| SMA-12..... | \$3.50 | \$15.00 |
| CBC..... | 2.50 | 6.00 |
| Urinalysis..... | 1.50 | 3.00 |
| VDRL..... | 3.00 | (¹) |
| ABO..... | 1.50 | 3.50 |
| Rh..... | 1.50 | 3.50 |
| Glucose..... | 2.50 | 5.00 |
| Pap smear..... | 4.00 | 10.00 |
| All cultures..... | 5.00 | 10.00 |
| G.P. smear..... | 1.50 | 3.00 |
| TEC..... | 1.50 | 3.00 |
| Stool O/P..... | 1.50 | 3.00 |
| TIBC..... | 3.00 | 7.00 |
| T-3..... | 6.00 | 12.00 |
| T-4..... | 6.00 | 12.00 |
| PBI..... | (²) | (²) |
| Na..... | 2.00 | 3.00 |
| K..... | 2.00 | 3.00 |
| Creatinine..... | 3.00 | 7.00 |
| ASO..... | 2.00 | 5.00 |
| Pregnancy..... | 3.00 | 8.00 |
| ANA..... | 6.00 | 12.00 |
| SGPT..... | 2.50 | 5.00 |
| Flocculation..... | 2.50 | 5.00 |
| Thymol..... | 2.50 | 5.00 |
| Latex..... | 2.00 | 5.00 |
| CRP..... | 2.00 | 5.00 |
| Ekg..... | 6.00 | 12.00 |

¹ No payment.

² Mr. Espino's clinic does not take these tests; they send to another firm.

Mrs. Delaney's affidavit continues: "When asked by Mr. Longhini if the clinic would get into trouble because of the variance of prices charged public and private patients, Mr. Espino responded, 'the clinic would not get into trouble because none of these prices are written down.'"

All in all, the offers received by BGA personnel ranged from a small discount offered to private patients to the full package offered by Mr. Footlick's firm, including: 20 to 30 percent of gross billings which would be paid in the form of rent (said to be as much as \$5,000 to \$6,000 a month) PLUS salary for a clinical secretary or a nurse, PLUS equipment and supplies, PLUS X-ray and technician's services, PLUS electrical and plumbing contracting services for the clinic.

Typical of the kickback offers was that of Mr. Nemie LaPena, sales representative, North Side Clinical Laboratory. (See picture, page 18.) In the first 6 months of fiscal year 1976, his firm was paid \$550,-802.64 for laboratory services by the Illinois Department of Public Aid (Medicaid), making them among the highest paid labs in Illinois for that period.

In a meeting with BGA Investigators Douglas Longhini and GERALYN DELANEY on December 23, Mr. LaPena said:

You'll make lots of money, I guarantee that . . . you'll get a rebate of 45 percent of your gross public aid billings. I'll deliver a check to you every Tuesday; and if your billings go over \$1,000 per week, then the percentage goes up to 50 percent.

During this conversation Subcommittee investigators were also present, and overheard the offer. On another date, CBS Correspondent Mike Wallace also heard the offer from behind, a partition. As shown in the "60 Minutes" segment of February 15, Mr. Wallace came out from behind the partition, identified himself, and announced that he was recording film for broadcast. With respect to the conversation between Mr. Wallace and representatives of the North Side Laboratory, the script of the February 15 program reads:

Wallace. "After a while, I walked into the front office, informed the lab representatives we would be recording, and told them I had overheard the offer they'd made. They didn't deny it, and our cameraman came out into full view to film what had turned into a pretty frank discussion about kickbacks."

Lab representative. "The—it's a fact of life that in the inner city of Chicago that—that it's done that way, and that's all I know."

Wallace. "And you know who picks up the tab? The taxpayer. Do you think that you can stay in business without—"

Lab representative. "No. We'd be out of business tomorrow. It's as simple as that. I've told you that already."

Wallace. "You'd be out of business tomorrow—"

Lab representative. "We'd be—we'd be out of business tomorrow."

Wallace (continuing). "If you were not kicking back to doctors?"

Lab representative. "Right, right."

Wallace. "And you kick back to every doctor with whom you do business?"

Lab representative. "No, we do not."

Wallace. "Not—well—"

Lab representative. "Some doctors, no. There are maybe one or two in which we don't and will not."

Sworn affidavits from BGA personnel documenting the arrangements offered by medical and clinical laboratories were turned over to the U.S. Department of Justice on February 11, 1976, and presented to the Subcommittee on Long-Term Care under oath in its February 16 hearing. The hearing record contains complete transcripts and verifications of what transpired in the storefront clinic. The activities of CBS's "60 Minutes," as presented to the public in their program of February 15, were not limited to the operation of the storefront clinic with BGA. The "60 Minutes" staff conducted an excellent and more widespread investigation of Medicaid fraud in Illinois.

Before leaving the subject of the storefront clinic, it is important to note at this point that it had been decided well in advance that no suggestion, request, or hint of a kickback offer would be made by any of the investigators. Particular care was taken that the conduct of the investigators in no way be interpreted as an incitement or inducement. Solicitations, if any were to be made, would have to be made on the volition of the laboratory representatives. This is what happened, in fact. Laboratories were simply asked what services they offered. Their responses are recorded in the affidavits.



Right to left, CBS Correspondent Mike Wallace and Cameraman Walter Dumbrow (back of head to camera) interview BGA and Committee staff investigators. On Mr. Wallace's right, Bert Rice, Patrick Riordan, David Holton, John Mendoza, Bill Recktenwald, Bill Halamandaris, and Carlos Contreras. President, but not shown, BGA Investigators Douglas Longhini, James Huenink, and Executive Director J. Terrence Brunner; also Val J. Halamandaris, associate counsel, Senate Committee on Aging.

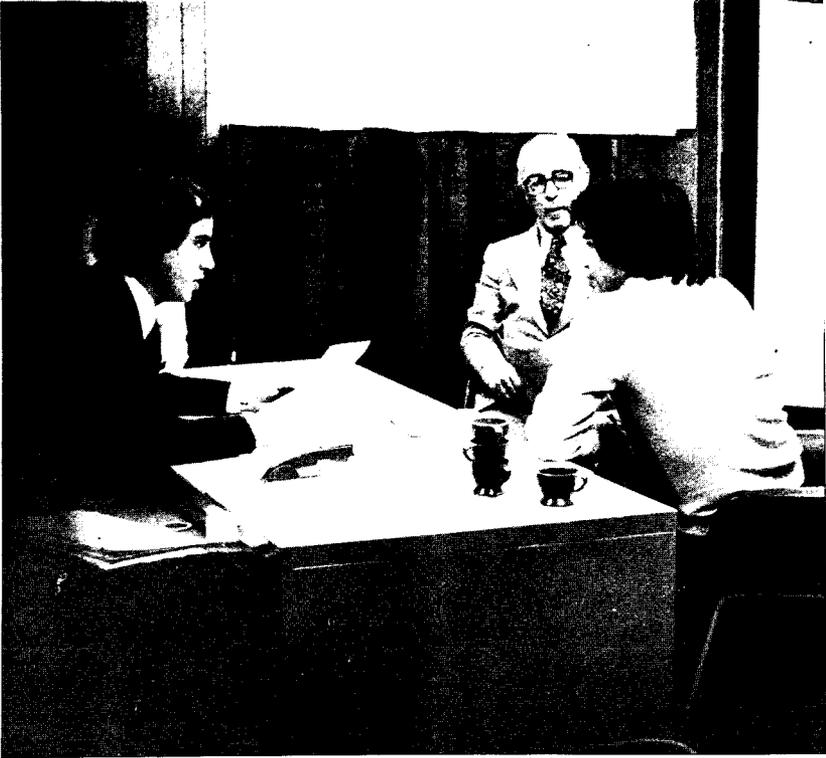


Photo by George Quinn, Chicago Tribune.

BGA Investigator Douglas Longhini (left) poses as the business manager of the storefront medical center; BGA employee Jean Butzen (right) plays the part of his secretary; Pulitzer Prize winning Chicago Tribune Reporter George Bliss (center) poses as one of the physician-owners of the storefront clinic. Ted Diancin, president of Tenn Clinical Laboratory, Chicago, Ill., offered a kickback of 15-25 percent of each month's billings for laboratory work. To disguise the kickback, Diancin suggested Tenn Lab would "rent" some space. Diancin stated that Tenn would rent as little as 1 square foot of space at the medical clinic. Diancin stated that Tenn would not actually use the rented space. He stated that the only reason Tenn would legally sublease the space at the clinic was "just for the IRS, just to make it look legal."



—Photo by Carlos Contreras, BGA

Mr. LaPena said, “You’ll make lots of money . . .”

D. INTERVIEWS WITH PHYSICIANS

From information gathered at the storefront, a profile was constructed of each laboratory. Billings presented to the State for medical testing on public aid patients were pulled and examined. The physicians using the services of labs identified were selected for interview. On January 7, 1976, interviews were made.

Four teams of investigators, comprised of one BGA and one Senate staff member, conducted more than 24 interviews on that day. Physicians were asked: (1) Whether they did business with a particular lab as indicated by bills paid by the Illinois Department of Public Aid; (2) whether they had an arrangement with that lab; (3) the details of any such arrangement; and (4) to examine particular bills submitted on their behalf by medical testing laboratories and paid by the Illinois Department of Public Aid.

In the great majority of cases, physicians confirmed the existence of "arrangements." They provided specifics concerning the amount of rebates and the method of payment. The primary exceptions to the above were cases where the physician was an employee of another physician, or a third party, or otherwise on salary from the medical clinic.

In one such example of the latter, the investigators interviewed Dr. Jose Jaime Hilao, of the Robert Taylor Medical Center, Chicago, Ill. Dr. Hilao indicated that he was on salary and that he knew nothing of any rebate arrangements. He referred the Committee staff to Mr. Robert C. Parro, president, Robert Taylor Medical Center. Dr. Hilao volunteered that Mr. Parro also owned the Professional Medical Center in Chicago.

Mr. Parro told Val J. Halamandaris, associate counsel, Senate Committee on Aging, and BGA investigator James Huenink that he (actually the two clinics) received some \$300,000 the previous year in Medicaid funds from the Department of Public Aid. He added that one of his clinics had been using the services of the North Side Medical Laboratory in Chicago and that the Parke-Dewatt Laboratory provided service to the second of his centers. Now both medical centers are using the Parke-Dewatt Laboratory.

Mr. Parro stated that his present rebate arrangement amounted to 50 percent of the amount his clinic charged Medicaid for lab services on behalf of Medicaid beneficiaries.

He added that he was troubled by this arrangement in that some might think it illegal. He described it as a gray area and stated that the law should be clarified. He added that his decision to give all of his business to this particular laboratory was not motivated by the desire to make greater profit. He volunteered that the North Side Medical Laboratory, which he had been using in one of his clinics, had offered him a kickback of 55 percent of total public aid billings which he turned down because he was dissatisfied with the services of this particular laboratory.

Halamandaris and Huenink also interviewed Mr. Roy Oliver, administrator, 47th Street Medical Center in Chicago. Mr. Oliver indicated that this medical clinic received some \$250,000 from the Department of Public Aid last year. The clinical lab services were provided by a laboratory which provided a rebate of 30 percent of

total volume (approximately \$900 a month). The rebate was received disguised as a rental fee for a 5- by 7-foot room in the clinic. In addition, the lab paid \$325 a month (some \$160 each) to two clinic employees.

In the other situation most frequently found, the physician is the owner of the clinic. Dr. H. M. William Winstanley, King Drive Medical Center, told investigators Halamandaris and Huenink that he received some \$100,000 from Medicaid for his medical center last year. He paid a rent of \$1,050 a month. He receives rental of \$1,000 a month from a pharmacy subleasing space in this building; a dentist pays him about \$800 a month and an optician about \$400 per month. He sends his lab business to the United Medical Laboratory. They pay him a constant \$950 a month which he views as a rental fee for a 7- by 10-foot room in his clinic. In addition, he is paid \$130 per month for an employee to draw blood and perform related services in this room. (These specifics should not be interpreted as making any judgments as to the quality of medical services offered by Dr. Winstanley. It is assumed he is providing needed and valuable service to his community.)

Other arrangements which other physicians admitted included: Acceptance of salary for staff, supplies and equipment, the use of double pricelists, rental arrangements based on volume, and discounts for private paying patients. Discounts for private paying patients enable a physician to have tests such as a urinalysis done for him free or at a sizable discount. The doctor can then turn around and bill private patients \$3 to \$5. With respect to rental agreements based on volume, Dr. Julio Lara-Valle told investigators that the third largest laboratory in terms of public aid business (D. J. Medical Laboratory), paid him \$1,000 a month for the use of a closet-sized room in a suite that cost him \$300 a month to rent.

Senators Frank E. Moss and Pete V. Domenici interviewed Dr. Lara-Valle. He told them that the D. J. Medical Laboratory was now closed down and that its operator (Mr. Espino) "has flown the coop." Dr. Lara-Valle confirmed that he now has the identical "rental" arrangement with another laboratory.



Senator Frank E. Moss examines billings with Dr. Julio Lara-Valle.



Senator Pete V. Domenici (front) and Investigator Bill Recktenwald visit a so-called "Medicaid mill." The signs in the window encourage Medicaid beneficiaries (those with "green cards") to drop in off the street to see a doctor, dentist, podiatrist, optometrist, or other practitioner. Since a pharmacy is also located on the premises, Medicaid patients generally obtain their drugs here as well. Typically, these storefront medical centers will be owned by a businessman who "leases" space to each of the above providers. The "lease" generally requires the practitioner to pay the owner a percentage (often 50 percent or more) of the Medicaid money generated by the practitioner.

Part 3

BILLING: TECHNIQUES OF FRAUD AND ABUSE

Throughout the month of January and in early February Committee staff continued physician interviews. All in all, more than 50 doctors were questioned. These interviews disclosed a number of significant problems with bills presented for payment by clinical laboratories in Illinois, including:

1. Labs charging Medicaid for tests not ordered by the physicians.
2. Labs charging Medicaid for questionable tests, i.e., tests that were inappropriate for the disease diagnosed by the physician.
3. Charging Medicaid patients more than private patients.
4. Billing Medicaid for component parts of automated profile tests.
5. The use of forms supplied by the laboratory which encourage overutilization by making it impossible for the physician to order certain lab tests without also ordering related tests.

A. LABS CHARGING MEDICAID FOR TESTS NOT AUTHORIZED BY THE PHYSICIAN

On February 6, 1976, Senators Frank E. Moss and Pete V. Domenici interviewed Dr. Lara-Valle. The Senators were accompanied by Counsel Halamandaris and Investigator Recktenwald of the Committee staff and Jim Huenink of the BGA. A random sample of nine bills representing a total of \$259 in lab work for various patients of Dr. Lara-Valle and presented to Medicaid for payment by the North Side Medical Laboratory, produced the following results:

1. Some 55 percent of the tests (\$141 worth) were not ordered by the physician.
2. Only two of the nine bills were free from any unauthorized tests.
3. Dr. Lara-Valle had not ordered any of the tests listed on three invoices presented for payment by D. J. Medical Laboratory.

Similarly, in another random sample of 20 bills submitted by D. J. Medical Laboratory on behalf of Dr. R. Bascon, the Committee staff learned that only \$112 of the \$885 in bills submitted by the lab had been ordered by the physician.

In 12 out of the 20 cases, the doctor had no record of ever seeing the patient at any time near or before the date of service. In fact, in 2 of the 12 cases, the patient's first visit was after the date of service. In one case, the doctor had no record of having ever seen the patient. In 7 of the 20 cases, tests were added that the doctor had not ordered and for which the doctor had not received results. In many cases, the lab had billed for blood tests when no blood was drawn. In only 1 of the 20 invoices were all the tests requested by the physician. (See appendix 2, page 61.)

See Instructions On Reverse.

Illinois Department of Public Aid

STATEMENT OF SERVICES RENDERED INDEPENDENT LABORATORY
(Type or Print all Information)

1. Services for Month of March 19 75

2. CASE LAST-NAME FIRST NAME
ADDRESS:

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name
JAMES

4. Case Identification Number

5. Office Account No.
3639

6. Birthdate
10 55

Leave Blank

Report of Services

| 9. Date of Service | 10. Procedure Code | 11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given | 12. Charges |
|--------------------|--------------------|---|-------------|
| 3-5 | 85010 | CBC | \$ 7.00 |
| 3-5 | 85650 | Sedimentation Rate | 5.00 |
| 3-5 | 86140 | C-Reactive Protein | 10.00 |
| 3-5 | 86360 | RA Latex | 10.00 |
| 3-5 | 84550 | Uric Acid | 6.00 |
| 3-5 | 86060 | ASO Titer | 10.00 |
| 3-5 | 84075 | Alkaline Phosphatase | 10.00 |
| | | | |
| | | | |
| | | | |
| | | | |

16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp

17. Provider # 14-0266
Print, Type or Stamp

18. Name & Add. of Referring Physician
**Dr. Hilao
3920 S. State St.**

13-TOTAL CHARGE \$ **58.00**

14. CREDIT \$ **-**

15-NET CHARGE \$ **58.00**

19. DIAGNOSIS OR CONDITION:
Rheumatoid Arthritis, Sinusitis

20. Living Arrangement or Time of Service.
 Group Care Facility
 Hospital
 Other (Specify)

21. **CERTIFICATION**
This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VII of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

[Signature] 3-7-75
SIGNATURE OF PROVIDER DATE SIGNED

22. FOR SPRINGFIELD OFFICE USE ONLY - Do Not Write in This Box

Special Approval - If Required for Procedure Code(s):
() Approved () Not Approved By: _____ Date: _____

A review of bills indicates similar problems for most of the labs under investigation. The above statement provides a quick and graphic example of this particular problem. The attending physician could offer no evidence that he had ordered any of the \$58 in tests that were billed to North Side Medical Laboratory.

In two sample statements representing lab procedures allegedly performed by Azteca Medical Laboratory for Dr. Frank Boone, Boone Clinic, Chicago, Ill., the physician stated he did not order 35 percent of the procedures. Two sample statements with respect to United Med-

ical Laboratory also indicated that 56 percent of the services were not requested by the authorizing physicians.

Similarly, the Department of Health, Education, and Welfare's audit agency surveyed three Illinois laboratories in 1973 and 1974. Two of the laboratories, 2001 Medical Lab and International Clinical Laboratory, were unable to locate any records to support the services billed under title 19 (Medicaid). The third laboratory, Monticello Medical Laboratory, had its records available for audit. From a sample of 250 laboratory tests for which the laboratory claimed reimbursement on 80 bills, HEW found they were unable to account for 38 percent of the tests and were unable to locate requisitions to support 26 of the 250 tests.

HEW visited the physicians who had reportedly requested 62 of the 94 tests not recorded on the laboratory's log; the physicians had evidence of results on only 10 of the 62 tests. With respect to the 18 of the 26 tests for which HEW could find no requisitions, the doctor who reportedly requested the tests had no record of the results. This audit was released December 23, 1975, recommending that the State review high-volume providers for similar problems.¹⁰

B. LABS CHARGING MEDICAID FOR QUESTIONABLE TESTS: TESTS INAPPROPRIATE FOR THE DISEASE DIAGNOSED

Investigators were alerted to the fact that doctors were not authorizing tests because labs often billed Medicaid for tests inappropriate for the patient's diagnosis. Here are some examples:

1. Sedimentation rate tests ordered for a patient whose diagnosis was diabetes.
2. Sickle cell tests (a disease which predominantly appears in black people) being ordered for middle aged white adults.
3. EKG tests (electrocardiogram tests) with interpretation for a patient with a sinus condition.

C. CHARGING MEDICAID MORE THAN PRIVATE PATIENTS

The BGA pulled more than \$10,000 worth of paid bills (samples surveyed 14 selected tests) for each of eight clinical labs doing a high volume of public aid business in the State of Illinois. Each of these labs charged public aid patients (Medicaid patients) substantially more than they charged private patients. This practice violates HEW regulations, which require that bills submitted to Medicaid must be usual and customary charges for these services. HEW regulations further state that if two price lists exist, the lower of the two charges will be used as the basis for reimbursement.

In BGA's examination the range of difference was from 3.7 percent to 200 percent. The median average was 116 percent.

A chart showing comparative charges to Medicaid and to private patients for selective labs follows on next page.

A second chart with respect to five labs shows the difference between what the State paid and what they should have been paid. (See page 27.)

¹⁰ Report on Review of Management Controls and Selected Operating Practices Under the Medicaid Program, Title XIX of the Social Security Act, State of Illinois Department of Public Aid, Dec. 23, 1975, Audit Control No. 05-80201.

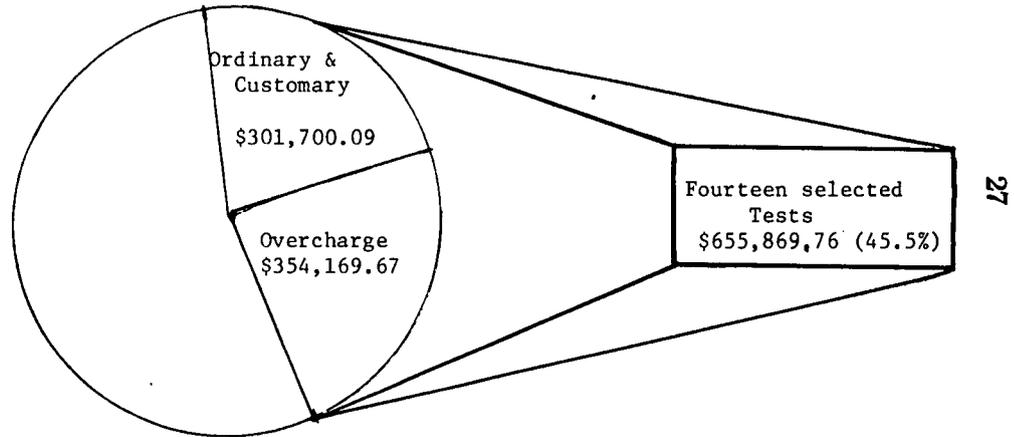
COMPARATIVE PRICE LISTS, CLINICAL LABORATORIES, COOK COUNTY, ILL.

| Procedure | D.J. private charge | D.J. public charge | Illinois private charge | Illinois public charge | Norsom private charge | Norsom public charge | North Side private charge | North Side public charge | Tenn private charge | Tenn public charge | United private charge | United public charge | West- lawn private charge | West- lawn public charge |
|---------------------------------|---------------------------|--------------------------|-------------------------------|------------------------------|-----------------------------|----------------------------|------------------------------------|-----------------------------------|---------------------------|--------------------------|-----------------------------|----------------------------|------------------------------------|-----------------------------------|
| Urinalysis..... | \$1.50 | \$3 | \$5 | \$10 | \$2.40 | \$5 | \$1.50 | \$3 | \$5 | \$5 | \$1.50 | \$3 | \$3 | \$4 |
| Sickle cell..... | | | 10 | | 3.60 | 8 | 2.50 | 5 | 5 | | 5.00 | | | |
| P.B..... | | | 10 | 15 | 3.60 | | | | | | 3.00 | 10 | | |
| T-3..... | 6.00 | 12 | 15 | 15 | 4.20 | 10 | 7.50 | 10 | 10 | 15 | 3.00 | 15 | 10 | 15 |
| T-4..... | 6.00 | 12 | 10 | 15 | 6.00 | 12 | 7.50 | 15 | 10 | 15 | 10.00 | 15 | 10 | 15 |
| C.b.c..... | 2.50 | 6 | 5 | 12 | 3.60 | 8 | 3.00 | 7 | 7 | 10 | 3.00 | 6 | 6 | 6 |
| Sed. rate..... | | 4 | 5 | | 2.40 | 3 | 2.50 | 5 | 5 | 4 | 1.50 | 3 | 4 | 3 |
| R.A. latex..... | 2.50 | 7 | 10 | 12 | 3.60 | 7 | | | 5 | 5 | 2.00 | 5 | 5 | 5 |
| A.S.O. titre..... | 2.00 | 7 | | | 3.60 | 7 | 2.50 | 10 | 5 | 10 | 5.00 | 10 | 10 | 10 |
| SMA (12)..... | 3.50 | 18 | | | | 15 | 7.50 | 15 | 2 | 25 | 5.00 | 15 | | |
| Calcium..... | | | 5 | | 2.40 | | | | | | | | | |
| Phosphorus..... | | | 5 | | 3.60 | | | | | | | | | |
| Creatine..... | 3.00 | 7 | 5 | 12 | 3.60 | 7 | 2.50 | 6 | 8 | 10 | 1.50 | 6 | 5 | 5 |
| Creatine- phosphokinase..... | | | | 12 | 2.40 | 7 | 2.50 | 6 | 10 | 5 | 1.50 | | | |
| Uric acid..... | | 5 | 5 | 12 | 2.40 | 7 | 2.50 | 6 | 5 | 8 | 1.50 | 6 | | |
| Cholesterol..... | | | 5 | 12 | 2.40 | 7 | | | 5 | 8 | 1.50 | 6 | | |
| Total protein..... | | | | | 3.60 | 7 | | | | 5 | | | | |
| Albumin..... | | | | | 3.60 | 7 | | | | | | | | |
| Bilirubin..... | | | | | 2.40 | 7 | | | | 7 | | 5 | | |
| Alkaline- phosphotase..... | | | 5 | | 2.40 | 7 | | | | 6 | | 8 | | |
| LDH..... | | | 10 | | 2.40 | 7 | | | | | | 8 | | |
| SGOT..... | | | | | 2.40 | 7 | | | | 8 | | 8 | | |

Note: Prices based on private price lists and random samples of bills submitted for payment.

PROJECTION OF OVERCHARGES TO MEDICAID BY FIVE MEDICAL LABORATORIES

(Based on 8% sample)



Total Payments by Illinois Department of
Public Aid \$1,441,472.08
First 6 months of F.Y. '76

These practices were discovered by the HEW audit agency in their report released November 21, 1974, again with reference to the State of Illinois. This report is based on HEW Medicaid payments made to providers in 1972. It describes problems with Antilles Medical Laboratory and Division Medical Laboratory, stating:

One of the laboratories was billing for services provided to Medicare patients at rates commensurate with those charged non-Medicaid patients. The other laboratory which had its Title 19 bills (Medicaid) submitted to the State through a billing agency, billed the State agency during calendar year 1972 for certain laboratory procedures at rates which exceeded those charged to the general public for the same services.¹¹

D. BILLING MEDICAID FOR COMPONENT PARTS OF AUTOMATED PROFILE TESTS

During the last 5 years technology has advanced to the point where it is now possible to run a number of tests simultaneously on the same specimen. Typically, from 12 to 20 determinations can be made from 1 blood sample. The most common profile is called an SMA-12 and includes the following tests:

1. calcium.
2. phosphorus.
3. creatinine.
4. creatinine phosphokinase.
5. uric acid.
6. cholestrol.
7. total protein.
8. albumin.
9. total bilirubin.
10. alkaline phosphatase.
11. lactic dehydrogenase (LDH).
12. glutamic oxalacetic transaminase (SGOT).

A number of manufacturers, including Technicon Instruments Co. of New Jersey and Coulter Electronics of Florida, manufacture equipment capable of performing these analyses at the rate of 60 an hour. The cost of performing these tests with automated equipment ranges from 60 cents to \$1 for this entire panel of tests. Clinical reference laboratories using this equipment charge patients an average of \$1.50 to \$2 for this battery of tests.

Medicare and Medicaid regulations, as well as the Current Procedural Guide of the American Medical Association, require that when three or more of the above tests are ordered by the physician, they should be billed as a panel. The prevailing Medicaid rate in the State of Illinois for an SMA-12 panel is \$16. These same 12 tests billed individually could total more than \$100.

One of the most frequent areas of questionable activity encountered by the investigators was reduction of panel tests into component parts and billing for each test separately.

¹¹ Report on Audit of Medical Laboratory Services Provided Under Title XIX of the Social Security Act, State of Illinois Department of Public Aid, Nov. 21, 1974, Audit Control No. 05-50015.

For example, United Medical Laboratory billed Medicaid \$8 for an LDH, \$8 for an alkaline phosphatase, \$5 for a total bilirubin, \$8 for an SGOT and \$6 for a creatine test. These five elements for an SMA-12 had a total cost to Medicaid of \$41. The same laboratory charges private patients only \$5 for an entire SMA-12.

Another billing example from the Illinois Medical Laboratory is shown on page 30. As the invoice shows, four of the five tests were billed at a cost of \$48. These same four tests and the other eight component parts of an SMA-12 panel are available at a rate of \$5 for non-Medicaid patients using this same lab.

Similarly, the Committee staff collected several examples relating to another laboratory (Norsom Medical Reference Laboratory) showing separate billings for three tests: chlorides, potassium, and sodium constituting an electrolytes profile, meaning that they should have been billed as a panel. Instead they were billed at a cost of \$8 each. The same laboratory bills the same three tests as a panel for a cost of \$6 to private paying patients.

There are a number of similar examples that could be offered of profile tests which are being "pyramided"—that is, the laboratory is billing separately for each of the component parts in a profile. On one invoice found by Committee investigators, Medicaid was charged \$40 by United Medical Laboratory for a thyroid profile which they list to private patients at \$10, \$20 for a lipids/triglycerides panel they list to private patients at \$12, and more than \$15 for an SMA-12. The dollar difference is more than \$50 out of a total of \$81, and that does not begin to consider the larger question of whether any of these tests were in fact necessary.

The complete blood count profile provides other opportunities for separate billing. Included within a CBC are the following tests: hemoglobin, red cell count, white cell count, differential, hematocrit, indices (3 tests), and red blood cell (RBC) morphology. The average cost of a CBC is some \$6 or \$7 but the component parts may be billed individually at sums three or four times this amount each.

Other related abuses range from the subtle to the blatant. Evidence indicates Medicaid paid for a component part (creatinine) and an SMA-12. A number of laboratories bill more than \$25 for a combined SMA-12 test and an A/G ratio (albumin-globulin). In the days before automated tests were possible, a charge of \$10 or more for an A/G ratio was understandable. The proportion of albumin and globulin had to be determined and compared. But now, with current technology, this determination is part of a standard SMA-12 profile. All that remains is a simple slide-rule calculation to determine the ratio. This process takes 10 seconds at most and hardly justifies a charge of \$10 to Medicaid.

But there is yet another aspect to breaking down test procedures into component parts. Most panel tests are automated whereas individual tests for the most part are performed by hand. Some clinical labs make a practice of billing most procedures as if they were performed by hand when in fact they were performed by machines. This fact came to HEW's attention in the HEW audit agency's report concerning Medicaid operations in the State of Illinois in 1972. The audit released November 21, 1974 states:

Due to computer audit problems, many medical laboratory bills for performing various blood tests were improperly paid

See Instructions On Reverse.

Illinois Department of Public Aid
**STATEMENT OF SERVICES RENDERED
 INDEPENDENT LABORATORY**
 (Type or Print all Information)

1. Services for Month of 1975
OCTOBER 19

2. CASE LAST NAME FIRST NAME
SUSIE
 ADDRESS:

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name
SUSIE
 4. Case Identification Number
04 - 228 - 432538
 5. Office Account No.
 6. Birthdate
11 - 44
 Leave Blank 7. /

Report of Services

| 9. Date of Service | 10. Procedure Code | 11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given | 12. Charges |
|--------------------|--------------------|---|-------------|
| 10-17-75 | 85010 | C.B.C. | \$ 12.00 |
| 10-17-75 | 84330 | GLUCOSE | 12.00 |
| 10-17-75 | 84520 | BUN <i>3.14A.10</i> | 12.00 |
| 10-17-75 | 82565 | CREATININE | 12.00 |
| 10-17-75 | 84550 | URIC ACID | 12.00 |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

16. Name & Address of Client
 17. Provider # 14-8287
 Print, Type or Stamp
 18. Name & Add. of Referring Physician
RAUL PELAEZ M.D.
1540 N. MILWAUKEE AVE.
CHICAGO ILL. 60622
 13. TOTAL CHARGE \$ 60.00
 14. CREDIT \$
 15. NET CHARGE \$ 60.00

19. DIAGNOSIS or CONDITION: U.T.I.
 20. Living Arrangement at Time of Service.
 Group Care Facility
 Hospital
 Other (Specify)

21. **CERTIFICATION**
 This is to certify that I have rendered the services and provided the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.
Raul Pelaez 10-31-75
 SIGNATURE OF PROVIDER DATE SIGNED

22. FOR SPRINGFIELD OFFICE USE ONLY - Do Not Write in This Box
 Special Approval - If Required for Procedure Code(s):
 Approved Not Approved By: Date:

at rates established for manual tests rather than at the lower rates established for automated tests. About \$32,000 in excessive payments were made during the 7-month period that ended March 31, 1973.

A final example is reprinted on page 32. The form, obtained by Committee on Aging investigators, clearly shows that D. J. Medical Laboratory billed Medicaid twice for the same test (a complete blood count with differential).

E. BROKERING: SUBCONTRACTING LABORATORY TESTS

Another significant problem which came to the Subcommittee's attention during this investigation was brokering, or the practice of subcontracting laboratory tests. With the rapid development of new technology, the increased use of reference laboratories has become more common. Under Medicare or Medicaid regulations an independent clinical lab can perform only those services and procedures that are within the specialties in which the laboratory director is qualified. Of the more than 3,000 independent labs participating in Federal programs, some 85 percent were approved to perform clinical microscopy, routine chemistry, and hematology. Approximately 25 percent were approved to do tissue and oral tests while only 1.6 percent were approved for all procedures. The following table provides details.

TYPE OF PROCEDURE APPROVED IN MEDICARE-APPROVED INDEPENDENT LABORATORIES: JANUARY 1973

| Type of procedure | Number | Percent |
|---------------------------------|--------|---------|
| Total laboratories | 2,906 | 100.0 |
| Bacteriology | 1,911 | 65.8 |
| Mycology | 1,214 | 41.8 |
| Parasitology | 1,663 | 57.2 |
| Virology | 164 | 5.6 |
| Syphilis | 2,058 | 70.8 |
| Routine chemistry | 2,461 | 84.7 |
| Clinical microscopy | 2,468 | 84.9 |
| Hematology | 2,499 | 86.0 |
| Blood group and Rh typing | 1,955 | 67.3 |
| Rh titers | 1,001 | 34.4 |
| Cross matching | 237 | 8.2 |
| Tissue pathology | 730 | 25.1 |
| Oral pathology | 665 | 22.9 |
| Diagnostic cytology | 912 | 31.4 |
| EKG services | 855 | 29.4 |
| Radiobioassay | 909 | 31.3 |
| All specialties | 47 | 1.6 |

Source: Social Security Administration, Office of Research and Statistics.

Obviously, it is necessary to some degree to send complicated lab tests to establishments that are qualified to perform them. However, abuse can occur when a lab represents itself as having capabilities which it does not have. In practice, given current fee schedules, a storefront clinic with as little capacity as was established by the BGA at 1520 West Morse can acquire Medicaid accounts, subcontract those tests to other independent laboratories in other cities, and even in other States, at a cost of half of what they will be paid for presumably performing these services by Illinois Department of Public Aid.

See Instructions On Reverse.

Illinois Department of Public Aid

STATEMENT OF SERVICES RENDERED
INDEPENDENT LABORATORY

(Type or Print all Information)

1. Services for Month of July 1975

CASE LAST NAME: Clairstone
FIRST NAME: Clairstone
ADDRESS: _____

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name: Clairstone
4. Case Identification Number: 04
5. Office Report No.: 866329
6. Birthdate: 4-1-38
7. Leave Blank /

Report of Services

| 9. Date of Service | 10. Procedure Code | 11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given | 12. Charges |
|--------------------|--------------------------------------|---|-------------|
| 7-31-75 | 85010 | Complete blood count w/diff. | 6.00 |
| | 85650 | Sedimentation rate | 4.00 |
| | 85640 | Retic count | 4.00 |
| | 83550 | T. Iron binding capacity | 10.00 |
| | 82250 | T. Bilirubin | 7.00 |
| | 81000 | Urinalysis routine complete | 3.00 |
| | 85010 | Complete blood count w/diff. | 6.00 |
| | 87095 | Vaginal culture of sensitivity | 15.00 |
| | 88100 | Pap smear | 10.00 |
| | 87014 87015 | Stat urethral smear | 7.00 |

16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp

17. Provider # 148250
Print, Type or Stamp

18. Name & Add. of Referring Physician
P. Basson MD
4809 W. MADISON
CHGO. ILL.

13. TOTAL CHARGE \$ 69.00
14. CREDIT \$
15. NET CHARGE \$

19. DIAGNOSIS or CONDITION:
Non-specific vaginitis
210 Urtemia

20. Living Arrangement at Time of Service. Group Care Facility Hospital Other (Specify)

21. CERTIFICATION
This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

SIGNATURE OF PROVIDER: [Signature] DATE SIGNED: 7-31-75

22. ON SPRINGFIELD OFFICE USE ONLY - Do Not Write in This Box

Special Approval - If Required for Procedure Code(s): _____ Date: _____

() Approved () Not Approved By: _____

From Medicaid's point of view the practice of brokering results in the payment or unnecessary charges for services not rendered or not rendered by the provider submitting the invoice for payment.

Dr. Frank Boone told the Committee staff that Azteca Medical Laboratory was a small operation and did not have capability to perform tests he needed. He also complained of delays of a week or more before results were returned.

He told the Committee staff that these delays and overall poor service were the reasons he dropped this lab. He said that this decision was precipitated when he learned that the lab was "farming out" much of the work he ordered to a laboratory in Columbus, Ohio.



BGA Investigator James Huenink (left) and Senator Frank E. Moss (right) examine billings with Azteca Laboratory owner Guillermo Velez (center).

F. THE USE OF FORMS WHICH ENCOURAGE OVERUTILIZATION

The forms which some labs furnish to physicians are structured in ways which encourage overutilization. These forms make it impossible to order certain lab procedures without ordering other unnecessary tests. The following form furnished to physicians by North Side Medical Laboratory is a good example of this practice. (See below.) As can be seen under the heading "Microbiology," the form does not allow a separation between throat culture and sensitivity (two tests). The result is that in ordering one, the physician must order the other. The same holds true for stool culture and sensitivity.

An examination of this lab's billing pattern provides numerous instances where the use of these forms resulted in overutilization.

| | | Services for | |
|------------------|-------------|----------------------------|--------------------|
| | | Month | Year |
| Case Name: _____ | _____ | Patient's First Name | Office Account No. |
| _____ Last | _____ First | _____ | _____ |
| Address: _____ | | Case Identification Number | Birthdate |
| | | _____ | _____ |
| | | Medicare No | _____ |
| | | _____ | _____ |

Please check procedures desired

FOR LABORATORY EXAMINATION

| | | | | |
|---|---|---|--|--|
| CHEMISTRY: <input type="checkbox"/> Glucose Blood <input type="checkbox"/> Glucose Tolerance Test <input type="checkbox"/> BUN <input type="checkbox"/> Creatinine <input type="checkbox"/> Uric Acid <input type="checkbox"/> Calcium <input type="checkbox"/> Potassium <input type="checkbox"/> Chloride <input type="checkbox"/> T 3 <input type="checkbox"/> T 4 <input type="checkbox"/> Serum Iron <input type="checkbox"/> Iron Binding Capacity <input type="checkbox"/> Total Bilirubin <input type="checkbox"/> Direct Bilirubin <input type="checkbox"/> Indirect Bilirubin <input type="checkbox"/> Total Cholesterol <input type="checkbox"/> CO ₂ | <input type="checkbox"/> Thymol Turbidity <input type="checkbox"/> Ceph. Flocc. <input type="checkbox"/> Triglyceride <input type="checkbox"/> Total Protein <input type="checkbox"/> Albumin <input type="checkbox"/> Globulin <input type="checkbox"/> Alkaline Phosphatase <input type="checkbox"/> Acid Phosphatase <input type="checkbox"/> SGOT <input type="checkbox"/> SGPT <input type="checkbox"/> LDH Total <input type="checkbox"/> CPK <input type="checkbox"/> Amylase Blood <input type="checkbox"/> Lipase Blood <input type="checkbox"/> Sodium <input type="checkbox"/> Electrolytes | HEMATOLOGY <input type="checkbox"/> C.B.C. <input type="checkbox"/> Sed. Rate <input type="checkbox"/> Retic. Count <input type="checkbox"/> Platelet Count <input type="checkbox"/> Prothrombin Time <input type="checkbox"/> Bleeding Time <input type="checkbox"/> Coagulation Time <input type="checkbox"/> Fragility Test <input type="checkbox"/> Clot. Retraction <input type="checkbox"/> Fibrinogen <input type="checkbox"/> Prothrombin <input type="checkbox"/> Consumption <input type="checkbox"/> L.C. Prep. <input type="checkbox"/> Sickle Cell Test <input type="checkbox"/> Blood Group <input type="checkbox"/> Coombs Test, Direct | <input type="checkbox"/> Coombs Test Indirect SEROLOGY <input type="checkbox"/> VDRL <input type="checkbox"/> Rubella Test <input type="checkbox"/> R.P.R. <input type="checkbox"/> A.S.O. Titer <input type="checkbox"/> C-Reactive Protein <input type="checkbox"/> R.A. SPECIAL TESTS <input type="checkbox"/> T ₃ T ₄ T ₇ <input type="checkbox"/> Protein Electrophoresis <input type="checkbox"/> Hemoglobin Electrophoresis <input type="checkbox"/> Lipoprotein Electrophoresis <input type="checkbox"/> Immunoelectrophoresis MISCELLANEOUS | URINALYSIS <input type="checkbox"/> Routine Examination <input type="checkbox"/> U. C. G. <input type="checkbox"/> Diaper Blue MICROBIOLOGY <input type="checkbox"/> Urine Culture & Sensitivity <input type="checkbox"/> Stool Culture & Sensitivity <input type="checkbox"/> Throat Culture & Sensitivity <input type="checkbox"/> Gram Stain <input type="checkbox"/> Ova and Parasites <input type="checkbox"/> Smear for TB MISC. <input type="checkbox"/> EKG <input type="checkbox"/> Pap Smear <input type="checkbox"/> Strip Screening |
| <input type="checkbox"/> Arthritis Panel SMA-12 CBC Sed-rate CRP ASO Titer Ra Latex | <input type="checkbox"/> Coagulation Panel CBC Pro-Time PTT Mono Screen Calcium Screen | <input type="checkbox"/> Hypertension Panel SMA-12 Sodium (Na) Potassium (K) T ₃ , T ₄ , T ₇ Tryglycerides CBC Urinalysis Lipoprotein Electrophoresis EKG | <input type="checkbox"/> Thyroid Panel T ₃ , T ₄ , T ₇ Glucose Cholesterol Triglycerides CBC Urinalysis | <input type="checkbox"/> Renal Panel SMA-12 Sodium (Na) Potassium (K) Creatinine CBC Urinalysis Urine culture & Sensitivity ASO Titer |
| <input type="checkbox"/> Anemia Panel CBC Sickle Cell Prep Iron Binding Cap Serum Iron Reticulocyte Cl. Ova & Parasite Protein Electrophoresis Urinalysis | <input type="checkbox"/> Child Panel CBC Sickle Cell* Urinalysis SMA-12* | <input type="checkbox"/> General Health Panel SMA-12 CBC T ₄ EKG* Urinalysis Sickle cell* RPR | <input type="checkbox"/> Lipid Panel Triglycerides Cholesterol Lipoprotein electrophoresis Glucose, 2 hrs. post 100 gm glucose ingestion | <input type="checkbox"/> Pre-Natal / OB CBC Urinalysis Blood Grouping RH Typing RPR Pap Smear* |
| <input type="checkbox"/> Cardiac Panel SMA-12 Triglycerides Sodium (Na) Potassium (K) EKG CBC Urinalysis Lipoprotein Electrophoresis Urine 24 hrs K, Na, VMA | <input type="checkbox"/> Hepatic Panel SMA-12 Protein electrophoresis CBC Urinalysis Thymol Turbidity Cephalin Flocculation Pro-Time | <input type="checkbox"/> Obesity Panel SMA-12 T ₃ , T ₄ , T ₇ Triglycerides CBC Urinalysis Lipoprotein Electrophoresis EKG* | Impressions: | |

* Only if needed

REFERRING PHYSICIAN

ADDRESS

Part 4

WIDELY VARYING FEE SCHEDULES

Most of the problems relating to the clinical lab services inevitably have a common root in the fee schedules established by Medicare and Medicaid. The number of these schedules is a problem in and of itself. California alone has a separate price list for each of 28 geographical areas. There is variability in prices from city to city and from county to county within each State. There is great variability from State to State.

The principal problem appears to be that most of these rates were established 8 to 10 years ago—prior to the development and proliferation of sophisticated automated analytical equipment. In very simple terms, the cost of performing most tests is now a fraction of what it was. Much of this cost saving, at least in regions known to committee investigators, has not been passed on to Medicaid consumers. Instead, much of it has apparently gone for “educational programs” or “incentive marketing plans,” “rebate referral programs,” and profits to the providers of kickbacks.

As an example of this development in technology, a complete blood count done manually will take half an hour to 45 minutes. The average cost is \$6 or \$7. The same tests can be performed by a machine called a Coulter Counter at a rate of one every 45 seconds and at a cost of 17 cents each. An SMA-12 panel performed manually could take the technician the better part of an afternoon. The Technicon automated system performs 60 tests an hour at a cost of about \$1 per test. The cost of performing an electrolytes panel is about 75 cents. Medicaid pays as much as \$10 for the panel, and the components can be billed separately for three times that amount.¹² (See earlier discussion of profile components.)

As noted earlier, BGA undertook an examination of 20,000 billings representing more than \$10,000 in selected tests for each of 8 laboratories. The median average overpayment is 116 percent. The immediate implications of this statistic is that a restructure of the price list is necessary. Medicaid in Illinois is paying twice as much as it should. Similar conclusions were reached by investigators in New York and New Jersey.

Testimony before the New Jersey Commission on Investigation indicated that the fee schedule was antiquated. It was estimated that 50 percent of gross payments to clinical labs in that State might be saved by the adoption of a fee schedule more realistically attuned to technology. The fee schedule has subsequently been reduced by 40 percent. More details on the New Jersey hearings can be found in part 5, page 37.

¹² Information relating to costs using automated machines obtained in an interview between Bill Halamandaris and Charles Jackson, sales representative, Coulter Electronics, Hialeah, Fla., Jan. 30, 1976.

After abortive attempts at utilization review, a decision was made by officials in the city of New York to scrap the present system in favor of a series of regionally based laboratories. New York City was divided into areas and bids were invited for all service within each of these regions for a period of 1 year. The total bid for the city of New York (including each of the several regions) amounted to approximately \$5.7 million or about \$5 per eligible patient. The current rate of payment to labs is \$11 million a year or about \$9 per eligible patient. It is interesting to note that the contracts contained the city's option for renewal for three additional years at the same rate. For the past 5 years the cost of lab services in New York has been increasing at the rate of some 30 percent a year.

Part 5

EVIDENCE OF SIMILAR PRACTICES IN OTHER STATES

When it comes to questionable practices perpetrated by clinical laboratories, the State of Illinois is hardly unique. Similar problems have been identified in New York, New Jersey, California, Pennsylvania, and Michigan, to name a few States.

A. NEW JERSEY

The New Jersey study of independent clinical laboratories conducted by the State's Commission of Investigation substantiated the practice of offering kickbacks to acquire accounts, documented gross overutilization of some laboratory services by physicians receiving kickbacks, and indicted a practice defined as unconscionable profiteering by small laboratories, brokering services, and others billing for services not performed. In some cases, the State was even billed for tests run free by its own health department.

In addition, the Commission found fault with the basic system of reimbursement, the management of the reimbursement system by the fiscal intermediary and the surveillance of the entire reimbursement system by the State government. It concluded the design of the reimbursement system was such that it not only resulted in gross overpayments but, in effect, created a preference for small, cost-inefficient clinical laboratories to the point where the normal operation of a competitive market was disrupted and abusive practices encouraged.

Profits to labs permitted under this system, the Commission stated, were so exorbitant that it was inevitable that a portion would be used in efforts to persuade physicians to utilize and overutilize their services. Excessive profit was seen as the most important single incentive, promoting corruption of segments of the medical care industry.

Component parts of panel tests were billed individually at a rate exceeding the charge for the cluster itself in violation, not only of general provisions of Medicare and Medicaid, but in specific violation of the New Jersey Administrative Code (Sec. 10:61-1.5). Medicaid was charged on the same billing for a complete blood count and an RBC morphology (a part of a complete blood count); for a complete urinalysis and an occult blood (part of a urinalysis).

In addition, a determination was made that Medicaid had often been charged for Rubella tests (a test for German Measles) conducted by the State department of health without charge. for a pregnancy test (A-Z pregnancy test) using animals when, in fact, an alternate method (a slide test which does not use animals) had been

employed. The rate of reimbursement for the A-Z pregnancy test is nearly twice that of the slide test.

A pregnancy test can also be run a third way involving urine which can cost even less.

One provider, Saul Fuchs, Clinical Lab Director, Physicians Lab Service, admitted kickback arrangements on both ends. He received a rebate from International Drugs—his supplier—but gave kickbacks to a number of physicians and to two nursing homes: The Chestnut Hill Convalescent Center and the Hartwick Nursing Home.

Another, Seymour Slotnick, representing himself as an independent contractor offering specific services, stated his marketing fee was nearly 60 percent of all accounts he acquired. In the case of one such account, his personal earnings were determined to be \$96,000 of the \$164,000 billed Medicaid by Park Medical Laboratory.

Park Medical Laboratory was determined to be located in a residential area on the first floor of a converted townhouse in an area of some 600 square feet. A second laboratory was found to be a converted sunporch. Neither facility possessed the equipment necessary to perform the tests they billed. Slotnick "brokered" the tests to other labs, keeping the difference between what they charged and what the State of New Jersey paid him.

Four basic kickback techniques were identified by the Commission. The first technique was straight cash, known as "greens." Second was the providing of personnel (individuals not involved in performing laboratory work, but rather working for the provider of service in whatever capacity he desired). Third was the rental of space from the referring source, very often at a rate determined by a percentage of gross billings. Fourth was the provision of supplies and equipment and miscellaneous services for the referral of specimens.

Only about 2 percent of the 184 clinical laboratories in the State were found to be involved in these machinations, but it was also determined that some 12 firms out of that total received more than half of all Medicaid dollars expended in the State for medical testing.

Further, none of these 12 laboratories were major, nationwide providers. Representatives of Roche Laboratories and MetPath Laboratories testified Medicaid accounts represented a fraction of a percentage of their total business in New Jersey. The reason was said to be the prevalence of kickback schemes.

As Dr. Paul A. Brown, Chairman of the Board of MetPath, stated:

We have a continuing program of education and marketing, but when you're looking at as much as 40 percent as a rebate to the referring source, it becomes very difficult to match that education.¹⁸

agencies quickly reacted to these disclosures by the SCI, enacting and agencies quickly reacted to these disclosures by the SCI, enacting and implementing the most modern and comprehensive clinical laboratory law in the Nation. As noted above, fee schedules were reduced by 40 percent.

¹⁸ Excerpt taken from sworn testimony. State of New Jersey Commission of Investigation, Public Hearing in the Matter of the Investigation With Relation to the New Jersey Program of Medical Assistance and Health Services, June 24 and 25, 1975.

B. NEW YORK

New York State Department of Health officials have stated a number of times that similar practices exist in New York and have for some years now. More than 15 years ago, New York made a major effort to crack down on fraudulent mail order laboratories. Despite this and successive subsequent efforts, the fraud has been found to continue. The fee schedule was determined to be more than twice as high as it should be. Some 16 laboratories were found to control more than 70 percent of the Medicaid referral business. After attempting in the intervening years to exercise control through utilization review, it was decided to attempt a totally different system, one geared more realistically to current capability.

The incentive of the current system encouraged overutilization. The system was open-ended. The more tests that were ordered, the more the provider was reimbursed. Consequently, program costs increased at an alarming rate. The solution sought was to reverse the incentive by placing a ceiling on the program and lowering unit cost by opening up the program to competitive bids.

Under the bids accepted, the unit cost per test ranged from 89 to 87 cents. The total of all bidders for the city of New York was approximately \$5.6 million. It was estimated that once clinical chemistry tests in the city reached the 1 million (tests) mark, the cost could be reduced to 25 to 50 cents per test.

Before this program could be implemented, it was challenged in the courts by a coalition of small independent laboratories. Subsequently, HEW joined the suit, filing an amicus curae brief stating that the concept of regional laboratories interfered with the Medicaid patient's freedom of choice. On this basis, the District Court invalidated the regional laboratory concept. However, due to the persuasive arguments that had been made with respect to possible cost and efficiency, the judge asked that the program be continued on an experimental basis by HEW under a section 115 grant. The Borough of Queens has been selected as the site for these tests and details of this proposed pilot program are currently under negotiation.¹⁴

C. MICHIGAN

The State of Michigan has one of the most efficient Medicaid programs in the Nation. According to testimony received by the Subcommittee on September 26, 1975, some 97 percent of all provider claims are paid within 30 days. A sophisticated computer system not only allows rapid payment, it also facilitates program review. Computers are programmed to flag unusual or suspicious Medicaid payment patterns. Michigan's Post Payment Surveillance Unit, called the "Fraud Squad," investigates such suspicious patterns relating to any and all providers participating in the Medicaid program.

In 1974, the "Fraud Squad" investigated five clinical laboratories, recovering about \$60,000 in fraudulent or questionable payments. One index to this problem is obtained by dividing the number of providers in the State program into the amount of money recouped as fraudu-

¹⁴ Lab World, April 1975, and Cadence, the Journal of the American Society of Medical Technology, November-December 1975.

lent. In this connection, Michigan recovered about \$6 for each of the more than 13,000 physicians participating in its Medicaid program in 1974. In that same year, they recovered \$211 for every participating pharmacist and \$592 for every participating clinical lab owner.

The "Fraud Squad" checks labs to make sure that payments are usual and customary and to verify that services were performed. They check the lab's equipment to insure that tests which are preformed by machine are not charged as if they were performed by hand.

In 1975 the "Fraud Squad" found one provider submitting bills for lab services using a physician's code when in fact the billings submitted were those of a laboratory. They found that many invoices submitted for payment in the first 2 months of 1975 had been rejected and resubmitted in March and April, resulting in many double billing errors. Perhaps most significantly, a fire in June of 1964 had put the lab out of business but the lab was still accepting lab work from doctors which was being performed at other laboratories although it was reported on this provider's report forms.

Investigating further, the "Fraud Squad" found that in the majority of cases the lab did not have a doctor's order to support the tests it said it performed and for which it billed Medicaid. Many tests which were billed as manually performed were actually done on semiautomated equipment. Many lab results were not found in lab records. Procedure codes were wrong and double billing had resulted from submitting bills a second time for payment.

The "Fraud Squad" immediately suspended this provider. Photographs were taken of all laboratory equipment and submitted to the Michigan Division of Laboratory Improvement for identification to determine whether the tests performed on this equipment would be considered automated or manual tests. A conference was held with the provider to search for additional documentation of tests.

In the end, the provider was notified that 34 percent of his billings were in error or lacked documentation in the form of a physician's order. The Michigan Department of Social Services withheld \$106,594.74 for the provider representing the amount of refund in this case.¹⁵

D. PENNSYLVANIA

The Philadelphia based Ludlow Clinical Laboratory was cited in early 1975 for overcharging the State by \$2.4 million over a 22-month period for tests performed on the poor and elderly. These charges were made public by representatives of the Department of Public Welfare and by the State's Auditor General who noted that the overbilling took place primarily from February to November 1974. Among the charges was the finding that the laboratory was unable to produce records indicating that lab services for which the lab was paid were in fact ordered by physicians. The lab was closed in January 1975.

Another laboratory, reportedly affiliated with Damon Medical Laboratories, and called the Philadelphia Medical Laboratory had its license revoked, based on its markup of laboratory bills.

Dr. James Prier, Pennsylvania's director of Bureau of Laboratories offered an estimate of what lab fraud and abuse is costing nationwide.

¹⁵ Hearings cited in footnote 3, unpublished.

His estimate was 10 percent of total income from lab tests, that is \$1.6 billion out of \$16 billion paid to the industry (in fiscal year 1976).¹⁶

E. CALIFORNIA

Los Angeles City attorney Burt Pines, in 1975, charged illegal kick-backs were being made amounting to more than \$150,000 and involving 100 physician clients of Damon Medical Laboratory in the San Fernando area. According to *Lab World*, the State permits fees for service but does not permit referral fees, as the laboratory was found to provide. The rebates were "laundered" through a Santa Barbara, Calif., company according to Mr. Pines. A consent decree has been filed in which the laboratory and its parent company based in Massachusetts agree to stop the practice, reimburse Medicare and Medicaid (called Medi-Cal in California), and individual patients plus pay civil penalties.¹⁷

In other cases, the district attorney of Los Angeles County in May filed a consumer protection action in the form of an antitrust suit. The district attorney charged two medical laboratories and a number of physicians of illegal price fixing and defrauding patients over a period of 2 years. The laboratories were Central Diagnostic Laboratory and Medical Diagnostic Laboratory, both subsidiaries of TFI, Inc.

In San Diego, the district attorney filed antitrust suits against Central Diagnostic Laboratory and National Health Laboratories, whose parent firm is Revlon, Inc. The complaints alleged illegal price fixing. It was charged that the labs set up partnerships with physicians, who then referred tests to the laboratories, that agreed schedules of prices up to 300 percent of the other local prices were charged; and that excess profits were refunded to physicians. Restitution with interest was asked for all patients who could be identified.

In April of 1975, National Health Laboratories agreed to an out-of-court settlement which denied any wrongdoing, dissolved partnerships, and agreed to pay a civil penalty of \$75,000, which will cover legal fees and pay individuals said to have been overcharged.

A month later a consent decree was filed with respect to the TFI Subsidiaries, Central Diagnostic and Medical Diagnostic Laboratories (the latter was a limited partnership of more than 100 physicians) consolidating actions brought by both Los Angeles and San Diego County. Under this consent decree TFI (or its subsidiaries) agreed to pay \$435,000 in settlement. No wrongdoing was admitted.

At the time of settlement TFI had divested itself of Central Diagnostic pursuant to prior unrelated negotiations and Medical Diagnostic was being dissolved. Although denying liability, TFI subsidiaries Central and Medical have agreed to pay civil penalties and costs of \$180,000 (divided between the two counties) and to make restitution of \$35,000 to patients "substantially overcharged" during the previous 4 years. Central has also agreed to undercharge patients during the next 7 years or until a sum of \$200,000 is reached, whichever comes first, as part of a compensation referred to as a "fluid class recovery." The latter will be accomplished by reducing the service

¹⁶ *Lab World*, April 1975.

¹⁷ Feb. 2, 1976, letter to Val J. Halamandaris from Burt Pines, copy in committee files.

charge of \$3 to \$2.70 for a single test, or from \$5 to \$4.50 for two or more tests.¹⁸

Several of the orders in the consent decree sound familiar notes. The California labs were ordered in part, not to enter into any agreements or business arrangement fixing or setting clinical lab prices between competing entities. They were ordered not to pay rebates, "in whatever form, to physicians or their agents for laboratory work." They were ordered not to charge different rates for identical work performed for physicians, third party payors, public payors (Medicaid) or private patients and not to have more than one fee schedule for laboratory tests performed.

In short, it is obvious that investigations in other States have produced the same patterns of fraud or abuse that the Subcommittee staff and BGA investigators detailed in depth among laboratories in Chicago, Ill.

¹⁸ Quotations excerpted from Lab World, June 1975, and from the consent decree filed in Superior Court of the State of California for the County of Los Angeles on May 1, 1975, by James Knapp, deputy district attorney, Los Angeles County, copy in committee files.

Part 6

CONCERNS ABOUT THE QUALITY OF LABORATORY SERVICES

As Edmond Morgan stated in his testimony before the Subcommittee on September 26, "If there is cheating on costs, the quality of services must be suspect."

Inevitably, the rush for Federal and State Medicaid dollars cannot but have an effect on the services offered. The New Jersey hearings produced clear examples where the desire for excess profits resulted in poor lab procedures or inaccurate tests. The *Newark Star-Ledger*, for example cited as abuses in commercial labs in that State:

. . . dirty and broken laboratory equipment soaking in filthy, soapy water; use of reagents outdated since the early 1960's; premises strewn with unlabeled vials and specimens, making proper identification next to impossible; inability on the part of lab workers to make the most elementary clinical determinations . . .¹⁹

While stressing the need for improvement, hearings by the Kennedy Health Subcommittee generally determined that the quality of laboratory procedures is much better today than it was 8 years ago when the Clinical Laboratories Improvements Act was first promulgated. Hearings in 1965, 1966, and 1967 had indicated that as much as 75 percent of the clinical lab procedures were performed incorrectly and that more than 60 percent of the lab tests in selected samples were inaccurate.

Testimony at the 1975 hearings revealed HEW estimates 7.6 percent of the microbiology tests performed by interstate labs were in error; other large labs had an error rate of 16.7 percent. According to the Bureau of Standards study 26 percent of the sample tests performed by Medicare and Medicaid approved laboratories were inaccurate. A New Jersey study reports an error rate of 42 percent in physician run labs with respect to Tuberculosis determinations. Nationwide the Center for Disease Control estimates 15 percent of all lab tests are in error.²⁰

Assuming (conservatively) that 15 percent of all lab tests performed in the United States are performed in error, this would mean that 675 million inaccurate tests would be reported every year based on the 4½ billion tests completed annually. This works out to almost 2 million test errors for every day of the year. The exact figure would be 1,849,315 errors per day.

As Senator Jacob Javits pointed out, the consequences of such test errors can be severe:

¹⁹ Quoted by Senator Kennedy in his article, "Doing Away With Potential Mischief" in *Cadence* magazine, November-December 1975, p. 15-16.

²⁰ In hearings cited in footnote 1.

Mr. Chairman, I would like to put into the record, because it is so much more eloquent even than witnesses we might produce to give us terror stories about the terrible dangers of laboratory testing, a few cases on this subject.

I might say that one of the worst examples of what happens with inadequate or improper or neglectful testing comes in ways which are shocking to morality and shocking to psychological makeup of the patient. I refer specifically to tests regarding pregnancy in which there have been a tremendous number of faulty findings with disastrous results which are not easy to catalogue, but which are very real and very human, one of the worst of all.

And, in addition, in the cancer field, which people consider a sentence of death, the same kind of slovenliness which has characterized a great deal of other testing.

So we have in our hands in this way which the patient never knows who did it or how or why. He just gets a result. And unless he has a suspicious doctor who will check it back, because he does not believe the result, often is put in great peril and dies simply by virtue of a faulty test.

The Senator added:

While the printed word is limited in portraying human suffering, to provide some insight into the human dimension of the need for quality laboratory performance standards, I call the Committee's attention to a few brief abstracts of actual case citations:

Schnelby v. Baker, 217 N.W. 2nd 708 (Iowa 1974), where a laboratory furnished wrong results on the bilirubin level because of an unreliable reagent solution—and thus an RH negative baby was not transfused, which resulted in a severely brain damaged infant.

Cornell v. Clinical Laboratories, Cal. Super Ct., Los Angeles Cty., Docket No. NCC 3792, June 29, 1971, 25 Citation 163 (1971), where a patient suffered invasive cancer as a result of delay in diagnosing cancer, due to an erroneous laboratory test result from an inadequate Pap smear.

Kinel v. Hycel Inc., Ill. Cty. Cir. Ct., No. 70 L241 (Nov. 3, 1973), where a patient suffered irreversible brain damage, lapsed into a coma and died, when a physician prescribed the wrong medication (insulin for diabetes) based upon a faulty laboratory test finding of blood sugar level.²¹

Subsequent to the hearings and writing in *Cadence*, the magazine of the American Society of Medical Technology, Senator Kennedy summed up:

(W)e found many of the same disturbing facts we had originally found in 1967. And we additionally found some defects that the legislation had failed to correct. For example:

Only interstate laboratories are regulated under CLIA 1967—that's just 6 percent of the Nation's total number of clinical laboratories.

²¹ In hearings cited in footnote 1.

Barely half of our States have enacted legislation respecting laboratories and the majority of these are largely ineffective.

Fewer than a dozen States license clinical laboratory personnel.

Intrastate labs are regulated only if they participate in the Medicare program.

Hospital labs undergo periodic but cursory examination.

Physician-office laboratories continue to operate freely without any agreed-upon standards.

Fundamental differences exist between the Federal agencies responsible for assuring high quality laboratory work.

Reports of "bureaucratic infighting" and "territorial imperatives" within the Department of Health, Education, and Welfare are as troubling as those revealing shoddy laboratory work.

Senator Kennedy concluded, citing his intention to push for speedy passage of S. 1737, the Clinical Laboratories Improvement Act of 1975:

If we could depend upon other States to follow this example, we would be able to rest a little easier. Unfortunately, the vast majority of States have neglected regulation of laboratories in their own jurisdictions. This matter of health policy is too important to be left to the uncoordinated and obviously contradictory actions of the several States. This being the case, the Federal Government has a clear responsibility to improve laboratory standards and apply them on a uniform basis in order to protect the public health.

As long as gaps in laboratory standards continue to exist, and as long as there is fragmented jurisdiction and ambiguous regulation, the potential for mischief will be great. Faulty diagnosis will continue to end in tragedy for some and cause deep uncertainty about the reliability of tests for others.

S. 1737, the Clinical Laboratories Improvement Act of 1975, corrects the problems described above and will assure that the public receives optimal laboratory service.²²

The Clinical Laboratories Improvement Act passed the Senate on April 29, 1976. Fortuitously, the Health Subcommittee's markup of the bill was held on February 17, one day after this Subcommittee's hearings and disclosures on fraud and abuse among laboratories. At that markup, Senator Thomas Eagleton, acting for himself and for the bill's sponsors, Senators Kennedy and Javits, added amendments to make it grounds for revocation, suspension, or limitation of a clinical laboratory license under the terms of the act if the laboratory operator has: (a) offered, paid, or solicited any kickback, bribe, or anything of value, (b) engaged in false, fictitious, or fraudulent billing for purposes of obtaining payment under *any government program* funded in whole or in part by the United States, (c) charged Medicaid patients more than private paying patients.

In floor action on the bill, Senator Henry Bellmon of Oklahoma added an amendment which would bring the financial records of

²² Page 16 reference cited in footnote 19.

laboratories under Government scrutiny. Senator J. Glenn Beall, Jr., of Maryland, added an amendment increasing the bill's penalties for offering or receiving kickbacks from "not more than 1 year's imprisonment or a fine of \$1,000, or both" to "imprisonment for not more than 3 years or a fine of \$10,000, or both." Accordingly, the enactment of S. 1737 will undoubtedly have salutary effects in reducing fraud and abuse as well as in improving the quality of laboratory services.

Part 7

SUMMARY AND CONCLUSIONS

After an intensive 6-month investigation involving 21 medical laboratories and about 50 medical clinics in the State of Illinois, as well as assessing independent evidence in other States, the subcommittee and its investigators conclude that clinical laboratory services under Medicare and Medicaid are fraught with fraud and rampant abuse.

Numerically the number of offenders identified in investigations is small but their proportion of public funds for lab services is large. In New York, 16 clinical laboratories controlled 70 percent of the Medicaid business. In New Jersey, a dozen clinics controlled more than 60 percent of Medicaid funds. In Illinois, the 21 labs under the Subcommittee's scrutiny controlled 80 percent of the State's Medicaid business.

It appears to the subcommittee—based upon firsthand investigation and analyses of findings from other States—that kickbacks are so rampant that laboratories are almost barred from obtaining a Medicaid account unless they offer a kickback. This conclusion was reinforced again and again during the investigation. For example, principals at the Illinois Masonic Hospital and Laboratory informed Senator Frank E. Moss on his visit to that facility that they had spent a great deal of money for new sophisticated laboratory equipment only to find that they were unable to acquire outpatient business. Hospital officials stated that physicians had become accustomed to receiving money back and insisted upon it. As has been noted, Dr. Paul A. Brown, chairman of the board of MetPath Labs Inc., told the New Jersey Commission on Investigations that only \$10,000 of MetPath's more than \$2 million annual business in that State was made up of Medicaid payments. The reason he said was the firm's decision to avoid kickback arrangements. (It should be noted that, in Illinois at least, physicians often were not the recipients of the rebates, instead the funds were passed on to clinic owners who employed physicians on a contractual basis.)

The full dimensions of Medicare and Medicaid fraud with respect to clinical labs is unknown. However, it is the subcommittee's judgment that at least \$45 million of the \$213 million in Medicare and Medicaid payments for clinical labs is either fraudulent or unnecessary. In short, almost \$1 out of \$5 for lab services is wasted. This figure is deliberately conservative. A reasonable case can be made that 50 percent of current payments are inappropriate. This can be demonstrated by New York's experience and conclusion that payments to labs could be reduced 50 percent without any loss of service. This conclusion is further supported by New Jersey's action in cutting lab fee schedules by 40 percent and finally by the findings of our investigation, that the Illinois Medicaid program, in the extensive sample

already described, overpays for lab services by 116 percent. In a larger context some experts estimate that 10 percent of \$12 billion in payments for laboratory services last year consisted of fraudulent or questionable payment. By this standard the total volume of the fraud and abuse may be more than \$1.2 billion a year.

The average kickback in Illinois was 30 percent of total public aid business. Kickbacks took several forms including cash, long-term credit arrangements, gifts, supplies and equipment, and furnishing business machines. Most commonly, it involved the supposed rental of a small space in a medical clinic, and paying for the doctors staff and assistants. It is apparent that the larger the kickback the greater the opportunity for obtaining public aid business.

Just as apparent as the kickbacks, is the fact that section 242 of Public Law 92-603, otherwise known as 42 U.S. Code 1395nn., and other pertinent fraud provisions are not being enforced.

In practical terms this all means that any medical testing laboratory which is so inclined can bill Medicaid for a patient a doctor has never seen, for blood never drawn, for tests never performed, at a rate exceeding four times cost and twice the prevailing charge for private paying patients, with a nearly absolute assurance that they will not be caught and prosecuted.

There is an immediate need for the Congress, the Department of Health, Education, and Welfare and the Department of Justice and appropriate State officials to act. Through modification of the fee schedule, proper monitoring and surveillance, and the enforcement of current laws and regulations, much of the current Medicaid expense for medical tests could be saved.

Part 8

RECOMMENDATIONS

TO THE CONGRESS

1. The Clinical Laboratories Improvement Act of 1975 should be enacted at the earliest possible opportunity.²³
2. The Congress should enact legislation to consolidate HEW's Medicare and Medicaid enforcement efforts. An Office of Inspector General for Health should be created to monitor Medicare and Medicaid fraud and abuse.

TO THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

1. HEW should increase its surveillance of possible fraud and abuse in Federal health care programs.
2. HEW should require the States to license owners and operators of clinical laboratories as a precondition of certifying them for participation in Medicare and Medicaid.
3. Clinical laboratory services should be added as another area of oversight in current HEW enforcement efforts.
4. Existing regulations prohibiting the practice of charging public (Medicare and Medicaid) patients more than private patients should be enforced.
5. HEW should require the revision of fee schedules for clinical lab services so that they more realistically reflect current automated technology. Such schedules should be standardized as much as possible.
6. HEW should require that the same billing form be used from the doctor ordering the test, to the lab and to Medicaid for payment. Specifically it should include the signature and provider number of the physician authorizing the test, the signature and provider number of laboratory performing the tests and a certification of the location of where the test was performed. Moreover, the form should carry a warning with appropriate legal citation indicating that false or misleading statements are a violation of Federal law.
7. Inasmuch as the Federal Government provides 100-percent funding to help States in establishing modern computer capability, HEW should require the States to construct appropriate provider profiles for physicians, pharmacies, and recipients as well as clinical laboratory services. HEW should be given access to such profiles to aid in its enforcement efforts.
8. The New York City regional laboratory proposal should be funded by HEW on an experimental basis. Consideration should be given to testing this and other proposals in rural areas as well.

²³ Passed the Senate April 29, 1976.

9. HEW should consider the feasibility of a bonding system in which a small portion of the funds payable to providers are held in escrow to be applied as an offset against any subsequent disallowance for fraud or questionable payments.

10. HEW should enforce section 242 of Public Law 92-603 otherwise known as 42 U.S. Code 1395nn which makes offering, accepting, or soliciting a kickback or rebate a crime punishable by a \$10,000 fine, a year in jail, or both. After investigation and the recoupment of funds inappropriately paid out, HEW should refer such cases to the Department of Justice for prosecution.

TO THE DEPARTMENT OF JUSTICE

1. The Department should intensify its efforts to identify Medicare and Medicaid fraud and to recover Federal funds inappropriately paid out under these programs.

2. The Department should consider criminal actions under 18 U.S.C. 286, 287, 1001, 1341, and 1395nn. Appropriate civil remedies should also be brought including action under 31 U.S.C. 231 as well as possible antitrust action, such as the California cases.

APPENDIXES

Appendix 1

STATEMENTS BY MEMBERS OF THE SUBCOMMITTEE ON LONG-TERM CARE AT HEARING ON FEBRUARY 16, 1976

OPENING STATEMENT BY SENATOR FRANK E. MOSS, CHAIRMAN

We would like to welcome you here this morning as the Subcommittee on Long-Term Care continues its hearings into various aspects of Medicare and Medicaid fraud and abuse.

At our September 26 hearing, Mr. Edmond Morgan, president of the Illinois Clinical Laboratory Association, testified that he feared the criminal element was muscling into the ownership of clinical laboratories in his State. He added that \$1 out of every \$6 in Medicaid payments to clinical laboratories was fraudulent. He cited the most frequent abuses among certain quarters of his profession as: (1) performing additional tests not ordered by a doctor, (2) claiming lab tests were performed manually when they were performed by automated machines, (3) billing twice for the same services by falsifying dates, (4) reporting the completion of procedures when the clinic does not have the equipment to perform the tasks.

I asked the staff of the Committee on Aging to make a full investigation into this matter. The investigation focused on the States of Illinois, New Jersey, California, Pennsylvania, and New York.

The report concludes that a small number of clinical laboratories control the bulk of Medicaid payments. In New York, 17 labs control 70 percent of the Medicaid business. In New Jersey, 12 labs control nearly 60 percent of Medicaid payments. In Illinois 26 labs control over 90 percent of the Medicaid business.

The report concludes that, at least in the States which came under investigation, kickbacks are widespread among labs specializing in Medicaid business. In fact, it appears to be necessary to give a kickback in order to secure the business of physicians or clinics who specialize in the treatment of welfare patients.

The average kickback to physicians or medical center owners in Illinois was 30 percent of the monthly total the lab received for performing tests for Medicaid patients. Kickbacks took several forms, including cash, furnishing supplies, business machines, care or other gratuities, as well as paying part of a physician's payroll expenses.



Left to right: Senators Charles H. Percy, Frank E. Moss (Chairman), and Pete V. Domenici listen to testimony from Committee staff and Better Government Association witnesses.

Most commonly it involved the supposed rental of a small space in a medical clinic.

The report concludes that it is apparent that the law passed by the Congress in 1972 prohibiting kickbacks and mandating a \$10,000 fine and a year in jail upon conviction is not being enforced.

When I was confronted with an early draft of this report, I was shocked by the conclusions that the staff reached in their work with Chicago's Better Government Association. I decided to go to that city and see things for myself. I was accompanied by Senator Pete V. Domenici of New Mexico.

—I saw the proliferation of so-called medical clinics spreading like mushrooms all over Chicago;

—I saw their glaring signs beckoning Medicaid patients to utilize health care services;

—I visited a postage-stamp-size clinical laboratory which billed Medicaid for almost \$200,000 last year. There was little in the way of equipment and no lab technicians in evidence. While the owner assured us as to the quality of the work performed, I heard from the owner himself that he chose to send his wife's blood test to another laboratory.

—I visited the sparkling new laboratory of Illinois Masonic Hospital and saw its sophisticated new machines—only to learn that the hospital could not obtain much Medicaid lab business because of its refusal to offer kickbacks.

—I interviewed a physician who received over \$100,000 from Medicaid last year. I asked him to check nine lab invoices presented to Medicaid for payment by D. J. Clinical Laboratory of Chicago against his records. The doctor told us that he had not ordered 55 percent of the \$259 total in lab tests for which D. J. had billed the Illinois Medicaid program on these nine invoices. This same doctor told us that he received a rebate of \$1,000 per month from the laboratory in exchange for sending them all this Medicaid business. The kickback was disguised as rent for a 6-by-8-foot room in the physician's office. The doctor's rent for the entire suite was \$300 a month and yet he received \$1,000 per month for the "rental" of a 6-by-8 room!

Finally, I interviewed a man who owns two medical clinics which received about \$300,000 in Medicaid payments last year. This man admitted sending all of his lab business to one company in Chicago. He told us he received a rebate of 50 percent of the amount Medicaid paid for laboratory tests which physicians in his clinics ordered for welfare patients.

As a result of the work of the staff and the BGA, as well as my own personal investigations, I am even more convinced that the Medicaid program is rampant with fraud and abuse. I renew my pledge to root out those who abuse the system in whatever quarter they may lie. It is my belief that eliminating fraud, abuse, waste, and inefficiency in the Federal health care programs may make it possible for us to move toward that balanced Federal budget that we all desire. And it will no doubt improve the quality of health service to the poor and aged.



Left to right: Secretary Geralyn Delaney, Investigator Douglas Longhini, Executive Director J. Terrence Brunner, Chief Investigator William A. Recktenwald (from September 1, 1975, through February 29, 1976, Mr. Recktenwald was serving as an investigator with the Senate Committee on Aging) of the Better Government Association testify concerning fraud and abuse among clinical laboratories along with Val J. Halamandaris, associate counsel, Senate Committee on Aging (right).

STATEMENT BY SENATOR CHARLES H. PERCY

I would like to first comment on the rather unusual alliance that has been formed between this Senate subcommittee, a civic organization—the Better Government Association—and the media.

This is a technique that has been developed over a long period of very careful work.

The Better Government Association formed its “Operation Watch-dog” almost a decade and a half ago. I had the privilege of serving as its founder and first chairman.

The Better Government Association at first only screened candidates for political office. We felt at that time there was need for an oversight operation that would look at what government was actually doing at the State and local level in Illinois. I know that there were charges at that time that the forestry department was padded with city workers who were not working. There were strong denials from the city of Chicago.

The simple technique of having a camera go out and follow these crews to see where they were at what time, how they were using State or city equipment, if it was for their own personal usage, to see the amount of working time they were putting in—revealed the whole story once and for all. Someone said a picture is better than a thousand words. There was no disputing the facts that the camera revealed. Since then, various techniques have been used to simply provide public disclosure to put the spotlight on abuses.

We cannot investigate every single thing, but what we can do is spotcheck enough things so that with the help of the media, who have been extraordinarily cooperative, we can reveal things that will cause a cleanup. I think what has actually been done in nursing homes has been as a result of the exposure that the work of this committee has given to regulations that were not adequate and regulations that were not being enforced. So I think that this new effort, carefully planned ahead of time by the Subcommittee staff under Val Halamandaris’ direction, has proved remarkably successful.

There is no question but that there is a terrific ripoff of the public purse here. It is engaged in by professions that should be above that. They have a code of ethics that should be accepted. But the exploiters have moved in to take advantage of Federal programs in such a way that I do not see how, Mr. Chairman, it is going to be possible for this country to even act on national health insurance.

I think that what we are doing is simply demonstrating that we do not have the capability or the linkage between government and the private sector that would enable us to move into a program the size of national health insurance. Only if we correct some of these abuses can this be anticipated.

We have here a program that should be administered carefully. The ones we investigated in the clinic setup in Rogers Park that was revealed on “60 Minutes” last night are in an area just a few blocks from where I spent my entire childhood.

The neighborhood in Rogers Park is now densely populated by the elderly. To have these people exploited and the public exploited in this way is reprehensible.

As our report indicated, in practical terms, it is possible for any medical testing laboratory, which is so inclined, to bill Medicaid for a patient that a doctor has never seen, for blood never drawn, for tests never performed, at a rate exceeding costs of four times—and twice the prevailing charge for private paying patients—with the nearly absolute assurance they will not be caught and prosecuted—that is, until today.

I think we have changed all that. Certainly the State of Illinois has been moving very aggressively in recent periods, and within recent weeks. There has been an admission by State officials that this investigation has caused them to perform in a way we expected the States to be doing all along.

We do not have Federal enforcement agencies out there; we do not have Federal enforcement officers. We depend on the States to do this, and it is not just the State of Illinois that has not been doing it, it is many, many other States.

What we are revealing today is a pattern, not just in Illinois or peculiar or unique to Illinois, it is a pattern that possibly can be developed, and has been developed, in many, many other States. The purpose of these hearings is to alert the country once again that this particular aspect of the care of elderly patients is going to be in the spotlight and that these kinds of practices are going to be stamped out.

Just as I am pleased to report that we are making considerable progress now in nursing homes and in correcting the abuses in this area which this subcommittee, under your leadership, Mr. Chairman, found some time ago, so too, I feel that in this particular area, the one revealed in the study released today, we can and will make progress.

We warmly welcome the active participation of the distinguished Senator from New Mexico, Senator Domenici. He has gone with our chairman to see for himself in Chicago some of these abuses, and can report firsthand. The reports that were made to the Nation last night are not exaggerated; they are factual accounts of the ripoff occurring in this particular activity.

STATEMENT BY SENATOR PETE V. DOMENICI

I am pleased to be here this morning as this Subcommittee continues its hearings concerning fraud and abuse in the Medicare and Medicaid programs. As we know, Medicare is a Federal health insurance program for the elderly. Medicaid is a Federal-State program for the poor, aged, blind, and disabled.

With respect to Medicaid, we should remember that the Federal Government provides more than 50 percent of the money and that the elderly are the program's prime beneficiaries. More than one-third of Medicaid funds go toward supporting the elderly in nursing homes.

The topic of nursing homes has historically been of great importance to this Committee. In our hearings in New York City last year, many of us were shocked by the revelations of fraud and abuse released through the exercise of our subpoena power. We found the following abuses more or less common practices:

—Making "donations" to political parties and charging them to Medicaid as "legal fees."

- Charging parking tickets to Medicaid as “travel and entertainment expenses.”
- Charging the State for wine and liquor under the heading of “medical and professional fees.”
- Making interest-free loans or gifts to various individuals including relatives. Such gifts also included Cadillacs and chauffeur-driven Rolls Royce automobiles.
- Charging Medicaid for tuition paid to enable family members or relatives to attend college or law school.
- Withholding patients' account moneys (the \$25 a month welfare patients receive for personal expenses).
- Listing wives as employees of the nursing home when no work was performed.

I believe our hearings served a valuable purpose in bringing these facts out into the open. As we know, those hearings have led to a large number of indictments and more indirectly to expanded nursing home investigations in other States.

But the examination of subpoenaed records in New York also caused us to begin to look at fraud and abuse by other providers, including physicians, pharmacists, clinical laboratories, ambulance companies, factoring companies, and others.

Preliminary investigations by the staff of this Subcommittee have indicated that fraud and abuse seems to be everywhere. Medicaid in particular has been a sitting duck. Neither HEW nor the States apparently have been equipped to meet this problem. Until recently, HEW had less than 10 investigators in its Office of Investigations and Security for the entire Nation. The majority of the States have neither audited a single provider for Medicaid fraud nor referred any cases of fraud to HEW and the Department of Justice for prosecution. In fact, it is estimated that less than 1 percent of all Medicaid fraud cases are ever prosecuted.

What I am saying this morning is nothing new to most of the people in this room. We have heard these stories with growing frequency for some time. However, all the talking in the world cannot equal the impact of one visit. I recently had the opportunity to visit parts of Chicago, and what I saw has troubled me greatly.

I saw the proliferation of medical clinics in dilapidated buildings all over the city of Chicago. Buildings which had once been taverns and pornography shops now house a more lucrative enterprise. The fancy signs attract the poor and the elderly with the promise of free health care. The care may be free to the poor and aged who have Medicaid cards, but it is not free to you, and me, and the other taxpayers of this country. This year we will spend some \$15 billion on this kind of “free care.”

I am disturbed by many aspects of this problem. In the first instance, the owner of a so-called Medicaid mill may be renting space in an office building. The building itself may be owned by another corporation in which the clinic operator has an interest. A second possible problem is that many clinics are owned, not by physicians, but by private entrepreneurs. There is some evidence that these businessmen not only share in the profits of the medical practice and that they may also pressure the physician to order unnecessary tests and the like to increase the clinic's revenue.

Yet another factor that disturbs me is that most of the physicians working in these clinics are from foreign countries. Many do not have deep ties to the United States or to any particular city. Many of them see service in a clinic as a way to make some money in a hurry and return to their own country. In other cases, the overriding ambition is to open a Medicaid mill of their very own. I am afraid that many of these physicians are carrying the mistaken notion that kickbacks and Medicaid abuses are the norm of medical practice in the United States. I am sure that many of them do not even know that they are breaking a law when they request or receive a kickback.

The possibilities for kickbacks in these Medicaid mills are endless. Generally, one person rents the clinic for, let us say, \$300 a month, and then subleases a tiny part of this space to a pharmacist who pays him \$1,000 a month in rental—and perhaps a kickback on every prescription filled. Similarly, the clinical lab may be paying him \$1,000 for 1 month for a closet-sized room. The payment disguised as rent. This is not a hypothetical example. We visited just such a place last week.

But there is yet another practice which is even more offensive to me. This is the practice of “ping-ponging.” This describes the procedure where a welfare recipient will be seen by all the practitioners in a clinic irrespective of need. Typically, a patient will be seen (or at the least Medicaid will be billed for such visits) by the general practitioner, the podiatrist, the dentist, the optometrist and the chiropractor—all in one visit, on 1 day.

It is apparent to me that something must be done immediately to head off the uncontrolled proliferation of these Medicaid mills. After my visit to Chicago, I can understand why some experts project that \$1 out of every \$5 we spend for health care under Medicare and Medicaid is ripped off.

Furthermore, I don't think we should stop with efforts to reform Medicaid mills. I think the problem of factoring companies requires our immediate attention. A factoring company is a brokerage. Physicians who have large outstanding accounts receivable from Medicaid can sell their receivables for cash, while the factoring company takes a cut of about \$12 to \$24 for collecting them.

Significantly, the factoring companies seem able to receive prompt payment while physicians, pharmacies, laboratories, and nursing homes have to wait months, even years in some States, to receive payment from Medicaid. When you figure an average turnaround time of 60 days on their money, factoring companies are making anywhere from 48 percent to 15 percent interest on their money. Someone has called factoring legalized loan sharking.

I would also like to mention clinical laboratories. I don't believe I will ever forget the visit to a tiny lab in the back of one of these Medicaid mills. This lab does about \$200,000 in business from Medicaid. You would think with that dollar volume the lab would be buzzing with technicians. It was, in fact, as quiet as a church. There was a distinct lack of sophisticated laboratory equipment. It looked like a rundown high school chemistry lab.

I must say, I would have serious doubts about the quality of the work performed by the laboratory. I wonder if they billed for the tests not authorized by physicians as we found with respect to other

labs. I wonder if they are claiming lab tests performed manually when, in fact, they were subcontracted and performed more cheaply by machine at some nearby laboratory. I wonder about the full extent of rebates and kickbacks. Did the lab owner pay them to his suppliers? Did he pay kickbacks to physicians and nursing homes?

I wonder if the laboratory ever uses the "sink test." That consists of pouring the specimen down the sink and then writing down some meaningless numbers which are sent to the ordering physician. We heard of this being done.

I wonder what percentage of the tests in this facility were inaccurate and what were the consequences to the totally helpless people waiting expectantly for life or death news from the laboratory.

I wonder why neither the State nor HEW was around to check up on these schemes that I have witnessed. May I suggest at this point, that perhaps large spending programs involving both the States and the Federal Government are not ever going to be efficiently administered. Too many problems, such as enforcement, fall between the cracks of bureaucracy. Yes the programs are needed. Perhaps Medicaid should be run entirely by the Federal Government. In return, the Federal Government should relinquish its control over other programs best handled by the State alone.

I know the Senators here this morning share my concern of this particular scandal. I think that it is time we knew the answers to some of these questions.

I think it is time that the Congress stepped in and ended this gold rush in the area of health care of the poor and aged. As our report says, it is time to stop the hemorrhage of Federal funds.

I plan to do everything that I can to bring about some improvement in the present sorry state of affairs. I want to see for myself how Medicare and Medicaid are working at the street level. I invite the members of this Subcommittee to join me. It appears that we have much to do and we must begin at once if we are ever to control the massive and wholesale fraud that feeds upon the public dollar.

Appendix 2

Twenty bills, chosen at random, presented for payment by D. J. Medical Laboratory in Chicago, Ill., purportedly on behalf of Dr. R. Bascon, 4809 West Madison. In 12 of the 20 cases, the physician has no record of seeing the patient. The aggregate total paid by Medicaid for these 20 bills was \$885. According to Dr. Bascon's records, only \$119 of this amount was actually ordered by him. Following each individual bill is a caption with specific details.

| Case Instructions On Reverse. | | Illinois Department of Public Aid : STATEMENT OF SERVICES RENDERED INDEPENDENT LABORATORY (Type or Print all Information) | | 1. Services for Month of MARCH 19 75 | |
|--|--|--|--|---|--|
| 2. CASE LAST NAME | FIRST NAME | 3. Patient's First Name | 5. Office Account No | | |
| ADDRESS: | BEATRICE | LINDA | 6. Birthdate | 12 58 | |
| 4833 W. | Enter Exactly as Shown on Case Identification Card | | 4. Case Identification Number | | |
| Report of Services | | | Leave Blank | | |
| 9. Date of Service | 10. Procedure Code | 11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given | 12. Charges | | |
| 3-7-75 | 84330 | Glucose | \$ 5.00 | | |
| | 84520 | Blood Urea Nitrogen | 5.00 | | |
| | 82565 | Creatinine | 7.00 | | |
| | 87120 | Urine Culture w/sensitivity | 15.00 | | |
| | 81000 | Urinalysis, routine complete | 3.00 | | |
| | 85010 | Complete Blood count w/differential | 6.00 | | |
| 16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp. | | | 17. Provider 14-8250 Print, Type or Stamp | 13. TOTAL CHARGE \$ 41.00 | |
| D. J. Medical Laboratory P. O. Box 794 Skokie, Ill. 60075 | | | 18. Name & Add. of Referring Physician R. Bascon MD. 4809 W. Madison Chgo. Ill. | 14. CREDIT \$ | |
| 19. DIAGNOSIS OR CONDITION: r/o renal insufficiency | | | 20. Living Arrangement at Time of Service. <input type="checkbox"/> Group Care Facility <input type="checkbox"/> Hospital <input type="checkbox"/> Other (Specify) | | |
| 21. CERTIFICATION This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges reported by the Department of Public Aid will constitute the full and complete charge, hence, that I will not accept additional payment from any person or persons. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may result in appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service. | | | | | |
| SIGNATURE OF PROVIDER | | | DATE SIGNED 3-7-75 | | |
| 22. FOR SPRINGFIELD OFFICE USE ONLY - Do Not Write in This Box | | | | | |
| Special Approval - If Required for Procedure Code(s): | | | | | |
| <input type="checkbox"/> Approved <input type="checkbox"/> Not Approved By: _____ Date: _____ | | | | | |
| DPA 115 (R-8-73) | | | | | |

No such tests requested.

Illinois Department of Public Aid
STATEMENT OF SERVICES PROVIDED
INDEPENDENT LABORATORY
 (Type or Print all Information)

| | | | |
|---|----------------------|-----------------------------------|--------------------------------|
| 1. Name of Institution or Provider _____ | | 3. Service Requested _____ | |
| 2. CASE LAST NAME _____ | FIRST NAME GLORIA | 4. Patient's First Name GLORIA | 5. Office Accession # _____ |
| ADDRESS: 5021 W. _____ | | 6. Birthdate 10 11 53 | |
| 7. Live / Blank | | 8. Case Identification Number | |

| 9. Date of Service | 10. Procedure Code | 11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given | 12. Charges |
|--------------------|--------------------|---|-------------|
| 8/4/75 | 80520 | Blood urea nitro. en | \$ 5.00 |
| | 80535 | Creatinine | 7.00 |
| | 87120 | Urine culture w/ sensitivity | 15.00 |
| | 81000 | Urinalysis routine complete | 3.00 |
| | 85010 | Complete blood count w/ diff. | 6.00 |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| | | |
|---|---|---|
| 16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp D. J. Medical Laboratory P. O. Box 794 Chicago, Ill. 60675 | 17. Provider # 14-8250 Print, Type or Stamp 18. Name & Add. of Referring Physician R. BESCON, M.D. 4609 W. Madison Chicago, Ill. | 13. TOTAL CHARGE \$ 36.00 14. CREDIT \$ 15. NET CHARGE \$ |
|---|---|---|

| | |
|--|---|
| 19. DIAGNOSIS or CONDITION: _____ _____ _____ | 20. Living Arrangement at Time of Service. <input type="checkbox"/> Group Care Facility <input type="checkbox"/> Hospital <input type="checkbox"/> Other (Specify) _____ |
|--|---|

21. CERTIFICATION
 This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

SIGNATURE OF PROVIDER: [Signature] DATE SIGNED: MAR 17 1975

22. FOR SPRINGFIELD OFFICE USE ONLY - Do Not Write in This Box
 Special Approval - If Required for Procedure Code(s): _____
 () Not Approved By: _____ Date: _____

Tests not requested. No blood taken.

See Instructions On Reverse.

Illinois Department of Public Aid
**STATEMENT OF SERVICES RENDERED
 INDEPENDENT LABORATORY**
 (Type or Print all Information)

1. Services for Month of Aug. 1975

2. CASE LAST NAME FIRST NAME
Barbara
 ADDRESS:
5101 W

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name
Barbara
 4. Case Identification Number
 5. Office Account No.
818714
 6. Birthdate
11 48

Leave Blank 7. 6

Report of Services

| 9. Date of Service | 10. Procedure Code | 11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given | 12. Charges |
|--------------------|--------------------|---|-------------|
| 8/28/75 | 87095 | Throat Culture w/ Sensitivity | \$ 15.00 |
| | 84475 | Triglyceridos | 10.00 |
| | 83440 | T-3 | 15.00 |
| | 83440 | T-4 | 15.00 |
| | 85010 | Complete Blood Count w/ Diff. | 6.00 |
| | 81000 | Urinalysis Complete Routine | 3.60 |
| | 82465 | Cholesterol | 5.00 |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp
D. J. MEDICAL LABORATORY,
P. O. Box 794
Skokie, Illinois 60076

17. Provider # 14-8250
 Print, Type or Stamp
 18. Name & Add. of Referring Physician
R. BASCON M.D.
4809 W Madison
Chgo, Ill.

13-TOTAL CHARGE \$ 69.00
 14. CREDIT \$
 15-NET CHARGE \$

19. DIAGNOSIS or CONDITION:
Chronic Thyroiditis

20. Living Arrangement at Time of Service:
 Group Care Facility
 Hospital
 Other (Specify)

21. CERTIFICATION
 This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons, I do hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of "state" fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

[Signature] 8/28/75
 SIGNATURE OF PROVIDER DATE SIGNED

22. FOR SPRINGFIELD OFFICE USE ONLY - Do Not Write In This Box

Special Approval - If Required for Procedure Code(s): _____

Approved Not Approved By: _____ Date: _____

No such tests requested. No blood drawn.

| | | | |
|--|--------------------|--|-------------------------------|
| See Instructions On Reverse. | | Illinois Department of Public Aid | |
| STATEMENT OF SERVICES RENDERED INDEPENDENT LABORATORY (Type or Print all Information) | | 1. Services for Month of FEB 1975 | |
| 2. CASE LAST NAME FIRST NAME SHIRLEY | | 3. Patient's First Name SHIRLEY | 5. Office Account No. |
| ADDRESS: 4901 W. | | 4. Case Identification Number 04 | 6. Birthdate 4 39 |
| | | Leave Blank | 7. 4 |
| Report of Services | | | |
| 9. Date of Service | 10. Procedure Code | 11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given | 12. Charge |
| FEB 10 1975 | 86360 | Latex RA | 7.00 |
| | 85650 | Sedimentation rate | 4.00 |
| | 84550 | Uric Acid | 5.00 |
| | 86060 | ASO Titer | 7.00 |
| | 84075 | Alkaline phosphatase | 7.00 |
| | 86140 | C-reactive protein | 7.00 |
| | 87095 | Sputum culture w/ sensitivity | 15.00 |
| 16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp | | 17. Provider # 14-8250 Print, Type or Stamp | 13. TOTAL CHARGE 52.00 |
| D. J. Medical Laboratory P. O. Box 794 Shokie, Ill. 63076 | | 18. Name & Add. of Referring Physician R. BASCON, MD. 4809 W. Madison Chgo., Ill. | 14. CREDIT \$ |
| | | | 15. NET CHARGE \$ |
| 19. DIAGNOSIS or CONDITION: Rheumatoid arthritis, hypertension | | 20. Living Arrangement at Time of Service. <input type="checkbox"/> Group Care Facility <input type="checkbox"/> Hospital <input type="checkbox"/> Other (Specify) | |
| CERTIFICATION | | | |
| This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons, hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request, I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action, I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of services. | | | |
| SIGNATURE OF PROVIDER [Signature] | | DATE SIGNED FEB 10 1975 | |
| 22. FOR SPRINGFIELD OFFICE USE ONLY - Do Not Write in This Box | | | |
| Special Approval - If Required for Procedure Code(s): | | | |
| () Approved () Not Approved By: Date: | | | |

DPA 315 (R-8-73)

No record of a patient with this name.

| 2. CASE LAST NAME | | FIRST NAME | 3. Patient's First Name | | 5. Office Account No. | |
|-------------------------------|--|------------|-------------------------|--|-----------------------|--|
| ADDRESS: 11722 S. | | VERNON | OLIVIA | | | |
| 4. Case Identification Number | | | 6. Birthdate | | | |
| 04 | | | 8 58 | | | |
| 7. Leave Blank | | | | | | |

Illinois Department of Public Aid
STATEMENT OF SERVICES RENDERED
INDEPENDENT LABORATORY
(Type or Print all Information)

1. Services for Month of
FEB 1975

9. Date of Service: FEB 6 1975

10. Procedure Code:

| 9. Date of Service | 10. Procedure Code | 11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given | 12. Charges |
|--------------------|--------------------|---|-------------|
| | 84330 | Glucose | \$ 5.00 |
| | 84520 | Blood urea nitrogen | 5.00 |
| | 82565 | Creatinine | 7.00 |
| | 87130 | Urine Culture w/ sensitivity | 13.00 |
| | 81000 | Urinalysis routine complete | 3.00 |
| | 85010 | Complete blood count w/ diff. | 6.00 |

16. Name & Address of Independent Laboratory (No. & St., City, State, Zip Code) Print, Type or Stamp

D. J. Medical Laboratory
P. O. Box 794
Skokie, Ill. 60076

17. Provider # 14-8250
Print, Type or Stamp

18. Name & Add. of Referring Physician
R. Bascon, MD.
4809 W. Madison
Chgo., Ill.

13-TOTAL CHARGE \$ 41.00
14-CREDIT \$
15-NET CHARGE \$

19. DIAGNOSIS or CONDITION:
Genito-urinary tract infection,
anemia

20. Living Arrangement at Time of Service:
 Group Care Facility
 Hospital
 Other (Specify)

21. CERTIFICATION
This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charges therefor, that I will not accept additional payment from any person or persons. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

SIGNATURE OF PROVIDER: *[Signature]* DATE SIGNED: FEB 8 1975

22. FOR SPRINGFIELD OFFICE USE ONLY - Do Not Write in This Box

Special Approval - If Required for Procedure Code(s):

() Approved () Not Approved By: _____ Date: _____

IPA 3-5 (R-4-73)

No visit to doctor in January or February 1975.

See Instructions On Reverse.

Illinois Department of Public Aid
STATEMENT OF SERVICES RENDERED
INDEPENDENT LABORATORY
 (Type or Print all Information)

1. Services for Month of
MARCH 19 75

2. CASE LAST NAME FIRST NAME
LAVERNE
 ADDRESS:
4676 W.

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name
ISHA
 5. Office Account No.
 4. Case Identification Number
04
 6. Birthdate
2 74
 Leave Blank

| 9. Date of Service | 10. Procedure Code | 11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given | 12. Charge |
|--------------------|--------------------|---|------------|
| 3-4-75 | 85D10 | Complete blood count w/differential | \$ 6.00 |
| | 85B50 | Sedimentation rate | 4.00 |
| | 85B40 | Retic count | 4.00 |
| | 83550 | T. Iron Binding capacity | 10.00 |
| | 82250 | T. Bilirubin | 7.00 |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

15. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp
D. J. Medical Laboratory
P. O. Box 794
Skokie, Ill. 60076

17. Provider # **14-8250**
 Print, Type or Stamp
 18. Name & Add. of Referring Physician
R. Bascon MD.
4809 W. Madison
Chgo. Ill.

13. TOTAL CHARGE \$ **31.00**
 14. CREDIT \$
 15. NET CHARGE \$

19. DIAGNOSIS OR CONDITION:
nutritional anemia

20. Living Arrangement at Time of Service. Group Care Facility. Hospital Other (Specify)

21. CERTIFICATION
 This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will accept additional payment from any person or persons. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

[Signature] 3-4-75
 SIGNATURE OF PROVIDER DATE SIGNED

22. FOR SPRINGFIELD OFFICE USE ONLY - Do Not Write in This Box.
 Special Approval - If Required for Procedure Codes:
 Approved Not Approved By: _____ Date: _____
 DPA 115 (A-8-73)

No such tests requested. No visit to doctor in March 1975.

See Instructions On Reverse.

Illinois Department of Public Aid
STATEMENT OF SERVICES RENDERED
INDEPENDENT LABORATORY
 (Type or Print all Information)

1. Services for Month of
FEB 1975

2. CASE LAST NAME FIRST NAME
PANNIE
 ADDRESS:
21 N.

Enter Exactly as Shows on Case Identification Card

3. Patient's First Name
PANNIE
 4. Case Identification Number
04
 5. Office Account No.
8 49

Report of Services

| 9. Date of Service | 10. Procedure Code | 11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given | 12. Charges |
|--------------------|--------------------|---|-------------|
| FEB 5 1975 | 84330 | Glucose | \$ 5.00 |
| | 84520 | Blood urea nitrogen | 5.00 |
| | 82565 | Creatinine | 7.00 |
| | 87130 | Urine culture w/ sensitivity | 15.00 |
| | 81000 | Urinalysis routine complete | 3.00 |
| | 85010 | Complete blood count w/ diff. | 6.00 |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp
**D. J. Medical Laboratory
 P. O. Box 794
 Shokie, Ill. 60076**

17. Provider # **14-8250**
 Print, Type or Stamp
 18. Name & Add. of Referring Physician
**R. Bascon, MD.
 4809 W. Madison
 Chgo., Ill.**

13. TOTAL CHARGE \$ **41.00**
 14. CREDIT \$
 15. NET CHARGE \$

19. DIAGNOSIS or CONDITION:
R/O Pyelonephritis

20. Living Arrangement at Time of Service. Group Care Facility Hospital. Other (Specify)

21. **CERTIFICATION**
 This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons, hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request, I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

[Signature] FEB 5 1975
 SIGNATURE OF PROVIDER DATE SIGNED

22. FOR SPRINGFIELD OFFICE USE ONLY - Do Not Write in This Box
 Special Approval - If Required for Price/Rate Control:
 Approved Not Approved By: _____ Date: _____

First visit to doctor was February 17, 1975.

| 2. CASE LAST NAME | | FIRST NAME | 3. Patient's First Name | | 5. Office Account No. |
|--|--------------------|---|---|--------------|------------------------------------|
| | | OTIS | OTIS | | |
| ADDRESS: | | | 4. Case Identification Number | 6. Birthdate | |
| 5115 W. | | | 03 | 12 43 | |
| Report of Services | | | Lever <u>7</u> / <u>5</u> Blank | | |
| 9. Date of Service | 10. Procedure Code | 11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given | | | 12. Charges |
| 3-7-75 | 86360 | LATEX RA | | | \$ 7.00 |
| | 85650 | SEDIMENTATION RATE | | | 4.00 |
| | 84550 | URIC ACID | | | 5.00 |
| | 86060 | ASO TITER | | | 7.00 |
| | 84075 | ALK. PHOSPHATASE | | | 7.00 |
| | 86140 | C-REACTIVE PRO | | | 7.00 |
| 16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp | | | 17. Provider # 14-8250 Print, Type or Stamp | | 13. TOTAL CHARGE \$ 37.00 |
| D. J. Medical Laboratory P. O. Box 794 Skokie, Ill. 60076 | | | 18. Name & Add. of Referring Physician R. EBSCON MD. 4809 W. MADISON CHGO. ILL. | | 14. CREDIT \$ 15. NET CHARGE \$ |
| 19. DIAGNOSIS or CONDITION: <u>rheumatoid arthritis</u> | | | 20. Living Arrangement at Time of Service. <input type="checkbox"/> Group Care Facility <input type="checkbox"/> Hospital <input type="checkbox"/> Other (Specify) | | |
| 21. CERTIFICATION This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service. <u>[Signature]</u> 3-7-75 SIGNATURE OF PROVIDER DATE SIGNED | | | | | |
| 22. FOR SPRINGFIELD OFFICE USE ONLY - Do Not Write in This Box | | | | | |
| Special Approval - If Required for Procedure Code(s) | | | | | |
| [] Approved [] Not Approved By _____ Date: _____ | | | | | |

No such tests requested. No visit to doctor in March 1975.

See Instructions On Reverse.

Illinois Department of Public Aid
STATEMENT OF SERVICES RENDERED
INDEPENDENT LABORATORY
 (Type or Print all Information)

1. Service for Month of July 1975

2. CASE LAST NAME Clairstine FIRST NAME Clairstine
 ADDRESS: _____

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name Clairstine 5. Office Account No. 806329
 4. Case Identification Number 04 6. Birthdate 4 1 38

7. Leave Blank 7

Report of Services

| 9. Date of Service | 10. Procedure Code | 11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given | 12. Charges |
|--------------------|--------------------------------------|---|-----------------|
| 7-31-75 | 85010 | Complete blood count w/diff. | \$ 6.00 |
| | 85650 | Sedimentation rate | 4.00 |
| | 85640 | Ptic count | 4.00 |
| | 83550 | T. Iron Binding Capacity | 10.00 |
| | 82250 | T. Bilirubin | 7.00 |
| | 81000 | Urinalysis Routine Complete | 3.00 |
| | 85010 | Complete Blood Count w/diff. | 6.00 |
| | 87095 | Vaginal culture of sensitivity | 15.00 |
| | 88100 | Pap smear | 10.00 |
| | 87014 87015 | Stat Cervical smear | 7.00 |

16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp
D. J. MEDICAL LABORATORY
 P. O. Box 794
 Skokie, Illinois 60076

17. Provider # 4-8250 Print, Type or Stamp
 18. Name & Add. of Referring Physician
R. Pearson MD
4809 W. 140th St
Orgo. Ill.

13. TOTAL CHARGE \$ 69.00
 14. CREDIT \$ _____
 15. NET CHARGE \$ _____

19. DIAGNOSIS or CONDITION: non specific vaginitis
R10 Uremia

20. Living Arrangement at Time of Service. Group Care Facility Hospital Other (Specify) _____

CERTIFICATION
 This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons. I do not agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

SIGNATURE OF PROVIDER [Signature] DATE SIGNED 7-31-75

22. ON SPRINGFIELD OFFICE USE ONLY - Do Not Write in This Box
 Special Approval - If Required for Procedure Code(s):
 Approved Not Approved By: _____ Date: _____

Only three tests requested. No blood drawn.

See Instructions On Reverse.

Illinois Department of Public Aid

**STATEMENT OF SERVICES RENDERED
INDEPENDENT LABORATORY**
(Type or Print all information)

1. Services for Month of Aug. 19 75

2. CASE LAST NAME FIRST NAME
Fredr
ADDRESS:

Enter Exactly or Shown on Case Identification Card

3. Patient's First Name **Freda**
4. Case Identifying Number **04**
5. Office Account No **818676**
6. Birthdate **10 2 52**
Leave Blank

Report of Services

| 9. Date of Service | 10. Procedure Code | 11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given | 12. Charge |
|--------------------|--------------------|---|------------|
| 8-22-75 | 84520 | Blood urea nitrogen | \$ 5.00 |
| | 82565 | Creatinine | 7.00 |
| | 87120 | Urine culture with sensitivity | 15.00 |
| | 81000 | Urinalysis routine complete | 3.00 |
| | 85010 | Complete blood count with diff. | 6.00 |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp
**D. J. MEDICAL LABORATORY
P. O. Box 794
Skokie, Illinois 60076**

17. Provider # **14-8250**
Print, Type or Stamp

18. Name & Add. of Referring Physician
**R. Bacon MD.
4809 W. Madison
Chgo. Ill.**

13-TOTAL CHARGE \$ **36.00**
14. CREDIT \$
15. NET CHARGE \$

19. DIAGNOSIS or CONDITION:
non specific vaginitis
genitu urinary infection

20. Living Arrangement at Time of Service. Group Care Facility
 Hospital
 Other (Specify)

21. **CERTIFICATION**
This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons. I hereby agree to keep such records as are necessary to disclose fully the extent of service provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment or a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

[Signature] **8-22-75**
SIGNATURE OF PROVIDER DATE SIGNED

22. FOR SPRINGFIELD OFFICE USE ONLY - Do Not Write In This Box

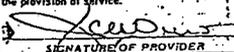
Special Approval - If Required for Procedure Code(s): _____
 Approved Not Approved By: _____ Date: _____

DPA 315 (R-6-73)

Only routine urinalysis requested. No blood drawn.

| 2. CASE LAST NAME | | FIRST NAME | 3. Patient's First Name | | 1. Services for Month of JUN 1975 | |
|---|--------------------|---|---|--|--------------------------------------|--|
| ADDRESS: 166 N. | | JUANITA | JUANITA | | 5. Office Appointment # 807473 | |
| Enter Exactly as Shown on Case Identification Card | | | 4. Case Identification Number 04 | | 6. Birthdate 11 3/46 | |
| Report of Services | | | Leave 7. Blank | | | |
| 9. Date of Service | 10. Procedure Code | 11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given | | | 12. Charges | |
| | 84500 | BLOOD UREA NITROGEN | | | \$5.00 | |
| | 82565 | CREATININE | | | 7.00 | |
| | 87120 | URINE CULTURE w/ SENSITIVITY | | | 15.60 | |
| | 81580 | URINALYSIS ROUTINE COMPLETE | | | 3.00 | |
| | 85010 | COMPLETE BLOOD COUNT w/ DIFF. | | | 6.00 | |
| | 87085 | VAGINAL CULTURE w/ SENSITIVITY | | | 15.00 | |
| | 88190 | PAP SMEAR | | | 10.00 | |
| | 88190 | STAT URETHRAL SMEAR | | | 4.50 | |
| 16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp | | | 17. Provider # 14-8250 Print, Type or Stamp | | 13. TOTAL CHARGE \$ 65.00 | |
| D. J. Medical Laboratory P. O. Box 794 Stokio, Ill. 60076 | | | 18. Name & Add. of Referring Physician R. BASCON, MD 4809 W. MADISON CHGO ILL. | | 14. CREDIT \$ 15. NET CHARGE \$ | |
| 19. DIAGNOSIS or CONDITION: ACUTE PELVIC INFLAMMATORY DISEASE ACUTE URINARY INFECTION | | | 20. Living Arrangement at Time of Service. <input type="checkbox"/> Group Care Facility <input type="checkbox"/> Hospital <input type="checkbox"/> Other (Specify) | | | |
| 21. CERTIFICATION This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information, regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service. | | | | | | |
| SIGNATURE OF PROVIDER | | | DATE SIGNED JUN 18 1975 | | | |
| FOR SPRINGFIELD OFFICE USE ONLY - Do Not Write in This Box | | | | | | |
| Special Approval - If Required for Procedure Code(s): | | | | | | |
| () Approved () Not Approved By: _____ Date: _____ | | | | | | |

Only three tests ordered. No blood drawn.

| | | | | | |
|---|--------------------|--|--|---|-------------|
| See Instructions On Reverse. | | Illinois Department of Public Aid STATEMENT OF SERVICES RENDERED INDEPENDENT LABORATORY (Type or Print all Information) | | 1. Service Month FEB 1975 | |
| 2. CASE LAST NAME | | FIRST NAME | | 3. Patient's First Name | |
| | | GLORIA | | CYNTHIA | |
| ADDRESS: | | 4. Case Identification Number | | 5. Office Account No. | |
| 4840 W. | | 0A | | 2 66 | |
| | | Leave 7. Blank | | / | |
| Report of Services | | | | | |
| 9. Date of Service | 10. Procedure Code | 11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given | | | 12. Charges |
| FEB 4 1975 | 85010 | Complete blood count w/ diff. | | | 6.00 |
| | 85650 | Sedimentation rate | | | 4.00 |
| | 85640 | Reticulocyte count | | | 4.00 |
| | 83550 | Total iron binding capacity | | | 10.00 |
| | 82250 | Total bilirubin | | | 7.00 |
| | 87015 | Ova & Parasite | | | 4.00 |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| 15. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp | | | | 17. Provider # 14-8250 Print, Type or Stamp | |
| D. J. Medical Laboratory P. O. Box 794 Skokie, Ill. 60076 | | | | 18. Name & Add. of Referring Physician R. Bascon, MD. 4809 W. Madison Chgo., Ill. | |
| 19. DIAGNOSIS or CONDITION: Sickle cell anemia, w/o liver disease | | | | 20. Living Arrangement at Time of Service. <input type="checkbox"/> Group Care Facility <input type="checkbox"/> Hospital <input type="checkbox"/> Other (Specify) | |
| 21. CERTIFICATION This is to certify that I have rendered the services and provided the information above is true, accurate and complete, that payment therefor has not been received, that the charges reported by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons, I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service. | | | | | |
|  | | | | FEB 4 1975 | |
| SIGNATURE OF PROVIDER | | | | DATE SIGNED | |
| 22. FOR SPRINGFIELD OFFICE USE ONLY - Do Not Write in This Box | | | | | |
| Social Approval - If Required for Procedure Code(s): | | | | | |
| [] Approved [] Not Approved Ly: _____ Date: _____ | | | | | |

DPA 315 (R-9-73)

First visit to doctor March 6, 1975.

See Instructions On Reverse.

Illinois Department of Public Aid
**STATEMENT OF SERVICES RENDERED
 INDEPENDENT LABORATORY**
 (Type or Print all Information)

1. Services for Month of July 1975

2. CASE LAST NAME FIRST NAME
NANCY

ADDRESS:
718 S. CHICAGO, ILLINOIS 606

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name
NANCY

4. Case Identification Number
07

5. Office Account #
80657

6. Birthdate
12 28 53

Leave Blank /

Report of Services

| 9. Date of Service | 10. Procedure Code | 11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given | 12. Charges |
|--------------------|--------------------|---|-----------------|
| <u>7/24/75</u> | <u>89370</u> | <u>3HA-12</u> | <u>\$ 18.00</u> |
| | <u>84425</u> | <u>TRICHYCEPHIDS</u> | <u>10.00</u> |
| | <u>87130</u> | <u>URINE CULTURE WITH SENSITIVITY</u> | <u>15.00</u> |
| | <u>81000</u> | <u>URINALYSIS ROUTINE ROUTINE</u> | <u>3.00</u> |
| | <u>85010</u> | <u>COMPLETE HICOD COUNT WITH DIFF</u> | <u>6.00</u> |
| | <u>87025</u> | <u>URINAL CULTURE WITH SENSITIVITY</u> | <u>15.00</u> |
| | <u>83100</u> | <u>POP SHEAR</u> | <u>10.00</u> |
| | <u>87025</u> | <u>5000 URINE RAL SHEAR</u> | <u>7.60</u> |

16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp
D. J. MEDICAL LABORATORY, P. O. Box 794, Skokie, Illinois 60076

17. Provider # 19-825
 Print, Type or Stamp

18. Name & Add. of Referring Physician
R. BASCON M.D., 4809 W. MADISON, CHICAGO, ILLINOIS

13. TOTAL CHARGE \$ 81.00

14. CREDIT \$

15. NET CHARGE \$

19. DIAGNOSIS or CONDITION:
RELIC INFLAMMATORY DISEASE
RL HYPERPLASIA

20. Living Arrangement at Time of Service. Group Care Facility Hospital Other (Specify)

21. CERTIFICATION
 This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

[Signature] 7/24/75
 SIGNATURE OF PROVIDER NAME SIGNED

22. FOR SPRINGFIELD OFFICE USE ONLY - Do Not Write in This Box

Special Approval - If Required for Procedure Code(s): _____

() Approved () Not Approved By: _____ Date: _____

Only three tests ordered. No blood drawn.

Appendix 3

COMPARISON OF THE HIGHEST PAID LABORATORIES IN ILLINOIS IN TERMS OF MEDICAID REIMBURSEMENT

BILLS PAID DURING CALENDAR YEAR 1974

| County | Name | AMA No. | Charges | Payments |
|------------|---|------------|-----------|-----------|
| Total..... | | | 8,311,587 | 6,498,493 |
| 200 | Chicago Medical Laboratory..... | LAB0148227 | \$620,137 | \$515,067 |
| 200 | General Medical Laboratory..... | LAB0148243 | 617,502 | 451,249 |
| 200 | Division Medical Laboratory..... | LAB0148185 | 468,731 | 412,663 |
| 200 | Norven Medical Laboratory..... | LAB0148204 | 413,764 | 344,485 |
| 200 | Gerson Clinical Laboratories..... | LAB0148212 | 443,204 | 331,392 |
| 200 | Westlawn Medical Laboratories..... | LAB0148240 | 350,457 | 289,415 |
| 200 | United Medical Laboratories..... | LAB0148001 | 357,916 | 282,529 |
| 200 | Ridgeland Medical Laboratories..... | LAB0148254 | 390,024 | 253,051 |
| 200 | Parke DeWatt Laboratories..... | LAB0148155 | 307,316 | 237,673 |
| 200 | Tenn Clinical Laboratories..... | LAB0148246 | 313,290 | 233,359 |
| 200 | S. & S. Medical Laboratories, Inc..... | LAB0148156 | 256,723 | 215,338 |
| 200 | Greenview Clinical Laboratories..... | LAB0148239 | 213,197 | 188,233 |
| 200 | Western Medical Laboratories, Inc..... | LAB0148236 | 244,329 | 186,098 |
| 200 | Antillas Medical Laboratory..... | LAB0148208 | 253,600 | 183,588 |
| 200 | Mediscreen Corp..... | LAB0148219 | 173,090 | 166,393 |
| 200 | Aaron S. Cahan, M.D..... | LAB0148077 | 183,849 | 148,561 |
| 200 | Garco Medical and X-Ray Laboratories..... | LAB0148221 | 191,456 | 145,837 |
| 200 | Garfield Medical Laboratory..... | LAB0148209 | 204,680 | 136,738 |
| 200 | International Clinical Laboratory..... | LAB0148225 | 171,914 | 131,106 |
| 200 | Laboratory Associates..... | LAB0148191 | 160,743 | 128,443 |

STATE OF ILLINOIS ANNUAL PAYMENTS TO LABS

| Name of laboratory | Fiscal year-- | | | |
|--|---------------|--------------|-------------|-------------------|
| | 1973 | 1974 | 1975 | 1976 ¹ |
| Azteca Medical Laboratories..... | 0 | 0 | \$70,330.00 | \$14,553.00 |
| Chicago Medical Laboratory..... | \$168,954.88 | \$304,168.31 | 742,645.41 | 210,806.06 |
| D. J. Medical Laboratory..... | 0 | 0 | 0 | 381,662.00 |
| Division Medical Laboratory..... | 217,885.86 | 492,758.48 | 628,331.67 | 344,080.59 |
| E. B. Laboratory Service..... | 9,153.00 | 50,500.00 | 115,803.00 | 32,329.98 |
| Fomaro Clinical Laboratory..... | 0 | 0 | 279,944.00 | 68,623.00 |
| Garco Medical & X-Ray Laboratory..... | 108,796.00 | 150,487.50 | 148,113.12 | 32,933.66 |
| Garfield Medical Laboratory..... | 141,671.96 | 159,894.60 | 135,397.30 | 29,682.00 |
| General Medical Laboratory, Ltd..... | 0 | 369,175.60 | 582,635.77 | 284,445.31 |
| International Clinical Laboratory..... | 174,243.97 | 232,923.93 | 47,230.70 | 175.50 |
| Monticello Medical Laboratory..... | 0 | 48,755.00 | 133,820.50 | 2,039.00 |
| Norven Medical Laboratory..... | 175,241.50 | 206,972.50 | 337,560.98 | 67,966.54 |
| Ridgeland Medical Laboratory..... | 0 | 100,736.68 | 316,727.97 | 86,317.95 |
| West Lawn Medical Laboratory..... | 0 | 144,986.75 | 521,400.28 | 3,960.50 |

¹ Through November 4, 1975; in other words, 4 months into fiscal year 1976.

