



Office of the Inspector General

Commonwealth of Massachusetts

Department of Medical Assistance: Orthopedic Footwear Benefits, Policies, and Procedures

**Robert A. Cerasoli
Inspector General
April 2000**



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Omnibus ad quos praesentes literae pervenerint, salutem.

I hereby submit to you a report entitled "Department of Medical Assistance: Orthopedic Footwear Benefits, Policies and Procedures." This report is issued pursuant to an Order of the House of Representatives, House Bill No. 4949, adopted on September 22, 1997. The Order requested that the Office of the Inspector General investigate and study the "boot-making benefits, policies and procedures administered under the Medicaid program by the Division of Medical Assistance within the Executive Office of Health and Human Services."

More particularly, the Order requested this Office to study and investigate "the eligibility of certain beneficiaries for medically necessary handmade boots; the billing procedures and the accountability for ensuring the effective administration of the medical benefits dispensed for the 'boot making' program, so called; the rules and regulations established by said Division for its management and internal operations for said program; and, whether such rules and regulations are in conformity with federal and state statutes for the Medicaid program."

In response to the House request, my Office conducted a comprehensive investigation of the Orthopedic Footwear Program administered by the Division of Medical Assistance (DMA). During the conduct of this investigation, this Office discovered a pervasive pattern of overcharging by many of the Commonwealth's major orthopedic footwear suppliers. In order to stem the ongoing overpayments, I directed my staff to notify DMA and the Department of the Attorney General about these improper billing practices during the conduct of the investigation, rather than wait for its completion.

As a result, DMA expeditiously tightened procedures and revised certain sections of the regulations governing the provision of orthopedic footwear benefits, and retained a consultant to analyze and modify its reimbursement methodology for durable medical equipment. DMA also hired a new program manager and a full-time consultant to work in and oversee the durable medical equipment area. DMA also undertook audits of certain providers identified by this Office's investigation as having submitted questionable claims. This report makes additional recommendations for additional improvements.

The Office of the Inspector General is grateful for the assistance provided by the Medicaid Fraud Unit of the Department of the Attorney General (MFCU) during the conduct of this investigation. The professional team of attorneys and investigators at MFCU demonstrated to this Office the ongoing anti-fraud efforts currently administered by the Department of the Attorney General. During the conduct of its investigation, this Office notified MFCU officials about potentially actionable violations of DMA regulations by particular orthopedic footwear providers. In addition, this Office incorporated in its report recommendations of the MFCU to improve inter-agency operations between MFCU and DMA to strengthen the Commonwealth's anti-fraud program.

During the conduct of this investigation, my staff reviewed 21,703 transactions between DMA and the fifteen highest-volume providers of orthopedic footwear to the Medicaid program, representing approximately 93 percent of the statewide annual dollar expenditure. The results of that review are described in this report. In addition, my staff reviewed the complete transaction history of a particular orthopedic footwear provider, Boston Boot Makers, Inc., over a fourteen-year period. As the result of the discovery of additional and significant problems, my staff expanded the scope of its investigation during its course.

This Office notified DMA and MFCU in August and September of 1998 of its findings with respect to billing irregularities among orthopedic footwear providers. In addition, this Office notified MFCU in the fall of 1998 at the time of its findings with respect to Boston Boot Makers, Inc. This Office kept these agencies informed of additional findings during the conduct of the expanded investigation.

I hope that by implementing these changes, DMA will enhance the quality of health care for MassHealth clients, make the Medicaid system more accessible to

providers, and further protect the interests of the taxpayers who finance this program. If my Office may be of any further assistance, please do not hesitate to contact me. Thank you.

Sincerely,

Robert A. Cerasoli
Inspector General

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Executive Summary

Boston Boot Makers, Inc. (BBM), an orthopedic footwear provider for the Commonwealth's Medicaid program since 1983, withdrew from the program as part of a financial settlement with the Division of Medical Assistance (DMA) in 1997. The matter gained public attention when a legislator publicly aired charges that DMA had allegedly purchased hundreds of pairs of lavish \$1,000 custom boots from BBM for Russian immigrants with dubious medical needs. According to the legislator, DMA's Commissioner initially told her, "that's a bizarre story; it's just not true." Upon repeated inquiries from the legislator, however, DMA subsequently confirmed key elements of the case, including the fact that DMA had paid for many pairs of stylish boots and shoes that DMA officials later concluded were not medically justified. DMA declined to release records about the case to the legislator or to the reporter for the *Boston Globe* who reported the controversy, asserting that DMA had referred the matter for investigation to the Department of the Attorney General. The legislator subsequently filed an Order in the House of Representatives requesting that the Office of the Inspector General investigate the Medicaid program for provision of orthopedic footwear. This report responds to that request.

Part One of this report presents a history and analysis of the BBM controversy. Part Two analyzes transactions between DMA and the Commonwealth's other top fifteen orthopedic footwear providers, citing a widespread pattern of over billing by providers and overpayment by DMA.

The two parts of the report together describe how more than \$4 million taxpayer dollars were wasted over the past ten years. Evidence outlined in this report shows that enterprising providers, accommodating doctors, unrelenting Medicaid recipients, and lax DMA administrators combined to overwhelm the weaknesses in the Medicaid system.

During the conduct of this investigation, this Office notified DMA that it had detected a pervasive pattern of overcharging by many of the Commonwealth's major orthopedic footwear providers. This Office initially brought these findings to the attention of DMA officials in August and September of 1998, and in full detail on December 4, 1998, in order to curtail the ongoing overpayments. On February 5, 1999, this Office conducted a follow up meeting with DMA officials to provide additional information. As a result, DMA tightened procedures and revised certain sections of the regulations governing the provision of orthopedic footwear benefits. DMA retained a consultant in the fall of 1998 to analyze and modify its reimbursement methodology for durable medical equipment. DMA also hired a new program manager and a full-time consultant to work in and oversee the durable medical equipment area. DMA also initiated audits of certain providers identified by this Office's investigation as having submitted questionable claims. This report also makes recommendations for additional improvements in DMA's administration of the durable medical equipment area.

This Office notified the Medicaid Fraud Control Unit (MFCU) of the Department of the Attorney General about the pervasive pattern of overcharging among many of the Commonwealth's major orthopedic footwear providers as well. On March 2, 1998, this Office notified the MFCU of its interim findings concerning prescribing physicians in the BBM case. On September 10, 1998, investigators fully briefed MFCU on this Office's findings regarding the BBM case and billing irregularities among the other top fifteen orthopedic footwear providers. On February 11 and 16, 1999, this Office gave lengthy follow-up briefings to MFCU concerning the results of a meeting between this Office and BBM's owner and further information concerning the BBM case and the fifteen top providers. Subsequently, this Office worked closely with MFCU regarding these matters.

In total, DMA wasted more than \$2 million purchasing exquisite, handcrafted, custom designed shoes and boots from BBM between 1983 and 1997. It wasted at least \$2 million more purchasing shoes from other orthopedic shoe providers since 1990. This report presents strong evidence that BBM routinely ignored the

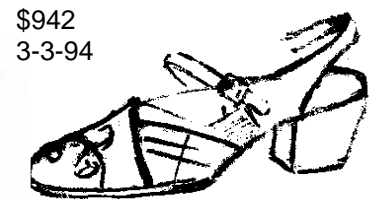
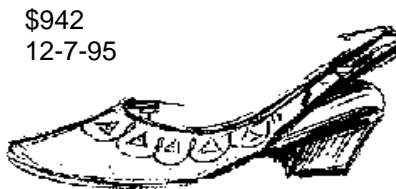
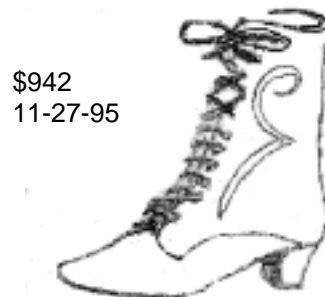
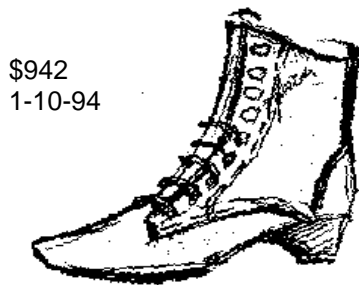
orders of physicians who prescribed standard orthopedic shoes for their patients. Instead of following the orders of the physicians, BBM commonly gave its Medicaid recipients what they wanted, including high-heeled pumps, summer sandals, mountain boots, and party shoes. This Office concludes that DMA should not have purchased a single pair of shoes or boots from BBM. Instead, it should have purchased state-of-the-art custom-molded shoes and ready-made shoes from dozens of other orthopedic providers for BBM's recipients at far less cost. The record shows that DMA was in fact purchasing custom-molded shoes for the rest of Medicaid's orthopedic recipients, other than BBM's clients, throughout the fourteen-year period. This Office shows in this report that after BBM left the Medicaid program, DMA paid an astounding average of \$808 less per pair of orthopedic shoes for the same patients.

After reviewing the kinds of custom-molded and ready-made shoes that DMA was purchasing for Medicaid patients statewide, examples of which are shown on the following page, this Office concludes that DMA should not have purchased footwear from BBM at prices greater than it paid to other orthopedic footwear providers. The photographs below compare the kinds of shoes and boots that DMA purchased from BBM as compared to custom-molded shoes it purchased from other orthopedic providers. Depictions of manufacturing methods are also shown.

Examples of fashionable and recreational shoes provided by Boston Boot Makers to Medicaid recipients at an average cost of \$953 per pair.



Copyright, Boston Globe
Photo/Bill Greene



Examples of custom molded shoes that DMA purchased for other Medicaid patients at \$257.50 per pair. BBM Medicaid recipients should have received these shoes or less expensive ready-made orthopedic shoes for \$100.05 - \$154.50 per pair, instead of receiving BBM's shoes.



In addition to describing DMA's troubles with BBM, this report identifies many serious problems with DMA's administration of the orthopedic benefit program. This Office's investigation uncovered pervasive billing irregularities by orthopedic footwear providers that resulted in millions of wasted taxpayer dollars. The providers employed an array of schemes to pad their bills. These included double billing for orthopedic shoes; charging for custom-made shoe inserts that were factory made; billing for orthopedic shoes and duplicating same for component parts; charging for odd-size shoes when standard sizes were provided; and adding a host of other unnecessary charges.

This Office estimates that approximately sixty-five percent (65%) of DMA's transactions for the purchase of off-the-shelf and custom orthopedic shoes, over a three and one-half year period, consisted of overpayments in violation of DMA regulations. Violations included payments exceeding maximum limits set by the Division of Health Care Finance and Policy and payments for other improper add-ons and over-charges.

One of the most disturbing findings of the investigation is that DMA's computerized claims payment system failed to filter out over-charges that exceeded the maximum amount allowed by the Division of Health Care Finance and Policy. An astounding forty-two percent (42.7%) of DMA's transactions exceeded Division of Health Care Finance and Policy maximum limits for the purchase of off-the-shelf and custom orthopedic shoes over a three and one-half year period. This forty-two percent (42.7%) figure does not count overpayments to BBM or other kinds of over-billings such as unnecessary add-ons and charges for charging for custom-made shoe inserts that were factory made. Rather, providers submitted claims that were too high, and DMA paid them anyway. DMA's average overpayment in those instances was \$54.53 per pair for off-the-shelf orthopedic shoes and \$202.08 per pair for custom orthopedic shoes. These double billings alone resulted in 3,934 overpayments totaling more than \$250,000 over three and one-half years.

The overpayments also resulted from the failure of DMA's computer systems to differentiate between a pair of shoes and a single shoe. Several high volume orthopedic providers took advantage of this flaw in the system by routinely double-billing Medicaid, i.e., by charging the "per pair" rate for each shoe. Most other providers never submitted charges exceeding the limits established by the Division of Health Care Finance and Policy.

One of the most disconcerting findings of the investigation is that DMA knew as early as October, 1993 that at least one major orthopedic footwear provider had bilked the Medicaid program by using the same billing schemes later identified by this office's investigation. DMA apparently did nothing to tighten its system for more than five years to prevent other providers from doing the very same thing. This investigation shows that during that five-year period, other providers took advantage of DMA by using the very same schemes. DMA finally corrected the problems in late 1998 when this Office notified it of widespread billing violations mirroring the ones identified by MFCU in 1993.

As early as October, 1993, DMA knew that MFCU had initiated an investigation of an orthopedic footwear provider that had bilked DMA during 1992 and 1993. MFCU's self-generated investigation indicated that the provider had submitted double-billings, billings for items not provided, billings for orthopedic shoes and duplicating such for component parts, and over-billings for orthopedic footwear. On March 28, 1994, MFCU officials met with six DMA managers to notify them that it had initiated a criminal investigation of a Roslindale-based orthopedic footwear provider for bilking the state Medicaid program of more than \$150,000, and to review the details of MFCU's initial findings. This Office's investigation found that DMA did not tighten its computerized and administrative claims payment system to correct the systemic problems until the fall of 1998 after this Office brought to DMA's attention that many other of DMA's other orthopedic providers were exploiting the same weaknesses in the system at a cost to the taxpayers of millions of dollars.

The record shows that DMA officials were well aware that false claims had slipped undetected through its systems in the case of the Roslindale-based orthopedic footwear provider, but that they did not correct the underlying flaws to prevent repeat occurrences by other providers. Court records show that DMA officials participated in the Commonwealth's prosecutorial efforts. One DMA program policy analyst was a witness for the Commonwealth during the trial. Three other DMA officials submitted testimonial evidence during the trial. On March 16, 1996, the orthopedic footwear provider pled guilty in Suffolk Superior Court to five counts of criminal Medicaid provider fraud and four counts of larceny from the Medicaid program.

MFCU's press release about the conviction on March 19, 1996 stated in part as follows,

“[the provider] defrauded the DMA through a number of schemes, including over billing Medicaid for removable arch supports, overcharging the program far in excess of the maximum allowable amount for orthopedic footwear and charging for custom-made shoe inserts that were pre-made. Other schemes included billing for shoes and inserts that were never provided to residents and billing Medicaid for unauthorized services.”

Incredibly, DMA failed to fix the holes in its payment systems at that time to prevent other orthopedic footwear providers from doing the same things. In total, 20,018 of the 21,703 claims reviewed by this Office during the course of its investigation were paid by DMA after MFCU had indicted the Roslindale-based orthopedic footwear provider for the fraudulent schemes. As previously described, this Office estimates that approximately 65 percent (65%) of all transactions for off-the-shelf and custom shoes represented over-payments by DMA, either because they exceeded the Division of Health Care Finance and Policy maximum rates or included improper add-on charges or inappropriate charges.

When this Office notified DMA in August 1998 that this Office's ongoing investigation had uncovered a pervasive pattern of orthopedic billing abuses,

DMA officials informed this Office by letter that DMA would take appropriate steps to clarify the proper claims procedures and recover any overpayments that had been made. On December 4, 1998, this Office presented DMA officials with a detailed description of an array of widespread ongoing billing abuses by orthopedic footwear providers. At that meeting, DMA officials told this Office the DMA had recently retained a consultant to analyze its reimbursement methodology for durable medical equipment, and had hired a new program manager as well as a full-time consultant to work in and oversee the durable medical equipment orthotic area. In addition, DMA adopted two sets of amendments to its regulations to improve administration of the orthopedic footwear benefit area. DMA also undertook audits of certain providers to identify overpayments.

DMA officials did not, however, inform this Office that they had been fully aware for almost five years that double billings, over billings and bill padding for orthopedic shoes had slipped through DMA's claims-payment system undetected, as demonstrated by the orthopedic footwear fraud case. This Office finds that DMA wasted taxpayers' money by not instituting measures earlier to prevent similar widespread abuses by other orthopedic footwear providers in the Medicaid program.

Summary: Part One. Boston Boot Makers, Inc.

This report presents photographs and drawings of footwear designed by BBM's in-house shoe designer to the stylistic specifications of Medicaid recipients over a period of fourteen years. The pictures depict an array of fashionable and exquisitely designed and constructed shoes and boots that often contradicted the specifications of the physicians who prescribed them. Recipients frequently



SKETCH 1. December 27, 1996. Doctor prescribed, "extra depth shoe, wide width." Recipient requested, "open summer shoes white kid leather." BBM provided shoes above as specified by recipient. Cost to taxpayers: \$942.

requested and received summer shoes like the one shown in Sketch 1 (above) that cost the taxpayers \$942. When this Office showed pictures of shoes such as this to prescribing physicians, the physicians commonly expressed harsh criticism of BBM and their patients for having ignored the intent of their prescriptions.

Many factors apparently contributed to the breakdown of the system that allowed this to happen. Recipients took advantage of the system to get something for nothing. Doctors accommodated their patients without taking appropriate steps to safeguard the system. DMA administrators overturned the actions of their in-house anti-fraud staff, gave in to BBM's lobbying efforts, and failed to set up an effective system to monitor BBM's transactions. Consequently, BBM took advantage of weaknesses in the system, failed to comply with Medicaid regulations, and reaped the financial rewards accordingly.

From 1983 to 1997, records show that ninety percent (90%) of the individuals who received Medicaid-financed shoes from BBM were qualified aliens eligible for Medicaid through the Immigration and Nationality Act. More than eighty

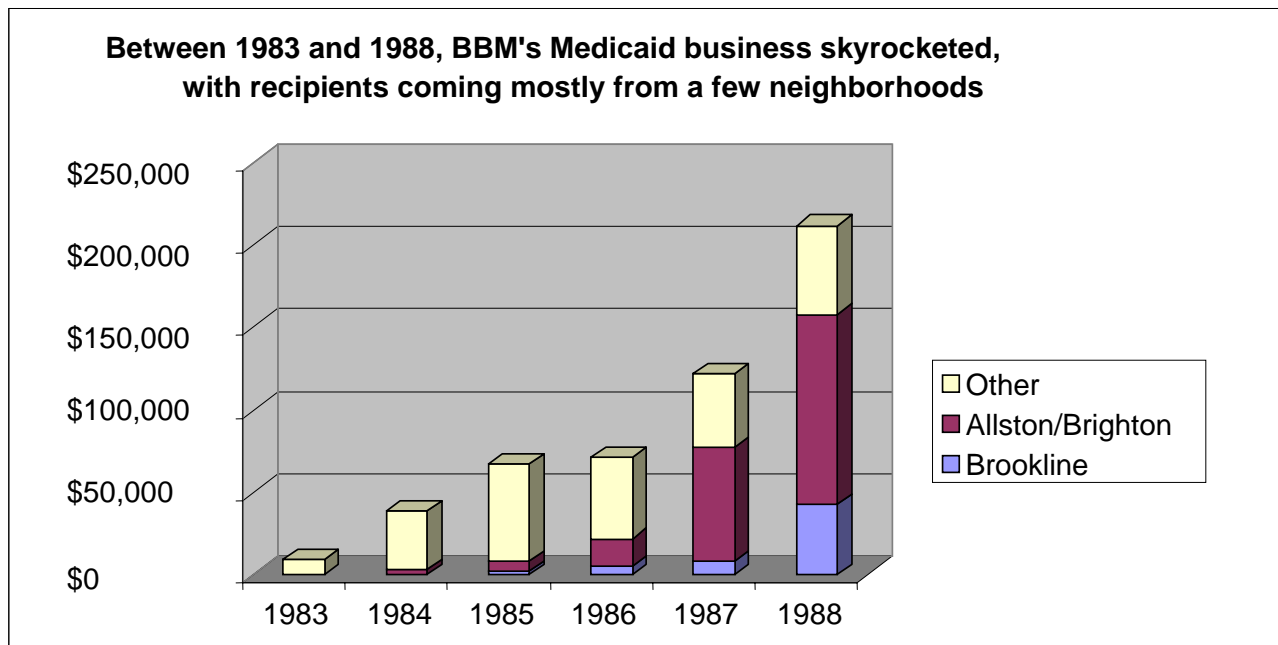
percent (80%) of BBM's Medicaid recipients came from a few neighborhoods of Brighton, Allston, Brookline and Lynn. More than forty-five percent (45%) of the recipients, in fact, lived in just ten senior citizen apartment buildings. Some recipients received shoes and boots from BBM like clockwork, oftentimes receiving two or more pairs per year over a period of many years. For example, DMA paid \$23,555 for shoes for a single Medicaid recipient over fourteen years. Married couples often amassed colossal Medicaid-sponsored invoices at BBM over time; typically receiving shoes on the same days approximately every six months apart. One couple received \$22,680 in shoes paid for by Medicaid; other couples received \$21,281; \$20,007; \$18,159; \$17,360; and \$16,013. Many of BBM's customers built-up large collections of shoes in different styles and colors at taxpayers' expense.

A detailed review of BBM's claims shows that four doctors wrote more than half of the prescriptions billed to Medicaid. One doctor wrote prescriptions resulting in claims totaling \$451,177; another doctor's claims totaled \$255,434. Both physicians were Russian born practitioners who served a largely Russian-speaking patient base. In total, Russian born and trained physicians wrote nearly half of the prescriptions that resulted in BBM claims between 1987 and 1997. This report concludes that prescribing physicians share a large part of the blame for the waste of taxpayers' dollars at BBM.

During its fourteen years in the program, BBM provided services to 853 Medicaid recipients and generated \$2,251,729 in Medicaid sales on 2,508 claims. Between 1994 and 1996, 82 percent (82%) of BBM total income came from Medicaid payments.

In interviews conducted by this Office, prescribing doctors typically denied knowledge of and responsibility for the misuse of public funds associated with BBM. Prescribing doctors typically expressed outrage when this Office showed them pictures of the shoes provided to their patients by BBM pursuant to their prescriptions. In fact, several doctors told this Office that they routinely turned

away clients with no discernable medical need for orthopedic shoes who persistently requested prescriptions for orthopedic shoes from BBM.



The record shows that four members of DMA's Surveillance and Utilization Review Subsystem (SURS), the division responsible for detecting provider fraud, recognized the BBM problem from early on. These anti-fraud "watchdogs" repeatedly attempted to stop DMA's wasteful payments to BBM, only to be overturned by higher-level DMA administrators. On two occasions they actually halted payments to BBM only to have their actions overturned by DMA's Assistant Commissioner for Program Policy once in 1991 and again in 1992. The record shows that these employees doggedly persevered until BBM was finally forced to withdraw from the program in 1997. By 1989, four SURS staff members were aware of many of the key facts later identified by this Office's investigation. They discovered in 1989 that BBM's recipients came from only a few neighborhoods; that the recipients were receiving multiple pairs of shoes per year; that husbands, wives and sometimes their children were receiving shoes on the same day; that the medical necessity of the shoes was highly questionable; and that BBM had provided shoes to a person with the same name as its owner.

A revealing memorandum written by SURS staff in 1991 about BBM states that DMA's Program Manager for Durable Medical Equipment "believes that they are 'thieves' and should do time."

Records indicate that DMA administrators gave special treatment to BBM on at least two occasions after BBM solicited and received help from elected public officials. On the first occasion in 1988, a DMA administrator, acting upon the request of the Governor, set up a special payment system for BBM after BBM's owner complained to the Governor about DMA's slow payment of BBM's claims. In a letter to BBM on March 9, 1988, the Associate Commissioner acknowledged that the Governor had referred the complaint to him. The letter notified BBM's owner of the immediate release of \$14,000 by DMA to BBM. In addition, the letter conveyed the pledge that DMA's claims staff would henceforth intercept BBM's claims from the Medicaid payment process by hand, review them in advance, and specially deliver payment to the owner's place of business by courier once a week.

On another occasion, in 1992, BBM's owner sought and received assistance from her State Senator to reverse the actions of DMA compliance staff who had actually stopped DMA's payments to BBM for the second time. After the Senator contacted DMA's Commissioner seeking a meeting, DMA's Assistant Commissioner for Program Policy sent DMA's Director for Ambulatory Programs and its Program Manager for Durable Medical Equipment to meet with the Senator and BBM's owner at the Senator's State House office. According to DMA official who attended the meeting, *"The Senator thought Medicaid should make sure only those who need the service get it, but I would be less than honest if I didn't say I felt some pressure."*

At that meeting, according to records reviewed by this Office, DMA officials stated to the owner and the Senator that 90 percent (90%) or more of BBM's claims should be filled by other orthopedic providers at far less cost, using standard billing codes. Nothing in the records indicates that DMA informed the

Senator about the history of concern and suspicion by DMA's SURS staff regarding BBM's questionable pattern of claims. Following that meeting, DMA reversed its previous action by allowing the company to continue to bill Medicaid at rates in excess of \$900 per pair, using a claims "protocol" established by DMA exclusively for BBM.

The new protocol allowed BBM to continue using an "unlisted procedure code" subject to certain conditions, as follows:

- 1) the owner had to be personally present to verify that the recipient needed special hand-made custom footwear and could not be served by other less-expensive orthopedic footwear providers;
- 2) the physician's prescription had to include an order specifying "hand-made shoes"; and,
- 3) the physician had to sign a medical necessity form that included the statement: *"Please note that your signature below confirms your understanding that you are ordering a hand-made customized shoe for your patient."*

DMA's compliance staff assigned to the case were so frustrated by their superiors' decision to allow BBM to continue in the program under the new protocol they drafted a memorandum to DMA's compliance officer on June 24, 1992 protesting the decision. The memorandum noted their strong objection, as follows:

- We were not included in any of these meetings, nor were we notified of any changes that were being made, which, incidentally, were in direct opposition to our findings and recommendations;
- The recipients are being given a choice between an expensive product and a less costly alternative;
- We question the medical necessity of custom crafted shoes for the substantial number of recipients that Boston Boot Makers services;
- Of particular concern is the fact that Boston Boot Makers Medicaid clientele represents nothing like a demographically varied population of medically needy Massachusetts recipients, but rather an extremely finite group of recipients and referring physicians;

- Since when do we allow the provider to determine and drive the approval process?;
- This provider should be dealt with at a level and a manner that precludes the providers promotion of her self-interest at the expense of Medicaid programs designed to meet legitimate medical needs;
- Since when do we practice the unquestioned acceptance of the providers cost analysis without any independent verification?

Records reviewed by this Office show that DMA's Director for Ambulatory Programs (now an Assistant Commissioner of DMA) appeased members of DMA's compliance staff at that time by telling them that she would be tightening the regulations in the area of prescriptions for orthopedic footwear. In addition, DMA's Director of Ambulatory Programs told the frustrated compliance staff that while the unlisted procedure code (L3649) still existed, these services would henceforth be reviewed and priced by the Program Manager for Durable Medical Equipment. DMA officials did not, however, amend DMA's regulations in the area of prescriptions for orthopedic footwear until August of 1998, during the course of and in apparent response to the investigation by this Office. Neither did DMA adopt the recommendations of DMA's Program Manager for Durable Medical Equipment to employ a part time certified orthotist to review the medical necessity of each claim prior to payment.

The record of the case shows that the concerns and criticisms expressed by DMA staff in the above-cited protest memorandum were valid ones, as evidenced by information learned during this Office's investigation. For example, this Office found a wide discrepancy between what BBM reported to the Internal Revenue Service and what it told DMA about the company's labor expenses, a discrepancy that indicated substantial overpayments by DMA to BBM. This Office identified \$74,193 in direct labor expenditures by BBM for 1996, as reported on BBM's federal tax returns and supporting work papers. These figures seem to conflict with DMA's payment of \$218,044 to BBM for direct labor charges for 302 pairs of footwear the same period, 1996. This discrepancy of

\$143,851 represents an apparent over-payment by DMA to BBM for just a single year.

This Office's investigation raises serious questions about the accuracy of the per-shoe labor costs that BBM reported to DMA when DMA was determining how much it would pay BBM for its footwear in 1992. DMA required BBM to submit information about the company's direct and technical labor expenses at that time. Under DMA regulations, DMA determines the rate it will pay on "unlisted procedures" based upon the financial records presented by the provider. Records show that BBM's president submitted figures to DMA indicating that the company's direct labor expenses were \$600 per pair of shoes. In 1996, BBM submitted a revised job-cost estimate to DMA stating that the company's per-shoe labor expenses were \$800 per pair. BBM's assertions to DMA of \$600 to \$800 per pair for labor costs is apparently contradicted by the \$246.00 per pair indicated by BBM's 1996 tax return and supporting documents. The disparity between the two figures suggests that BBM claimed and DMA paid \$143,851 more than BBM's reported labor expenses in 1996. DMA officials told this Office that DMA relied upon BBM's representations about its per-shoe labor expenses in determining the rate that DMA would pay for BBM's shoes.

This Office asked BBM's president to explain the apparent discrepancy between the figures, and why the company did not claim such expenses on its 1995, 1996, or 1997 tax returns if the company had in fact incurred such expenses. The president explained that the company had, in fact, incurred the higher labor expenses and that the president had subsidized the company with personal funds, the full extent of which she acknowledged had not been reflected in the company's financial statements. The president did not offer an explanation as to why the company had not taken a tax deduction for these expenses. The president told this Office that the company paid certain employees "under the table" without recording the payments. The president said that payments were made in cash but she did not explain the total amount of the cash transactions or how they were undertaken. The president also admitted that the company had

paid part of an employee's salary to the employee's spouse in order to allow the employee to keep his social security benefits.

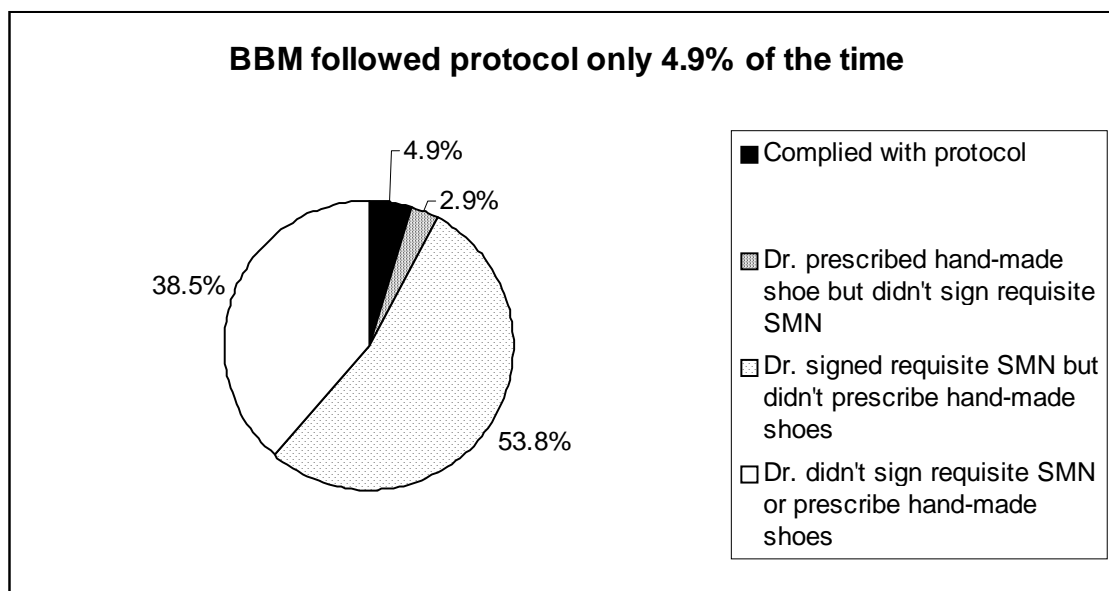
BBM's 1996 tax return indicates that the company claimed to have sold fewer than five pairs of shoes per month to non-Medicaid recipients during 1996. BBM's total sales revenue was \$344,768.98 for calendar year 1996, as reported. During 1996, BBM received \$284,878.00 in Medicaid payments, representing 82.6 percent (82.6%) of the company's reported income. This indicates that BBM's non-Medicaid sales for 1996 added up to only \$59,890. This equals less five pairs of shoes per month, at BBM's average 1996 per pair price of \$964. In consideration of the previously described questions about BBM substantial unreported cash payments and questionable labor figures submitted during the rate determination process, this Office concludes that appropriate state authorities should conduct a complete audit of BBM's financial records.

During a meeting between investigators of this Office and BBM's president and attorney in December 1998, this Office asked the president to provide a response in writing to explain the apparent disparity between the conflicting labor figures. BBM submitted a written response that addressed many other issues discussed at the meeting but did not address the labor discrepancy. A copy of the letter is attached as Addendum A of this report. This Office brought this and related information to the attention of MFCU.

Another significant finding of this investigation is that BBM rarely complied with the protocol after DMA established it on May 29, 1992. BBM's records reveal that in only 4.9 percent (4.9%) of 1,216 subsequent claims did BBM comply with the agreed-upon protocol. This contradicts the oft-repeated claim of BBM's president that the company strictly complied with the protocol.

In 35 BBM claims, 2.9 percent (2.9%), the physician specified hand-made shoes on the prescription or written order, but did not sign a medical necessity statement that included the statement acknowledging that he was ordering hand-

made customized shoes.¹ In 654 other claims, 53.8 percent (53.8%), the physician signed the requisite Statement of Medical Necessity without specifying “hand-made shoes” on the prescription or written order. In such cases, the physicians’ prescription or written order called for something other than hand-made shoes, commonly for far less costly “extra-wide extra-depth orthopedic shoes.” In the remaining 468 claims, 38.5 percent (38.5%) the physician prescribed something other than hand-made shoes and did not sign the requisite SMN.



This Office interviewed several physicians who wrote many prescriptions specifying ready-made shoes while also signing Statements of Medical Necessity with boiler plate language “confirming [the physician’s] your understanding that you are ordering a hand-made customized shoe for your patient.” One physician explained, “I didn’t prescribe hand-made custom shoes. My prescription takes precedence. Patients come in here with all sorts of forms. I don’t have time to

¹ This Office found that 439 of BBM’s 1,216 claims had Statements of Medical Necessity that BBM had changed to remove the statement: “*Please note that your signature below confirms your understanding that you are ordering a hand-made customized shoe for your patient.*” BBM used these altered forms over a period of three years.

read all the fine print. All I know is that what I write on my prescription pad is what I prescribed.”

This Office observed that BBM often provided fashionable footwear to the specifications of the Medicaid recipient that contradicted what the doctor ordered. For example, on April 8, 1993 a physician from the Joselin Diabetes Center wrote a prescription for a diabetic patient specifying “P.W. Minor Extra-Depth Shoes Ladies Contour with Velcro closure” and signed the Statement of Medical Necessity including the aforementioned boilerplate language. P.W. Minor, Inc. is a leading orthopedic footwear manufacturer and supplier to many orthopedic footwear providers participating in the Commonwealth’s Medicaid program. On the Statement of Medical Necessity, the physician wrote, “Patient would benefit from extra-depth shoes, does not need custom-molded shoes.” The photograph, below, shows a P.W. Minor extra-depth ladies contour shoe. According to the manufacturer’s catalog, the P.W. Minor extra-depth shoe is considered the premier pedorthic shoe for “Acute Care” of the foot affected by diabetes, recommended most by doctors, foot specialists, and allied health professionals. Instead of referring the recipient to another orthopedic footwear provider that offered ready-made extra-depth shoes, BBM responded to the recipient’s request by making the recipient a pair of black 15-inch wool-lined kid leather boots, shown below.



What the Doctor ordered.

The physician ordered a Ladies extra-depth, contour shoe with Velcro closure. Records show that Medicaid purchases this type of shoe frequently. DMA pays Medicaid providers \$125.66 for this shoe, including costs of fitting and adjustment.



What the BBM provided instead.

When the patient asked instead for a pair of 15-inch wool-lined kid-leather boots, BBM ignored the prescription and gave him the boot shown above, billing Medicaid \$993.00.

Notwithstanding the explanations of physicians in this case, they shared an affirmative obligation to safeguard the public interest and protect against fraud, waste and abuse of Medicaid funds. This Office concludes that prescribing physicians failed to exercise due diligence by ascertaining what was being provided pursuant to their prescriptions. In interviews with this Office, several physicians frankly admitted that they had been besieged by Russian immigrants who were unrelenting in their demand for BBM's products. Yet the same physicians uniformly denied knowing anything about the misuse of public funds associated with these claims. The physician who prescribed \$451,177 in prescriptions filled by BBM claimed that he knew nothing about the high costs of BBM's products or about the fact that his patients were receiving fashion-oriented shoes from BBM. This Office referred information about high-volume physicians to MFCU.

This Office tracked what happened to BBM's recipients after BBM left the Medicaid program. Subsequent Medicaid billing records show that BBM's Medicaid recipients went to other orthopedic footwear providers after BBM withdrew from the program. Medicaid saved an astounding average of \$808 per pair when BBM's Medicaid customers brought their prescriptions to other orthopedic footwear providers in the Medicaid program. The savings are largely attributable to the fact that the subsequent orthopedic footwear providers provided what the physician's actually ordered: usually standard, off-the-shelf orthopedic shoes. This Office interviewed several such recipients in the conduct of the investigation. These recipients indicated that their new shoes were comfortable and functional, but that they preferred BBM's attractive shoes.

This Office identified 146 instances where former BBM Medicaid recipients received shoes from other orthopedic footwear providers. The following example illustrates the history of one of BBM's former clients, demonstrating how much the taxpayers saved after BBM left the program.

Customer #1:

08/01/90	Boston Boot Makers	Custom hand-made footwear	\$904
02/01/91	Boston Boot Makers	Custom hand-made footwear	\$963
12/30/91	Boston Boot Makers	Custom hand-made footwear	\$993
05/22/92	Boston Boot Makers	Custom hand-made footwear	\$993
11/13/92	Boston Boot Makers	Custom hand-made footwear	\$993
05/14/93	Boston Boot Makers	Custom hand-made footwear	\$993
11/26/93	Boston Boot Makers	Custom hand-made footwear	\$993
05/25/94	Boston Boot Makers	Custom hand-made footwear	\$993
11/18/94	Boston Boot Makers	Custom hand-made footwear	\$993
01/17/95	Boston Boot Makers	Custom hand-made footwear	\$993
07/11/95	Boston Boot Makers	Custom hand-made footwear	\$993
02/13/96	Boston Boot Makers	Custom hand-made footwear	\$993
08/20/96	Boston Boot Makers	Custom hand-made footwear	\$993
04/01/97	Boston Boot Makers	Custom hand-made footwear	\$993
07/24/97	Company A	Ladies orth. shoes depth inlay	\$129
12/22/98	Company B	Ladies orth. shoes depth inlay	\$100

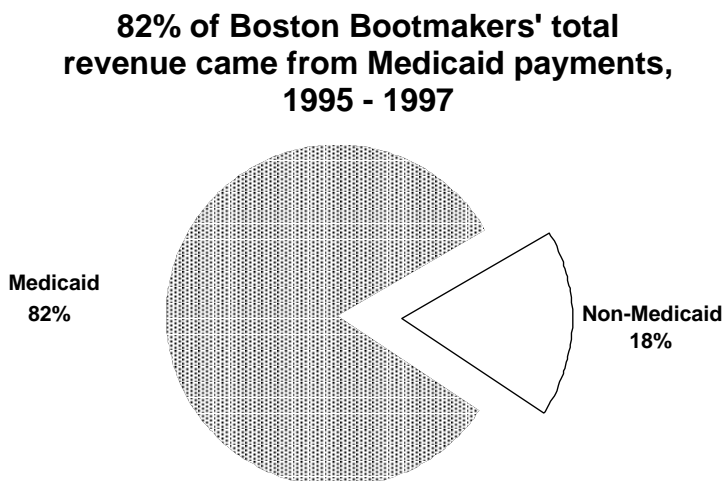
This customer received fourteen pairs of hand-made custom footwear from BBM in less than seven years at a cost to Medicaid of \$13,783. Three months after BBM left the Medicaid program, the customer received a pair of ladies depth inlay shoes from a different orthopedic shoe provider for \$129.00; seventeen months after that, the customer received a second pair from a different provider, this time for \$100.00.

This report finds that DMA administrators did not establish a procedure after they implemented the new protocol to determine whether the physicians had in fact prescribed hand-made shoes. For one thing, DMA did not require that BBM submit prescriptions with its claims. While DMA required BBM to submit signed Statements of Medical Necessity with its claims, this Office's investigation found that DMA routinely rubber-stamped BBM's claims even when the physicians did

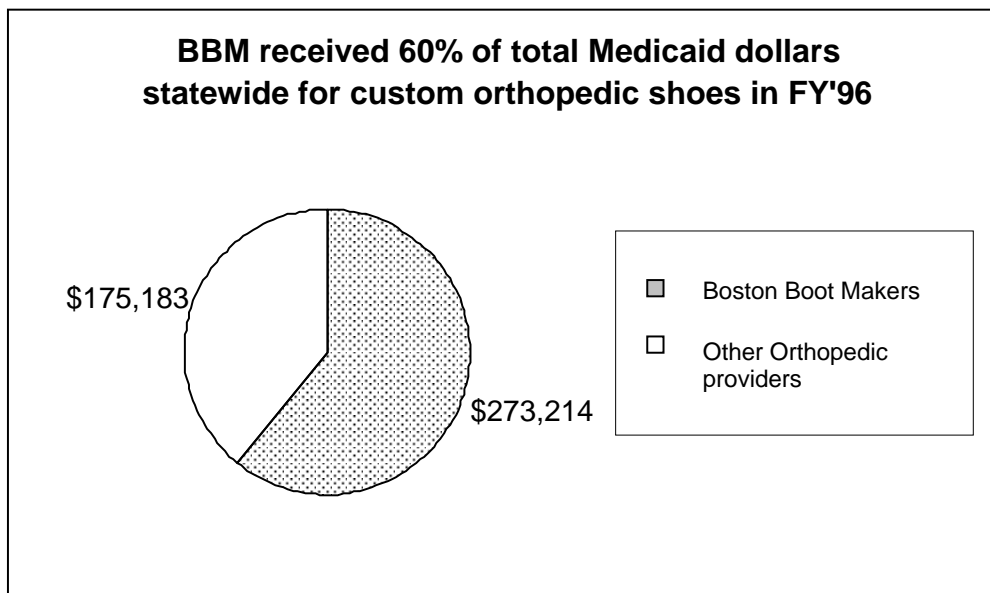
not sign a statement confirming their understanding that they were ordering hand-made customized shoes. Records show that DMA simply reviewed the claims to see if the math was correct, and then it sent out payments without considering issues addressed by the protocol.

The record shows that DMA failed to hire a part-time orthotic consultant to review each claim as recommended by the Program Manager for Durable Medical Equipment after DMA established the new protocol. The Program Manager for Durable Medical Equipment submitted the names and qualifications of two independent orthotists to the Director for Ambulatory Programs and recommend that DMA hire them on a per-diem basis to review orthopedic footwear claims. Her recommendation was rejected.

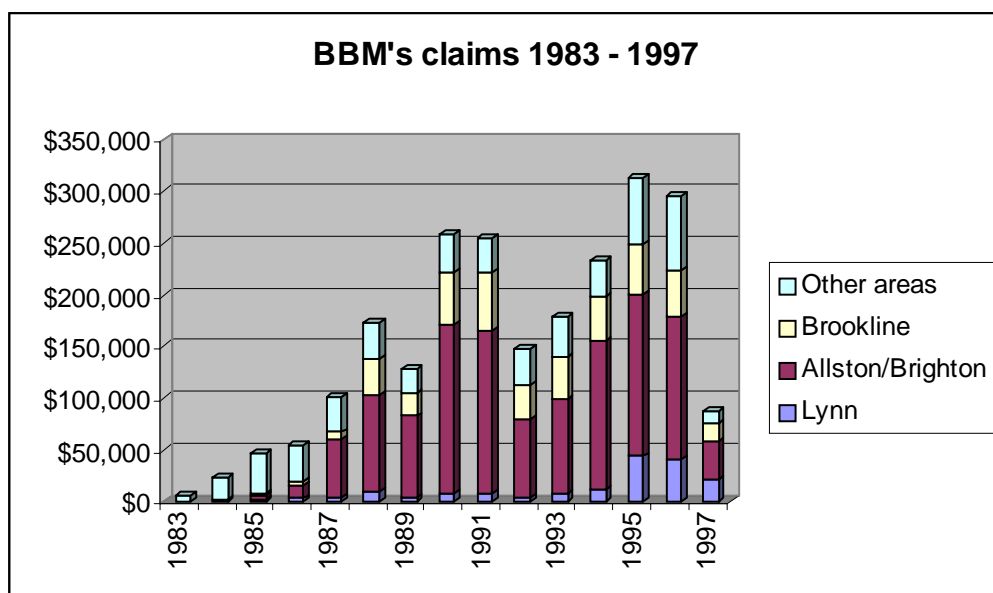
After the protocol went into effect, BBM's claims initially declined and then surged again to higher levels than before. BBM's Medicaid claims continued to grow until the company became a virtual Medicaid mill. BBM's federal tax returns indicate that the company derived approximately 82 percent (82%) of its total revenue from Medicaid recipients from 1995 through 1997.



This Office's analysis shows that BBM received 60 percent (60%) of the Commonwealth's total Medicaid payments statewide for custom-made orthopedic shoes in Fiscal Year 1996, despite the fact that BBM's clientele came from a centralized geographical area comprising less than one percent of the state's population. DMA paid \$273,214 for 286 claims to BBM during Fiscal Year 1996. DMA paid all other companies combined \$175,182 for 720 claims during the same period.



From 1983 to 1997, BBM's growing number of claims came primarily from a few neighborhoods. These initially included neighborhoods in the Allston/Brighton area of Boston, as well as nearby areas of Brookline. Later, beginning in 1995, claims began to come from Russian immigrants living in Lynn, as well. Most of BBM's recipients who lived outside of those neighborhoods were Russian immigrants. Over all, from 1983 to 1997, 90 percent of BBM's recipients were qualified aliens eligible for Medicaid under the Immigration and Nationality Act, almost exclusively of Russian origin.



Another troubling fact in this case is that DMA did not refer the matter to MFCU until after DMA had signed a final, binding agreement with BBM waiving the Commonwealth's rights to recovery. DMA seemingly made its referral to MFCU only days after a legislator asked DMA's Commissioner for a full explanation about DMA's purchase of "\$1,000 boots for Russian immigrants."

Records indicate that DMA administrators failed to inform MCFU of the well-documented suspicions of its SURS staff about BBM's claims until after they made their referral in 1997. In interviews with this Office, MFCU officials were critical of DMA's failure to bring the matter to their attention earlier enough to enable MFCU to conduct an effective investigation, and of DMA's decision to execute a Settlement Agreement with BBM before MFCU could conduct such an investigation. The record shows the MFCU conducted its own independent investigation of BBM in 1989 after it independently noted that DMA was paying the same high payment for every BBM claim. The record indicates that MFCU met with DMA staff in 1989 to inquire about BBM but that a DMA official indicated that everything was under control.

According to records, a DMA financial specialist in the Special Payments Unit told MFCU investigators that DMA had received from the Governor's office in 1988 a letter directing timely payment to BBM. She said that subsequent to that

date, a person in DMA had been assigned to expedite payments to BBM by reviewing suspended claims on an individual consideration basis, in advance of their receipt by the department from the claims processor. She explained that the Special Claims Unit hand-pulled checks early for BBM for special delivery by courier. She also explained that DMA payment staffpersons individually reviewed each claim. The financial specialist informed MFCU investigators that she and others in the Claims Resolution Department knew how BBM was billing for its products. The financial specialist told MFCU investigators that a DMA payment specialist had told BBM's owner, "you billed the same price [on each claim] and that makes it easier for him." Based in large part upon these reassuring statements by DMA's Special Payment Unit Representative, MFCU investigators ended their inquiry. This Office concludes that DMA should have informed MFCU investigators in 1989 of the well-documented suspicions of its SURS staff about BBM. Instead, DMA indicated to MFCU that DMA was aware of BBM's claims and was closely monitoring them through an individualized payment plan, including special delivery by courier once per week.

According to state and federal Medicaid Anti-Fraud and Abuse regulations, DMA is required to bring suspicious billing practices promptly to MFCU's attention in order to allow MFCU investigators, attorneys and auditors to investigate and prosecute possible fraud and abuse. In this case, DMA instead settled with BBM by paying the company in full for all unpaid claims, waiving DMA's claims to recover \$189,421.44 from the company in over-payments for FY1997, and agreeing not to seek recovery for overpayments in prior years. DMA also "released and discharged all claims, causes of action, liabilities and suits of every kind" against the company. In exchange, BBM voluntarily withdrew from the Medicaid program. Puzzling also is the fact that DMA made payments to BBM after referring the matter to MFCU. Moreover, by referring the matter to MFCU, DMA officials avoided releasing public records about the case to the legislator and, subsequently, to the Boston Globe.

Records indicate that BBM's recipients received a fantastic variety of exquisitely designed and constructed shoes and boots, hand-crafted over a wooden last in the old-fashioned European style.² Many Medicaid recipients requested and received from BBM designer footwear in shapes and styles that contradicted the specifications of the prescribing doctor. One of BBM's directors submitted a photo of Fred Astaire's dancing shoes and ordered the company to make an exact replica for his son, a Medicaid recipient, at a cost to the taxpayers of \$964. In total, the son received 15 pairs of shoes and boots from BBM, costing Medicaid \$13,300, including boat shoes, mountain climbing shoes, white calf leather boots, and beach sandals at an average cost of \$887 per pair.

This Office interviewed the physician who prescribed the shoes and boots that BBM provided to the son of a BBM director. This Office showed the physician photographs and the payment history of the shoes and boots that resulted from his prescriptions. The physician, now retired, told this Office that he never intended to order the kinds of shoes that BBM provided. "If I had any idea that he was enhancing his wardrobe I would not have written the prescription; I really am shocked", he said. He explained that he had examined the patient's feet and had not seen anything visibly wrong with them. He indicated that the father had "pressured him" for prescriptions and that he felt compassion for the son, "but I feel I was taken advantage of." The physician said that he had intended to prescribe standard orthopedic shoes and that the patient should have received off-the-shelf orthopedic shoes instead. The physician's comments and photographs of the shoes are presented later in this report.

² BBM's owner described a last as follows: *"The 'last' is the essential tool of customized shoe making. It is a foot shaped block of wood, which is honed by hand to evolve into the exact duplicate of an individual foot. The shoemaker starts with a standard size and shape and then grinds it down in some areas and builds it up in others. This intricate process of honing and building corresponds exactly to the measurements noted during the client's initial visit. All idiosyncratic aspects of a client's foot are accounted for and duplicated."*

BBM allowed its Medicaid recipients to design their shoes with the help of BBM's in-house designer who drew sketches according to the whim of the Medicaid recipient. Between 1987 and 1997, Medicaid paid between \$812 and \$1,268 per pair, averaging \$935, for 2,249 pairs of shoes and boots. One BBM Medicaid recipient submitted pictures from fashion magazines of high-heeled pumps and received taxpayer-funded replicas of the shoes in the ad.

This report concludes that DMA should have required BBM's Medicaid clients to take their prescriptions to any one of the many Massachusetts orthopedic providers that sold state-of-the art custom-molded shoes and ready-made orthopedic shoes. BBM was the only Medicaid-licensed orthopedic shoe provider reviewed by this Office that did not offer ready-made or custom-molded shoes. Instead, BBM exclusively sold expensive hand-made custom footwear and no other kinds of orthopedic footwear. According to DMA regulations and the agreed-upon protocol, BBM instead should have referred the Medicaid recipients to other orthopedic shoe providers who could have met their needs at a fraction of the BBM's cost.

The record shows that in many cases, physicians prescribed off-the shelf orthopedic shoes, typically costing between \$100.00 and \$154.00 per pair, for BBM's customers, and that BBM ignored the prescriptions by providing fancy shoes at prices exceeding \$900 per pair instead. Review of records and interviews with prescribing physicians indicate that in almost every case the shoes and boots provided by BBM were not medically necessary or were far more expensive than needed to meet the recipient's medical needs.

Custom-molded shoes (Code L3230) cost Medicaid between \$200.00 and \$254.00. They are built over exact plaster replicas of the recipient's foot using technology first developed in the 1930s and 1940s to make custom-molded skates for professional skaters.³ A host of custom-molded shoe manufacturers

³ Schuster, Richard O.; *A History of Orthopedics in Podiatry*, (J Am Podiatry Assoc., 1974), 64(5):332-45.

have improved upon the process since then. According to experts, custom-molding technology represents an improvement over the method formerly used to make custom foot appliances, i.e., over modified wooden lasts. BBM was the only Medicaid orthopedic shoe manufacturer still using the former technique before the company withdrew from the program. In the following excerpt, an expert describes how and why custom molding represents a technological advancement over prior methods:

There were often problems since tracings and shoe sizes produced only two-dimensional information for a three-dimensional device. The foot appliance maker quickly adapted to the situation by using the tracings and shoe sizes to select a shoe last, which was then modified and used for a base for the construction of the foot appliance. Although the technique was far from ideal by modern standards; it was a realistic step which almost always produced an insert that fitted the shoe and more often than not could be worn by the patient with some degree of comfort . . .

During the 1930s and 1940s, Allan E. Murray, an ice skater with an inventive talent, developed a shoe which is molded directly onto a cast of the foot. It was originally intended as an improved shoe for an ice skate, but it was quickly evolved into general use. It was a boon to many people, particularly those who could not be fitted with the usual last-made shoe. Many podiatrists were quick to recognize the orthopedic benefits of the shoe and became involved in its use.

After reviewing the kinds of custom-molded and ready-made shoes that DMA was purchasing for Medicaid patients statewide, this Office concludes that DMA should not have purchased footwear from BBM at prices greater than that paid to other orthopedic footwear providers.

Regarding possible involvement of Russian organized crime.

When DMA's Deputy General Counsel referred BBM to MFCU "for investigation of possible Medicaid fraud" on May 30, 1997, the Deputy General Counsel explained in the letter that DMA staff had recently attended a conference on

Medicaid Fraud in New England. DMA's referral of the BBM matter to MFCU stated that one of the speakers had noted,

...the 'Russian Mafia' has been in collusion with Russian immigrants, providers of durable medical equipment, and physicians to obtain payment from Medicare. As Boston Boot Makers provided orthotic equipment to a large number of Medicaid recipients who are Russian immigrants, your Office may want to investigate into possible Medicaid fraud.

This Office found no reference in any internal or public DMA documents, aside from the above-cited referral letter itself, to questions about the "Russian Mafia" by DMA employees in the BBM case. To the contrary, the official who recommended referring the matter to MCFU – two days after a legislator's request for answers about the BBM case – did not mention anything in her memorandum about Russian organized crime.

Medicaid fraud involving Russian organized crime had been a major concern of the federal and state governments for many years before DMA settled this case. On May 22, 1995, for example, the United States Senate unanimously adopted a concurrent budget resolution expressing the sense of the Senate that high priority should be given to proposals that identify, eliminate, and recover funds fraudulently expended through Medicare and Medicaid. The resolution specifically cited concern about activities of the Russian Mafia, as follows:

It is so easy and so lucrative to defraud the Medicaid and Medicare programs, in fact, that Federal Bureau of Investigation Director Louis Freeh recently testified that many cocaine dealers have been switching from drug trafficking to health care fraud. Director Freeh also reported that the Russian Mafia and other organized crime groups from around the globe are now actively involved in defrauding the Medicare and Medicaid programs. Some thefts are sophisticated; others are brazen. In the later category, we find that Medicare paid one home health care company's \$85,000 bill for gourmet popcorn, which was given as a promotional item to doctors; in the former category, we find large-scale organizations that create paper trails for nonexistent laboratories and patients, and collect enormous sums for treatments that were never performed. Cracking down on fraud will greatly ease the financial crises facing Medicare and Medicaid today."

This Office brought DMA's suggestion about possible involvement of the "Russian Mafia" in the BBM case to the attention of officials at the FBI and the Office of the Inspector General of the federal Department of Health and Human Services. This Office also discussed this issue with officials at the MFCU, to whom DMA had referred the suggestion of involvement of Russian organized crime.

Summary: Part Two. The Commonwealth's 15 Top Orthopedic Footwear Providers

Widespread Fraud and Abuse in the Medicaid Orthopedic Footwear Program

This Office's investigation revealed a widespread pattern of fraud and abuse by Medicaid orthopedic footwear providers, coupled with inadequate administrative and computerized screening systems at DMA. Aside from BBM, many of DMA's other top fifteen orthopedic footwear providers routinely "gamed the system" by engaging in "creative" fraudulent billing to maximize their own income. Other providers complied with program rules and regulations in their billings with few exceptions. "Creative billing methods" that slipped past DMA's computerized screening system included the following:

Billing for services not rendered— billing for footwear and footwear additions and conversions that were not provided;

Upcoding— billing for more elaborate and expensive orthopedic footwear and additions than were actually provided;

Unbundling— billing for an orthopedic shoes, and duplicate billing for component parts;

Double billing— billing for a pair of orthopedic shoes by charging the "per pair" rate for both shoes, resulting in a double payment;

Excess billing— billing in excess of the DMA's rates for the orthopedic shoe or shoe addition;

Gang billing— billing for a number of shoe-fittings and follow-up adjustments to separate nursing home residents based on a single walk through the facility and billing for nursing home travel for each claim; and,

Balance billing— billing the recipient for shoe additions in violation of program regulations and subsequently billing Medicaid for the same shoe additions.

DMA's automated claims-tracking system was unable to detect certain kinds of abusive over-billings because of built-in shortcomings of the computer program and claims payment system. DMA paid double for orthopedic shoes more than one thousand times in the two-and-one-half year period reviewed by this Office. In each of these instances, DMA's computerized claim checking system disregarded the "unit" description that distinguishes a pair of shoes from a single shoe. While most orthopedic footwear providers properly billed Medicaid \$128.00 per pair for extra-depth shoes, for example, as required by regulation, other providers routinely charged double, or \$256.00 per pair, for the same shoes. Some providers listed a pair as *one unit* on their invoice, others as *two units*. No matter how the provider listed the units, however, DMA paid the claim in full. In this case, the computer simply failed to detect and flag the double billing. One provider alone over-billed DMA more than \$100,000 for these kinds of shoes. Specific examples of overpayments include the following:

Specific individual purchases

- A provider charged Medicaid \$464.92 for a pair of ladies depth shoes it had purchased from its supplier for \$75.00, then charged Medicaid "the per pair" rate for each individual shoe (double-billing.) The provider then added an extra charge for "non-standard size" although the provider had purchased the shoes at standard rates from his supplier, with no "non-standard size" charge paid by him. The provider then added a charge for custom-molded inserts that were neither prescribed nor provided. In total, the provider charged Medicaid six times more than the provider paid his supplier for the shoes. Maximum charge for this shoe under Division of Health Care Finance and Policy regulations was supposed to be \$125.66.
- Another provider charged Medicaid \$602.80 for a pair of custom shoes it purchased from a supplier for \$180.00, charging Medicaid the "per pair" rate for each individual shoe (double-billing), then adding four units of extra charges for "conversion to Velcro closures." The provider added these extra charges even though the shoes came standard with Velcro closures at no extra charge. The provider should have charged Medicaid \$257.50 for the shoes.
- Another provider charged Medicaid \$399.00 for a pair of men's extra depth shoes it purchased from its supplier for \$78.00, charging Medicaid the "per pair" rate for each individual shoe (double-billing), then adding an extra

charge for “non-standard size.” The provider added this extra charge despite the fact that it had purchased the shoes at standard size rates. The provider should have charged Medicaid \$154.50.

- Another provider charged Medicaid \$830 for shoes it purchased from its supplier for \$207.00, charging Medicaid the "per pair" rate for each individual shoe (double-billing), then adding a total of \$330.00 in charges for two pairs of dual density inserts for which the provider paid only \$21.00. Provider should have charged Medicaid \$257.50.

Charging \$210.00 for custom molded inserts that were not provided

One provider apparently padded its Medicaid bills by more than \$65,735 with extra charges for “custom molded inserts.” The provider added an extra charge of approximately \$210 each in 352 of 354 instances when it sold custom shoes to Medicaid recipients over a period of less than three years. Records indicate that the provider charged Medicaid for "custom insert molded to positive model of patient’s foot,” but in the instances reviewed by this Office the provider had not in fact provided custom inserts. Instead, the provider gave the recipient inexpensive double-density factory inserts that came standard with the shoe from his supplier. Other providers rarely added such charges.

Extra charges for custom inserts on custom shoes (L3230)

Some providers added extra charges for “custom insert” with a custom shoe; others did not.

	# Shoes	# Inserts	% with insert charges
Company 1	354	352	99.15%
Company 2	197	28	14.21%
Company 3	37	34	91.89%
Company 4	31	0	0.00%
Company 5	35	5	14.29%
Company 6	8	0	0.00%

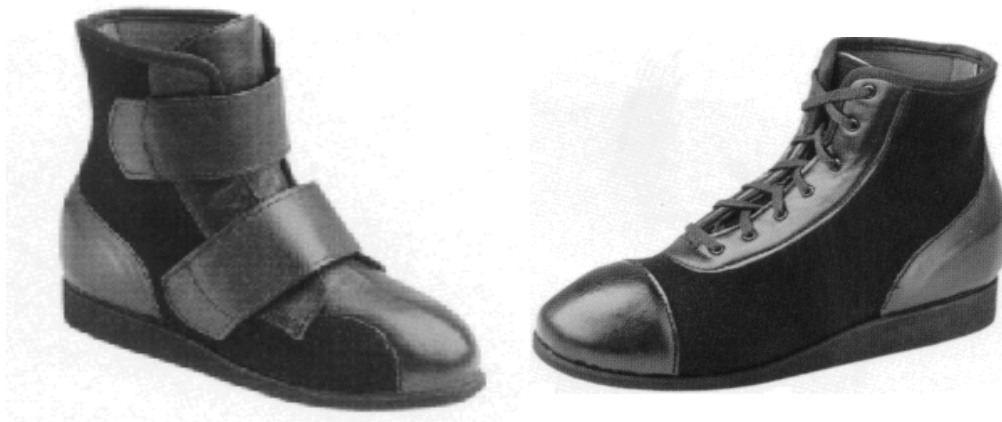
Double Charging

One provider, on 736 separate occasions, doubled-charged DMA for ready-made orthopedic shoes it provided to Medicaid recipients, charging the "per pair" rate

for each shoe, resulting in \$95,793 in total overpayments. Another provider, on 198 separate occasions, doubled-charged DMA by charging \$500.00 - \$515.00 per pair for custom shoes for which he was supposed to charge a maximum of \$250.00 - \$257.50 per pair, resulting in \$49,624.50 in total overpayments. Other orthopedic providers never double-charged Medicaid on a single occasion.

Extra charges for Velcro strips that come standard with the shoe

Some providers routinely and improperly added extra charges to their bills for Velcro strips that come standard with the shoes they provided to Medicaid recipients. For example, one provider added four separate charges of \$21.95 each to his Medicaid bill in a single transaction for "converting a lace shoe to Velcro closure." The shoe is shown below. The provider admitted in an interview that he had simply counted the number of Velcro strips that came as a standard component on the shoe and added a charge to Medicaid of \$21.95 for each one, adding a total of \$87.80. The supplier described this as "a corollary charge." This Office's investigation of the supplier's invoices and price list showed that the tie model cost the same as the Velcro model, shown below.



Custom molded boot – Velcro model
Manufacturer's list price: \$191.00

Custom molded boot – Tie model
Manufacturer's list price: \$191.00

According to the provider's invoice, the provider purchased the Velcro model shoe (pictured above left) from its supplier for \$180.00, with no extra charge for Velcro closures. The provider paid exactly the same amount for the Velcro

model as it would have paid for the tie model: \$180.00 after standard discount. The provider then charged Medicaid \$602.80 for the boots. The company padded its bill by charging twice the Medicaid-approved rate for the shoes ($2 \times \$257.50 = \515.00) and then adding the inappropriate Velcro charges as described ($\$515.00 + \$87.80 = \$602.80$). Medicaid paid \$602.80 to the provider. It should have paid \$257.50.

Padding the bill when recipient's feet come in two different sizes

Another area of billing abuse occurs when providers pad their bills with extra charges for "split size shoes." One provider, for example, added two such charges on February 19, 1998 when he sold a pair of shoes to a Medicaid recipient who had feet of two different sizes (i.e., 9 ½ D left foot and 10 ½ C right foot). The provider billed Medicaid for two separate pairs of shoes (i.e., four individual shoes) and then added not one, but two extra charges of \$46.35 apiece for "split size."

The provider told this Office that he threw away one brand-new shoe from each pair. When asked to produce an invoice demonstrating that the provider had in fact ordered two pairs of shoes, the provider produced two invoices, one dated four months and the other six months before the date of the prescription ordering the shoes in question. Upon further questioning, the provider admitted that he had in fact taken two shoes "out of inventory."

In the case of "split-sizes", Medicaid rules require that providers place a special order with the supplier, in this instance, for example, for a 9½ D left shoe and 10½ C right shoe. Medicaid accordingly allows providers to add a single \$46.35 charge to its Medicaid bill for a pair of split-sized shoes. One leading manufacturer charges providers a \$40.00 special order fee and delivers two shoes in the specified sizes within four to five weeks. When this Office asked the provider why he added any charge at all for split-sized shoes after he had billed Medicaid in full for both pairs of shoes, the provider stated that he always did it that way, and Medicaid always paid without any problem. When asked why he

had added not one but two charges for split size shoes, the provider said, “The left shoe didn’t match the right shoe, and the right shoe didn’t match the left shoe.”

Phantom “amputee” charges for recipients with two feet

One provider billed Medicaid 182 times for special prosthetic shoes for recipients with complete or partial amputations of the foot. Records show that the recipients commonly did not have complete or partial foot amputations. Medicaid authorizes payment of \$412.00 per pair for custom-molded shoes for recipients with partial foot amputation, and \$250.00 for custom shoes for recipients without amputations.

Providing more expensive kinds of shoes than the doctor ordered

Providers frequently sold their Medicaid recipients expensive custom-made shoes when the prescription called for less expensive off-the-shelf or extra depth orthopedic shoes. Records show that providers frequently provide more expensive types of shoes, for higher prices, than those prescribed.

Some providers charged Medicaid \$90.00 extra for “non-standard size” shoes even when they paid 50 cents – or nothing – extra for the shoes

One provider routinely padded his Medicaid bills by adding bogus charges for “odd-size width” and “odd-size length.” The provider added these charges even though he had purchased the shoes at no additional charge from his suppliers. The provider reaped a \$16,350 bonanza by adding extra charges 196 times, typically at \$92.75 per charge, when he sold off-the-shelf depth shoes to Medicaid recipients. Records indicate that Medicaid once paid the provider \$810 in “non-standard size” charges for shoes he sold in a single day. This Office reviewed samples of his invoices and did not find an instance where the provider paid his suppliers a fee or charge for non-standard sizes. In an interview with this Office, the provider reviewed a specific instance of over-billing. Documents showed that the provider purchased a pair of ready-made shoes, size 7-E, from his supplier for \$67.50 and that the provider paid no extra charge for “non-

standard size.” The provider subsequently billed Medicaid \$295.00 for the shoes (double billing), and added a \$90.00 “non-standard size” charge to the bill. Medicaid paid \$385.00 to the provider for the shoes. The provider told this Office, “I consider an E-width shoe to be an odd size, don’t you? It’s a billing vehicle.”

Another provider submitted “odd-size” charges 874 separate times, representing more than 80 percent of the total number of billings between July 1, 1995 and January 18, 1999. This provider generally charged \$12.00 or \$15.00 extra per pair. He reaped an extra \$12,755.00 in total payments from Medicaid during the period reviewed.

Number of times providers added extra charges for “odd size” shoes	
	# Charges
Company 1	874
Company 2	196
Company 3	29
Company 4	16
Company 5	10
Company 6	10
Company 7	1
Company 8	0
Company 9	0
Company 10	0
Company 11	0
Company 12	0
Company 13	0
Company 14	0
Company 15	0

This Office observed that DMA and the Division of Health Care Finance and Policy have established rates for odd-size shoes (i.e., \$46.35) that seem far out of line with what shoe manufacturer's charge Medicaid providers. The pricing sheet for a leading manufacturer describes its nominal charges as follows:

Wide Widths - Add the following charges when ordering wide widths:

Women's E, 2E, 2W: \$.50

Women's 3E, 4E, 5E, 3W:	\$1.00
Men's E, 2E, 2W:	\$1.50
Men's 3E, 4E, 5E, 3W:	\$2.00

Large Sizes – no additional charge.

Charging for the shoe addition “du jour”

One provider's billing history demonstrates how providers can abuse the system by routinely adding charges for shoe additions that other orthopedic shoe providers rarely add to their shoes. The provider in question added extra charges of \$150.00 per pair for “pre-molded longitudinal arch supports” almost every time the provider dispensed a pair of off-the-shelf orthopedic shoes to a Medicaid recipient over a period of 14 months. During that time, DMA paid the provider a total of \$23,005.00 for questionable add-on charges to 151 pairs of shoes. The provider's charges constituted approximately 66 percent (66%) of the total statewide Medicaid billings among all orthopedic footwear providers statewide for that particular type of insert over that period. After the Division of Health Care Finance and Policy reduced the reimbursement rate for that type of insert to a maximum of \$67.94 per pair, the provider never submitted another bill to Medicaid for that kind of insert. Instead, the provider began to charge for a different kind of shoe addition, a “removable insert formed to the patient foot” for which Medicaid paid \$110.18 per pair. The provider then added this charge to nearly every one of the next 213 pairs of shoes it provided to Medicaid recipients over the following 26 months, collecting a total of \$23,869.00 in payments from Medicaid over that period. During that twenty-six months following the rate change, the provider's claims for that particular kind of insert represented fifty-three 53 percent (53%) of the statewide total among all orthopedic footwear providers.

Forty-two nursing home visits in a single day

Results of this Office's investigation indicate that some providers “gang-bill” for nursing home visits. One provider billed Medicaid 42 times on the same day at

\$41.20 per recipient. Another provider made a \$6,000 profit on 26 pairs of shoes that he provided to 26 nursing home patients on the same day. The provider charged Medicaid \$8,270 in total for the shoes. Records show that the provider overcharged Medicaid for each of these pairs of shoes by double billing and sometimes adding inappropriate “non-standard size” charges. Based on a review of his billings and samples of his invoices, this Office estimates that the provider paid his supplier approximately \$2,250 for these 26 pairs of shoes, resulting in a one-day profit to him of more than \$6,000.

Some providers routinely charge Medicaid for three separate visits to provide a recipient with one pair of shoes; first to measure; next to deliver, and lastly to “check up” and readjust, thus adding \$123.60 to Medicaid’s costs for a single pair of shoes. Nursing home charges are intended to compensate the provider for having to leave his place of business, but the cost of fitting and adjusting shoes is specifically built-in to the base rate established by the Division of Health Care Finance and Policy. Thus, orthopedic providers are prohibited from charging extra for fitting and adjusting shoes. This Office concludes that in this context, multiple nursing home charges for visits *to the same facility* on the same day represent a form of double dipping by some orthopedic footwear suppliers for travel expenses. As described in the recommendation section of this report, this Office recommends that the Division of Health Care Finance and Policy amend its regulations to establish reasonable limits on such charges to prevent such abuses.

Pervasive record-keeping deficiencies among providers

This Office observed pervasive record keeping violations by numerous providers. In many cases, providers could not produce records to demonstrate that they had actually provided the goods for which they billed Medicaid. Nor could they prove how much the provider had paid to purchase the materials and services or show whether a physician had actually prescribed the goods and services. This Office was unable to determine in many cases whether the providers had abided by DMA regulations because of missing and inadequate records. When records did

exist, this Office found that providers often billed Medicaid incorrectly by using the wrong billing codes, unit amounts, and product descriptions.

DMA overpaid providers in 42.7 percent (42.7%) of all claims for ready-made, extra-depth and custom orthopedic shoes

This Office found that DMA overpaid orthopedic footwear providers in 3,934 of 9,211 claims for off-the-shelf, extra-depth and custom orthopedic shoes, representing 42.7 percent (42.7%) of the total transactions between July 1, 1995 and January 18, 1999.⁴ In 3,934 instances, DMA's payment exceeded the allowable rate established by the Division of Health Care Finance and Policy for the purchase of the orthopedic shoes. Overpayments ranged from \$1.00 to \$257.50, averaging \$63.71 per pair overall. The average overpayment by DMA for a pair of custom shoes (L3230) was \$202.08; the average overpayment for off-the-shelf shoes (L3215, L3219) was \$54.53; the average overpayment for extra-depth shoes (L3216, L3217, and L3221) was \$49.62. In total, DMA overpaid for off-the-shelf, extra-depth and custom shoes by \$250,624.57 over three and one-half years. These figures do not include other kinds of overcharges, including payment for custom molded prosthetic shoes (L3250) for recipients who did not have partial foot amputations, unjustified charges for shoe additions, or payments for other kinds of unjustified claims discussed in this report. Many of DMA's overpayments for off-the-shelf, extra-depth and custom orthopedic shoes are explained by the fact that DMA's computerized claims payment system did not adequately discriminate properly between "per unit" and "per pair" charges, and that their system failed to detect this pattern of overpayments.

This Office notified DMA of billing irregularities early on

In August of 1998, this Office notified DMA of the specific billing and payment irregularities identified during the course of the investigation, and did so on an ongoing basis thereafter, rather than wait for its conclusion. The policy of this

⁴ Transactions for L3215, L3216, L3217, L3219, L3221, L3230.

Office was to enable DMA to take immediate action to curtail improper payments and address administrative problems as this Office identified them. Specifically, this Office notified DMA of widespread double-billing, bill-padding, over-charging, up-coding and questionable billing by many of the orthopedic footwear providers under review. As a result, DMA responded by initiating audits of providers, and taking steps to tighten its computerized payment programs to flag and block improper payments. In August of 1998 it revised the provider regulations, requiring for the first time the submittal of a prescription with the claim, limiting recipients to two pairs of orthopedic shoes per year. Staff of this Office continued to meet with DMA officials during the course of the investigation to provide additional information about questionable transactions.

This Office notified the MFCU about the above-described irregularities as well. On March 2 1998, this Office notified the MFCU of its interim findings about transactions between BBM and DMA, including information discovered during the investigation that had been unknown at the time of the Settlement Agreement between DMA and BBM in 1997, particularly concerning referring physicians. On September 10, 1998, investigators fully briefed MFCU on this Office's findings regarding the BBM case and billing irregularities among the other top fifteen orthopedic footwear providers. On February 11 and 16, 1999, this Office gave lengthy follow-up briefings to MFCU concerning the results of a meeting between this Office and BBM's owner and further information concerning the BBM case and the fifteen top providers. This Office worked closely with MFCU thereafter.

In the course of the investigation, this Office requested information directly from fifteen orthopedic footwear providers and reviewed questionable claims directly with officials of these firms or their legal representatives. Several providers subsequently offered to amend prior claims to correct billings and to refund overcharges. This Office referred these offers to DMA, with notice to MFCU.

Introduction

This report indirectly came about as a result of a state legislator's efforts to convince DMA to pay for a \$2,800 auto power transfer seat for a constituent, a disabled Vietnam veteran. Although the constituent never received funding for the car seat, the State Representative continued to ardently pursue the issue of alleged \$1,000 boot payments. The legislator told this Office that during the course of her efforts to win approval for the car seat, a lawyer from her district asked her a question, "Why does Medicaid pay for hand-made leather boots for non-citizens, but not for a wheel-chair lift for a disabled war veteran?" The Representative called the Commissioner of DMA and repeated the question. According to the Representative, she spoke with the Commissioner and was told, "That's a bizarre story; it's just not true." Later, the Commissioner acknowledged to the legislator that DMA had in fact purchased expensive hand-made shoes from BBM but that the BBM was no longer a Medicaid provider. When DMA refused to provide information about the matter to the legislator, she and other members of the House of Representatives filed the Order requesting an investigation by the Office of the Inspector General.

The Representative, during an initial meeting with investigators of this Office, requested that this Office look into possible 'fraud, waste, and abuse' concerning Russian immigrant recipients receiving doctor approved hand-made boots from BBM. The representative also expressed doubts about the medical necessity of the boots, the Medicaid-eligibility of those persons who received the boots from BBM, and the license status of the prescribing physicians.

Objectives, Scope and Methodology of Investigation

In accordance with the House Order, this Office undertook an investigation of the BBM matter and an evaluation of the effectiveness of DMA's administration of the orthopedic footwear benefits program. In conducting this investigation, this Office gathered and analyzed information from numerous sources as follows:

- Reviewed applicable state and federal laws, rules, regulations and policies governing the provision of orthopedic footwear under the Medicaid and Medicare programs in Massachusetts and in several other states;
- Reviewed Division of Medical Assistance (DMA) records of 21,703 transactions between DMA and its fifteen top providers of orthopedic footwear and supplies by annual dollar amount over a period of forty-three months, between July 1, 1995 and January 18, 1999;
- Reviewed DMA records of 2,560 transactions between DMA and BBM;
- Conducted 24 interviews with current and past officials of the Division of Medical Assistance about DMA's history of transactions with BBM;
- Requested and received information and assistance from administrators of DMA concerning the operation of DMA and its Durable Medical Equipment Program;
- Requested and received information and assistance from administrators of other agencies and departments of the state and federal government, and professional organizations, which included: the MFCU; the Department of the Attorney General of the Commonwealth; the Division of Health Care Finance and Policy; the Medicaid program of the federal Department of Health and Human Services (HHS); the Durable Medical Equipment Carrier (DMERC) for the Health Care Financing Administration (HCFA); the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC)); the Federal Bureau of Investigation (FBI); the federal Office of Inspector General of the Health and Human Services Administration; the Pedorthic Footwear Association (PFA); and, the American Orthotic and Prosthetic Association (AOPA);
- Toured DMA's claims payment division;
- Interviewed officials from MassPro, Inc., DMA's contracted provider of field audits of Medicaid footwear providers, concerning its field audit of BBM; also reviewed documents and contracts;
- Interviewed physicians and orthotists who wrote frequent orthopedic footwear prescriptions;
- Contacted providers of orthopedic footwear, of which the Office visited several of their places of business, interviewed many of them, and requested and reviewed claims documents;

- Visited the homes of a number of DMA recipients who received orthopedic footwear benefits through Medicaid to see shoes and ask questions about the history of transactions;
- Interviewed the owner of BBM;
- Reviewed BBM financial records, provided voluntarily, for three tax years;
- Toured BBM to see its facilities and operations;
- Reviewed BBM's Medicaid claims records, provided voluntarily, for all claims over a period of fourteen years;
- Reviewed this Office's findings and solicit a response;
- Met with legislative sponsor of the House Order requesting an investigation.

Background: putting the Orthopedic Footwear Program in perspective: a tiny part of a \$5 billion Medicaid budget, but a far-reaching lesson to administrators

Put in perspective, spending for orthopedic footwear and footwear modifications will amount to less than \$1 million in Fiscal Year 2000, about two one-hundredths of one percent (.02%) of the Commonwealth's \$5 billion Medicaid budget. Of approximately one million total eligible recipients, approximately one-half of one percent, or 4,250 recipients, will receive orthopedic footwear benefits this year. In an interview with OIG staff, one DMA official described the program as "a small microcosm of the Medicaid budget." The legislative sponsor of the House Order requesting this investigation told this Office, "The scope of the program is small, but the lessons may be more far-reaching." Accordingly, OIG staff attempted to look at systemic deficiencies in the course of their investigation.

Of the approximate one million (1,000,000) Medicaid recipients DMA is serving in Fiscal Year 2000, about 165,000 are adults and children made eligible for comprehensive health care coverage under the Health Care Access and Improvement Act (Chapter 203 of the Massachusetts Acts and Resolves, 1996). In addition, 144,000 children and working adults are newly eligible for health care coverage under the Children's' Health Insurance Program and the Family

Assistance Program, authorized by Chapters 47 and 170 of the Massachusetts Acts and Resolves, 1997. DMA manages the MassHealth program, which provides comprehensive health insurance and premium assistance to low and moderate income children, families, and persons with disabilities. DMA also manages the CommonHealth Plan that provides benefits to employed disabled adults and disabled children. In Fiscal Year 1998, the MassHealth program began to expand its eligibility requirements to maximize health care access for uninsured and underinsured families and individuals. In addition to the traditional populations, DMA has expanded its provision of assistance to long-term unemployed individuals and working families with incomes up to 200 percent of the federal poverty level. DMA offers a wide range of benefit packages depending on eligibility category, including premium assistance for families who have access to private health coverage.

In addition to its responsibilities in overseeing the expanding MassHealth program in recent years, DMA has also faced the challenge of assisting the Department of the Attorney General in compiling evidence critical to the Commonwealth's lawsuit against the nation's major cigarette manufacturers. DMA undertook an intensive, time-consuming and comprehensive review of past Medicaid expenditures that was critical to demonstrating the Commonwealth's claims of financial damages related to cigarette smoking.

Background: Fraud and Abuse in the Medicaid Program

By virtue of its size and complexity, the Medicaid system is vulnerable to abuse. This is true not only on the state but on the also the federal level. The General Accounting Office and Department of Human Services estimates that Medicare pays out approximately \$23 billion a year in improper payments.⁵

The term "fraud," as defined by federal Medicare and Medicaid regulations, is the intentional deception or misrepresentation that an individual knows to be false or

⁵ *HCFA's \$23 Billion Error Rate Said to Show Need for Random Audits*, (BNA Health Care Daily), 18 July 1997.

does not believe to be true and makes, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. The term "abuse" includes incidents or practices of providers, physicians, or suppliers of services that are inconsistent with accepted sound medical practices, directly or indirectly resulting in unnecessary costs to the program, improper payment, or program payment for services that fail to meet professionally recognized standards of care or are medically unnecessary.⁶

Fraud and abuse occur when providers, suppliers, or recipients intentionally, recklessly, or negligently attempt to obtain something of value to which they are not entitled under the regulatory and contractual rules that govern the program. Fraud occurs, for example, when a provider willingly and knowingly claims payment for a service he did not deliver, or for a service that he delivered knowing it to be unnecessary. For example, abuse occurs when a party "games the system" by claiming reimbursement for a more expensive shoe than that actually delivered or by charging per shoe the amount allowed for a pair of shoes, resulting in double billing. Abuse, like fraud, usually involves misconduct when health care or equipment is in fact provided.

Background: Who Enforces the Commonwealth's Fraud and Abuse Laws?

Responsibility for enforcing fraud and abuse laws is shared by many agencies of the federal and state governments. In the Commonwealth, DMA has an array of in-house personnel and contract vendors who seek to detect and prevent fraud and abuse. As provided by federal law, the Medicaid Fraud Control Units (MFCUs) take primary responsibility for prosecuting Medicaid fraud. The U.S. Department of Justice and the Department of the Attorney General of the Commonwealth prosecute criminal cases and bring civil false claim actions. The Federal Bureau of Investigation expends considerable effort in investigating Medicaid and Medicare fraud. The Commonwealth's District Attorney's offices

⁶ *Manual Instructions for Medicare Career Fraud Units*, (MCFU), 14001. PART B MEDICARE FRAUD, 1977.

also investigate and sometimes prosecute fraud and abuse matters, often working closely with the Department of the Attorney General when so doing. On the federal level, the primary responsibility for investigating suspected incidents of fraud and abuse, and for bringing administrative sanction cases, rests with the Office of Inspector General of Health and Human Services.

Division of Medical Assistance (DMA) A large part of the responsibility for detecting patterns of fraud and abuse falls on DMA's monitoring staff, i.e., SURS staff, as previously described in this report. In the case of BBM, the record shows that DMA's SURS staff successfully identified the BBM problem early on by using their technological claims monitoring system. Another means of fraud detection at DMA's disposal are its in-house and contracted field auditors who are instructed to look for and report wider patterns of billing irregularities. Because they typically see only a narrow sample of claims, usually only 25 clients during an audit, the auditors are inherently limited in their ability to discern broader patterns of fraud. Nevertheless, these auditors attempt to identify individual instances of fraud as well as patterns and trends. A key conclusion of this report is that DMA lacks sufficient manpower and resources to identify prevent, detect and remedy fraud and abuse in its \$5 billion dollar program.

DMA primarily uses a "pay and chase" system to monitor and enforce program compliance. This system represents a fundamental tool used by DMA to prevent fraud and abuse. It is effective to the extent that providers are unwilling to bear the risk of falling into the audit net and being forced to pay "extrapolated charges." For example, if DMA auditors determine that 10 percent (10%) of a provider's 32 audited claims are out of compliance with Medicaid regulations, DMA typically demand repayment of 10 percent (10%) of all claims paid by DMA to the provider in the audited period. This theoretically represents a powerful incentive for providers to comply with the Medicaid regulations. The effectiveness of the pay and chase system is watered down, however, by the perception of providers that they won't be audited or, if they are selected for audit, that they will be able to negotiate and pay only a small settlement. In

addition to using the “pay and chase” system, DMA also mails Explanations of Benefits to randomly selected recipients, in accordance with HCFA requirements.

Medicaid Fraud Control Unit (MFCU) In 1977, Congress authorized the creation of state Medicaid Fraud Control Units (MFCUs) to detect and prosecute fraud and abuse in the Medicaid system and patient abuse and neglect in health care institutions. The MFCU operates independently of DMA, just as other state’s MFCUs operate independently of their respective Medicaid agencies. The MFCU is a division of the Department of the Attorney General and is manned by teams of attorneys, investigators and auditors specializing in health care fraud. Medicaid payments from the federal government are linked to each state’s fraud and abuse recoveries. The federal government subsidizes the costs of the MFCU. The MFCU executes the same investigative roles on the state level as the OIG executes on a federal level. The MFCU has far-reaching powers to audit Medicaid programs for fraud, abuse and waste, to conduct investigations, to suspend, exclude or impose civil monetary penalties upon health care providers, and to prosecute fraud within the health care programs.

The OIG of the Department of Health and Human Services (OIG-HHS) The Office of the Inspector General (OIG) for the Department of Health and Human Services (HHS) is the main federal investigative agent for detection of fraud and abuse in the federal health care programs. It conducts fraud and abuse investigations and oversees the investigations undertaken by state MFCUs into fraud and abuse in the Medicaid program. The OIG has a regional office in Boston. The OIG divisions have broad powers to audit Medicare and Medicaid programs for fraud, abuse and waste, to carry out inspections and make policies to curb fraud and abuse. The OIGs carry out investigations, suspend and fine Medicaid and Medicare providers, develop compliance programs, coordinate state, federal and private investigations and litigation related to fraud within the health care programs, and promulgate fraud alerts. The OIG can impose civil penalties of up to \$10,000 per false claim plus three times the amount claimed.

Health Care Financing Administration (HCFA) The Health Care Financing Administration (HCFA) is responsible for administering the Medicare and Medicaid programs. The Medicaid program provides grants to states for medical care for low-income people.

Peer Review Organizations (PROs) Private organizations commonly known as Peer Review Organizations (PROs) contract with HCFA and DMA to conduct independent reviews of physician and medically related services, including hospital-based care. DMA contracts with MassPro to review, as well, durable medical equipment providers.

The sponsor of the House Order that requested this study explained that while the investigation's scope may be small relative to total Medicaid spending, its importance is larger because it seeks to determine the causes of a systemic failure.

Why do providers try to take advantage of the Medicaid system?

“Providers . . . often realize that what they are doing violates the letter of the law, but rationalize their actions as a justifiable reaction to program complexity or to inadequate payment levels. Minor deviations from billing requirements often go undetected or are ignored. Finally, there are the genuinely confused and bewildered. Providers who meant to deliver only authorized services, to bill only for services actually rendered, and to code accurately the services provided, but who are overwhelmed by the confusion and complexity of the program. Most providers charged with fraud or abuse claim to be in this category; some undoubtedly are. This is particularly true when major program changes are implemented.”⁷

Medicaid fraud is facilitated also by the lack of sufficient anti-fraud resources dedicated to detecting and preventing it. On the state level, DMA has only about one full time equivalent employee for every \$6 million (\$6,000,000) in claims. The federal OIG and the FBI together currently have only about one full time equivalent employee for approximately every 9 million claims.

⁷ Jost, Timothy S. and Davies, Sharon; Medicare and Medicaid Fraud and Abuse, the West Group, 1998 Edition.

“Although providers often characterize fraud cases as ordinary billing disputes that have resulted in brutal prosecutorial overreactions. Only a tiny proportion of cases that involve questionable billing end up being investigated, and even fewer end up in prosecution. Physicians, supply companies, or diagnostic laboratories have only a 3 in 1000 chance of having their billing practices audited by Medicare in a given year. Most cases in which problems are identified are settled with the provider agreeing to make restitution. Often penalties are not pursued because the provider declares bankruptcy or otherwise hides its assets after the fraud is detected, making the pursuit of a recovery futile. In sum, though federal and state prosecutors and agencies possess a considerable armamentarium for dealing with false claims, most questionable claims seem to go unpunished.”⁸

⁸ Jost, Timothy S.; Davies, Sharon L.; *The Law of Medicare and Medicaid Fraud and Abuse*, West Group, 1997, p. 43-44.

Part One. Boston Boot Makers Inc.

Finding 1. BBM defrauded DMA by providing a \$13,300 collection of designer shoes for the son of the company's director (cousin of present owner) at taxpayers' expense



Medicaid paid \$942 for exact replicas of Hollywood star Fred Astaire's dancing shoes for the son of one of BBM's directors. The two-tone wingtip shoes were modeled after the photograph below that the nephew found in a

magazine. The nephew told investigators that he wears the shoes only on special occasions such as weddings.

Investigators visited the nephew's place of residence on Cape Cod and photographed his Medicaid-financed shoes and boots with his permission. In total, BBM made 15 pairs of shoes for the director's son over ten years, billing Medicaid \$13,300 in total.



The nephew told investigators that he had walked five miles that morning. Investigators noted that he was wearing a pair of relatively inexpensive off-the-shelf Reebok shoes. He described the Reeboks as comfortable. This raised the question of whether he needed the expensive orthopedic shoes in the first place. The nephew explained that he purchased the Reeboks after he could no longer get footwear from BBM through the Medicaid program.

The photographs on the following two pages show shoes and boots that BBM provided to the son of the company director.

Other-custom made shoes Medicaid purchased from BBM for director's son.



White leather boat shoes copied from advertisement at right: \$846.50.



Director's son submitted this advertisement of \$9.99 men's leather boat shoes as a model for \$846.50 shoes at left.



White calf-leather shoe: \$680



"French-tip" shoe, calf-leather: \$680



Burgundy calf-leather sandals: \$921



Brown dress shoes: \$921

Medicaid paid \$13,300 for 15 pairs of designer shoes for for the son of the director of BBM.



Medicaid paid for fifteen pairs of Boston Boot Makers shoes and boots for the son of the company director over ten years. The nephew provided these shoes as examples, including beach sandals, hiking boots, mountain boots and two pairs of white calves-skin loafers, costing an average of \$887 per pair.

Undated medical orders and claims for orthopedic shoes that BBM never provided

Investigators found that BBM billed Medicaid three times within a twelve-month period, between June 1995 and June 1996, for orthopedic shoes for the nephew of the owner, but did not provide orthopedic shoes on any of the three occasions. Medicaid paid \$2,768 for the three pairs of orthopedic shoes that were never provided. Instead, upon the request of the former owner, BBM gave the nephew twelve pairs of relatively inexpensive inserts made to fit a pair of the nephew's sneakers. The handwritten note below stated, "Enclosed 2 orders for shoes not

dated. Instead of shoes make junior at least twelve pairs of inserts. I have mailed a pair of sneakers to fit the inserts to.” The nephew confirmed that he received inserts on those occasions. Under questioning by the Office, the owner said: “Because of my schedule, I was at the office only one or two days a week, so my bookkeeper signed my name on those claim forms. But if an error was made I will reimburse the state.”

*Boston Boot makers
Enclosed 2 orders
for shoes not dated,
instead of shoes make
Jr. at least 12 pair of
inserts
I have mailed a
pair of sneakers to fit
the inserts to.*



Hand-written order for shoes: “Enclosed 2 orders for shoes not dated, instead of shoes make Jr. at least 12 pair of inserts. I have mailed a pair of sneakers to fit the inserts to.” At right, a pair of inserts provided.

RETURN TO: BOSTON BOOT MAKERS, INC. 55 WINTHROP ST. BOSTON, MA 02110 617-314-2140		Commonwealth of Massachusetts DIVISION OF MEDICAL ASSISTANCE REQUEST FOR PAYMENT - MEDICAL SERVICES	
20473 M		1502921	
STATEMENT OF SERVICES			
A	660295	orthopedic shoes L 3649	1 942-

RETURN TO: BOSTON BOOT MAKERS, INC. 55 WINTHROP ST. BOSTON, MA 02110 617-314-2140		Commonwealth of Massachusetts DIVISION OF MEDICAL ASSISTANCE REQUEST FOR PAYMENT - MEDICAL SERVICES	
20473 M		1502921	
STATEMENT OF SERVICES			
A	660296	orthopedic shoes L 3649	1 942-

RETURN TO: BOSTON BOOT MAKERS, INC. 55 WINTHROP ST. BOSTON, MA 02110 617-314-2140		Commonwealth of Massachusetts DIVISION OF MEDICAL ASSISTANCE REQUEST FOR PAYMENT - MEDICAL SERVICES	
11-1978		1502921	
STATEMENT OF SERVICES			
A	660296	orthopedic shoes L 3649	1 942-

Three invoices for orthopedic shoes never provided to recipient.

Interview with the physician who prescribed the shoes for the son of a company director

Investigators reviewed the case file with the physician that prescribed orthopedic shoes for the son of a director of BBM. The physician explained in the interview that he examined the son's feet but, "didn't see anything wrong with them." According to the now-retired physician, the father (the company director and incorporator) pressured the physician for prescriptions year after year, telling the physician that his son had been diagnosed with semi-clubfeet. The physician told this Office that he never visibly saw anything wrong with his patient's feet, but his feet "could have been corrected before I saw him." The physician explained that he went along with the father's directions. According to the physician, the father "pressured me." This Office observed that the medical necessity forms accompanying some prescriptions had apparently been filled out in the handwriting of the recipient's father, the company director. The physician told this office that it was not his writing on the form, but that it was his signature. According to the physician, the father coached him on how to fill out the forms. The physician explained, "I felt compassion for his son, but I feel that I was taken advantage of."

When told that the son had been wearing Reebok shoes when he met with staff of this Office, the physician said that if the son is wearing Reeboks now, "it indicates that he doesn't need orthopedic shoes." The physician explained that when the patient came to see him, he wore conservative, standard shoes, not the fancy ones in the photographs. The record shows the physician never prescribed custom shoes for his patient. Instead he consistently prescribed ordinary orthopedic shoes, with the left shoe one-half ($\frac{1}{2}$) inch higher than the right. The physician said that he intended for his patient to receive off-the-shelf orthopedic shoes, as indicated by his prescriptions. According to DMA regulations, BBM was not allowed to provide custom hand-made shoes based upon the prescriptions as written by the physician. The physician did not write prescriptions for any other BBM patients aside from the son of the company

director. This Office asked the physician to comment on a number of issues as follows:

- The number of shoes that were provided, and the total cost to the State Medicaid Program (15 pairs of shoes totaling \$13,300):

The doctor said, *"My God! I am amazed! I am shocked at the costs! I wasn't aware of the costs."*

- Whether the doctor ever examined the son's feet:

The doctor said that he examined his feet, *"but I didn't see anything wrong with them"*. He said that if his patient had clubfeet, they could have been corrected before he saw him. The doctor said, *"I never saw anything wrong with his feet visibly."*

- The finding that the cousin was wearing Reebok shoes on June 23, 1999, and that he had walked five miles that morning:

The doctor indicated that he was aware that his patient took long walks, but if he was wearing Reeboks now, it indicates that he doesn't need orthopedic shoes. *"He should have been seen by an orthopedic surgeon or a podiatrist."*

- The photographs of the shoes provided by BBM:

The doctor indicated that he had no idea that each year his patient was getting highly fashionable shoes instead of the orthopedic shoes that he thought he was prescribing for his patient. He said, *"These are stylish shoes. There was no way that I intended to prescribe a wide array of stylish shoes for him! Obviously, he doesn't need all of these shoes."* The doctor stated that he saw his patient come in wearing only conservative, standard shoes. He indicated that if he had known otherwise, he would have declined the father's requests.

- The medical necessity of the shoes:

"Who am I to determine the medical necessity of shoes? I am not a podiatrist!" The doctor explained that almost every year the father would come in and tell the doctor that his son needed a prescription for a new pair of shoes. The doctor asked, *"How was I to know what he was doing? I just went along with the father's direction. I would blithely write the prescriptions on the father's advice."*

- The issuance of typewritten prescriptions and statements of medical necessity:

The doctor explained that the father would assist his secretary in filling out the forms, but the doctor would always sign them. He explained that he never would have signed a blank form and that all the signatures on those forms were his.

- The “Fred Astaire” shoes:

The doctor verified that the signature on the prescription was in fact his own, but said, *“it is terrible that there is no date on it!”* The doctor explained that it is against his principles to send out a prescription without a date on it and that there was a slip up on his part. He indicated that he never had any intention of prescribing those shoes and that his patient never mentioned them to him. *“How could they be worth that much?”* he asked.

- The appropriateness of the sandals that were provided on 5/29/91:

The doctor explained that he did not intend to provide his patient with a pair of sandals. He said that he thought he was prescribing a pair of regular orthopedic shoes for his patient.

- The appropriateness of the “mountain shoes” that were provided on 8/25/92:

The doctor stated that there was no way that he intended to order mountain shoes for his patient. He indicated that he thought he was prescribing plain orthopedic shoes, and that he expected orthopedic shoes. He said, *“If I had any idea that he was enhancing his wardrobe I would not have written the prescription. I am really shocked!”*

- The appropriateness of the white boat shoes that were photographed:

The doctor explained that he prescribed standard orthopedic shoes for his patient, not boat shoes. He stated that he didn’t think he was prescribing anything like that (referring to the photo of the shoe). He stated that he thought he was prescribing something like a standard, orthopedic shoe with a contour insert.

- The appropriateness of the boots that were provided on 10/14/94:

The doctor said, *“This is shocking.”* He explained that if he had realized he was taking part in this, he would have reported it. *“I wish someone had,”* he said.

- The substitution of inserts for orthopedic shoes on 6/26/95 and 1/3/96:

The doctor commented that he did not specify boots. *"I specified orthopedic shoes. That's what I thought I was ordering,"* he said.

- The statement of medical necessity for the service date of 6/26/95:

The doctor stated that his patient's father typed out the statement of medical necessity and that he took it at face value and signed it. He explained that someone else wrote the date on the form. *"I should not have signed an undated form,"* he said.

- The undated statement of medical necessity for the service date of 1/3/96:

The doctor said that the father had *"put a lot of pressure"* on him. *"I should not have signed the undated forms."*

- Whether ready-made or custom molded shoes would have been more appropriate:

The doctor indicated that a ready-made orthopedic shoe with an insert would have sufficed, *"like a depth-inlay shoe from P.W. Minor, Inc., but not a custom molded shoe."*

- Whether he knew that the father was associated with BBM:

The doctor explained that the father had told him that he worked for a shoe company.

- His summation:

The doctor indicated that he was shocked and dismayed that his patient was using these prescriptions to get various high-style shoes instead of the standard orthopedic shoes that he thought he was prescribing for his patient. *"I had no idea he was doing this. If I had known I would have declined the father's requests. I felt compassion for his son, but I feel that I was taken advantage of,"* he said.

Finding 2. BBM made stylish shoes that were inappropriate and medically unnecessary

DMA regulations require Medicaid providers to furnish or prescribe services to recipients only under the following conditions:

- It is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the recipient that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and
- There is no comparable medical service or site of service available or suitable for the recipient requesting the service that is more conservative or less costly. Medical services shall be of a quality that meets professionally recognized standards of health care, and shall be substantiated by records including evidence of such medical necessity and quality.

We found many cases in which BBM's products did not conform to the prescriptions written by the referring physicians, but, instead accommodated the stylish whims of the recipients that BBM allowed to design the shoes. In many cases BBM provided seasonal shoes (boots for the winter, sandals for the summer), shoes for special occasions, and even pumps when the prescription specified extra depth, extra wide orthopedic shoes. BBM commonly ignored prescriptions for custom molded shoes and ordinary, ready-made orthopedic shoes that BBM did not offer. Rather, BBM substituted its own products. An example is presented on the following page.

Aktueller Pumps
aus hochwertigem
Synthetik, gefuttert,
50 mm überzogener
Absatz, Synthetiksohle

Weiterhin lieferbar:
Art. 82066 Farbe: weiß
Art. 82040 Farbe: rosé
Art. 82058 Farbe:
schwarz-lack



Art. 82031
Farbe: bleu
Gr. 35, 38,
37, 38, 39, 40, 41

225.-

*High Shine
einfach,
Hoch. 110 mm
Hoch. 110 mm
Hoch. 110 mm
Hoch. 110 mm*

225 art. 82031

R

Extra Depth Shoe

ORDER NO. 19136 B LAST. NO. 2232
STYLE pump (copy picture)
LEATHER red COLOR white

Work order said “copy picture.”

The referring physician said that the pumps were completely out of compliance with the prescription, and were absolutely inappropriate for the patient, a 72-year old female, 5' 0" tall, 160 pounds, diagnosed with bunions, hammer toes and HDV deformity. He stated,

"She never told me she got those shoes. I never saw them. I never would have ordered them. She wore very stylish clothes."

Finding 3. While BBM told DMA officials that it was the state's only provider of hand-made customized footwear, DMA was actually buying handcrafted custom-made shoes from other manufacturers at far less cost to the taxpayers

In its dealings with DMA, BBM claimed that it was the state's only supplier of hand-made customized footwear. For example, in a letter to a DMA official in December of 1994, the owner of the company said: "To the best of my knowledge, BBM is the sole Medicaid provider of wholly hand-made footwear."

- In fact, we are the only company providing this service in the Commonwealth at this time;
- Although other forms of orthopedic footwear are provided by other suppliers, ours is the only product which is wholly customized;
- Since our work is specifically designed to serve handicapped clients, we necessarily service many Medicaid recipients.

However, this office found that many other manufacturers of handcrafted custom-made shoes have been filling orders for Medicaid patients for years. In fact, during fiscal years 1996 to 1998, while DMA was buying approximately 300 pairs of shoes per year from BBM, it was simultaneously buying more than 400 pairs of custom shoes per year handcrafted by other manufacturers. Physicians

commonly prescribe custom-made orthopedic shoes for patients with severe foot deformities who cannot be accommodated by ready-made orthopedic shoes. But while DMA was paying BBM \$900 to \$1000 for a pair of its custom-made shoes, DMA was restricting other providers to a rate of payment of only \$250.00 per pair that was in effect from January 1, 1992 until December 31, 1996, and \$257.50 thereafter. The disparity between these rates belies the excellent quality of the custom shoes made by other manufacturers. Unlike BBM, which fabricates its shoes on a customized wooden last, the other manufacturers handcraft their custom shoes on an exact replica of the recipient's foot. In this process, the provider first makes a cast of the recipient's foot, generally in plaster of Paris or fiberglass. The provider then sends the cast to the shoe manufacturer, who fills the cast (a "negative model of the foot") with plaster of Paris. The cast hardens into a "positive model of the recipient's foot," an exact three-dimensional replica revealing every anatomical detail. Finally, the manufacturer fabricates the shoe on the positive model. This type of shoe is commonly referred to as a "custom molded shoe." The process takes the guesswork out of shoe making, and ensures an exact fit for the recipient.

The owner of BBM told this office that the company did not make custom-molded shoes. This was also indicated in a production description that the owner submitted to DMA on several occasions in this case:

"If in some instances the shoemaker determines that a plaster mold is required to ensure accuracy for the making of the last, this is done during the initial visit. The client's foot is pressed into a dry foam block. A simple plaster mold is later developed by baking wet plaster in the foam impression. This process is used selectively and only as an enhancement to the shoemaker's precise measurements, since a plaster mold is not interchangeable with a wooden last in the process of building a shoe by hand."

"The 'last' is the essential tool of customized shoe making. It is a foot shaped block of wood, which is honed by hand to evolve into the exact duplicate of an individual foot. The shoemaker starts with a standard size and shape and then grinds it down in some areas and builds it up in others. This intricate process of honing and

building corresponds exactly to the measurements noted during the client's initial visit. All idiosyncratic aspects of a client's foot are accounted for and duplicated."

However, this was apparently a process of trial and error that often required adjustments before the shoes fit comfortably, as evidenced by recipient complaints that were recorded on some of the work orders that this office reviewed. Moreover, this problem was also cited in the production description that the owner submitted to DMA:

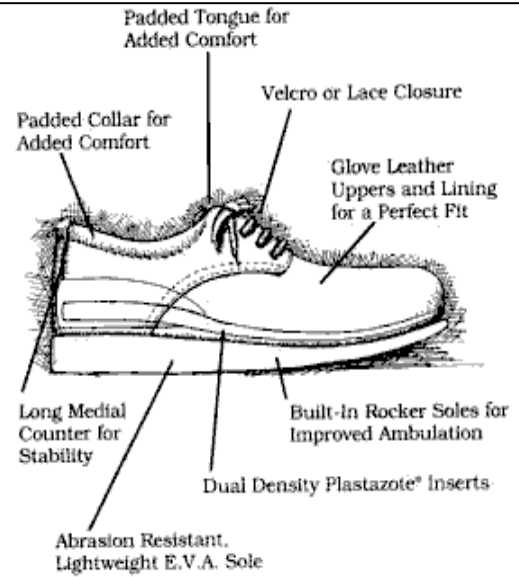
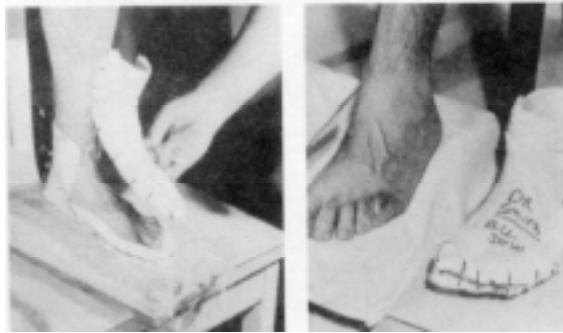
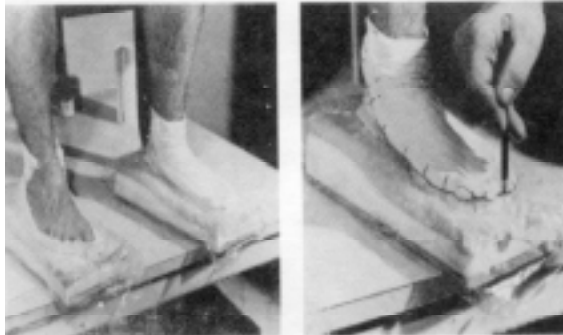
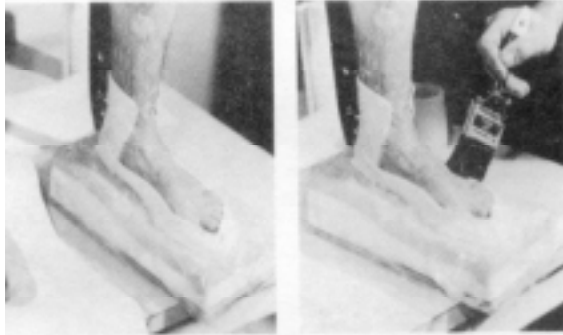
"The nature of our product demands patience. Alterations are often required before a shoe feels absolutely comfortable to the client. This can be a time and labor intensive process. We do not charge for adjustments and alterations, which are a natural part of the customizing of the fit of a shoe. It has sometimes occurred that we have completely remade shoes for some clients, doubling our own costs. We have not passed on those costs to the client or the insurer."

Notwithstanding this claim, DMA was paying BBM 3.7 times the rate it was allowing other manufacturers of custom shoes, an extravagance the state could ill afford. Moreover, the state of the art-technology and quality that is reflected in custom molded handcrafted shoes should have made them the only choice for DMA. High-tech manufacturers of custom-made shoes told this Office that they can and do routinely fit Medicaid recipients with foot problems into custom-molded orthopedic shoes. DMA's orthopedic footwear suppliers who regularly purchased these hand-made custom shoes said likewise. The product brochure for one of these companies states, for example:

"Our products fit your feet perfectly, because they are made from an exact plaster or fiberglass replica of your foot. Your custom shoes are built around this plaster 'cast.' Every external anatomical detail is revealed on this three-dimensional footprint. From this we are able to make a total contact shoe that takes into account all the contours and bio-mechanical aspects of your feet. Not only the precise foot length and width. But any profile as well, including arches, ankles, heels and toes. Plus any imperfections, like bony prominences, pressure points, sensitive areas and other conditions unique to your feet."

The two manufacturing processes and examples of shoes from BBM and other manufacturers are illustrated on the following page.

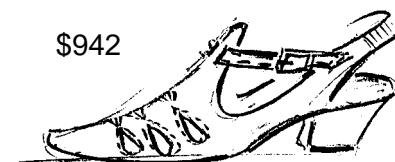
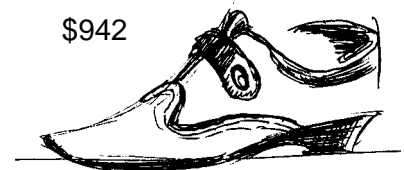
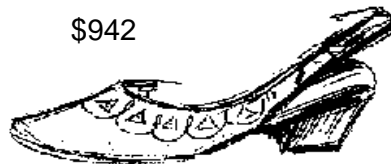
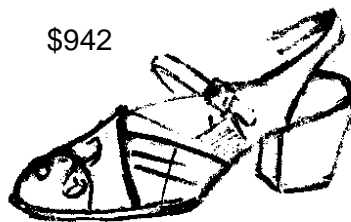
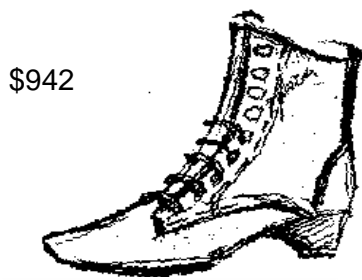
Medicaid's paid 720 claims per year --at far less cost-- for custom-molded shoes for recipients residing outside of BBM's finite geographical area. BBM's recipients should have received these kinds of shoes, or even less expensive ready-made shoes.



Medicaid billing code: L3230
Orthopedic footwear,
custom shoes, depth inlay.
\$257.50



Examples of custom shoes that BBM provided to patients who had prescriptions or orders for custom shoes. BBM and DMA should have referred these patients to other orthopedic footwear companies offering hand-made, custom-molded shoes at far less cost.



Examples of hand-made custom-molded shoes and boots that Medicaid purchased from other orthopedic footwear providers (approximately 720 claims per year).



\$257.50



\$257.50



\$257.50



\$257.50



\$257.50



\$257.50



\$257.50



\$257.50

Although BBM did not sell ready-made orthopedic shoes, it nevertheless provided extravagant, hand-made customized shoes to Medicaid recipients, instead of referring the recipients elsewhere

When physicians prescribed standard or extra-depth orthopedic shoes, without specifying “hand-made shoes,” BBM, which did not sell ready-made shoes, commonly disregarded the prescriptions and provided extravagant, stylized custom shoes and boots instead. Medicaid regulations required the company to refer the recipients to other providers of the less costly ready-made shoes. This Office reviewed all of the claims that BBM submitted during the period from May 1992 through May of 1997, when its new claims protocol was in effect. A significant finding of this investigation is that in only 4.9 percent (4.9%) of 1,216 subsequent claims did BBM comply with the protocol prohibiting the company from billing Medicaid unless a doctor signed two specific documents. The first was a specific order for “hand-made shoes” on his prescription; the second was a Statement of Medical Necessity (SMN) that included the statement: *“Please note that your signature below confirms your understanding that you are ordering a hand-made customized shoe for your patient.”*

This Office’s detailed review of BBM’s claims reveals that in 35 of BBM’s 1,216 claims (2.9%), the physician specified hand-made shoes on the prescription or written order but did not sign a medical necessity statement that included the statement acknowledging that he was ordering hand-made customized shoes⁹. In 654 other claims (53.8%), the physician signed a requisite SMN without specifying “hand-made shoes” on the prescription or written order. In such cases, the physicians’ prescriptions or written order called for something other than hand-made shoes, commonly for far less costly “extra-wide extra-depth

⁹ This Office found that 439 of BBM’s 1,216 claims had Statements of Medical Necessity that BBM had changed to remove the statement: *“Please note that your signature below confirms your understanding that you are ordering a hand-made customized shoe for your patient.”* BBM used these altered forms over a period of three years.

orthopedic shoes.” In the remaining 468 claims (38.5%) the physician prescribed something other than hand-made shoes and did not sign the requisite SMN.

MassPRO, a DMA contractor for compliance audits, conducted a review of BBM for the period of May 1, 1993 through April 30, 1994. MassPro cited BBM in 28 out of 32 cases for providing custom made shoes that were found to be medically unnecessary. In the other four cases, it found that the custom shoes provided by BBM were too expensive.

During the fiscal years of 1996 through 1999, DMA provided more than 2600 pairs of ready-made shoes per year, at rates of payment that ranged from \$100.05 to \$154.50 per pair. The shoes come in a wide range of types, styles and sizes to accommodate recipients requiring either initial therapy, acute care, or critical care of their foot maladies. These shoes incorporate state of the art-technology and quality features, and are appropriate for most recipients. The components of a ready-made shoe by a leading manufacturer are illustrated on following page.

Examples of custom shoes that BBM provided to patients who did not have prescriptions for custom shoes. BBM and DMA should have referred these patients to other orthopedic footwear companies offering non-custom shoes. Less than 5% of BBM's Medicaid clients had prescriptions for custom shoes.



Examples of non-custom shoes from other orthopedic companies, provided to patients who had prescriptions for non-custom orthopedic shoes. Medicaid pays for more than 2,600 pairs of non-custom shoes annually.



Finding 4. According to testimony of the prescribing physicians, BBM provided many inappropriate shoes to Medicaid recipients

BBM patterned each pair of shoes from a unique design that its craftsmen sketched for each Medicaid recipient. To verify that the company provided appropriate orthopedic shoes as prescribed, this Office reviewed many design sketches with the referring physicians, some of which are exhibited in the examples below. The exhibits are computer-scanned and rendered copies of actual sketches from the files of BBM. The records indicate that the exhibited shoes and boots were fabricated with kid leather, regular counters, and steel shanks. Other specifications are noted under each exhibit.



Case #1: Recipient receives leather-lined black open-back shoes.

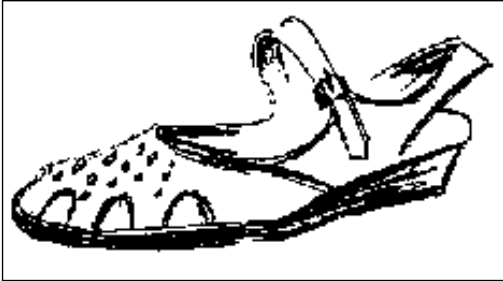
Cost to the taxpayers: \$942.

The referring physician prescribed one pair of orthopedic shoes with a wide toe box, a deep heel cup, and a metatarsal pad to accommodate osteoarthritis, metatarsalgia, and bilateral hallux valgus.

The records indicate that BBM fabricated this shoe with vibram out-soles and 1¼" heels. The referring physician said, "it is evidently clear that the shoes did not conform to the prescription. But I cannot determine whether the patient needs orthopedic, depth, or custom hand made shoes. I am not a shoemaker! That is the responsibility of the orthotist."

Case #2: Recipient receives leather-lined open-back summer shoes.

Cost to the taxpayers: \$942.

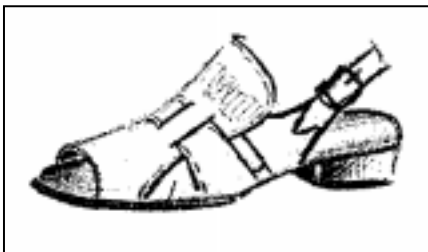


The referring physician prescribed a custom-made molded shoe with a wide toe box, wool lining, and a metatarsal pad to accommodate severe osteoarthritis, hallux valgus, and a severe hammertoe.

The records indicate that BBM fabricated these shoes with cushion-crepe out-soles, and $\frac{3}{4}$ " wedge heels. It is evidently clear that the wool lining was not provided. The referring physician had the same comments on these shoes as the ones exhibited in Case #1.

Case #3: Recipient receives leather-lined open toe and heel sandals.

Cost to the taxpayers: \$942.



The referring physician prescribed extra-wide, extra-deep orthopedic shoes to accommodate bunions and edema.

The records indicate that BBM fabricated these sandals with vibram out-soles and $\frac{3}{4}$ " heels. The referring physician said: "I prescribed extra wide, extra depth orthopedic shoes for the patient, not sandals."

Case # 4 Recipient receives leather-lined open toe and heel shoes.



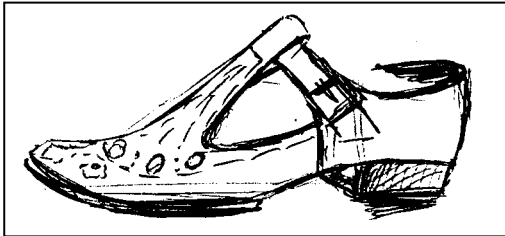
Cost to taxpayers: \$942.

The referring physician prescribed extra wide, extra depth custom shoes with extra cushioning to accommodate hallux valgus, hammertoes, and rheumatoid arthritis.

The records indicate that BBM fabricated this shoe with cushion crepe out-soles and $\frac{3}{4}$ " wedge heels. The referring physician would only say (with a grin) that the shoes looked more like sandals than the extra wide, extra depth shoes that were prescribed. This Office got a second opinion of this case from a board certified doctor of podiatry who is also a Fellow in the American College of Foot and Ankle Surgeons (FACAS). The doctor said that the prescription was appropriate for the condition of the patient, but the substitution of sandals for the prescribed shoes "was a joke".

Case # 5: Recipient receives leather-lined instep strap shoes.

Cost to the taxpayers: \$942.



The referring physician prescribed customized shoes for capillary artery disease and hallux valgus of the right foot.

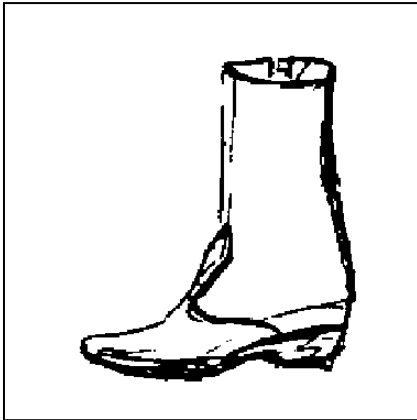
The records indicate that BBM fabricated these shoes with vibram out-soles and 1" heels. In a period of less than six months, the company provided this recipient with three pairs of instep strap shoes, the first of which was on a prescription from another doctor. In summary, the company provided this recipient with five pairs of instep strap shoes, three pairs of boots, and a pair of loafers between December 1992 and February 1997 for a total cost to the taxpayers of \$8,512.

Reflecting on the collection of shoes and boots that the recipient obtained, the referring physician muttered: "He used me. He made a fool of me. I am not a shoemaker. I don't know anything about making shoes. I rely on the shoemaker to provide appropriate shoes. I never saw the shoes he was getting." Finally, noting that the recipient had obtained three prescriptions for shoes from another doctor, he said: "DMA should require the recipients to select a primary care physician for better monitoring and control over their health care. All requests for

orthopedic shoes should be referred to orthopedic specialists, who would then prescribe the appropriate shoes.”

Case # 6: Recipient receives leather-lined 11” zipper boots.

Cost to the taxpayers: \$976.



The referring physician prescribed a pair of extra wide orthopedic shoes for a painful bunion on the right foot.

The records indicate that BBM fabricated these boots with cushion crepe wedge out-soles and 1 1/2 inch wedge heels.

MassPro, which audited this claim, found that custom-made shoes did not appear to be necessary in this case.

The referring physician argued that the prescription took precedence over the pro forma statement of medical necessity that was established specifically for BBM (notwithstanding its advisory statement that the doctor was ordering a hand-made customized shoe for the patient). Continuing this argument, the physician stated that the prescription did not specify custom-made shoes, steel shanks, or wedge heels, none of which was medically necessary. The physician also questioned the provider’s statement on the claim form that the recipient had a “deformity of both feet”, since only one foot had a bunion on it.

This Office continued to review the following four cases with this physician, who reiterated in each case that the prescription took precedence over the pro forma statement of medical necessity for shoes from BBM.

Case # 7: Recipient receives wool-lined 11" zipper boots.

Cost to the taxpayers: \$942.



The referring physician prescribed a pair of extra wide, extra deep orthopedic shoes for bunions and hammertoes.

The records indicate that BBM fabricated these boots with cushion crepe wedge out-soles and 1" wedge heels.

MassPro, which audited this claim, found that custom made shoes were not required, and that the patient could have been managed with standard orthopedic shoes.

The referring physician said that the prescription did not specify custom-made shoes. In addition, the physician said that the wedges and the steel shanks were not prescribed, and were not medically necessary. The physician agreed with MassPro's finding.

Case # 8: Recipient receives wool-lined 14" zipper boots.

Cost to the taxpayers: \$942.



The referring physician prescribed a pair of extra wide, extra deep orthopedic shoes for bilateral bunions and hammertoes.

The records indicate that BBM fabricated these boots with cushion crepe wedge out-soles, and 1" wedge heels.

MassPro, which audited this claim, found that custom made shoes were not required, and that the patient could have been managed with standard orthopedic shoes.

The referring physician said that the prescription did not specify custom-made shoes. In addition, the physician noted that the wedges and the steel shanks were not prescribed, and said that they were not medically necessary. The physician agreed with MassPro's finding.

Case # 9: Recipient receives leather-lined 12" zipper boots.

Cost to the taxpayers: \$942.



The referring physician prescribed a pair of orthopedic shoes with a built in medial arch support and a rocker bottom sole to accommodate hallux rigidus, a bunion, and pes planus.

The records indicate that BBM fabricated these boots with cushion crepe wedge out-soles, and 1" wedge heels.

MassPro, which audited this claim, found that custom-made shoes were not required for this recipient.

The referring physician said that the prescription specified neither custom-made shoes nor wedge heels. In addition, the physician said that a ready-made shoe could have been modified with medial arch supports and rocker bottom soles. Finally, the physician noted that the boots were not fitted with the prescribed rocker bottom soles, and said that they were inappropriate for the patient.

Case # 10: Recipient receives leather-lined instep strap shoes.

Cost to the taxpayers: \$976.



The referring physician prescribed a pair of orthopedic shoes with metatarsal bars, and rocker bottom soles to accommodate metatarsalgia.

The records indicate that BBM fabricated these shoes with cushion crepe wedge out-soles, and a 1½" wedge heel.

MassPro, which audited this claim, stated that: "metatarsalgia is rarely, if ever, treated with custom-made shoes."

The referring physician said that the prescription did not specify custom-made shoes. In addition, the physician noted that there was no indication in the records that the shoes had been fitted with the prescribed metatarsal bars and rocker bottoms, and said that they were therefore inappropriate for the patient.

Medicaid paid far less for orthopedic shoes for the same Medicaid recipients after BBM withdrew from Medicaid

Investigators of this Office visited the homes of several Medicaid recipients who received shoes from BBM and, subsequently, received orthopedic shoes from other orthopedic footwear providers after DMA removed BBM from the Medicaid program. Two sets of examples appear on the following page.



BEFORE

Medicaid paid \$964 for these custom shoes from BBM.



AFTER

Same recipient received these orthopedic shoes from another provider after DMA removed BBM from Medicaid. Cost: \$125.66.

The pair to the left above was made by BBM upon a prescription for “orthopedic shoes.” Medicaid paid \$964 for these shoes. The recipient told investigators that she liked the appearance of the shoes and found them to be very comfortable and functional. DMA purchased the pair to the above-right above for same recipient from another orthopedic shoe provider after BBM was removed from the Medicaid program. Medicaid paid \$125.66 for the shoes. The recipient described them as being very comfortable and functional, but not as attractive as the previous shoes.



BEFORE

Medicaid paid \$934 for these custom shoes from BBM.



AFTER

Same recipient received these orthopedic shoes from another provider after DMA removed BBM from Medicaid. Medicaid rate: \$125.66.

This pair above-left on the previous page was made by BBM for another recipient upon a prescription for “orthopedic shoes.” Medicaid paid \$934 for these shoes. The second recipient told investigators that she liked the appearance of the shoes and found them to be very comfortable and functional.

DMA purchased this pair above-right for the same recipient from another orthopedic shoe provider after BBM was removed from the Medicaid program. Medicaid paid \$125.66 for the shoes. The recipient described them to be very comfortable.

When BBM’s customers changed orthopedic providers, DMA saved an average of \$808 per pair

This Office tracked what happened to BBM’s recipients after BBM left the Medicaid program. DMA claim’s records show that when they took their prescriptions to other orthopedic footwear providers, the patients saved an average of \$808 per pair of shoes, a reduction from \$953 for shoes from BBM to \$145 for shoes from subsequent orthopedic footwear providers. This Office identified 146 instances where former BBM Medicaid customers received shoes from other Medicaid providers after BBM withdrew from the Medicaid program. Typically, BBM’s customers This Office interviewed several of these recipients. The following examples illustrate the history of several BBM’s clients, demonstrating how great the savings were to the Medicaid program after BBM left the program.

Customer #1:

08/01/90	Boston Boot Makers	Custom hand-made footwear	\$904
02/01/91	Boston Boot Makers	Custom hand-made footwear	\$963
12/30/91	Boston Boot Makers	Custom hand-made footwear	\$993
05/22/92	Boston Boot Makers	Custom hand-made footwear	\$993
11/13/92	Boston Boot Makers	Custom hand-made footwear	\$993
05/14/93	Boston Boot Makers	Custom hand-made footwear	\$993
11/26/93	Boston Boot Makers	Custom hand-made footwear	\$993

05/25/94	Boston Boot Makers	Custom hand-made footwear	\$993
11/18/94	Boston Boot Makers	Custom hand-made footwear	\$993
01/17/95	Boston Boot Makers	Custom hand-made footwear	\$993
07/11/95	Boston Boot Makers	Custom hand-made footwear	\$993
02/13/96	Boston Boot Makers	Custom hand-made footwear	\$993
08/20/96	Boston Boot Makers	Custom hand-made footwear	\$993
04/01/97	Boston Boot Makers	Custom hand-made footwear	\$993
07/24/97	Company A	Ladies orth. shoes depth inlay	\$129
12/22/98	Company B	Ladies orth. shoes depth inlay	\$100

Comment: This customer received fourteen pairs of hand-made custom footwear from BBM in less than seven years at a cost to Medicaid of \$13,783. Three months after BBM left the Medicaid program, the customer received a pair of ladies depth inlay shoes from a different orthopedic shoe provider for \$129.00; seventeen months later the customer received a second pair from still another different provider, this time for \$100.00.

Customer #2

11/22/91	Boston Boot Makers	Custom hand-made footwear	\$976
06/15/92	Boston Boot Makers	Custom hand-made footwear	\$993
12/11/92	Boston Boot Makers	Custom hand-made footwear	\$993
05/21/93	Boston Boot Makers	Custom hand-made footwear	\$993
11/19/93	Boston Boot Makers	Custom hand-made footwear	\$993
11/11/94	Boston Boot Makers	Custom hand-made footwear	\$993
01/03/95	Boston Boot Makers	Custom hand-made footwear	\$993
07/11/95	Boston Boot Makers	Custom hand-made footwear	\$993
02/13/96	Boston Boot Makers	Custom hand-made footwear	\$993
08/20/96	Boston Boot Makers	Custom hand-made footwear	\$993
04/01/97	Boston Boot Makers	Custom hand-made footwear	\$993

07/24/97 Company A	Men's orth. shoes depth inlay	\$184
01/26/99 Company B	Men's orth. shoes depth inlay	\$ 68

Customer #3:

12/31/87 Boston Boot Makers	Custom hand-made footwear	\$856
06/06/88 Boston Boot Makers	Custom hand-made footwear	\$812
05/31/89 Boston Boot Makers	Custom hand-made footwear	\$886
05/10/90 Boston Boot Makers	Custom hand-made footwear	\$887
10/02/90 Boston Boot Makers	Custom hand-made footwear	\$887
05/17/91 Boston Boot Makers	Custom hand-made footwear	\$921
01/24/92 Boston Boot Makers	Custom hand-made footwear	\$942
12/23/92 Boston Boot Makers	Custom hand-made footwear	\$942
06/04/93 Boston Boot Makers	Custom hand-made footwear	\$942
10/27/93 Boston Boot Makers	Custom hand-made footwear	\$942
05/13/94 Boston Boot Makers	Custom hand-made footwear	\$942
12/09/94 Boston Boot Makers	Custom hand-made footwear	\$942
02/07/95 Boston Boot Makers	Custom hand-made footwear	\$942
07/01/95 Boston Boot Makers	Custom hand-made footwear	\$942
02/13/96 Boston Boot Makers	Custom hand-made footwear	\$942
12/24/96 Boston Boot Makers	Custom hand-made footwear	\$942
05/01/97 Company A	Men's odd-size depth shoes	\$182

Finding 5. DMA administrators ignored DMA's own anti-fraud compliance staff who tried for many years to end the waste of taxpayers' money by BBM

As previously described in this report, DMA first identified the practice patterns and trends of BBM in February 1989, when its SURS unit reported its findings of a desk review of the company's billings for calendar year 1988. The SURS unit continued to monitor the company throughout 1990. During this time DMA also

initiated a study for a federally mandated conversion to the Health Care Financing Administration's Common Procedure Coding System (HCPCS codes).

The Program Manager for Durable Medical Equipment who conducted this study proposed two specific codes for custom shoes, which were approved by DMA and the Division of Health Care Finance and Policy. The new codes were implemented on April 1, 1991, and DMA suspended payment for services provided on or after February 4, 1991 that were billed under the prior coding system. As a result, payment was suspended for a significant number of BBM claims.

Around the same time, March 1991, DMA completed a review of BBM billings for the three-year period ended 12/31/90, and was fully aware of its practice patterns and trends. By this time, it had developed sufficient evidence to either curtail BBM or suspend it from the program pending the completion of a full-scale investigation. In May 1991, BBM appealed directly to the Assistant Commissioner for Program Policy for payment of the suspended claims. Instead of suspending BBM from the program pending the completion of an investigation, he provided BBM with a new HCPCS code for unlisted procedures (Code 3649) in June 1991, and allowed it to continue in the program without any curtailments. This failure ultimately cost the state nearly \$1.2 million in overpayments during the following six years.

After a lapse of nine months, DMA conducted a field audit of BBM February 1992. By then, DMA was aware that BBM was:

- a) rapidly growing its Medicaid business from a concentration of elderly Russian immigrants in Allston, Brighton, and Brookline;
- b) taking most of its referrals from several physicians who had also immigrated to this country from Russia;
- c) providing an excessive number of shoes to these recipients, some of whom received three pairs within a year;
- d) providing seasonal and stylish shoes to its recipients;

- e) providing shoes to many married couples from among this group;
- f) providing shoes to a relative of one of the owners of the business;
- g) using the same diagnosis and service description on its claim forms, i.e.; “deformity of both feet, one pair of specially made orthopedic shoes”; and,
- h) inflating its charges for direct labor hourly charges to cover its overhead expenses. (*note*: inferred from a job cost analysis that was provided by BBM during the on-site review in February of 1992.)

In the on-site review of February 1992, DMA's Review and Quality Assurance Unit cited a consultation with a podiatrist regarding the appropriateness of hand made shoes. He advised that \$800 was a realistic cost for custom crafted shoes, but “very few people should require this type of product, and one pair should suffice for two years.” The Review and Quality Assurance Unit recommended that the payment rate for hand made shoes be restricted, that payments for excessive labor charges be recovered, and that “custom crafted shoes” be discontinued as a Medicaid service. Consequently, on February 27, 1992, it notified BBM that henceforth the company was restricted to the effective payment rates for custom and custom molded shoes. Notwithstanding the March 2, 1992 BBM appeal, the unit also recommended to the Assistant Commissioner for Program Policy on March 16, 1992, that DMA discontinue the provision of custom-made shoes by BBM.

Finding 6. DMA accommodated BBM in response to a State Senator's intervention in 1992 by establishing a new “protocol” for BBM.

In April 1992, at the request of BBM's owner, the State Senator who represented BBM's legislative district arranged a meeting between BBM's owner, the Senator, and two DMA officials to address BBM's complaints that DMA had effectively removed the company from the Medicaid program by enforcing the new pricing codes. As a result of that meeting, DMA arranged a series of follow-up meetings with BBM's owner. During these meetings, BBM submitted a job cost estimate

which reflected an exorbitant direct labor cost. The estimate included \$600 for direct labor, or 30 man-hours at \$20 per hour. Despite its earlier findings that BBM's labor charges were probably inflated to cover their overhead costs, DMA accepted this estimate without verifying it. DMA waived its payment restrictions, abandoned its plans to recover prior overpayments, and instead allowed BBM to resume costing out their direct labor hour charges with the effective labor rate for repairs (which was \$44 per hour at the time).

In return for this arrangement, BBM agreed to abide by a new protocol for referrals and claims that she developed jointly with the DMA Program Manager for Durable Medical Equipment. The protocol required, among other things, that the referring physician specifically order hand-made shoes on the prescription, and also sign a pro forma statement of medical necessity for the hand made shoes. It also required the owner to personally screen all recipients to confirm the medical necessity for hand-made shoes, and to refer them to providers of ready-made or custom-molded shoes if appropriate. Under the agreement, DMA would suspend all claims for individually consideration prior to payment. Nevertheless, as described further in Finding 8, DMA failed to hire a certified orthotist to review the medical necessity of the claims, as recommended by the Program Manager of Durable Medical Equipment, and otherwise failed to manage the protocol with due diligence and necessary diligence.

Finding 7. Despite claims of its owner to the contrary, BBM did not comply with the referral and claims protocol that it established jointly with DMA

The DMA protocol was established in May 1992 and continued in effect until BBM was terminated in May 1997. During that period, BBM submitted a total of 1216 claims for orthopedic shoes totaling \$1,179,253. This Office's investigation of the claims showed that less than five percent (5%) or 59 claims totaling \$57,294 were in full compliance with the protocol. Furthermore, thirty-six percent (36%) or 439 statements of medical necessity for claims totaling \$426,882 were

altered, i.e.; the caveat concerning the hand made shoes was deleted from the pro forma statement.

It is also evident from our review of these claims that after the protocol was established, BBM continued the improper practice patterns and trends that were first detected by DMA's SURS staff in 1989. BBM continued to ignore the regulations regarding medical necessity, appropriateness, and cost of service. Instead, BBM provided stylish, seasonal, extravagant shoes that were unnecessary to the program.

Finding 8. DMA failed to exercise due professional care and necessary diligence.

DMA failed to exercise due professional care and necessary diligence at crucial points in this case, specifically as follows:

- A. In November of 1983, when DMA accepted BBM into the Medicaid program, it did not adequately assess the need for BBM's shoes. Otherwise, it would have determined that there were many factory-made alternatives available at far less cost. To compound this error, DMA also failed to establish a fair rate of payment for BBM's shoes when it accepted it into the program;
- B. DMA administrators could and should have dismissed BBM's erroneous claim that it was the state's only supplier for Medicaid recipients who needed hand-made shoes. DMA administrators ignored the obvious fact that DMA's own Durable Medical Equipment Division was purchasing more than 400 pairs per year of state-of-the-art hand-made custom-molded shoes from other orthopedic footwear providers at the same time DMA was buying Boston Boot Maker's shoes. These shoes served the rest of DMA's recipients statewide. BBM's argument should have been rejected out of hand considering that almost all of its customers came from a small geographical area and no comparable need for BBM's product

was demonstrated anywhere else in the Commonwealth. DMA's compliance staff recognized the fallacy of the argument in 1989 when a staff person rejected the idea that nearly 100 percent of the state-wide need for this product could come from such a concentrated area;

C. DMA did not require BBM to employ a certified orthotist, neither in 1983 when BBM's owner first applied, nor subsequent to his death in 1989, when his daughter succeeded him in ownership of the company;

D. DMA should have employed a qualified auditor no later than May 1991 to examine the financial records and reports of BBM, in order to verify BBM's production costs. That audit would have confirmed the fact that BBM was inflating the direct labor hours it was charging in order to cover its overhead costs. The findings would have provided sufficient evidence for expelling BBM from the program, and pursuing the recovery of prior overpayments for direct labor charges. Having failed to execute that plan of action, DMA should have employed a qualified auditor for the following other crucial points in the case:

- 1) during DMA's determination of the rate it would pay for BBM's products in 1991;
- 2) during the on-site review of February 1992;
- 3) in May 1992, when BBM submitted its job cost estimate;
- 4) in November 1994, when DMA initiated the MassPro audit;
- 5) in January 1996, when it began to examine the material and supply invoices of BBM; and
- 6) in May 1996, when BBM submitted a revised job cost estimate;

E. DMA's protocol required BBM to submit of the statement of medical necessity with its claims. DMA should have also required BBM to submit

the prescription form. This exception prevented a comprehensive review by DMA to determine the medical necessity of the services provided;

- F. DMA did not officially sanction the protocol, neither by a letter of confirmation to BBM, nor by promulgating it in the provider manual. As a result, DMA never officially notified the affected physicians in the Medicaid program that BBM's hand-made shoes were to be prescribed only as a last resort because of their expense. Instead, DMA shifted this responsibility to BBM, requiring the company to notify its referring physicians about the requisites of the protocol;
- G. Records reviewed by this Office show that DMA's Director for Ambulatory Programs (now an Assistant Commissioner of DMA) appeased members of DMA's compliance staff at that time by telling them that DMA would be tightening the regulations in the area of prescriptions for orthopedic footwear. In addition, DMA's Director of Ambulatory Programs told the frustrated compliance staff that while the unlisted procedure code (L3649) still existed, these services would now be reviewed and priced by the Program Manager for Durable Medical Equipment. Subsequently, however, DMA officials did not amend DMA's regulations in the area of prescriptions for orthopedic footwear. In fact, DMA did not finally do so until more than six years later, in August of 1998, pursuant to this Office's investigation;
- H. Despite the recommendations of the Program Manager for Durable Medical Equipment, DMA did not employ a certified orthotist when the newly established protocol was implemented to review the claims for the medical necessity of the services provided. As a result, many highly questionable claims were cleared for payment without appropriate review;
- I. DMA did not adequately plan the objectives, scope, and methodology of the audits conducted by its staff, nor by MassPro. As a result, there was no reasonable assurance that the audits would detect the full extent of the

suspected fraud, waste, and abuse in this case. For example, the methodology consisted of reviewing only a small random sample of BBM's claims, which did not provide sufficient evidence to determine the magnitude of the loss to the Medicaid program or the extent of potential recoveries. Moreover, the auditors did not confirm the medical necessity and appropriateness of the shoes with the referring physicians and the recipients. In addition, the extrapolative method of calculating overpayments significantly understated the magnitude of the loss to the state by limiting it to the audit period, which was only one year.

Furthermore, records indicate that DMA's SURS staff was aware as early as July 25, 1989 that BBM was providing custom shoes to a recipient "with the same name as the owner of the company." That person was, in fact, the company director's son who had already received by that point in time five pairs of custom shoes through the Medicaid program. He went on to receive ten more pairs after that, including the "Fred Astaire" shoes, at a total cost to Medicaid of \$13,300. Had DMA directed its auditors to look into the particular file that its SURS staff had specifically flagged as being suspect, DMA might have stopped BBM's waste of taxpayers' funds at that point in time. The SURS staff also identified, by 1989, many other questionable billing patterns of BBM, such as frequent services being provided to individuals and married couples. Instead of directing its auditors to examine the applicable suspicious recipient files identified by DMA SURS staff, DMA relied on an audit of a few randomly selected claims; and,

- J. DMA apparently failed to seek reimbursement from Medicare for BBM recipients with diabetic conditions that qualified them for depth shoes, custom-molded shoes, and shoe inserts under the Medicare Program. Congress amended the Medicare statutes to provide that coverage, which became effective on May 1, 1993, for qualifying Medicare Part B patients. This Office requested DMA to provide a list of all recoveries from the

Medicare Program for BBM's patients whose records indicate a diagnosis of diabetes, but DMA failed to respond to that request.

Finding 9. DMA's failure to refer this and other possible fraud cases to MFCU early enough to make a difference: a chronic problem

DMA did not keep MFCU adequately informed of developments in the case on a timely basis. In 1989, DMA officials waived off MFCU investigators, in effect, by telling them: 1) that DMA was aware of BBM's billing practices; 2) that DMA was reviewing each claim individually; and, 3) that BBM's billing method made it easier for DMA payment staff. In 1989, DMA told MFCU that a year earlier the Governor had requested that MFCU establish an expedited payment system for BBM. DMA failed to inform MFCU investigators of the well-documented concerns of its SURS staff about BBM's pattern of highly questionable billings. Nor did DMA inform MFCU of subsequent findings and recommendations of its SURS staff during the following years.

DMA settled this case without advising MFCU or involving MFCU in any way in the proceedings. DMA waived its claim to overpayments that were due from BBM, paid BBM \$83,356 in previously suspended claims, and released and forever discharged BBM from any and all claims, demands, causes of action, liabilities and suits of every kind, then existing or thereafter arising in connection with the case. As a result of its failure to inform MFCU, DMA hindered a potential civil or criminal prosecution by MFCU, and may have adversely affected the Commonwealth's ability to recover millions in overpayments from BBM.

This Office's investigation learned that DMA was reluctant in this and similar cases to make referrals to MFCU early enough in the process to facilitate effective fraud investigations by the independent agency. According to MFCU administrators, DMA has commonly attempted to resolve such matters without informing MFCU, by attempting to negotiate a financial settlement with providers independently. According to MFCU administrators, DMA often refers cases to

MFCU for investigation of fraud only after DMA has attempted to negotiate and the provider has refused to settle, or to settle at a dollar amount satisfactory to DMA. Such referrals, usually made by DMA to MFCU after the Medicaid provider is fully aware of the government's suspicions, inherently limit MFCU's investigative and prosecutorial functions.

DMA's hesitancy to refer cases to MFCU apparently relates in part to its desire to avoid adverse publicity. DMA officials reportedly chafed in 1995 when news reports described MFCU's successful prosecution of a mental health professional who fraudulently billed DMA for more than twenty-four hours of services per day over an extended period of time. This case gained publicity as an example of egregious Medicaid fraud, and was highlighted in a widely read reference book, Medicare and Medicaid Fraud and Abuse, published by the West Group. This Office finds that DMA should do much more to create an institutional environment where its staff utilizes MFCU as a partner and ally in fraud detection, prevention, and prosecution.

According to BBM's attorney, DMA officials settled the BBM controversy to avoid adverse publicity. BBM's attorney recounted in a letter to DMA on April 3, 1997 that DMA's attorney, not BBM, originally suggested a settlement, reportedly because DMA officials did not want to respond to BBM's public document request and thereby make information about the case public. In the letter to DMA's Assistant General Counsel, BBM's attorney wrote,

[DMA's Assistant General Counsel] subsequently called and indicated that the public records requested by Boston Boot Makers contained information that DMA would rather not make public, inasmuch as it might portray the agency in the best light. You suggested that instead of pursuing the implementation of Boston Boot Makers' public records request, DMA and Boston Boot Makers might agree to terminate their dispute, essentially by DMA issuing a Notice of Withdrawal withdrawing the Notice of Violation, and by Boston Boot Makers to cease making shoes for DMA recipients.

Finding 10. Deficiencies in the administrative regulations left the system vulnerable to fraud, waste, and abuse.

DMA's administrative regulations pertaining to orthopedic footwear benefits include only a general definition of medical necessity that is not supplemented by specific regulations that would impose effective, practical restrictions on the provision of orthopedic footwear benefits. For example, according to the regulations (130 CMR 450.204), a service is medically necessary if:

- it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the recipient that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and,
- there is no comparable medical service or site of service available or suitable for the recipient requesting the service that is more conservative or less costly. Medical services shall be of a quality that meets professionally recognized standards of health care, and shall be substantiated by records including evidence of such medical necessity and quality.

Many physicians told this Office that the orthopedic footwear medical necessity standards are so loose that they felt obliged to prescribe shoes whenever a patient complained of foot pain of any kind, even when there was no observable foot ailment or deformity. Furthermore, until August of 1998, DMA did not limit the number of shoes that could be provided without prior authorization. These deficiencies not only made the system vulnerable to fraud, waste, and abuse, but they created incentives for it.

Finding 11. BBM, recipients, and physicians exploited the weaknesses of the administrative regulations.

Demanding recipients, accommodating doctors, an enterprising provider, and the bureaucracy of DMA all combined to overwhelm the weaknesses in the Medicaid billing system. Physicians commonly wrote prescriptions for shoes without verifying the receipt and appropriateness of the shoes. This Office found

evidence of many prescriptions and statements of medical necessity that were unsigned and undated. In fact, some were photocopies of previously issued forms. In one case, this Office found that the doctor's secretary had issued many of the unsigned or undated prescriptions and statements of medical necessity. Instead of referring Medicaid recipients elsewhere, BBM encouraged and facilitated their patronage by adding several Russian interpreters to its staff to accommodate them.

Finding 12. The investigation disclosed irregularities in the financial records and tax returns of BBM.

In 1991 and 1992 BBM submitted job cost estimates to DMA that reflected an estimated direct labor cost of \$600 to produce a pair of hand-made shoes (30 man-hours at \$20 per hour). This estimate was used by DMA in establishing a rate of payment specifically for BBM. In order to verify that estimate, this Office examined the company's billings, Quarterly Federal Tax Returns, (Form 941), the U.S. Corporate Short Form Income Tax Return (Form 1120a), and the supporting work papers for the year ended December 31, 1996. This Office found that DMA paid BBM for 302 pairs of shoes and boots that the company provided to Medicaid recipients in 1996. These payments included approximately \$218,044 for direct labor charges or \$722 for each pair of shoes. However, this Office found that the company reported only \$74,193 for direct labor expenses on its federal tax returns for 1996, a disparity of \$143,851. After questioning the owner of BBM, this Office concluded that she apparently made misrepresentations to DMA concerning the company's labor expenses. DMA officials told this Office that they relied in good faith upon BBM's representations about its labor expenses and upon its assertions that the company complied in full with the so-called 1992 protocol. However, this Office found that the company failed to comply with the 1992 protocol more than 95 percent of the time. DMA's Deputy General Counsel suggested that if BBM officials knowingly made false statements, the Commonwealth could potentially seek recovery by claiming that BBM had committed fraud in the inducement. This Office found that BBM later

included a revised job cost estimate in its Petition and Reply to DMA's Notice of Overpayment in 1997. The revised estimate showed an increase in direct labor costs to \$800 per pair of shoes (40 man-hours at \$20 per hour). In addition, the evidence also indicates that BBM understated its wages and other expenses on its federal tax returns for 1995 through 1997, and misrepresented its statements of income and financial condition that are an integral part of those returns. These findings have been referred to the Department of the Attorney General. In light of these considerations, this Office recommends that a full audit of all relevant accounts be conducted by appropriate governmental agencies.

In a related matter, this Office observed that BBM failed to reduce its labor and material charges to Medicaid in instances when the company reused customized wooden lasts that DMA had already paid BBM to fabricate. This Office observed that BBM sometimes reused lasts when it provided subsequent pairs of shoes to the same recipient. In instances where no further modifications to the original last were required, BBM would have incurred no cost for fabrication or modification of a last. In instances where BBM modified a last that had previously been customized to the patient's foot, BBM would have incurred less expense than for original fabrication of a last. However, BBM submitted the direct labor charges at a constant rate throughout this case.

This Office also found that BBM did not comply with the sliding scale of allowable markups to the adjusted acquisition cost of materials, as specified in 130 CMR 442.422 (B) as follows:

- 1) 70% for any item whose adjusted acquisition cost is less than \$100;
- 2) 50% for any item whose adjusted acquisition cost is \$100 or greater and less than \$200;
- 3) 45% for any item whose adjusted acquisition cost is \$200 or greater and less than \$300;
- 4) 40% for any item whose adjusted acquisition cost is \$300 or higher.

The adjusted acquisition cost is defined in 130 CMR 442.402 as follows:

Except where the manufacturer is the provider, (the adjusted acquisition cost) is the price paid by the provider to the manufacturer or any other supplier for orthotic or pedorthic devices, customized equipment, or supplies, excluding all associated costs such as shipping, handling, and insurance costs in accordance with 130 CMR 442.421. Where the manufacturer is the provider, the adjusted acquisition cost is the actual cost of manufacturing such orthotic or pedorthic devices, customized equipment, or supplies.

This Office found that BBM always applied a 70 percent (70%) markup to its adjusted acquisition cost even though it commonly charged between \$100 and \$120 for direct materials for each pair of shoes. In such instances, the company should have charged only a 50 percent (50%) mark up rate to those costs, not 70 percent (70%). The evidence indicates that DMA never denied payment for these violations even though the mark up exceeded the maximum allowed by regulations, but instead paid the claims in full.

Summary of conclusions and recommendations

It is evident that no justification existed for BBM's hand-made shoes in the Medicaid program, since Medicaid recipients had ready access to many appropriate alternatives available at far less cost. In the future, all custom shoes should be billed under HCPCS codes L3230 or other established codes as appropriate.

It is also evident from the BBM-related findings that a combination of unrelenting demand for hand-made shoes, a circle of accommodating doctors, an enterprising provider, lax controls, and the bureaucracy of DMA resulted in the exploitation of the program for nearly \$2 million. DMA's senior management failed to respond effectively to the persistent early warnings of its staff, particularly the SURS analysts, the nurse reviewers, and their supervisors. It failed to establish the safeguards proposed by the Program Manager for Durable Medical Equipment. It failed, also, to establish and maintain a closer working relationship with MFCU. DMA failed to safeguard the public interest when it settled this case with BBM without consulting MFCU beforehand.

It is also evident that DMA must tighten its regulations pertaining to the medical necessity for orthopedic footwear and ancillary services in order to place effective, reasonable limits on the provision of these benefits.

Finally, this Office recommends that MFCU take all necessary steps to recover public funds improperly paid to BBM, to the greatest extent possible given the prior settlement by DMA and BBM. But most importantly, in order to prevent losses of this magnitude from occurring again, DMA administrators must tighten the management controls of the agency to ensure that the Medicaid program is administered in accordance with the objectives established by the Governor and the state legislature.

Boston Boot Makers, Inc. - Chronology with Analysis

1983. BBM entered the Medicaid Program

On July 26, 1983, BBM applied for approval to become a provider of orthopedic shoes to Medicaid recipients upon physician prescription. DMA approved the application in November 1983. Initially, DMA's payments were based on prior approval by DMA of all claims. This process remained in effect until October 1, 1985 when DMA allowed all orthopedic shoe providers to bill Medicaid without prior approval. BBM's claims in 1983, 1984, 1985 and 1986 were \$5,353, \$23,002, \$46,073 and \$54,023, respectively.

1987 and 1988. BBM's Medicaid claims began to grow when a surge of Russian immigrants from Allston/Brighton and Brookline began to seek hand-made boots and shoes

In 1987 and 1988, records show, BBM's Medicaid business began to grow rapidly. BBM's claims grew from \$54,023 in 1986 to \$173,218 in 1988. Its growth in Medicaid business during this period came almost exclusively from Medicaid recipients residing in a few neighborhoods of the Allston/Brighton area of Boston, and from nearby neighborhoods of Brookline. BBM's Medicaid claims more than tripled from 1986 to 1988, after word spread among certain recipients that hand-made shoes were available from the Medicaid program. During this time period, BBM's Medicaid business from outside of the Allston/Brighton and Brookline area actually declined. Ninety percent (90%) of the new recipients were eligible for Medicaid under the Immigration and Nationality Act (INA), almost all of who were of Russian nationality. Many of these recipients also qualified for Medicare. The median age of this group was approximately seventy-two years, and most of them obtained their health care from Russian born and trained physicians who also immigrated to this country.

1988. The Governor requested timely payments for BBM. DMA's Associate Commissioner for Medicaid Payments made special arrangements to intercept BBM's claims and pay BBM by courier

In early 1988, BBM's owner complained to the Governor's Office about delayed payments by DMA to BBM on its Medicaid claims. In response, DMA's Associate Commissioner for Medicaid payments wrote a letter to BBM's owner on March 9, 1988. The letter explained that the Governor had referred the owner's complaint to the Associate Commissioner about recent untimely payments by DMA to BBM. The Associate Commissioner notified the owner of the immediate release of \$14,000, with the pledge that the claims staff would thereafter intercept BBM's claims by hand from the Medicaid payment process, review them in advance, and deliver payment to the owner's place of business by courier once a week.

1988 – 1989. DMA investigators knew about the BBM problem as far back as 1988, but DMA higher-ups ignored staff recommendations to put a stop to it

DMA's front-line auditors recognized BBM's improper practices beginning in 1988, and doggedly tried to stop them until they finally succeeded in 1997. The investigation shows that DMA's internal fraud-detection system performed effectively, at least to the extent that it enabled DMA's internal investigators to identify accurately a pattern of waste and fraud concerning BBM. Unfortunately, line staff's repeated efforts did not translate into action by their superiors.

In a memorandum dated February 14, 1989, a SURS Analyst and his supervisor notified the SURS Manager of the results of a preliminary review they had conducted of BBM's claims during the previous year. The memorandum stated, "In calendar year 1988, Boston Boot Makers provided services to 180 Medicaid recipients. There were 207 claims paid for a total of \$165,298.00." The memorandum alluded to problems that the analysts believed were implied in the claims data:

- the majority of the provider claims were for recipients living in "Region 05" which is the Brighton/Brookline area;

- many of the recipients' addresses appeared more than once, and also that 55% were living at only six addresses;
- all of these recipients were over the age of 60 years of age;
- 18 of the recipients were couples with the same name and address;
- the orthotics for the couples were billed on the same day;
- ten of the recipients had two or more orthotic devices during that particular calendar year.

In a second memorandum, dated April 11, 1989, the SURS Analyst cited further questions about BBM's claims that included the following:

- of the recipients living in Region 05, almost all of them appear to be Russian immigrants;
- they appear to live in the same neighborhood since most of the street addresses are the same;
- none of them are in nursing homes.

In the April 11, 1989 memo, the SURS Analyst recommended as follows:

“...that some type of limitation be placed on this procedure code. A prior approval requirement would probably be best considering the high cost for the pair of orthotic shoes. Another suggestion would be to require orthotic providers to get a referral from a physician or podiatrist before providing services in order to insure that the services are medically necessary. There should also be a limitation on the number of orthotic shoes that a recipient can receive within a certain time period.”

This Office's investigation found that DMA did not institute the recommendations of the SURS Analyst after she submitted them. DMA never implemented the recommendation of the SURS Analyst regarding establishment of a prior approval process. Not until August 1, 1998, did DMA institute a two-pair per year limit on orthopedic shoes. This limit was implemented following discussions with this Office during the conduct of this Office's investigation.

On July 25, 1989, a Nurse Reviewer wrote to her supervisor about BBM. She expressed concern that:

“The [claims examiner] receives the 9 form and the P.O.P. form from Unisys. He checks to be sure that the \$ on both forms agree and he sends it through for payment! These dollars are filled in by the provider. We do not have a consultant review this code. The \$ amount is never questioned, nor is medical necessity or utilization.”

“There appears to be no prescription requirements or service limitations. We are paying \$850 per pair of orthopedic shoes for a diagnosis of ‘deformity of both feet.’ Several recipients are receiving multiple pairs of shoes per year. We have even paid for shoes for a recipient by the name of the owner of company. Manufacturing costs claimed on the P.O.P. forms are obviously inflated.”

In another memorandum, dated August 14, 1989, the same Nurse Reviewer advised the Supervisor of Medicaid Audits:

“...this process has proven to be nothing more than a blanket approval by a clerk with no clinical training.”

The Nurse Reviewer went on to state in the memorandum that she had spoken with “our podiatry consultant” who believed the following:

- the shoes in question being billed by the provider are not orthotics and therefore should not be billed as such;
- the price of the shoes are only realistic if the custom-made shoes is cast to the recipient’s feet; and
- very few people should ever need this service.

The Nurse Reviewer then concluded her memorandum, stating, “We need to determine that the provider type identified ‘Orthotics’ is accurate for Boston Boot Makers. If we are to hold the provider accountable to the Orthotic Regulations, we need to update the regulations ASAP to include prescription requirements and service limitations”.

1989. MFCU institutes an independent Investigation of BBM's Medicaid claims. DMA does not inform MFCU of its analysts' suspicions about BBM's billings. DMA instead tells MFCU that it is aware of BBM's billing pattern and expresses no objection

In 1989, MFCU instituted a review of BBM's Medicaid claims. It did so on its own initiative, independent of DMA, after MFCU's claims-tracking staff noticed BBM's high volume of expensive footwear, high cost, geographically concentrated client base and uniform prices charged for different kinds of shoes. MFCU officials reviewed the case notes of the 1989 review with this Office. Records indicate that the MFCU staff visited the homes of a number of recipients to verify that the recipients had in fact received the orthopedic shoes for which Medicaid had paid. The investigators found that the recipients had in fact received shoes made by BBM. MFCU observed that BBM billed DMA the same amount for each pair of shoes, notwithstanding apparent differences in labor and material costs.

MFCU met with DMA staff and asked whether the constant payments were in accordance with DMA's guidelines. According to case notes, a DMA Financial Specialist in the Special Payments Unit told MFCU investigators that in March 1988 a letter had been received from the Governor's office directing timely payment. She said that subsequent to that date, a person in DMA had been assigned to expedite payments by reviewing suspended claims on an individual consideration basis, in advance of their receipt by the department from the Claims Processor. She explained that the Special Claims Unit would have checks pulled early for BBM for special delivery by courier. She explained that DMA claims payment staff was individually reviewing each claim.

The Financial Specialist informed MFCU investigators that DMA's Claims Resolution and Review Department was aware of the manner in which BBM was billing the same numbers in the cost section of the claim form for each pair of shoes. The Financial Specialist told MFCU investigators that she recalled another payment specialist telling BBM's owner that, "you [BBM] billed the same price [on each claim] and that makes it easier for him."

MFCU investigators spoke with officials of BBM, visited BBM's store, and interviewed five orthopedic footwear professionals. As a result, MFCU investigators concluded that although labor costs were high, they did not exceed what was feasible according to industry sources. DMA did not make MFCU investigators aware of the other concerns that had been repeatedly raised by DMA SURS staff in the internal memoranda described previously in this report.¹⁰ After MFCU investigators verified that BBM had in fact made the shoes, that the recipients had the shoes in their possession, and that DMA claims staff considered the payments to be in line with DMA regulations, MFCU investigators terminated the review.

1989. Following the death of BBM's owner, SURS staff expected BBM would close its doors

On November 11, 1989, the owner of BBM died. At that time, the widow of the deceased owner became the new owner of the company. According to interviews with DMA staff, it was a common belief among the DMA SURS Analysts that BBM would soon close its doors, because the new owner was neither a boot-maker nor an orthotist. For the following fourteen months, DMA SURS staff monitored BBM's billing practices but otherwise took no formal action with respect to BBM.

1991. After fourteen months, DMA staff renewed its efforts to curb BBM

On March 14, 1991 the same DMA staff person who had previously raised issues about BBM did so again in a memorandum to his supervisor, noting a continuing high level of billing activity. He stated:

- after completing a desk review it would appear that another investigation on this provider is warranted. There is also the possibility that fraud exists if the provider did provide the orthotic services which were reimbursed;
- the provider has not changed the billing pattern in the last two years;

¹⁰ According to the contemporaneous notes of MFCU investigators in 1989.

- it appears that the patterns have gotten worse;
- a lot of recipients are getting new orthotic boots every 4-6 months;
- one recipient even received five pair in less than 18 months;
- in another example, a mother and her two children all receive a pair of orthotic boots on the same day with the same diagnosis.

The memorandum also suggested that DMA reinstate the prior approval system for these claims to be reinstated back into the regulations.

1991. DMA's Program Manager for Durable Medical Equipment recommends new orthopedic shoe billing code, capping Medicaid payment for non-prosthetic custom shoes at \$200.00 per pair. Division of Health Care Finance and Policy adopts recommendations

In the winter of 1990/1991, DMA's Program Manager for Durable Medical Equipment initiated a plan that she estimated would result in significant cost savings in Medicaid expenditures for orthopedic footwear and modifications. In conjunction with DMA's efforts to reorganize its pricing codes under the federally mandated HCPCS system, the Program Manager for Durable Medical Equipment undertook a review of products and pricing in the orthopedic shoe product area. On the recommendation of DMA's Program Manager for Durable Medical Equipment, the Division of Health Care Finance and Policy adopted eighty-eight (88) HCPCS codes and their corresponding rates of payment for the provision of orthopedic shoes, inserts, modifications, additions, and repairs. The Division of Health Care Finance and Policy instituted these codes on April 1, 1991. Among the resulting changes was the elimination of the code that BBM had been using to bill Medicaid for its custom shoes. Instead, the new codes included two codes for custom shoes, as follows:

L3230 Orthopedic Footwear, custom shoes. Depth inlay. \$200.00

L3250 Orthopedic Footwear, custom molded shoe.

Removable Inner Mold, Prosthetic Shoe. \$177.50

1991. DMA stops payments on BBM's claims following implementation of new custom shoe codes

After the Division of Health Care Finance and Policy adopted the product code and pricing recommendations of DMA's Program Manager for Durable Medical Equipment regarding orthopedic footwear and footwear additions, BBM continued to submit claims using its old rates and forms. Because the old forms were no longer recognized by the claims payment system, DMA's Claims Department rejected all of BBM's claims. By instituting the new custom shoe billing codes, DMA had limited BBM to charging the same amount as other custom shoemakers, \$200.00 to \$355.00 per pair.

1991. After new custom shoe rates went into effect, BBM's president asked DMA's Assistant Commissioner for Program Policy to allow BBM to bill in excess of new custom shoe codes; Assistant Commissioner for Program Policy authorizes BBM to continue charging in excess of \$900 per pair

After the Division of Health Care Finance and Policy approved the new custom shoe billing codes, BBM's owner contacted DMA payment staff and was informed that BBM would be subject to the new codes, including the much lower rates. BBM's owner then contacted the DMA's Assistant Commissioner for Program Policy, seeking his assistance to receive authorization for BBM to continue to bill at BBM's old rate rate. BBM's owner made the argument to the Assistant Commissioner for Program Policy that BBM offered a unique product that fulfilled a unique medical need not satisfied by other orthopedic shoe manufacturers. This Office's investigation has determined that, to the contrary, DMA had been purchasing hand-made custom shoes from other providers at far less cost.

On June 9, 1991, the Assistant Commissioner for Program Policy unilaterally authorized BBM to bill in amounts exceeding the two newly established custom shoe codes. The Assistant Commissioner for Program Policy authorized BBM to use another billing code, "L3649," for "unlisted procedure". He authorized BBM to do so despite the fact that DMA's staff Consultant had determined that, "the shoes in question being billed by the provider are not orthotics and therefore

should not be billed as such” and that, “very few people should ever need this service.” He did so also in spite of the many serious questions that had already previously raised by SURS staff as described earlier, including that:

- almost all of the clients seem to be Russian immigrants;
- 55% were living at only six addresses;
- no DMA consultant was reviewing this code;
- the \$ amount is never questioned;
- medical necessity or utilization is never questioned;
- there appears to be no prescription requirements or service limitations;
- recipients are receiving multiple pairs of shoes per year;
- we have even paid for shoes for a recipient by the name of (same name as owner of company);
- manufacturing costs claimed on the P.O.P. forms are obviously inflated; and,
- this process has proven to be nothing more than a blanket approval by a clerk with no clinical training.

1991. At the direction of the Assistant Commissioner for Program Policy, DMA reviewed BBM’s financial records and expressly approved payment of more than \$900 per pair of shoes

After the Assistant Commissioner for Program Policy agreed to allow BBM to bill in excess of the newly established Medicaid rate for custom shoes, he specifically directed DMA staff to determine how much DMA would allow BBM to charge Medicaid for its footwear. According to BBM’s owner, “it took an enormous amount of work with the people at [DMA] to sort out exactly how BBM should bill for our product.” DMA subsequently established a rate that BBM could charge for its shoes, authorizing a billing method that resulted in the company charging between \$921 and \$1,048 per pair.

The decision of the Assistant Commissioner for Program Policy allowed BBM to continue to bill on an “individual consideration” basis whereby DMA had the right to review and reject payment in advance. DMA payment personnel reviewed BBM’s material, labor and manufacturing costs, including overhead, in order to establish a rate for Boston Boot Makers. DMA regulations provide that DMA determines the rate it will pay for “unlisted procedures” after reviewing the provider’s financial records.

DMA staff reviewed BBM’s most recent annual expenses, as presented by BBM’s owner in May of 1991. DMA subsequently gave BBM approval to bill Medicaid on the following basis for its shoes: nineteen hours of technical labor at \$38.00 per hour; one hour of administrative costs at \$50.00 per hour; and materials on a cost plus sliding-scale mark-up rate established by regulation.

After that, BBM typically charged \$938 per pair of shoes as follows: \$722 for technical labor (19 hours x \$38.00), plus \$50.00 for administration (1 hour x \$50.00), plus \$158.00 for materials (\$90.00 for actual materials plus a 70 percent allowable mark-up rate). BBM’s material charges varied, depending upon the shoe in question, and from 1991 on, BBM’s shoes or boots cost from \$921 to \$1,048. Typically, however, BBM charged the same amount for its shoes, no matter what style, (i.e., it usually charged the same amount whether the shoe was a summer sandal or high top shoe, usually \$942.) In other instances, mostly for boots, BBM added additional material charges.

To set these rates, DMA personnel relied upon guidelines established by the Assistant Commissioner for Program Policy in a transmittal letter dated April 1, 1991, that was sent to all providers of orthotic devices. The letter notified orthopedic footwear providers of amendments to DMA’s Orthotics Manual. The letter stated, “For items that require labor for fabrication and fitting or that require labor to repair, the department will pay the provider an hourly rate for the cost of technical and professional labor in addition to the adjusted acquisition cost plus

mark-up for materials. These hourly rates for labor are established by the Division of Health Care Finance and Policy.”¹¹

Thus, by authorizing BBM to bill for its shoes as “unlisted procedures,” DMA’s Assistant Commissioner for Program Policy allowed BBM to bill Medicaid \$38.00 per hour, plus materials at an adjusted acquisition cost, to make custom shoes, resulting in the \$921 to \$1,048 final sale prices. By doing so, DMA in effect deemed BBM’s entire shoe manufacturing process as the “fabrication of orthotic devices.”

The Program Manager for Durable Medical Equipment had considered the same issues just months before, and came to the opposite conclusion, when she reviewed and set the rate for custom shoes (L3230) sold by the state’s orthopedic shoe providers. The Program Manager for Durable Medical Equipment did not deem the manufacture of such shoes to qualify as “fabrication of orthotic devices.” She knew that DMA had been buying custom-molded shoes from Massachusetts orthopedic shoe providers who routinely made plaster or fiberglass casts of their recipients feet, and sent these positive casts to several state-of-the-art custom shoe manufacturing companies, in New York and elsewhere. These companies in turn made custom-molded, hand-made shoes, fabricated over a plaster or fiberglass model of the recipients foot, in a range of styles and materials. The Program Manager for Durable Medical Equipment established a price for these products at \$200.00 per pair. Likewise, other states set rates for these products between \$178.00 and \$320.00 per pair.

1992. DMA conducts onsite review of BBM

Following the 1991 decision by the Assistant Commissioner for Program Policy to allow BBM to bill under the unlisted procedure code, L3649, staff members continued to track BBM’s billings. In 1992, DMA SURS Reviewers once again identified BBM as being among the top-20 cases of questionable billings as

¹¹ The Massachusetts Rate Setting Commission is the predecessor administrative agency to the Division of Health Care Finance and Policy.

identified by SURS tracking software. Subsequently, two DMA Nurse Reviewers conducted an on-site audit of BBM. In conjunction with a certified orthotist, they reviewed 40 claims for the period of July 1, 1989 through June 30, 1990. They also toured BBM's facility. In a memorandum to her supervisor, dated February 12, 1992, a DMA Nurse Reviewer noted several serious concerns, as follows:

- the review indicated that all claims were billed "orthotic service";
- all services were billed under individual consideration basis (including labor & acquisition costs of materials);
- the diagnosis 'deformity of both feet' and 'one pair of specially made orthopedic shoes' were always the same;
- the consultant determined that custom shoes are not orthotics and should not be billed as such;
- the cost of \$800 is realistic for custom crafted shoes, however, very few people should require this type of product;
- one pair should suffice for two years;
- the Nurse Reviewer also notes that a review was initiated by MFCU because every pair of shoes billed were always the same price;
- Boston Boot Makers, Inc., explained that the Division advised her to bill this way;
- the physician orders were written by 19 different providers; three providers writing the most prescriptions;
- some physicians are writing-up to three prescriptions in a year's time, secondary to seasonal changes. Example: Boots/Winter; Sandals/Summer.

The Nurse Reviewer subsequently met with the Program Manager for Durable Medical Equipment with regard to the BBM matter. The hand-written note in the Nurse Reviewer's files cite a number of recommendations and ideas discussed at their meeting, as follows:

- the provider should be cited for not having a certified orthotist on staff, and DMA should take back all monies paid after the owner passed away;
- the provider should be cited for medical necessity and over-utilization;
- all individual consideration requests should be personally priced;
- other providers usually charge between \$150.00-\$200.00 for custom-made shoes; and,
- the Program Manager for Durable Medical Equipment “believes that they are ‘thieves’ and should do time!”

On February 25, 1992, a DMA Compliance Officer/Analyst wrote a memorandum to three Nurse Reviewers in the Review and Quality Assurance Unit analyzing BBM’s billing for one individual pair of shoes from September 1990 and a “run of numbers” for BBM for FY1991. His comments included the following:

- the office should rely as little as possible on Boston Boot Makers’ FY1991 self-reported “breakdown”;
- this document is so bogus and unofficial, that it’s not even a very good tool with which to trip them up;
- is Boston Boot Makers’ claimed \$28,242.53 cost for leather pre-or post-mark up?;
- using these numbers as a basis for any kind of analysis or settlement could make us look foolish down the road;
- If anything, the POPS Form numbers are even more outrageous;
- these numbers were provided as an official document in order to receive payment from the Department;
- the bottom line is that they’ve given us absolutely nothing to document; i.e., (1) hourly wage for technical component; (2) documentation re: approximately 18 technical hours per pair of shoes; or (3) acquisition cost of leather and other materials before mark-up;
- the cost components of the shoes, and such records, at least covering hourly wage and acquisition cost, should be readily available, and if need be to use the office’s authority to request documents going back to 1988;

- Where they appear to be padding the most is in the area of technical hours. They're probably fudging the number of hours, but that might be hard to prove. But the hourly wage for the technical component as stated on the P.O.P.S. Form is \$38.00 in 1990; and,
- Their questionnaire states that the workday Boston Boot Makers runs eight to ten hours. Even if it were only eight hours a day, the workers would be making 40 hours x \$38.00 = \$1,520.00 per week which would be \$79,040.00 annually. If this seems out of line, then consider what the six laborers would cost per year (6 x \$79,040 = \$474,240).

The DMA Compliance Officer/Analyst ended the memorandum by asking if both state or federal records were available, and recommending that at a minimum the Division should look at the providers' payroll records. He concluded this memorandum by saying:

"If some sort of legitimate verification of rate of pay, as well as records pertaining to acquisition costs of materials, cannot be produced, then why not call all monies paid from February 1991 back (from now) to the limit of the four-year record-keeping statute overpayment."

1992. DMA officially instructs BBM to terminate billings in excess of standard rates

In a letter dated February 27, 1992, the Nurse Reviewer conveyed to BBM's owner the preliminary findings of DMA's internal desk audit. The letter instructed BBM's owner that the company had been using incorrect billing codes.

DMA's letter officially informed BBM that effective immediately it must use the service codes as outlined in the Orthopedic Manual dated February 4, 1991 and found on page 6 through 18, as follows:

L3230 Orthopedic Footwear, custom shoes. Depth inlay. \$200.00

L3250 Orthopedic Footwear, custom molded shoe.

Removable Inner Mold, Prosthetic Shoe. \$177.50

1992. DMA staff recommends complete termination of BBM

Following completion of the internal desk audit, a DMA Nurse Reviewer and Nurse Reviewer Supervisor sent an interoffice memorandum to the Assistant Commissioner for Program Policy recommending complete termination of BBM. Their memorandum stated that DMA had been paying approximately \$900 for custom-made shoes billed as an individual consideration item. They made the following recommendation:

“As this is an optional service, we recommend that the Department discontinue paying for this service. In addition it should be noted other Third Party payers . . . consider foot orthotic or corrective shoes a non-covered service.”

1992. After BBM's owner received DMA's notification to terminate billings in excess of standard rates, she sought help from her State Senator

After DMA staff directed BBM to use the newly established custom shoe billing codes, BBM's owner sought assistance from her State Senator in arranging a meeting with DMA officials to discuss the matter. She did so, according to BBM's president, after “getting nowhere with DMA compliance staff.” According to BBM's owner, she explained to the Senator that BBM provided a unique orthopedic product that was medically necessary in certain circumstances, and that the company could not possibly afford to provide the footwear at the rates allowed by the two new custom shoe billing codes. The State Senator contacted DMA officials to set up a meeting at the State House between DMA and the owner in April 1992.

Shortly thereafter, DMA's Assistant Commissioner for Program Policy directed DMA's Program Manager for Durable Medical Equipment Manager and the Director for Ambulatory Programs to attend a meeting in the Senator's office. The Assistant Commissioner for Program Policy was the same official who approved the company's request to bill using the L3649 billing code at a higher rate ten months earlier. The Director for Ambulatory Programs, one of the two DMA officials who attended the meeting, told this Office that the Senator told

them that Medicaid should make sure that only those who need the service should receive it. The Director for Ambulatory Programs said, however, “. . . *but I would be less than honest if I didn't say I felt some pressure.*” Nothing in the records indicates that DMA informed the Senator about the history of concern and suspicion previously expressed by DMA's SURS staff about BBM's questionable billings.

1992. DMA officials told the owner and Senator that less expensive shoes would cover the need of BBM's recipients 90% or more of the time

Following the State House meeting between DMA officials, the State Senator, and BBM's owner, DMA's Director for Ambulatory Programs met with a SURS Nurse Reviewer to explain the outcome of the meeting. On April 28, 1992, the Nurse Reviewer wrote a hand-written memorandum summarizing what the Director for Ambulatory Programs told her about the State House meeting. The Nurse Reviewer stated that she understood that at the State House meeting, DMA officials had told BBM's owner and the Senator that it was DMA's opinion that HCPCS codes L3230 (\$200.00 per pair) and L3250 (\$177.50 per shoe) would cover the needs of BBM's clients “90 percent or more of the time.” The Nurse Reviewer also wrote,

Therefore, based on advice from the Orthopedic Society, the [Director for Ambulatory Programs] is tightening the regulations in the area of prescriptions for orthopedic footwear, and, in addition, while the I.C. Code (Individual Consideration Code) still existed, these services will now be reviewed and priced by the Program Manager of Durable Medical Equipment. . . . The Assistant Commissioner for Program Policy will communicate this information to us as soon as it is in writing.

According to records provided to this Office by DMA, the Director for Ambulatory Programs did not subsequently take action to tighten DMA's regulations in the area of prescriptions for orthopedic footwear. Not until approximately one year after this Office began its investigation did DMA finally amend its orthopedic footwear regulations in the area of prescriptions for orthopedic footwear, in August 1998.

1992. An official of the Massachusetts Association of Certified Orthotists advises DMA that “ultimately the Department must make a policy decision if they want to purchase hand crafted orthotic shoes or manufactured machine orthotic shoes as a less costly alternative”

On May 18, 1992, the Program Manager for Durable Medical Equipment sent an interoffice memorandum to her superior outlining the specifics of a meeting she had recently held with BBM's owner. She also explained that she had consulted with a professional association about the question of whether BBM's services were valid from the perspective of medical need, as follows:

“I have also consulted with the Mass. Society of Orthotist and Prosthetist to determine the validity of Boston Boot Makers, Inc. services. They suggested that the services and related fee was justified, that there should be a monitoring of medical need and that ultimately the Department must make a policy decision if they want to purchase hand crafted orthotic shoes or manufactured machine orthotic shoes as a less costly alternative.”

The Program Manager for Durable Medical Equipment continued in her May 18, 1992 memorandum to the Director for Ambulatory Programs as follows:

“It is my feeling that Boston Boot Makers, Inc. provides a unique high quality service and with close screening of medically justifying the need for a handmade shoe that will control any over utilization of their product. I do not feel that from a human service perspective that Medicaid clients in need of this specialized service should be denied due to the cost alone.”

The Program Manager for Durable Medical Equipment then concluded the memorandum to the Director for Ambulatory Programs by stating that she planned to schedule another meeting with BBM's owner to “finalize the action of the plan.” She then says she wants to go over the labor costs with BBM and also to meet with the Claims Examiner to check on what will be allowed for reimbursement and what documentation will be necessary for the procedure.

1992. DMA's Program Manager for Durable Medical Equipment and BBM's owner establish a new claims "protocol"

During the weeks following the meeting in the State Senators' office, the Program Manager for Durable Medical Equipment and BBM's owner worked together to fashion a modification to BBM's billing procedure. Essentially, they structured a protocol through which BBM would continue to bill using the billing code authorized by the Assistant Commissioner for Program Policy during the preceding year, at the same hourly rate established during the previous year, with several additional requirements added. These modifications were recorded in two letters from BBM's owner to the Program Manager for Durable Medical Equipment. The first letter was sent on May 13, 1992, and stated:

"Thank you for your kind assistance these past weeks. It has been very helpful for us.

We resumed servicing new orders from Medicaid clients two weeks ago after a six-week hiatus. As I reviewed with you in our telephone conversation yesterday, we have made a sincere effort to monitor the orders for our product on a medical necessity basis. We have refused approximately 20 requests in the past two weeks, some for incomplete prescription information and some for obvious lack of medical necessity. We have accepted shoe orders for the clients most dramatically and severely compromised by foot problems.

Other changes include the following: 1. Medicaid orders are taken only when I am personally on site to monitor the medical necessity and documentation; 2. For additional documentation, a photograph is taken of the feet of all recipients whose orders we accept; 3. An explanatory letter is given to all recipients who are refused. This letter is addressed to the physician whose name is on the prescription. It clearly states that ours is an expensive and hand made product so as to distinguish it from other 'prescription shoes.' Also, it informs the physician of our effort to monitor the volume and nature of claims made to [DMA] for our product.

Although I hope the enclosed documents satisfy your request and do not require too much reworking, I truly appreciate your help. We are a small business and I do not have an administrative staff to assist me in generating reports. I have appreciated your patience.

In our relationship with Medicaid, we continue to operate in good -- faith and full cooperation."

By June 5, 1992, DMA's Program Manager for Durable Medical Equipment and the owner of BBM had finalized a new protocol, as memorialized in this letter from BBM's owner to the Program Manager for Durable Medical Equipment.

"In February of 1992, [a DMA Nurse Reviewer] conducted what was described as a routine audit of our procedures and facility for the Department of Public Welfare. As Medicaid providers of a unique and often misunderstood service, with a history of difficult reimbursement delays from the DPW, we viewed the audit as a welcomed opportunity. [Nurse Reviewer] and her associate photocopied numerous documents and randomly selected records from our files in their entirety, were given a tour of our facility, and were given a detailed walk through of the process of the making of a customized pair of shoes. The astonishing result of this inquiry was a notification received by me on March 2, 1992, from [Nurse Reviewer], instructing us to bill for services under a new service code which was not descriptive of our product and in an inappropriate price range.

At the time of the audit, we had in excess of \$50,000.00 in unremitted claims in the system at DPW. We were on the verge of bankruptcy. Immediately upon receiving the notice from the [Nurse Reviewer], I terminated several employees and interrupted the costly production of all Medicaid orders. This was a desperate effort to insure solvency for my company. This move generated great distress on the part of some severely handicapped Medicaid recipients who began to advocate in their own behalf with various Legislators and with the DPW administration.

As you know, [State Senator] facilitated a meeting at her office in April. It was at that meeting that I was able to meet and speak with you and with your associate, [Assistant Commissioner for Program Policy]. We had what I thought was an excellent and open discussion with the Senator about the nature of our experience as providers, the specifics of our service, and the concerns of the DPW. It was made clear that the DPW had a concern about the volume of Medicaid recipients who had been serviced by our company. The Boston Boot Makers had been in an untenable position, with great numbers of Medicaid recipients demanding service, all with proper documentation and medical prescriptions, straining our limited resources, and with the DPW searching for

ways to reduce or otherwise contain the cost to them of our services.

It is with great appreciation that I acknowledge the two meetings you and I subsequently had in May 1992. After my first meeting with you in early May, we resumed servicing Medicaid recipients. We did so with a new format. We demanded more specific narrative on all prescriptions, with your permission, we instituted our own on site evaluation procedure to insure medical necessity, and we kept photographic documentation of the disabilities of recipients whose orders we accepted. We notified referring physicians of the changes as well.

As you requested, I submitted various documents to your office. These included: a job cost analysis; a detailed description of the production of our product; a draft of an explanatory letter to our referring physicians; and a draft of a 'Statement of Medical Necessity', the final form of which would be filled out by physicians and ultimately be a prerequisite for service provided by our company to Medicaid recipients. During our second meeting, you and I reviewed and edited the documents referred to above.

On May 29, 1992, we formally instituted the new procedure. Enclosed are the two documents in their final form which have been in use since that date; the letter to physicians and the 'Statement of Medical Necessity.' A review of our records indicates that we have reduced services to Medicaid recipients by over 50% since March of 1992.

At the Boston Boot Makers we do not view our product, hand made, customized shoes, as a luxury item. We are dedicated to the mission of providing footwear to those who suffer compromising deformities and disabilities. Our marketing efforts in the private sector reflect this philosophy. It has been consistent throughout our 60-year history. Your recent efforts have been greatly appreciated. They should serve to make our company less vulnerable to misuse by either Medicaid recipients or their physicians. We view the newly instituted monitoring format as a protective of our integrity. We hope it serves the DPW and its mission well.

Again, thank you for your time and your profoundly helpful intervention."

The new protocol allowed BBM to continue to bill in excess of \$900 per pair of shoes using the "unlisted" procedure code under the following conditions: 1) the

owner had to be personally present to verify that the recipient needed special hand-made custom footwear and could not be served by other less-expensive orthopedic footwear providers; 2) the physician's prescription had to include an order specifying "hand-made shoes"; and, 3) the physician had to sign a medical necessity form with the statement: *"Please note that your signature below confirms your understanding that you are ordering a hand-made customized shoe for your patient."*

1992. Program Manager for Durable Medical Equipment memorializes new protocol in second memoranda to her superior

Again, on May 27, 1992, the Program Manager for Durable Medical Equipment sent a second memorandum to the Assistant Commissioner for Program Policy summarizing the final meeting with BBM's owner, explaining in detail the resolution of issues between DMA and BBM. In that memorandum, she stated the following:

- All Medicaid recipients requesting Boston Boot Makers' hand-crafted orthopedic shoes will be screened to determine if their needs could be met through a less costly manufactured orthopedic shoe;
- Due to their unique service any shoes provided to Medicaid recipients by Boston Boot Makers will require the completion of a certificate of medical necessity by the recipients' physician. This will be attached to Claim 9;
- Boston Boot Makers will also keep on file a Polaroid picture of the recipients malformed body member and the orthotic shoe(s) that were fabricated for them;
- Boston Boot Makers will be also submit a line item cost report for materials and labor, and this will be attached to the Claim 9; and,
- Boston Boot Makers will continue to use the unlisted code for orthotics and with the implementation of the new coding system will break out the labor charge with the new 'labor code'.

The Program Manager for Durable Medical Equipment concluded this memorandum by stating the following:

“Boot Makers have been cooperative with the Department in resolving the over utilization of their services by Medicaid recipients. It is my feeling that with the above protocol in place for reimbursement these services will not be abused. I will be working with [Claim's Examiner] to facilitate this process.”

1992. DMA never promulgated any system-wide program policy announcement or made any public statement regarding the BBM protocol. Instead, DMA officials recorded the terms of the protocol only in internal memoranda

This Office noted that DMA never made any official announcement of any kind to other Medicaid orthopedic footwear providers aside from BBM, including physicians, about the new protocol. Internal DMA memoranda recorded the terms of the protocol, but DMA did not publish any change to its orthopedic footwear policy in the Medicaid Provider Manuals that it distributes system wide to all providers. The only external signals that the protocol existed were the letters that BBM was required to send to its prescribing physicians. Records show that DMA's Program Manager for Durable Medical Equipment expressly agreed to the exact wording of those letters, and that she provided copies of it and related materials to her DMA supervisors. That letter stated,

“As a result of recent collaboration with [DMA], we have developed a protocol to monitor the medical necessity for our product and to expedite reimbursement for Medicaid recipients.”

The letter recounted the terms of the protocol, including the requirements of a prescription with a specific order for hand-made shoes and a signed statement of medical necessity.

Later, during the MassPro audit, DMA officials advised its auditors that they could cite BBM for improperly billing with the L3649 “unlisted procedure code.” This is the same code that DMA authorized BBM to use under the new protocol, with the aforementioned restrictions. In a letter to MassPro's Special Projects Manager on November 22, 1996, DMA's Program Manager for Provider Reviews wrote:

“Boston Boot Makers has not submitted anything in writing from the division that L3649 was the only code they were instructed to use.”

BBM has argued strenuously throughout the course of this controversy that DMA officials established a protocol in 1992, and then cynically instructed its auditors during the MassPro audit to act as if it never existed. In an interview with this Office, DMA’s Internal Control Fraud Manager said, “No consideration was given to the prior agreement” during the MassPro audit. This Office concludes that the aforementioned November 22, 1996 statement by a DMA official to MassPro did not accurately represent what DMA and BBM had agreed upon in 1992. Internal DMA records clearly show that the protocol was established expressly to pertain to BBM’s use of “the unlisted procedure code” (L3649). While BBM could have billed DMA using the less expensive billing codes L3230 and L3250, the essence of what transpired between DMA and BBM in 1992 was that DMA allowed BBM to use the “unlisted procedure code” so long as it complied with the terms of the protocol. Therefore, it is easy to understand why BBM officials reacted as they did to DMA’s denial of the applicability of the protocol during the MassPro audit.

However, this Office’s investigation does not exonerate BBM in this regard, either. As previously described in this report, this Office concludes that BBM failed to comply with the protocol in almost every one of the 1,216 claims it submitted to DMA after the protocol was established in 1992. The protocol required a prescription specifically ordering hand-made shoes and a statement of medical necessity signed by the physician. This Office’s investigation shows that BBM complied with these two provisions of the protocol in only 4.9 percent (4.9%) of subsequent claims. The protocol also required BBM’s president to be present for all claims in order to refer recipients elsewhere when their needs could be serviced at less cost by other orthopedic footwear providers. BBM’s president told this Office that her busy schedule prevented her from being on the premises on a regular basis. Most importantly, this Office’s investigation shows that BBM did not comply with the protocol because the company provided pumps, mountain shoes, dancing shoes, stylized boots and a host of fashion-

oriented shoes that contradicted the expressed orders of physicians in many cases.

DMA informed BBM after the MassPro audit that DMA intended to enforce its regulations as written, notwithstanding BBM's arguments about applicability of the protocol, because DMA regulations have the force of law and because the protocol was not intended to supercede BBM's responsibility to provide the least costly or more conservative service to a recipient. Neither DMA nor MassPro officials were aware at the time of the audit or subsequent settlement negotiations that BBM had failed to comply with the protocol in almost every instance after its establishment.

1992. Program Manager for Durable Medical Equipment recommended that DMA hire independent orthotist to review BBM's claims. Recommendation not followed

Following the conclusion of negotiations with BBM over the new protocol, the Program Manager for Durable Medical Equipment solicited the services of an orthopedic consultant to review claims on a per diem basis. She submitted a *curriculum vitae* for each of two certified orthotists to her superior, recommending that DMA hire either one of the two experts to individually review orthopedic claims to determine medical necessity. Her recommendation was rejected.

1992. DMA compliance watchdogs send protest memorandum against new protocol

DMA's compliance staff assigned to the case were so frustrated by their superiors' decision to allow BBM to continue in the program under the new protocol that they drafted a memorandum to DMA's Compliance Officer on June 24, 1992 protesting the decision. The memorandum noted their strong objection, as follows:

- we were not included in any of these meetings, nor were we notified of any changes that were being made, which, incidentally, were in direct opposition to our findings and recommendations;

- the recipients are being given a choice between an expensive product and a less costly alternative;
- we question the medical necessity of custom crafted shoes for the substantial number of recipients that Boston Boot Makers services;
- of particular concern is the fact that Boston Boot Makers Medicaid clientele represents nothing like a demographically varied population of medically needy Massachusetts recipients, but rather an extremely finite group of recipients and referring physicians;
- since when do we allow the provider to determine and drive the approval process?;
- this provider should be dealt with at a level and a manner that precludes the providers promotion of her self-interest at the expense of Medicaid programs designed to meet legitimate medical needs;
- since when do we practice the unquestioned acceptance of the providers cost analysis without any independent verification?

1992. Immediately following establishment of new protocol, BBM's claims declined temporarily

Records show that in the three months after establishment of the new protocol, BBM's claims dropped to less than half of the dollar volume of the same three month period a year earlier. Between June 1 and August 31, 1992, in the three months after the new protocol went into effect, BBM provided \$24,285 in footwear to Medicaid clients, less that half the amount it had provided during the same period a year earlier, June 1 and August 31, 1991: \$50,750. BBM's claims, however, began to grow again shortly thereafter. By June, 1993, BBM was providing footwear at a faster pace than it ever had before, \$26,105 in that month alone.

1992. BBM's owner says that she was aware of "misuse" of BBM's services by either recipients or physicians in 1992

BBM's owner directly acknowledged her awareness of "misuse" of BBM's services by either recipients or physicians after establishment of the new protocol. In the September 15, 1997 story that first disclosed the BBM matter,

the *Boston Globe* reported that BBM's observed "a surge of Russian customers about a decade ago." She said that she "discussed her concerns about fraud with Medicaid staffers at that time, and said the idea of creating more detailed forms was rooted in her own observations of possible fraud." According to the owner, even after DMA began to require the medical necessity form in 1992, customers who did not appear to have foot problems continued to show up at her store with signed prescriptions and medical necessity forms. According to the owner, BBM submitted copies of the signed forms, but DMA failed to adequately screen the claims and do what it was supposed to prevent unwarranted claims from being paid.

1993. Following adoption of new protocol by Department higher-ups, DMA watchdogs close BBM program review

On May 21, 1993, a memo was sent to the Program Manager for Durable Medical Equipment from a Nurse Reviewer concerning the protocol with BBM. The Nurse Reviewer stated that she is aware that the Program Manager for Durable Medical Equipment is monitoring the services billed to the Department by the provider. The memorandum stated, in part, as follows:

"...and that a plan of action developed between your department and Boston Boot Makers, Inc. is in place. A computer update of this provider shows monies paid by the Department for the prior year, and year to date has declined. Accordingly, this case will be closed in Program Review."

1993. SURS review again identifies BBM as among the top 20 questionable providers. SURS staff recommends audit

In November 1993, DMA's SURS staff once again cited BBM as being among the most questionable providers according to their internal tracking data. They recommended that DMA conduct a field audit of BBM. Not until a full year later, however, did DMA initiate an audit, through MassPro.

1994. Program Manager for Durable Medical Equipment leaves DMA employment

In November of 1994, DMA's Program Manager for Durable Medical Equipment left DMA's employment. DMA's Program Manager for Durable Medical Equipment was the official who had attended the meeting with the Senator, along with the Assistant Commissioner for Program Policy, at the behest of the Assistant Commissioner for Program Policy. She subsequently helped to formulate the new protocol, at the behest of the Assistant Commissioner for Program Policy, that allowed BBM to continue to bill using the same "unlisted procedure code" that the Assistant Commissioner for Program Policy had unilaterally authorized BBM to use ten months earlier, with new restrictions.

1994-95. A DMA Nurse Reviewer initiates a new audit of BBM, and begins to work with MassPro, the Contract Auditor, and a Consulting Orthotist

On November 18, 1994, a full year after SURS staff recommended that DMA conduct a full audit of BBM's transactions, the Nurse Reviewer for the Program Review Unit sent a letter is sent to BBM's owner notifying the proprietor of an upcoming review of her Medicaid transactions during the previous one-year period. The review was required by both federal and state laws, and requesting her cooperation:

"You will be receiving notification from MassPRO regarding a request for documentation, which may include (health care records, itemized bills, purchase invoices, etc.) for a sample of Medicaid recipients. This request will include either an on-site review of this documentation or a mail-in review of photocopies of your records for these recipients."

On December 12, 1994, MassPro's Manager of Special Projects received a letter from BBM's owner concerning the announced audit of BBM. She acknowledged a letter sent to her by DMA concerning the review and states she is happy to cooperate. BBM's owner stated in that letter the following:

- to the best of my knowledge, the Boston Boot Makers, Inc. is the sole Medicaid provider of wholly hand made footwear;

- in fact, we are the only company providing this service in the Commonwealth at this time;
- although other forms of orthopedic footwear are provided by other suppliers, ours is the only product which is wholly customized;
- since our work is specifically designed to serve handicapped clients, we necessarily service many Medicaid recipients.

On June 19, 1995, the Nurse Reviewer sent a short memo sent to MassPRO stating, “We feel that these services could have been provided at a more conservative or substantially less costly way.” The memorandum also pointed out the following:

- There is no medical necessity for orthopedic shoes in many cases;
- There is no need for “custom” shoes in almost all cases;
- Service rendered is not the one ordered by the script when there is a script.

1996. Preliminary results of MassPro Audit of BBM: non-compliance with Medicaid regulations in 100 percent of BBM’s audited claims

On March 7, 1996, MassPro’s Manager of Special Projects sent a memorandum to DMA’s Manager of Program Reviews explaining, “They are providing custom made shoes/boots, yet frequently only orthopedic shoes were ordered or requested (or required).” The memorandum also states that an orthotic consultant working on the case stated that, “he felt three claims for custom made shoes were medically necessary, however, the cost is excessive.” Also, she noted that the orthotist, “felt it is inappropriate to not have a Certified Orthotist or Prosthetist administering services; although they claim to have a physician prescription for all services, it is not always kept in the record; in their ‘description of procedures’ they indicate impression for molds are taken, yet this was rarely done; pictures were provided – the lasts that were shown appear to be for ‘regular’ feet.”

On May 21, 1996 the Manager of Program Reviews sent a memo to MassPro's Manager of Special Projects regarding BBM's labor claims. The memorandum stated, "I do feel that the labor hours that she charges are suspiciously exact."

On July 16, 1996, MassPRO notified BBM of the results of its initial review of the health care records submitted to their offices by BBM on December 5, 1994. The records were from a random sample of 25 recipients (of 32 claims examined) for the review period of May 1, 1993 through April 30, 1994. The review noted 32 instances of insufficient record keeping; 4 instances of incorrect service codes billed; and 28 instances of no medical necessity, according to the audit and a review by an independent orthotist hired by DMA to review the claims.

The notice included a summary of the results of MassPro's review of the 32 randomly selected case records. The review summary also identified practice patterns and trends with regard to the providers' services. Certain specific evidences of irregular business patterns were also identified, for example:

- The documentation provided for twenty-eight of the thirty-two claims did not support the medical necessity of the custom made orthopedic shoes or boots. It appears that Boston Boot Makers, Inc. is not in compliance with the regulations set forth in All Provider Manuals 130 CMR 450.204;
- In one instance, a pair of custom made orthopedic boots was ordered for a recipient with a right above the knee amputation;
- Custom-made shoes/boots were often provided, although the physician prescription or request form ordered orthopedic shoes and not custom made shoes/boots; and,
- In one instance, a pair of custom made orthopedic shoes with a one-inch shoe lift on the left shoe was ordered for a recipient with a leg length discrepancy. It appears this could have been done in a more cost-effective manner, i.e., the special lift could have been added to a regular pair of shoes; This practice is not in compliance with the regulations set forth in the All Provider Manual 130 CMR 450.204.

DMA preliminarily notifies BBM of finding that it must pay back DMA \$189,421.44

On July 16, 1996, as a consequence of the initial MassPro review, DMA employed its “pay and chase” regulations to recover money from BBM. Because the MassPro audit had found that 100 percent (100%) of BBM’s 32 audited claims failed to meet department regulations, DMA notified BBM that it had determined that BBM owed 100 percent (100%) of all claim amounts during the audited period, totaling \$189,421.44. BBM had the right to appeal this decision. DMA also stopped processing all of BBM’s pending claims, totaling \$58,511. In addition, DMA notified BBM that DMA’s recovery of the \$189,421.44 represented DMA’s claims against BBM only for the audited period, and that BBM remained potentially liable for other periods.

DMA officials notified BBM that if the company agreed with the findings, it should submit a check in the amount of \$189,421.44 made payable to the Commonwealth of Massachusetts. Otherwise, the letter provided, BBM could exercise its administrative rights of appeal.

1996. DMA worked closely with MassPro during MassPro’s review process

On September 30, 1996, MassPro’s Manager of Special Projects sent a memo to DMA’s Manager of Program Reviews with regard to the response of BBM, making the following main points:

- The recipients that were sampled for review did not require a custom fabricated shoe. BBM has stated in their response to the review findings that they do not intend to provide a standard shoe;
- Boston Boot Makers, Inc. has a fine reputation for making an excellent product, but that the cost is excessive, and that these services should not be provided to recipients that do not require custom made shoes;
- if BBM does not intend to provide a custom molded shoe, then they should refer patients and/or the prescribing physician to another provider who does;
- the Orthotist referred to Boston Boot Makers as the ‘Cadillac’ of custom made shoes;

- non-custom made orthopedic shoes would accommodate 22 of the 25 recipients that were sampled for review;
- the person providing the services is a Registered Nurse and the shoe technicians 'European Craftsmen'; it appears that the personnel are not qualified. The person providing these services should be a certified Orthotist or Pedorthotist;
- the physicians were not aware of the costs for the products and that they should be educated and informed of what the provider makes and the costs involved. The prescribing physician probably orders the orthopedic shoes and is not aware that the shoes will be custom-made at a very high cost;
- Boston Boot Makers should be allowed the fee schedule for their shoes.

MassPro's Program Manager of Special Projects concluded the memo by stating that although more information was received and reviewed by the provider, it did change the outcome of the review or findings. She then commented that, "Boston Boot Makers refers to previous correspondence and agreements with DMA in their response. These issues were not addressed since we cannot comment on them."

On November 22, 1996, the Nurse Reviewer sent a final memo to MassPro in conjunction to the memo dated September 30, 1996. The Nurse Reviewer stated the following:

- a provider's responsibility is to provide the less costly or more conservative service to a recipient (130 CMR 450.204);
- I don't think that the (boots and shoes) provided to the recipients were appropriate and medically necessary since they were not fabricated by a qualified person;
- since January 1995, Boston Boot does not meet the eligibility criteria in this regulation.; (See pp. 2-11, regulations effective January 13, 1995, 130 CMR 450.212); and,
- and although we can not address this issue in the review period, it will certainly be an issue to discuss when we meet with them.

1997. DMA and MassPro conclude that despite medical necessity statements, 100 percent (100%) of audited transactions were for medically unnecessary or overly-expensive boots and shoes

On January 22, 1997, a DMA official sent BBM a final “Notice of Overpayment; Notice of Withholding Payments” in the amount of \$189,421.44. The letter also notified BBM that DMA had begun withholding payment of all pending claims, pursuant to 130 CMR 450.240.

Notwithstanding the signed statements of medical necessity, DMA concluded that the footwear was medically unnecessary or inappropriate in each of the 32 audited claims. DMA based its decision on Medicaid regulations (130 CMR 450.204), stating the following:

A service is medically necessary if:

- a) “it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the recipient that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity.” and,
- b) “there is no comparable medical service or site of service available or suitable for the recipient requesting the service that is more conservative or less costly. Medical services shall be of a quality that meets professionally recognized standards of health care, and shall be substantiated by records including evidence of such medical necessity and quality.”

1997. BBM’s responds to MassPro audit and DMA action

On February 25, 1997, BBM’s attorney sent DMA a Petition and Reply to the audit. The document argued that DMA’s had made capricious demands upon BBM over the past year, and had that its audit made conclusive assertions. BBM argued that DMA was unfairly withholding payments that threatened to put BBM out of business. BBM’s Petition and Reply traced the history of the dealings between BBM and DMA and concluded that described BBM as, “a conscientious company that consistently has sought to work with DMA to protect the integrity of the Medicaid program, and indeed is on record as having asked DMA for a prior

approval required program for each claim submitted.” The Petition and Reply presented a detailed response to each finding included in the audit.

1997. BBM argues that it complied with medical necessity requirements because physicians specifically ordered “hand-made customized” shoes

Following MassPro’s audit, BBM demonstrated that it had presented auditors, during the audit, with 32 statements of medical necessity for each of the 32 audited claims. Each included the following statement above the physician’s signature:

“Please note that your signature below confirms your understanding that you are ordering a hand-made customized shoe for your patient.”

BBM argued that these statements of medical necessity demonstrated that the company had fulfilled its responsibility to verify medical necessity. Moreover, company officials vehemently argued that a DMA official, the Program Manager for Durable Medical Equipment, had helped to draft, and later approved, the medical necessity form, including the authorizing language for hand-made customized shoes. BBM argued that DMA had done so expressly to address the very issues then in dispute as a result of the MassPro audit.

The company stated that DMA’s Program Manager for Durable Medical Equipment and the company owner had negotiated and drafted the statement of medical necessity at the direction of DMA administrators. The Program Manager for Durable Medical Equipment later confirmed this fact during interviews with this Office. The company also argued that DMA had drafted, with assistance of the company owner, a letter that it required BBM to send to physicians in 1992 explaining why the medical necessity form was necessary. The former Program Manager for Durable Medical Equipment confirmed this fact. The letter of explanation, sent by BBM (not DMA) to physicians stated as follows:

“We [Boston Boot Makers, Inc.] are suppliers of hand made, wholly customized footwear for patients with disabilities or those suffering from illnesses which severely compromise form or function of their

feet. Our services are available to Medicaid recipients who demonstrate a clear medical necessity for our product. As a result of recent collaboration with the department of public welfare, we have developed a protocol to monitor the medical necessity for our product and to expedite reimbursement for Medicaid recipients.

In order to initiate your patient's claim for coverage, please provide the following documentation:

- 1) prescription which includes:
 diagnosis; a
 specific order for hand-made shoes; and,
- 2) a signed copy of the enclosed statement of medical necessity."

1997. BBM argues that MassPro and DMA completely ignored the existence of the agreed upon 1992 protocol

To counter DMA's conclusions, BBM's Petition and Reply relied in large part upon the company's claim that it had strictly adhered to the terms and conditions of the protocol established in 1992. BBM argued strenuously that DMA auditors and administrators had acted throughout the audit as if DMA had never established the 1992 protocol with BBM, and had completely overlooked its existence during the audit. BBM argued that the company had relied in good faith upon the protocol and had fulfilled its responsibilities under the protocol to establish medical necessity and establish prices for its footwear. According to the Petition and Reply, BBM "wanted to know why the methodology worked out in 1992 with the assistance of [State Senator] now is unsatisfactory." BBM complained, "DMA has yet to answer this response in any meaningful way."

1997. MassPro officials confirmed to this Office that DMA officials instructed MassPro to conduct the audit strictly in conformance with Medicaid regulations as written, notwithstanding any claimed agreements

MassPro auditors and administrators told staff of the Office of the Inspector General that BBM, during the audit, claimed to be operating under the terms of an agreed-upon protocol for determining medical necessity and payment levels. MassPro representatives told this Office that they brought BBM's claims to the attention of DMA officials and that DMA officials told them conduct the audit

strictly in accordance with Medicaid regulations as written, irrespective of any claimed agreements.

On September 30, 1996, the MassPro's Special Projects Manager wrote to DMA's Manager of Program Reviews, "Boston Boot Makers has not submitted anything in writing from the Division that L3649 [the unlisted procedure code] was the only code they [BBM] was instructed to use [by DMA]."

1997. BBM claims in Petition and Reply that its products are different from off-the-shelf orthopedic shoes

BBM provided specifics of its custom-made shoemaking process in its Petition and Reply, with many examples, including the following,

to illustrate the differences between BBM's customized manufacturing of shoes and off-the-shelf orthopedic shoes available on a retail basis. . . . Obviously, the mass-manufactured, retail brands work fine for many people, while others will depend upon customized shoes to ameliorate their handicaps or relieve their suffering and pain.. . . It is not a sort of 'super market' of prefabricated orthotics and shoes either, holding a stock of items from which to choose to serve customers on a retail basis. Rather, it is a destination point facility, which fabricates and manufactures one simple range of service; hand-made custom shoes and orthopedic adjustments. This is a fine and rare service in its own right, and when it is understood and used appropriately can be enormously helpful to some people, enabling them to forestall further injury or deterioration to their feet when disease or compromised function is present.

1997. BBM claimed that it relied upon physician's determination of medical necessity when dispensing footwear

The recurring theme of the Petition and Reply was that BBM "leaves the medical determination as to who needs its shoes to physicians who service Medicaid recipients." BBM repeatedly asserted this theme, as follows:

- that it followed the medical necessity protocol established in 1992;
- that it, has no desire, apart from complying with 130 CMR §202's prohibition against recipient discrimination, to serve DMA's clients; indeed, the overhead

costs of dealing with DMA make it unprofitable to make shoes for DMA recipients;

- these issues were the subject of discussion and resolution in 1992, and since then the methodology agreed upon has operated with respect to each claim presented;
- the recipient is not Boston Boot Makers' 'patient'; the recipient is its customer. He or she is the 'patient' of the physician who prescribed the product;
- was ensuring that the only party capable of making the determination necessary for 130 CMR 450.204 – the Medicaid recipient's physician – was submitting the correct authorizations;
- given the foregoing understanding reached in 1992 that BBM had not other responsibility to engage in medical necessity determinations than would, say, a pharmacist, the DMA utilization review findings that twenty-five claims lack medical necessity come to naught;
- if DMA wishes to better police medical necessity, it should start with the recipients' health care providers, e.g., their physicians; and
- BBM believes that its history of compliance is impeccable.

Furthermore, BBM denies any allegations of misuse of billing codes.

BBM then used the Freedom of Information Act to request copies of public records relating to her Medicaid business.

1997. The unorthodox Settlement between DMA and BBM

Following BBM's submittal of the Petition and Reply and Freedom of Information Act request to DMA, DMA's Assistant General Counsel reportedly called BBM's attorney to suggest a settlement between DMA and BBM, according to BBM's attorney. In a follow-up letter to that conversation, BBM's attorney wrote,

- In addition to rebutting DMA's claims of lack of medical necessity with documentation showing that Boston Boot Makers and DMA had agreed to a protocol in 1992, the Petition and Reply also requested an informal conference pursuant to 130 CMR 450.244, and sought DMA's public records pertaining to Boston Boot Makers in accordance with G.L. c. 66, s.10 (a);

- You subsequently called and indicated that the public records requested by Boston Boot Makers contained information that DMA would rather not make public, inasmuch as it might not portray the agency in the best light;
- You suggested that instead of pursuing the implementation of the public records request, DMA and Boston Boot Makers might agree to terminate their dispute, essentially by DMA issuing a Notice of Withdrawal withdrawing the Notice of Violation, and by Boston Boot Makers agreeing to cease making shoes for DMA recipients.

The letter then recounted that DMA's Assistant General Counsel had indicated that should BBM chose not to agree to discontinue enrollment from Medicaid, that DMA's recouping action would continue. In addition, DMA would seek to involuntarily discontinue enrollment with the provider, and should that not work, would regard the provision of custom-made shoes medically unnecessary and disallow any future claims.

The attorney for BBM continued,

I have reviewed the above terms with . . . the President of Boston Boot Makers. Candidly, I must record my embarrassment in attempting to explain to a Massachusetts resident that a state agency will make use of the public records law to leverage itself out of a problem. However, the benefits of ending this matter without additional litigation costs are attractive, especially as DMA, in consistently refusing to enter into discussions with BBM regarding a prior approval program, and other similar constructive issues raised by the provider, has demonstrated that it does not wish to have custom made footwear available to DMA recipients.

The attorney for BBM, Inc. then summarized the terms of the proposed agreement:

- Boston Boot Makers will agree to voluntarily disenroll as a Medicaid provider and will cease providing custom made shoes to Medicaid recipients as of a date certain;
- DMA will issue a Notice of Withdrawal in the instant matter, and will also execute a General Release to Boston Boot Makers for any and all claims submitted up to the date certain, not just the ones that are the subject to the Notice of Violation. The point, of course, is that if the parties are going to end their relationship, they should do so entirely;

- In addition, DMA should agree to pay Boston Boot Makers in full for all claims submitted up to the date of cessation in the program, payment for which should be coterminous with the signing of the Release and receipt of the Notice of Withdrawal.

1997. DMA and BBM executed the Settlement Agreement. After 14 years as a Medicaid provider, BBM is terminated as a provider

On May 30, 1997, DMA and BBM executed the Settlement Agreement as proposed. With the Settlement Agreement, DMA paid the provider \$58,511 for 60 outstanding claims. Eighteen days later, on June 17, 1997, DMA paid BBM \$23,852 more, for 25 additional outstanding claims. DMA made a final payment to BBM of \$993 for one outstanding claim on July 22, 1997.

1997. Legislator seeks answers about BBM and the \$1,000 boots

During the first week of June, 1997, just days after DMA and BBM executed the Settlement Agreement, a State Representative called DMA's Commissioner asking about reports she had heard that DMA had provided many pairs of \$1,000 custom boots to Russian immigrants with dubious medical needs. According to the legislator, DMA's Commissioner initially told her "that's a bizarre story; it's just not true." On June 10, 1997, the legislator delivered a letter to DMA's Commissioner, stating the following:

- I have recently learned that Medicaid funds were used to purchase \$1,000 boots for certain Russian immigrants, perhaps through the Massachusetts Office for Refugees and Immigrants;
- It is also my understanding that the boots are manufactured by Boston Boot Makers Inc.;
- Would you please look into this matter. I am interested in learning the details of this transaction, and why it occurred; and,
- I am particularly interested in learning why Medicaid would pay for such boots when a constituent of mine was unable to obtain a medically necessary power transfer seat a few months ago.

1997. Two days after the State Representative's inquiry, and twelve days after DMA and BBM executed a settlement, DMA's Internal Control Manager recommended that DMA refer the case to MFCU

In a letter dated June 12, 1997, two days after State Representative made her request for information, DMA's Internal Control Manager submitted a letter to DMA's Deputy General Counsel formally requesting that DMA refer the case to the MFCU "for their review and whatever action seems appropriate." The Internal Control Manager recommended enclosing a copy of the division's notice of overpayment, the audit findings, and BBM's response.

1997. Five days after DMA official recommended referring the case to MFCU, DMA paid BBM \$23,852 as part of the settlement

On June 17, 1997, DMA paid BBM an additional \$23,852 more, for 25 pairs of shoes and boots of additional outstanding claims.

1997. DMA officially referred BBM for investigation of fraud to the MFCU, citing the "Russian Mafia"

On June 24, 1997, DMA's Deputy General Counsel sent a letter to the Chief of the Medicaid Fraud Control Unit in the Attorney General's Office. The letter stated as follows,

Subsequent to the Division entering into a Settlement Agreement with Boston Boot Makers, [DMA's Manager of Program Review and Acute Utilization Program] and other staff from the Division attended a conference on Medicare Fraud in New England. At the conference, one of the speakers, Chris Covington from CIGNA Medicare, spoke about the "Russian Mafia" being engaged in Medicare fraud. He noted that, "... 'Russian Mafia' has been in collusion with Russian immigrants, providers of durable medical equipment, and physicians to obtain payment from Medicare." He particularly noted this activity has been occurring with orthotic equipment. As BBM provided orthotic equipment to a large number of Medicaid recipients who are Russian immigrants, your office may want to investigate into possible Medicaid fraud.

1997. DMA made its final payment to BBM

DMA made a final payment to BBM of \$993 for one outstanding claim on July 22, 1997, more than four weeks after DMA referred the matter to MFCU.

1997. DMA's Commissioner writes to the State Representative, stating, "Currently, we have no knowledge of \$1,000 custom-made boots"

The Commissioner wrote back to the State Representative on July 25, 1997, stating in part:

- As of April 1, 1997, Boston Boot Makers no longer participates in the Massachusetts Medicaid Program; and,
- If a provider attempts to overcharge for an item, the Division would audit the provider and recoup any monies inappropriately paid.

This Office notes that at the time of the Commissioner's July 25, 1997 letter, DMA had already agreed, as part of its settlement with BBM, not to recoup monies inappropriately paid to BBM by DMA and instead to pay all outstanding claims.

1997. The State Representative continues to pursue the matter

The State Representative responded in writing to the DMA Commissioner's letter on August 18, 1997. The letter stated, " ... my second question concerning Boston Boot Makers' relationship with the Massachusetts Medicaid Program was not answered." The Representative further stated,

You noted in your letter that 'Orthotic' shoes are covered by Medicaid and generally cost between \$250.00-\$600 depending on a recipient's medical condition' and further that 'If a provider attempts to overcharge for an item, the Division would audit the provider and recoup any monies inappropriately paid. . . '. I would appreciate it if you would send me a list of invoices submitted by and payments made to Boston Boot Makers from July 1, 1996 to April 1, 1997.

1997. Commission responds to the State Representative again by letter

On September 3, 1997, DMA's Commissioner responded to the State Representative's request, "After a lengthy audit by our program review staff of the billing activity of Boston Boot Makers, it was agreed earlier this year that Boston Boot Makers would no longer participate in the Medicaid program. Overcharging was one of the issues addressed by the audit. The Commissioner

continued, “Although Boston Boot Makers provided services to Medicaid recipients pursuant to orders obtained from physicians, it was our belief that their materials and labor costs were excessive and resulted in inappropriately high charges.” The Commissioner concluded his letter, “This situation took some time to correct. We understand your frustration with the apparent inequities that existed, but we believe that the resolution of the audit effectively eliminated these inequities.”

September 15, 1997: the Boston Globe article

The State Representative subsequently brought the matter to public attention, first by disclosing it in a story in the Boston Globe and then by filing an Order calling for an investigation by the Office of the Inspector General. On September 15, 1997, the Boston Globe published a detailed story written by reporter David Armstrong documenting the State Representative’s efforts to uncover the facts about the \$1,000 boots. In the story, DMA officials confirmed that the department had paid more than \$1,000 apiece for hundreds of pairs of hand-made, custom-crafted, stylish leather boots that the department later determined was medically unnecessary, with rare exception. The story quoted the owner of BBM as saying that she had observed “a surge of Russian customers” requesting hand-made boots and shoes beginning ten years earlier, many carrying prescriptions from physicians of Russian descent. The owner claimed that she discussed her observation of possible fraud with DMA staffers as early as 1991, and that her observations led to the effectuation of the new medical necessity statement requirements. She stated that the department paid the claims thereafter without questioning the need of those seeking boots. She stated that customers with no apparent foot problems continued to come in with valid prescriptions and medical necessity forms.

The Commissioner stated in the story that DMA had taken too long to resolve the problem, explaining, “it takes time to resolve these things.” The Commissioner stated that the product prepared by the Boot Makers was needlessly expensive, but that DMA had informed BBM that it, as a Medicaid provider, was required by

Department to meet the medical needs of the recipients in the most cost-effective way possible. DMA explained that it had subsequently settled all claims against Boston Boot Makers, Inc. and paid all pending claims in return for the agreed-upon termination of BBM from the Medicaid program. The news story reported that DMA officials refused to release public records to the media related to the case, saying that the matter had been referred to the Attorney General's Office.

1997. House adopts Order requesting the Inspector General to make an investigation and study of the matter

On September 22, 1997, the House of Representatives, Commonwealth of Massachusetts, adopted an Order requesting the Office of the Inspector General to investigate and study the "bootmaking" benefits and the procedures administered under the Medicaid program by the Division of Medical Assistance within the Executive Office of Health and Human Services.

Part Two. The Commonwealth's 15 Top Orthopedic Footwear providers

This Office's investigation revealed a pervasive pattern of fraud and abuse by Medicaid orthopedic footwear providers, coupled with administrative and computerized screening systems at DMA inadequate to detect or prevent such abuses. Many of DMA's top fifteen orthopedic footwear providers routinely "gamed the system" by engaging in "creative" fraudulent billing to maximize their income. Other providers, by contrast, complied with program rules and regulations in their billings with few exceptions.

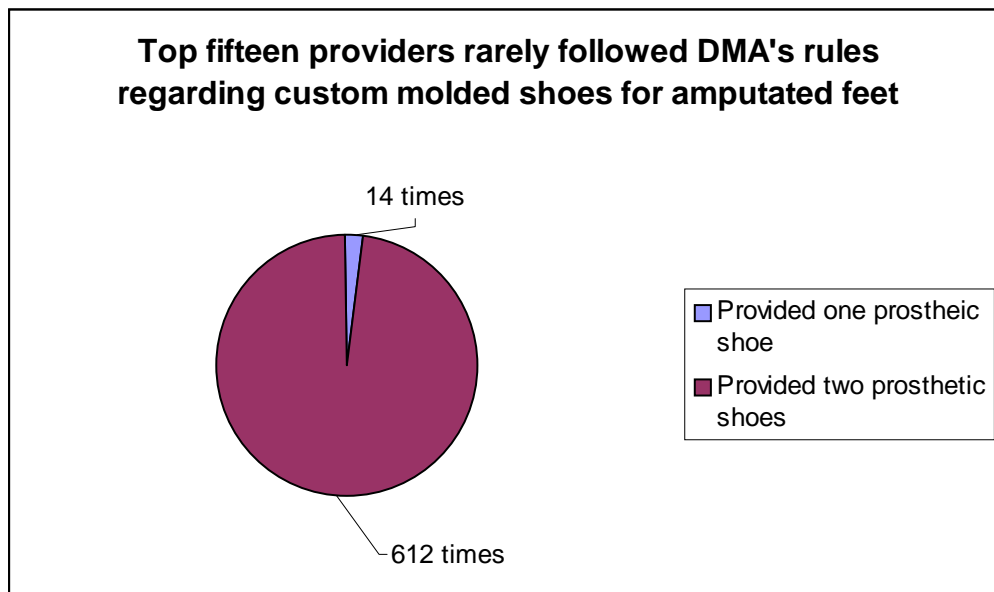
Finding 1. Some providers overcharged Medicaid by billing for two pairs of shoes when they actually provided only one pair

One provider, on 736 separate occasions, doubled-charged DMA for ready-made orthopedic shoes he provided to Medicaid recipients, charging the "per pair" rate for each shoe, resulting in \$95,793 in overpayments. Another provider, on 198 separate occasions, doubled-charged DMA by charging \$500.00 - \$515.00 per pair of custom shoes for which he was supposed to charge a maximum of \$250 - \$257.50 per pair, resulting in \$49,624.50 in overpayments. Other orthopedic providers never double-charged Medicaid on a single occasion.

Finding 2. Some providers issued one prosthetic shoe, but billed DMA for a pair

An example of abusive billing that slipped past DMA's computerized claims checking system concerns shoes for recipients with partial foot amputations. Under DMA regulations, orthopedic shoe providers may provide a prosthetic custom-molded shoe, costing \$206 per shoe, only for a fully or partially amputated foot. For example, if a recipient has amputated toes on one foot, he may receive one custom-molded shoe that typically includes fillers to compensate for the missing toes. This Office's investigation observed that

orthopedic shoe providers routinely billed Medicaid for two units of prosthetic shoes when the patient did not have whole or partial amputations of either foot. If a matching shoe is required for an intact foot for a patient with an amputation of the other foot, DMA regulations require a prescription for a less expensive one. Of 626 cases reviewed where providers billed Medicaid for prosthetic shoes, providers billed for 612 pairs of these shoes, at \$412 per pair. This Office's interviews with orthopedic footwear providers demonstrated that with rare exception, the providers were dispensing these shoes to persons with no amputations. DMA's computerized claims system did not include a built-in check to flag the fact that 98 percent of such claims were being submitted for two shoes, a billing pattern indicating overcharging by the providers.



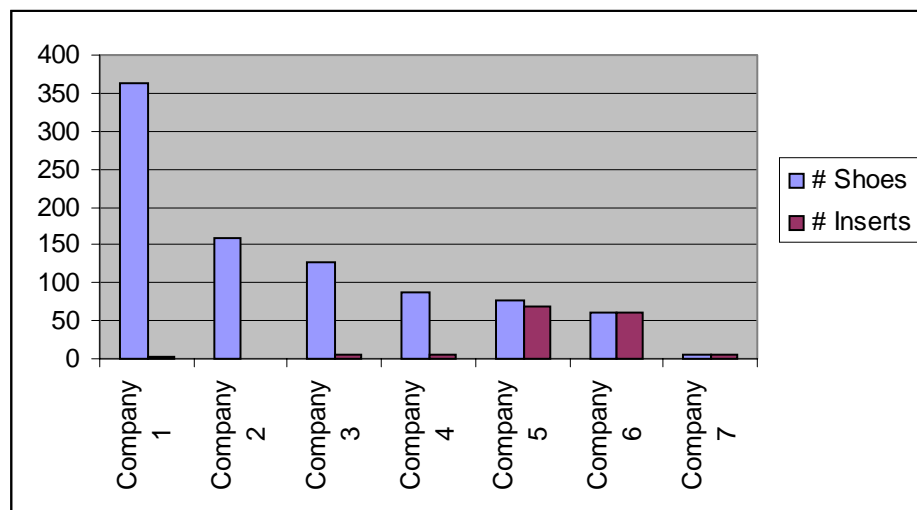
Finding 3. Some providers charged extra for custom inserts that are included in the rates for custom-molded and custom shoes

Some orthopedic footwear providers almost always billed Medicaid extra for a removable custom insert (molded to patient model, plastazote or equal - L3002)

when they provided a custom-molded prosthetic shoe (L3250). According to the Division of Health Care Finance and Policy, “This code (L3250) is for a complete custom prosthetic shoe, including a custom insert.” As demonstrated above, other companies rarely added extra charges for the custom insert that is included in the basic price of the shoe.

Number of times providers added extra charges for
“custom insert” with a custom-molded prosthetic shoe (L3250)

	# Shoes	# Inserts	% Inserts
Company 1	364	2	0.5%
Company 2	160	0	0.0%
Company 3	126	6	4.8%
Company 4	88	6	6.8%
Company 5	76	68	89.5%
Company 6	62	62	100.0%
Company 7	6	6	100.0%



Another example of billing abuse that went undetected by DMA’s computerized claim system concerns add-on charges for component parts that are supposed to be included in the base price of the shoes. One provider charged Medicaid extra for custom inserts in 352 of 355 instances when the provider dispensed a custom

shoe (L3230) for non-amputees, adding \$208 per shoe in addition to the cost of the custom shoes, even though the inserts came as standard components of the custom shoe from the manufacturer. Other providers never added such charges. According to the Division of Health Care Finance and Policy, custom shoes must be formed to a positive model of the recipient's feet and include a customized foot bed, formed to the recipient's foot. While most providers never once charged Medicaid to put a custom foot insert into a custom shoe, or did so only in exceptional cases where special orthotic inserts were required, this provider did so almost every time. DMA's computerized claims checking system failed to detect this discrepancy in billing patterns among providers or to detect simultaneous billing of component parts with the comprehensive shoe charge. The Division of Health Care Finance and Policy told this Office that custom shoes include custom inserts in the base price, as follows:

While custom shoes include custom inserts, there are situations in which inserts need to be replaced or a physician requests more than one insert because of the patient's medical condition. These situations should be documented in the shoe prescription form.

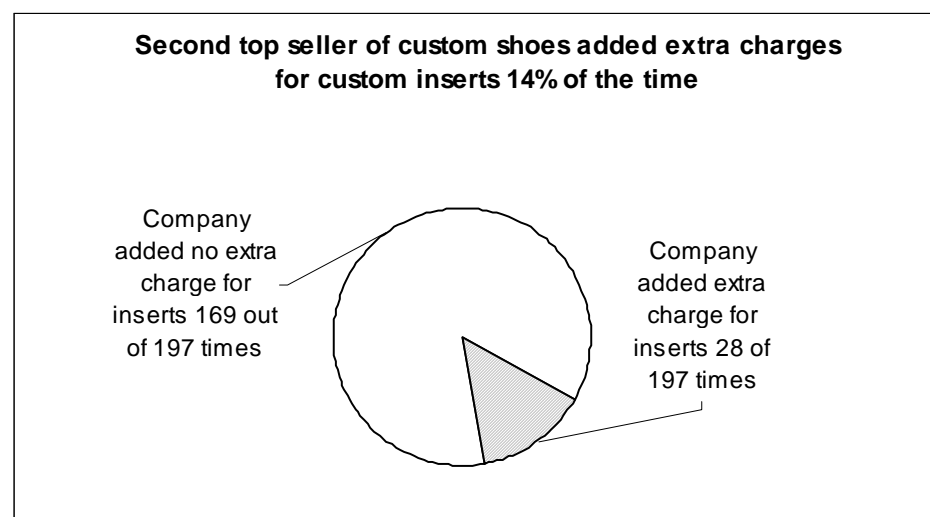
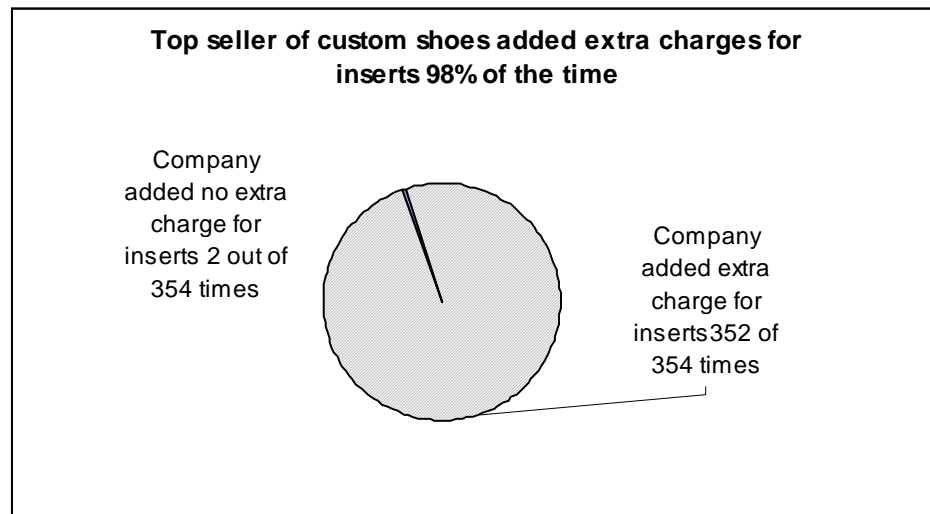
This Office reviewed records and interviewed officials of the firms with the highest percentage of add-on insert charges. Those records and interviews demonstrate that the companies were charging Medicaid for the custom inserts that were supposed to be included in the basic price of the shoe, not for an extra pair.

Extra charges for custom inserts on custom shoes (L3230)

Number of times providers added extra charges for
"custom insert" with a custom shoe (L3230)

	# Shoes	# Inserts	% with insert charges
Company 1	354	352	99.15%
Company 2	197	28	14.21%
Company 3	37	34	91.89%
Company 4	31	0	0.00%
Company 5	35	5	14.29%
Company 6	8	0	0.00%

This Office observed vast differences in the billing practices of different providers. The Commonwealth's leading provider of custom shoes (L3230) added extra charges for custom molded inserts more than 99.15 percent (99.15%) of the time. By comparison, the Commonwealth's second leading provider of custom shoes (L3230) added insert charges 14.21 percent (14.21%) of the time.



Finding 4. Providers “followed the money” in determining what shoes to dispense

This Office’s investigation indicates that after the Division of Health Care Finance and Policy adjusted Medicaid rates on ladies’ and men’s off-the-shelf oxford shoes on January 1, 1997, many providers altered their billing practices to maximize profits.

	BEFORE	AFTER
	Men’s Oxfords at \$150/pr. Men’s Depth at \$150/pr.	Men’s Oxford at \$121.07/pr. Men’s Depth at \$154.50/pr.
Oxford shoes	309	147
Depth shoes	0	200

	BEFORE	AFTER
	Ladies Oxfords at \$150/pr. Ladies Depth at \$150/pr.	Ladies Oxford at \$121.07/pr. Ladies Depth at \$154.50/pr.
Oxford shoes	646	306
Depth shoes	11	417

The Division of Health Care Finance and Policy lowered rates for men’s oxfords, --basic off-the-shelf orthopedic shoes-- from \$150.00 to \$121.07 per pair effective January 1, 1997. At the same time, the Division of Health Care Finance and Policy raised rates for men’s depth shoes, i.e., extra-depth off-the-shelf shoes, from \$150.00 to \$154.50 per pair. One provider, who had not billed Medicaid once in the previous eighteen months for a single pair of men’s depth shoes, subsequently billed for 200 pairs of the more-profitable men’s depth shoes in the 24 months following the rate change. At the same time, the same provider reduced his sales of the then less profitable off-the-shelf oxford by more than half, from 309 pairs when the price was \$150.00 per pair to 147 pairs after the prices dropped to \$121.07.

Likewise, the same provider changed his pattern of dispensing ladies shoes after the Division of Health Care Finance and Policy adjusted its rates for those items. When the Division of Health Care Finance and Policy lowered rates for ladies oxfords shoes --basic off-the-shelf shoes-- from \$150.00 to \$100.05 per pair, the provider began dispensing more expensive extra depth shoes to Medicaid clients, at the newly established, higher price of \$125.66 per pair. The provider, who had billed Medicaid only 11 times for ladies extra depth shoes in the previous eighteen month, subsequently billed for 417 pairs of the more-profitable ladies depth shoes in the 24 months following the rate change. At the same time, the same provider curbed his sales of the then less profitable off-the-shelf ladies oxford by more than half, from 646 pairs when the price was \$150.00 per pair to 306 pairs after the prices dropped to \$100.05.

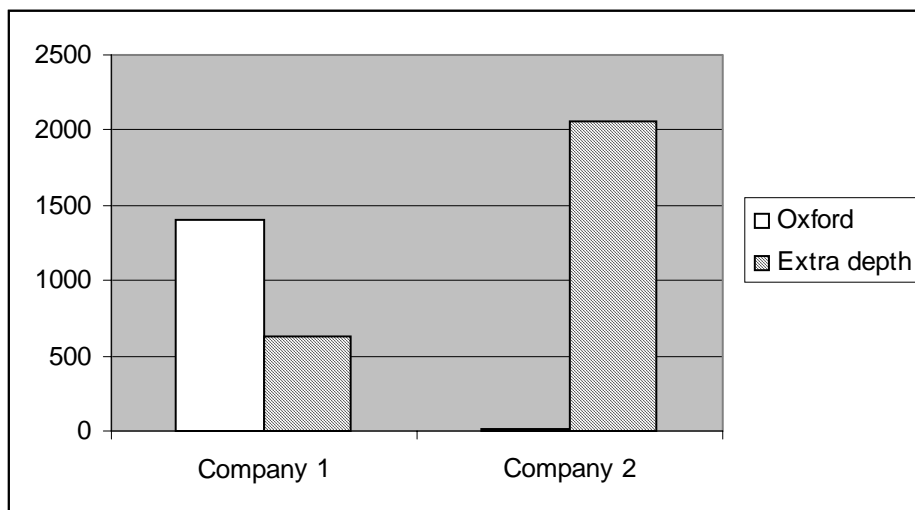
These dramatic shifts in provider's service patterns suggest an unabashed effort by the provider to "follow the money" rather than abide by the medical necessity regulations that govern the program. It is unlikely that such sudden, dramatic shifts are attributable to the provider's arms-length determination of "least-cost medically necessary" shoe type. Likewise, this Office's review of many underlying prescriptions for these shoes did not indicate that physicians had changed what they were prescribing following the Division of Health Care Finance and Policy re-pricing effort. Generally, the prescriptions continued to call for "orthopedic shoes." Instead, the record indicates that certain providers commonly altered the kinds of shoes they dispensed as a means of to maximizing their profits, irrespective of doctor's orders or DMA regulations.

Finding 5. Some providers padded their claims with unwarranted charges for "non-standard sizes"

Another area of billing abuse observed during this Office's investigation concerns add-on charges for "non-standard size or width (L3254)" and "non-standard size or length (L3255)." The established rate for both of these codes is \$46.35. One provider routinely added L3254 and L3255 charges to its Medicaid bills, whether

or not they had paid any extra to their suppliers for the shoes provided; on 810 separate occasions over a three and one-half year period, the provider added such charges. Some providers even added a double charge for “non-standard size or width” (i.e., 2 x \$46.36 = \$92.70) to pairs of ready-made shoes that he bought at the standard manufacturer’s rate. Finally, one provider added charges for non-standard sizes for custom-shoes on 54 claims, charging for two units in all but one case, in which he charged for one unit. Since custom shoes are made on a positive model of the patient’s foot, it would be illogical to pay for non-standard sizes for that type of shoe. However, DMA paid all of the claims in question. As evidenced in the following statistics, a few providers apparently abused the system with regularity.

Comparison of Off-the-shelf Oxfords versus Extra-Depth: Top Ten providers



	oxford	extra-depth	% extra-depth
Company 1	1408	628	31%
Company 2	18	2054	99%
Company 3	118	84	42%
Company 4	64	613	91%
Company 5	31	326	91%
Company 6	10	180	95%
Company 7	8	171	96%
Company 8	3	191	98%
Company 9	219	1	0%
Company 10	1	328	100%
	1880	4576	71%

Finding 6. Adding unjustified extra charges for “odd-size” shoes

Two providers abused Medicaid by adding extra charges for “odd-size” shoes; other providers did not do so. One company added these charges 874 times in a three and one-half year period, representing more than 80 percent of the total number of billings between July 1, 1995 and January 18, 1999. This provider generally charged \$12.00 or \$15.00 extra per pair. He reaped an extra \$12,755.00 in total payments from Medicaid during the period reviewed.

Another provider routinely padded his Medicaid bills by adding bogus charges for “odd-size width” and “odd-size length.” The provider added these charges even though he had purchased the shoes at no additional charge from his suppliers. The provider reaped a \$16,350 bonanza by adding extra charges 196 times, typically at \$92.75 per charge, when he sold off-the-shelf depth shoes to Medicaid recipients. Records indicate that Medicaid once paid the provider \$810 in “non-standard size” charges for shoes he sold in a single day. This Office reviewed samples of his invoices and did not find an instance where the provider paid his suppliers a fee or charge for non-standard sizes.

As demonstrated by the chart below, the billing practices of these two companies differed greatly from that of their competitors. This Office’s review showed that these providers commonly added odd-size charges even though the providers had ordered the shoes from their suppliers at standard size rates without paying extra.

Number of times providers added extra charges for “odd size” shoes	
	# Charges
Company 1	874
Company 2	196
Company 3	29
Company 4	16
Company 5	10
Company 6	10
Company 7	1
Company 8	0
Company 9	0
Company 10	0
Company 11	0
Company 12	0
Company 13	0
Company 14	0
Company 15	0

Finding 7. Padding the bill when recipient’s feet come in two different sizes

Another area of billing abuse occurs when providers pad their bills with extra charges for “split size shoes.” One provider, for example, added two such charges on February 19, 1998 when he sold a pair of shoes to a Medicaid recipient who had feet of two different sizes (i.e., 9 ½ D left foot and 10 ½ C right foot). The provider billed Medicaid for two separate pairs of shoes (i.e., four individual shoes) and then added not one, but two extra charges of \$46.35 apiece for “split size.”

The provider told this Office that he threw away one brand-new shoe from each pair. When asked to produce an invoice demonstrating that the provider had in fact ordered two pairs of shoes, the provider produced two invoices, one dated four months and the other six months before the date of the prescription ordering the shoes in question. Upon further questioning, the provider said that he had in fact taken two shoes “out of inventory.”

In the case of “split-sizes”, Medicaid rules require that providers place a special order with the supplier, in this instance, for example, for a 9 ½ D left shoe and 10½ C right shoe. Medicaid accordingly allows providers to add a single \$46.35 charge to its Medicaid bill for split size shoes. One leading manufacturer charges providers a \$40.00 special order fee and delivers two shoes in the specified sizes within four to five weeks. When this Office asked the provider why he added any charge at all for split size shoes after he had billed Medicaid in full for both pairs of shoes, the provider said that he always did it that way, and Medicaid always paid without any problem. When asked why he had added not one but two charges for split size shoes, the provider said, “The left shoe didn’t match the right shoe, and the right shoe didn’t match the left shoe.” This Office also found three cases in which the provider added an additional charge for split sizes for custom-shoes, which is absurd because that type of shoe is made on a positive model of the patient’s foot. However, DMA paid the claims in question.

Finding 8. Some providers issued more expensive kinds of shoes than the doctor ordered

Providers frequently sold expensive custom-made shoes to Medicaid recipients when the prescription called for less expensive off-the-shelf or extra depth orthopedic shoes. Records show that providers frequently provide more expensive types of shoes, for higher prices, than those prescribed. One provider routinely billed for prosthetic shoes (\$412) whenever he issued a pair of less expensive custom shoes (\$257.50).

Finding 9. Billing for questionable add-ons and services not rendered

This Office found widespread evidence of questionable add-on’s, such as charging extra for inserts that are included in the rate for custom-shoes, or charging extra for Velcro closures that are included in the base price of a shoe, or charging for questionable shoe modifications. One provider’s billing history demonstrates how providers can abuse the system by routinely adding charges

for shoe additions that other orthopedic shoe providers rarely add to their shoes. The provider in question added extra charges of \$150.00 per pair for “pre-molded longitudinal arch supports” (L3040) almost every time the provider dispensed a pair of off-the-shelf orthopedic shoes to a Medicaid recipient over a period of 14 months. During that time, DMA paid the provider a total of \$23,005.00 for questionable add-ons to 151 pairs of shoes. The provider’s charges constituted approximately 66 percent (66%) of the total statewide Medicaid billings among all orthopedic footwear providers statewide for that particular type of insert over that period. After the Division of Health Care Finance and Policy reduced the reimbursement rate for that type of insert to a maximum of \$67.94 per pair, the provider never submitted another bill to Medicaid for that kind of insert. Instead, the provider began to charge for a different kind of shoe addition, a removable insert formed to the patient foot (L3030) for which Medicaid paid \$110.18 per pair. The provider then added this charge to nearly every one of the next 213 pairs of shoes it provided to Medicaid recipients over the following 26 months, collecting a total of \$23,869.00 in payments from Medicaid over that period. During that time, the provider’s represented 53 percent of the statewide total among all orthopedic footwear providers for that particular kind of insert (L3030).

Finding 10. The investigation disclosed evidence of balance billing

This Office found evidence of balance billing in which a provider billed a recipient for services rendered and subsequently billed Medicaid for the same services in violation of Medicaid regulations. This practice, known as balance billing, is prohibited by Medicaid regulations.

Finding 11. Medicaid’s wide array of shoe benefits makes the system difficult to police

Because the Commonwealth’s Medicaid program offers a broad array of orthopedic shoe benefits, including multiple types of orthopedic shoes and shoe additions, DMA faces a challenging task in controlling provider’s billing practices.

As a result, providers found numerous ways to add questionable charges to their bills with little fear of detection. Many of the questionable claims reviewed by this Office concerned dissimilar claims patterns among orthopedic footwear providers across the range of shoes and shoe additions.

Fifteen top providers – breakdown of claims by type.

Orthopedic Shoes - Non-custom	1,367,550	
Factory-made orthopedic shoes with depth inlay		987,459
Factory-made orthopedic shoes, not extra depth		275,945
Junior, child and infant orthopedic shoes		76,176
Surgical boots		27,970
Orthopedic Shoes - Custom	543,380	
Custom shoes, depth inlay		257,197
Custom-molded, removable mold, prosthetic shoe		250,424
Custom-molded plastazote shoe		30,936
Orthopedic shoe, integral part of a brace		4,823
Shoe Additions	778,724	
Removable custom inserts		547,509
Arch supports; abduction and rotator bars		53,075
Heels		11,986
Lifts		98,742
Misc shoe additions		37,737
Wedges		29,675
Miscellaneous Charges	66,825	
Extra charge for non-standard and split size shoes		36,101
Conversion to velcro closure		26,660
Unlisted procedure		4,064
TOTAL	2,756,479	

Finding 12. Many providers are not complying with the record keeping regulations

This Office observed a pervasive pattern of inadequate record keeping by many, but not all, providers. In many cases, this Office was unable to determine whether the recipients had actually received the products paid for by DMA, and whether the provider's charges met regulatory standards.

Some providers readily offered to pay back Medicaid for individual claims after this Office questioned the claims. Some even mailed checks to this Office

offering settlement. Without exception, providers explained that if the questionable were out of compliance, it was because of innocent misunderstandings about the meaning of the regulations or unintentional administrative errors.

Finding 13. Inadequate automated detection systems

DMA uses computer software programs to identify patterns and trends among its Medicaid claims indicating potentially abusive claims. This Office's investigation indicates that DMA lacked sophisticated computer programming to ferret out fraud and abuse among the state's top orthopedic shoe providers. The fraud detection screens commonly focused on a limited number of variables, ignoring other obvious problems.

The claims payment system administered by Medicaid is complex. The Medicaid coding and billing policy sometimes baffles even providers with only good intentions. Providers who deliberately try to take advantage of the system often claim that they were confused or thrown-off by the program's complexity. The ungainliness of the system makes it unlikely that they will be caught in the first place. In many respects, DMA computer system designers are confronted by a moving target, and a system of complex laws and regulations that change frequently.

The goal of improving computerized fraud detection capability is a commonly cited goal of Medicaid administrators nationwide. Among the top priorities for system improvement cited at the Health Care Financing Administration's National Fraud, Waste and Abuse Conference on March 17, 1998 were the following:

- Develop and use software to catch aberrances -- look for large increases in expenditures and volume over short periods of time or in small geographic areas; uniform data and software to address scams and abusive actions in real time and across geographic and service areas;
- Use more computer edits: Medicaid experience is that Medicaid is getting taken for things that simple edits would have prevented.

This Office notes that last fall, Harvard Pilgrim Health Care's newly appointed chief executive, Charles D. Baker, former Secretary of Administration and Finance for the Commonwealth, awarded a \$700 million, ten year contract to a major systems integration company to improve Harvard Pilgrim Health Care's information and claims tracking systems. Even in the face of its financial difficulties, Harvard Pilgrim Health Care established as one of its highest short and long-term priorities the improvement of its information system. A significant lesson of this is that HCHP considered so large an expenditure to be cost-effective in the long run.

In comparison, this Office observed that it took DMA nearly three months to provide the non-archive billing information for the fifteen providers under review to this Office. DMA often explained the delays on the time-consuming nature of retrieving and producing data. Nevertheless, this Office expected DMA to produce that information on a more timely basis. This shortcoming, coupled with the failure of DMA's computer system to recognize obvious double-payments and unbundling of orthopedic shoes and shoe components, signal the need for further initiatives by DMA to improve its payment safeguarding and information retrieval systems. To contain losses and maximize revenues from third party insurers, DMA has contracted for extensive third party recovery projects based upon competitive bids. The contracts are on a contingency fee basis. This Office therefore requested a list of all recoveries pertaining to the recipients of services provided by BBM and the fifteen providers under review. However, DMA failed to respond to that request.

Finding 14. DMA's audit methodology failed to detect the kinds of faulty billings identified in this report

In September 1998, DMA directed MassPro to conduct a Professional Case Review of a Medicaid provider of orthopedic footwear. On January 22, 1999, MassPro issued its initial draft findings of 99 claims of 25 randomly selected

Medicaid recipients for the period from 7/01/96 to 6/30/97. MassPro's initial draft findings included the following:

“In all instances, the records submitted did not contain sufficient documentation to support the justification for the orthotic.”

- 71 instances of no medical justification of prescribed item;
- 71 instances of no manufacturer/supplier invoice;
- 60 instances of third party insurance not billed;
- 14 instances of time restriction violation;
- 2 instances of no manufacturer/supplier invoice;
- 2 instances of insufficient documentation to support repair code billed;
- 1 instance of no medical record;
- No manufacturer's invoices;
- A generic invoice was submitted for 21 of 25 members;
- No signed delivery slips;
- A company prescription form was used in 8 prescriptions; and,
- 12 claims did not have documentation to support claims for nursing home visits.

MassPro's draft initial findings included a “Computation of Member Sample Extrapolation.” This computation showed that the provider owed DMA an “extrapolated overpayment” of \$251,031.91 for the audited period. This extrapolated calculation was predicated on the draft initial finding that all 99 of the providers' claims were in error, totaling \$251,031.91.

MassPro's case review did not make any reference to the billing irregularities that this Office brought to DMA's attention during this Office's investigation of a thirty-

month billing period that included the same claims that MassPro reviewed. This Office's investigation indicated the following:

- The provider billed and received payment from Medicaid 1471 times in excess of maximum prices set by the Division of Health Care Finance and Policy for its shoes and shoe additions;
- The provider charged up to \$200 extra for inserts on 352 pairs of custom shoes while the inserts provided were included in the comprehensive shoe price;
- The provider had charged up to \$200 extra for custom inserts on 6 pair of custom-molded shoes, while the inserts provided were included in the comprehensive shoe price;
- The provider had charged \$200 extra for "custom inserts molded to patient model" for 310 pairs of extra-depth shoes. The owner's invoices from the manufacturer indicated that the provider supplied \$12 factory inserts instead, not molded to a patient model, for transactions individually reviewed by this Office;
- The provider submitted 958 separate charges for "odd-size" shoes, representing more than 80 percent of the statewide total;
- The provider had added multiple charges for "conversion instep to Velcro closures" in excess of program limits; and,
- The provider billed Medicaid for two pairs of shoes when its customers had "split sized" feet, i.e., two different sized feet. The provider billed for four shoes, but gave the recipient two. A company official conceded that the company sometimes took shoes from inventory for such orders.

MassPro's draft initial finding of a 100 percent (100%) claims error rate for this provider resulted in an "extrapolated overpayment" computation of \$251,031.91 for the audited period. Yet MassPro's review of this provider reveal the inherent limitations of small random sample tool in fraud and abuse detection. While the random sample review was effective in identifying at least one error in each claim, it did not go much beyond that level of scrutiny. Considering that an error could mean anything from outright fraud to an inadvertent mistake, the review was, to a certain respect, disinterested in the distinction. This shortcoming

becomes significant in examples such as this one, when an apparent array of improper billing practices lies beneath the surface. While the review detected a 100 percent (100%) error rate, it did not detect the underlying patterns of apparent fraud and abuse that would enable DMA to implement controls across the entire orthopedic footwear sector under the Medicaid program.

While DMA has the administrative right to notify the provider to pay \$251,031.91 in “extrapolated overpayments” because of the provider's inadequate records, DMA is unlikely to ever collect such a sum. DMA's demand is one step in a legal process that will likely result in a negotiated settlement reached by the parties to avoid the provider's threat of protracted litigation.

According to a Medicaid specialist, Medicaid providers complain that the extrapolated overpayment system fails to differentiate between inadvertent mistakes and outright fraud and is heavy-handed in determining overpayments. His remarks at the Health Care Financing, 1998 Administrations National Fraud, Waste and Abuse Conference, March 17, 1998 are excerpted as follows:

Now, I spent some time with the industry and provider groups and at compliance conferences and listened carefully to their view, their perception of what is happening here. I just want to try and summarize it. If it heard it right, this is what the industry is saying. Five short statements:

First, overly aggressive government investigators are mercilessly hounding honest providers without cause.

Second, providers settle when they get their false claims notices in the mail. They settle only because they're powerless to defend themselves against the formidable weaponry now being used by the government.

Third, government investigators are incapable of distinguishing between honest billing errors and deliberate fraud. They simply don't know the difference.

Fourth, billing errors do, of course, occur, but when they occur it's a result of a combination. A combination of extremely complicated

rules, coupled with overburdened, under-qualified billing clerks that the provider organizations can only afford to pay \$10 an hour or so.

Fifth, that when provider organizations plead guilty to criminal fraud and pay hundreds of millions of dollars in settlements, they do so out of expediency, as the cheapest and quickest way to get the government off their back so they can get back to the important work of delivering medical care. And that at the end of the day, they really did nothing wrong at all. I don't know who the industry is trying to kid. Maybe you kid each other, maybe you kid yourselves, but nobody else buys that story. In particular, the public is not fooled for a minute.¹²

This Office is concerned about other inherent weaknesses in the system as reflected by this investigation, including the following:

- MassPro's review, in this instance, did not look beyond record-keeping shortcomings for the most-part;
- it did not recognize other patterns of apparently abusive billing, including overcharging, double-billing, and unbundling which might have led DMA to look for similar patterns in claims of other orthopedic footwear providers.

In the transactions reviewed during this investigation, DMA paid the claims in full, unaware that providers were gaming the system. DMA educates providers of rules and guidelines, pays invoices as expeditiously as possible, and uses internal staff auditors and contract field auditors to "chase" providers by conducting internal service utilization reviews and outside spot audits of a small number of transactions.

The pay and chase system represents another tool available to DMA to prevent fraud and abuse. It is effective, however, only to the extent that providers are unwilling to bear the risk of falling into the audit net and being forced to pay "extrapolated charges." For example, if DMA auditors determine that 10 percent (10%) of a provider's 32 audited claims are out of compliance with Medicaid regulations, DMA can demand repayment of up to 10 percent (10%) of all claims

¹² Health Care Financing Administrations' National Fraud, Waste and Abuse Conference March 17, 1998, Dr. Malcolm Sparrow Lecturer, Harvard University

paid to the provider in the audited period. This theoretically represents a powerful incentive for providers to comply with the Medicaid regulations, except if providers believe that they won't be audited or, if so, that they will be able to negotiate and pay only a small settlement.

Another means of fraud detection at DMA's disposal are its in-house and contracted field auditors who are instructed to look for and report wider patterns of billing irregularities. Because they typically see only a narrow field of claims, usually only 25 clients during an audit, the auditors are inherently limited in their ability to discern broader patterns of fraud. This problem is exacerbated by the fact that DMA does not have sufficient manpower or resources to conduct audits with great regularity in every subpart of its \$5 billion dollar program.

A large part of the responsibility for detecting patterns of fraud and abuse rests on DMA's monitoring staff, i.e., the SURS staff. In the Boston Boot Makers case, they successfully identified a potential problem early on by using their technological claims tracking system. Unfortunately, DMA failed to respond expeditiously.

Finding 15. The Commonwealth's orthopedic footwear benefits are generous in comparison to benefits offered by Medicare and other states

In comparison to the orthopedic footwear benefits offered by Medicare, private insurance companies, and most other states, those of the Commonwealth are very generous. The Commonwealth's standards for medical necessity, for all practical purpose, are open-ended. By comparison, the federal government's Medicare program provides shoes only to recipients with diabetes or leg-braces. The Commonwealth's private health maintenance organizations and indemnity insurance plans generally offer no orthopedic shoe benefits. Likewise, the Commonwealth offers the widest possible array of orthopedic shoe types, including off-the-shelf orthopedic shoes. By comparison, Medicare of many other

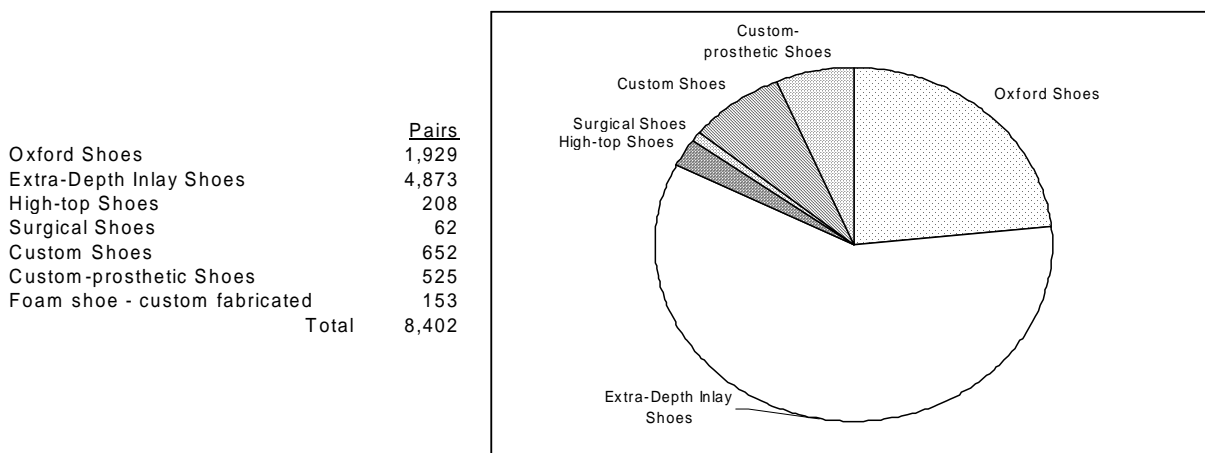
states limit their benefits to shoes types designed for more serious conditions, such as extra-depth and custom-molded shoes.

DMA regulations provide that orthopedic shoes will be considered “medically necessary” if they are reasonably calculated to “prevent the worsening of, alleviate, correct, or cure conditions in the member that . . . cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity.”

Likewise, regulations provide that DMA does not pay for orthotic or pedorthic services unless they can “reasonably be expected to make a meaningful contribution to the treatment of a member's condition or the performance of the member's activities of daily living.”

Several physicians commented to this Office that these standards, as they apply to orthopedic footwear, leave the physician little choice. As long as the physician determines that orthopedic shoes will alleviate foot pain and make “a meaningful contribution to the treatment of a member's condition or the performance of the member's activities of daily living,” he or she has little choice but to write a prescription for orthopedic shoes.

As demonstrated in the following chart and graph, the Commonwealth provides a broad array of orthopedic benefits, far exceeding those offered by the federal government and most other states.



Comparison of Orthopedic Footwear Benefits

MEDICARE – Unlike the Medicaid Program, Medicare covers shoes, inserts, and modifications only under limited circumstances. Medicare covers these benefits only if the following criteria are met:

- 1) The patient has diabetes mellitus; and
- 2) The patient has one or more of the following conditions:
 - a) Previous amputation of the other foot, or part of either foot, or
 - b) History of previous foot ulceration of either foot, or
 - c) History of pre-ulcerative calluses of either foot, or
 - d) Peripheral neuropathy with evidence of callus formation of either foot, or
 - e) Foot deformity of either foot; or
 - f) Poor circulation in either foot; and
- 3) The certifying physician who is managing the patient's systemic diabetes condition has certified that indications 1 and 2 are met and that he/she is treating the patient under a comprehensive plan of care for his/her diabetes and that the patient needs diabetic shoes.

Under Medicare, a qualifying patient is limited to one of the following footwear categories within one calendar year:

- a) One pair of depth shoes and three pairs of inserts, or
- b) One pair of custom molded shoes (including inserts) and two additional pairs of inserts.

In addition, separate inserts may be covered under certain criteria, and a shoe modification will be covered as a substitute for an insert. Finally, a custom molded shoe is covered when the patient has a foot deformity, that cannot be accommodated by a depth shoe.

Medicare defines therapeutic shoes and inserts for diabetics as follows:

A depth shoe is one that: 1) has a full length heel- to- toe filler that when removed provides a minimum of 3/16" of additional depth used to accommodate custom-molded or customized inserts; 2) is made from leather or other suitable material of equal quality; 3) has some form of shoe closure, and; 4) is available in full and half sizes with a minimum of three widths so that the sole is graded to the size and width of the upper portions of the shoe according to the American standard last sizing schedule or its equivalent. (The American standard last sizing schedule is

the numerical shoe sizing system used for shoes in the United States.) This includes a shoe with or without an internally seamless toe.

A custom-molded shoe is one that: 1) is constructed over a positive model of the patient's foot; 2) is made from leather or other suitable material of equal quality; 3) has removable inserts that can be altered or replaced as the patient's condition warrants, and; 4) has some form of shoe closure. This includes a shoe with or without a internally seamless toe.

An insert is a total contact, multiple density, removable inlay that is directly molded to the patient's foot or a model of the patient's foot, and that is made of a suitable material with regard to the patient's condition.

According to a national Medicare policy determination, shoes and related modifications, inserts, and heel/sole replacements for patients who do not meet the criteria for therapeutic diabetic shoes are covered only when the shoe is an integral part of a brace.

To contain costs, Medicare limits coverage to 80 percent (80%) of the established rates for the above benefits.

State by State Comparison of Orthopedic Shoe Benefits

In contrast to the Medicare restrictions, the Commonwealth's Medicaid program allows physicians to prescribe ready-made and custom-molded orthopedic shoes for a much broader category of medical conditions than Medicare.

CALIFORNIA - Stock conventional and stock orthopedic shoes are covered when provided by a prosthetist or orthotist on the prescription of a physician or podiatrist and when at least one of the shoes will be attached to a prosthesis or brace. Modification of stock conventional or orthopedic shoes is covered when medically indicated; custom made orthopedic shoes may be authorized when there is a clearly established medical need that cannot be satisfied by the modification of stock conventional or stock orthopedic shoes.

MAINE - "Space shoes – orthopedic shoes made from a mold or cast or with brace attached" may be billed only by the orthotist or manufacturer. Authorization prior to Provision (APT) is required.

MASSACHUSETTS – Orthopedic shoes of the following types are authorized: off-the-shelf orthopedic shoes, extra-depth shoes, custom shoes, custom-molded

shoes and a variety of other kinds. Limit: two pairs per year. Footwear additions, including custom inserts are also allowed. No age limit.

MICHIGAN – “Club foot shoes”; shoes attached to a brace, mis-mated shoes involving a full-size difference or more; shoe modifications for limb length discrepancy or rigid foot deformity, are covered. The following types of shoes are not covered: shoes for flexible flat feet (e.g., orthopedic shoes, tennis shoes, boots; shoes for toe-in or toe-out problems, except where there is a specific deformity of the foot; shoes for torsional problems of the extremities, except when shoes are attached to a brace.

NEW HAMPSHIRE – Purchase of corrective or orthopedic shoes, when prescribed by an orthopedic specialist.

OHIO – Orthopedic shoes are covered only if the shoe is an integral part of a brace with the following exceptions: molded, mis-mated, and club foot shoes or shoes for children under the age of eight, diagnosed as having certain kinds deformities.

PENNSYLVANIA – Payment for molded shoes is made only for those shoes prescribed for severe foot and ankle conditions and deformities of a degree that the recipient is unable to wear ordinary sturdy shoes with or without corrections and modifications. Payment for modifications to orthopedic shoes and molded shoes will be made only if those modifications are necessary for the application of a brace or splint. Payment for orthopedic shoes is made only if the recipient is 20 years of age or younger.

RHODE ISLAND – Orthopedic shoes are covered if attached to a brace. Molded shoes are a covered benefit for Categorically Needy recipients and EPSDT recipients under the age of 21.

It is evidently clear therefore that the Massachusetts Medicaid Program offers the most liberal orthopedic footwear benefits than any of the other states that this

Office reviewed. Therefore, In the face of increasing enrollments in the Medicaid Program, DMA will have to do more than restrict the provision of shoes to two pairs per year to contain costs, as it did in August of 1998, apparently in response to the investigation by this Office.

Finding 16. Some providers are exploiting a loophole in the regulations for nursing home visits by charging for visits on the same day to separate recipients who are confined to the same nursing home (Gang billing.)

Results of this Office's investigation indicate that some providers "gang-bill" for nursing home visits. One provider billed Medicaid 42 times on the same day at \$41.20 per recipient. Another provider made a \$6,000 profit on 26 pairs of shoes that he provided to 26 different nursing home patients on the same day. The provider charged Medicaid \$8,270 for the shoes. This Office's analysis indicates that the provider overcharged Medicaid for each of these pairs of shoes by double billing and sometimes adding inappropriate "non-standard size" charges. Based on a review of his billings and a sample of his invoices, this Office estimates that the provider paid his supplier approximately \$2,250 for these 26 pairs of shoes, resulting in a one-day profit to him of more than \$6,000. Some providers routinely charge Medicaid for three separate visits to provide a recipient with one pair of shoes; first to measure; next to deliver, and finally to "check up" and re-adjust, thus adding \$123.60 to Medicaid's costs for a single pair of shoes. Nursing home charges are intended to compensate the provider for having to leave his place of business, but the cost of fitting and adjusting shoes is specifically built-in to the base rate established by the Division of Health Care Finance and Policy. Thus, orthopedic providers are prohibited from charging extra for fitting and adjusting shoes. This Office concludes that in this context, multiple nursing home charges for visits to the same facility on the same day represent a form of double dipping for travel expenses by some orthopedic footwear suppliers. Accordingly, this Office recommends that the Division of

Health Care Finance and Policy amend its regulations to establish reasonable limits on such charges to prevent such abuses.

Finding 17. Weaknesses in the administrative regulations make the system vulnerable to fraud, waste, and abuse by providers

In addition to the weaknesses in the administrative regulations that have been cited in the BBM investigation, this Office found the HCPCS procedure codes to be inexplicit, and generally in need of clarification. DMA has not updated the HCPCS procedure codes effectively to reflect the latest technological advances in orthopedic footwear. Moreover, the codes are not supplemented by specific regulations that would provide the necessary clarification for their utilization.

This Office found that the rates of payment for these codes have been adjusted only three times since they went into effect in April of 1991. These conditions create incentives for fraud, waste, and abuse. The codes should be refined, explicitly defined, and reviewed annually for rate adjustments. Also, a supplemental policy manual should be developed that would regulate their utilization and impose more accountability on the providers. This Office noted that the revised prescription form that DMA instituted in August 1998 is evidently based on a format similar to the one commonly used for qualifying diabetics under the Medicare Program. Unless the Commonwealth ultimately restricts orthopedic footwear benefits to diabetic patients, DMA should revise the form to indicate a broader classification of covered foot conditions and HCPCS codes, in order to establish the accountability of the referring physicians and providers more clearly. For example, the classifications on the current form do not distinguish between depth and non-depth orthopedic shoes, or between custom-molded and pre-molded inserts. Finally, as an alternative to administered prices, DMA should consider best value contracting with manufacturers of orthopedic footwear in order to maximize cost savings for the Medicaid program.

Part Three: Summary of the Conclusions and Recommendations

In order to ensure that the Medicaid program is administered in accordance with the objectives of the Governor and the state legislature, it is obvious that DMA must tighten its administrative regulations and management controls. Specifically, DMA must adopt a more restrictive policy concerning the provision of Medicaid services for orthopedic footwear. It should work the Division of Health Care Finance and Policy to refine the procedure codes, redefine them explicitly, and develop a supplemental policy manual for utilization of the codes. To hold referring physicians and providers accountable in a more effective manner, DMA should redesign the prescription format to be more specific and more reflective of allowable footwear benefits. In addition, it should conduct annual reviews of the procedure codes and rates of payment and adjust them if appropriate. However, DMA should also consider replacing administered prices with best-value contracts with manufacturers of orthopedic footwear.

DMA has an urgent need to upgrade its computer systems in order to improve its ability to detect fraud, waste and abuse. It should have taken corrective action to close the loopholes in its computerized claims payment system in October of 1993 when MFCU advised it that MFCU had initiated an investigation of a provider for the same kinds of fraudulent practices that this Office later discovered. If DMA had done so, it could have prevented the losses to the Medicaid program identified in this report. DMA must improve its audit methodology and ensure that qualified auditors perform cost analyses or financial audits. In addition, it must ensure that qualified personnel perform special reviews, such as prior authorization or individual consideration reviews. As stated in Part 1 of this report, DMA must develop a closer working relationship with MFCU in order to facilitate an early detection of fraud waste and abuse. Finally, the findings in this report suggest that further investigation of the Medicaid program may be warranted.

Appendix A: Letter from BBM's attorney¹³

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December 28, 1998

BY HAND

Gregory Sullivan
First Assistant
Office of the Inspector General
One Ashburton Place, Room 1311
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RECEIVED

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OFFICE OF
INSPECTOR GENERAL

Dear Greg:

Thank you for meeting again last Tuesday with Boston Boot Makers in connection with your work with respect to House Order No. 4949. We appreciate your observation that Boston Boot Makers and its owner and employees have been fully cooperative with your study, meeting with you and your staff numerous times over this past year and providing you with any and all records and paperwork requested. You mentioned on Tuesday that your office intends to get its report out by December 31. Given the rush of the Christmas holiday we are obviously disadvantaged by this timetable, but nevertheless want to make a response to the couple of questions you raised.

To the extent that the Inspector General's report can impart a degree of rationality, common sense, and fair dealing into the manner in which we as taxpayers authorize the DMA to purchase supplies for needy Massachusetts residents, so much the better. It is precisely that hope which has motivated the company's commitment to fully cooperate with your office. Boston Boot Makers earnestly believes that substantial reform is necessary. This is not a new position for this third generation business of custom made boots and shoes. It has consistently requested sensible reforms of DMA's medical necessity protocols since the early 1990s. Indeed, in conjunction with members of the General Court, it convinced an uninterested DMA to put in place a protocol whereby doctors would authorize the need for Boston Boot Makers' expensive hand-made products. DMA agreed that it would review each physician authorization, in order to ensure medical necessity.

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¹³ This Office met with BBM's president and attorney in December, 1998 to question BBM's president about many of the issues addressed in this report. At the conclusion of the meeting, this Office invited BBM's president to respond in writing. BBM's attorney responded with the attached letter. This Office has redacted the names of certain parties from this copy of BBM's correspondence.

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Of course, we now know that DMA did none of this. It did not ever review any of the prescriptions that physicians provided for each pair of shoes made by Boston Boot Makers, it never reviewed any of the physician paperwork submitted with the claim form, and it never responded to Boston Boot Makers' numerous requests for a tighter, more conservative, and easily achievable prior claims approval process for each request made by a DMA recipient. We now know that DMA ignored this medical necessity compliance task entirely. Apparently it was willfully ignorant even of the identity of the physicians ordering the shoes. (Your investigators, who have had custody of Boston Boot Makers' customer records over the past year, pointed out that without access to these records your office would not have known the identities of the prescribing physicians.) DMA should have been reviewing prescriptions and speaking with physicians who were ordering these shoes for their patients. Instead it queried Boston Boot Makers on such largely irrelevant items as the cost of laces and eyelets.

Your office has copies of Boston Boot Makers' correspondence, in which the company consistently offered to work with DMA to create a prior approval protocol. Your office does not have any return correspondence from DMA, because there wasn't any. Apart from a meeting organized by a thoughtful and responsible State Senator in 1992, DMA was obtuse.

Ultimately, it brazenly attempted to blame Boston Boot Makers for DMA's own failure to police its physicians and its recipients. It threatened Boston Boot Makers with extraordinary penalties. Only when Boston Boot Makers invoked its rights under the public records law did DMA agree to communicate with Boston Boot Makers. As your office now knows, DMA told Boston Boot Makers that it would drop its trumped up charges against Boston Boot Makers, and would pay Boston Boot Makers the substantial accounts payable that the small company needed to survive for shoes it had made, if Boston Boot Makers agreed to no longer serve Medicaid recipients. Taxpayers presumably do not expect the regulatory agencies that serve them to engage in this sort of blackmail and bad faith. Your report should bring this misfeasance to light.

You raised a couple of questions last week after your office's exhaustive review of the Boston Boot Makers records. I must query, respectfully, whether too much attention is being focused on the trees and not on the forest as a whole. For example, you raised a question as to how the labor cost of shoes was calculated in 1992. It is worth recollecting that Boston Boot Makers charged DMA for hand-made shoes and boots the same price it charged any other customer. These prices were set well before 1992, long before any job cost information was requested by DMA. DMA never objected to the price of those shoes. It simply took in Boston Boot Makers' claim forms and, instead of reviewing them during the suspension period as contemplated by Boston Boot Makers and DMA in the 1992 protocol, it paid for the shoes. In 1992 one conscientious DMA employee worked to set up the medical necessity protocol after the meeting in Senator _____'s office. She asked that DMA's records be completed by a job cost for

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the shoes DMA was paying for. Boston Boot Makers, then run by the widow of the second generation owner of the business, herself failing in health, assisted by her daughter and a handful of artisans, attempted to cost out the different components of the charge. Plainly, this effort was not intended to set a price for these shoes. The price had been set and agreed upon years earlier. Rather, it was an effort to document cost components, using intelligent guesswork and approximations as to time needed to make shoes, time needed to rebuild shoes rejected by DMA recipients, and the like. Several versions of this job cost were prepared and submitted to DMA as shoemakers expressed different opinions, as administrative compliance costs were weighed, etcetera. That is why, as you noted, of DMA received a revised worksheet in 1996. Neither she nor anyone else at DMA asked for these revised figures. Boston Boot Makers sent them and other documents as part of an ongoing effort to enable DMA to better understand the company and its products. It is difficult to determine in finality what the job costs should have looked like. The important point is that DMA didn't care. It continued to pay the same price for the same high quality shoes that it had been paying before. Boston Boot Makers has enabled your office to review certain privileged financial documents, which of course you have no right to disclose. You know that from 1992 through 1997 Boston Boot Makers was not a profitable company. In those years in which it reported profits, they were negligible. You have also seen an appraisal of the company commissioned by the Executors of the Estate of Mrs. , who died in 1995. You are aware that this appraisal values the company in the (very) low five figures, and that the appraiser stated that Boston Boot Makers "has operated at a break-even level since 1990, and would have reported significant losses if the Company paid a fair market officers' compensation, and [therefore] a value based on earnings or any derivative of earnings is not appropriate".

Hence it should be obvious that this little company is not a "Medicaid mill" taking advantage of the system. Just the opposite. In fact, putting aside its loyalty to its aging long-term employees, it probably should have closed its doors before Mrs. ' death in 1995. Certainly, it found it useless (if not counterproductive) to have constantly been asking DMA for tighter protocols to ensure that only those people who really needed those shoes could get them. Your report hopefully will document these attempts and DMA's lack of response because those vignettes crystallize the problems with DNA. The agency obviously cannot manage itself, and when it finds itself under fire it attempts to tarnish or slander third parties, particularly when those third parties have been asking for them to do the right thing all along. No doubt this is why DMA is in the awkward position of suggesting that it was relying on elderly shoemakers to make medical necessity determinations.

You also queried whether Boston Boot Makers had fully complied with the protocol it set up with DMA in 1992. Recall that each recipient's customer file had a signed prescription from a doctor prescribing these shoes. Each physician received a "Dear Doctor" letter informing them

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that they were dealing with a company that made expensive, high quality shoes, and that Boston Boot Makers was not an orthotics or medical supplies that sold mass-produced items. Each recipient's file also contained a signed statement of medical necessity, jointly crafted by Boston Boot Makers and DMA in 1992, in which the physician listed reasons why the patient needed the shoes and signed the form. In thoroughly reviewing all of the Boston Boot Makers files, you noted that there were a number of these medical necessity statements that were reprinted without the final sentence on the form, which emphatically repeated that these were expensive hand-made shoes.

Is that really significant? Consider: 1) the doctor had read the "Dear Doctor" letter; 2) the doctor had signed a prescription; 3) if the doctor had called Boston Boot Makers, which some of them did, he or she was told about the kind of products sold by Boston Boot Makers. The doctors certainly should have known what they were prescribing for their patients, whether or not certain batches of the medical necessity statements contained the language or not. Also consider: (1) as part of the protocol, DMA said it would suspend and review each claim as it came in; and (2) DMA never questioned (and probably didn't even examine) any of the medical necessity forms. DMA simply paid for the shoes. Obviously, if the claim submitted was incomplete or even questionable, it should have been denied, or at least queried, by DMA.

So was this "noncompliance" material? Clearly, no.

You also noted that your office has spoken with some of the prescribing physicians, who variously denied knowing what they were ordering or expressed puzzlement at the shoes that were ordered, actually, nice looking shoes instead of chunky, custom made orthopedic varieties. Their untested and self-serving comments are of little probative value. Certainly they should have known what they were doing when writing prescriptions. Certainly DMA should have been reviewing utilization by physicians, yet Boston Boot Makers understands that DMA lacks even a list of the physicians who were prescribing these shoes. Certainly no physician ever complained to Boston Boot Makers of the quality or design of the shoes made by Boston Boot Makers. Any patients who complained received a newly built pair of shoes, with no additional charge to DMA.

In so responding to your questions, Boston Boot Makers does not intend criticism of the I.G.'s efforts. But the application of diligent forensic accounting to a small family business, whose principals went from father to mother to daughter over the course of a decade, who dealt with staff in a familial and informal manner, and who operated in a grey bureaucratic twilight with the DMA, simply doesn't work. That approach doesn't discover how many shoes were made by Boston Boot Makers but never charged it to DMA. It doesn't allow for the quantification of the extraordinary employee hours needed to deal with the DMA recipients and the enormous random and inconclusive paperwork requests made by DMA. It doesn't quantify, although it probably

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should, the number of shoes that Boston Boot Makers submitted claims for but were never paid for by DMA. It doesn't take into account the financial damage and the emotional toll caused when a regulatory agency of the Commonwealth slanders a small business, only to relent when it realizes that it might have to disgorge internal DMA records and documents to the inspection of the taxpayers of Massachusetts.

Boston Boot Makers hopes that the Inspector General certainly does disclose the DMA documentation and records to the public. This has been a seamy, unpleasant episode for Boston Boot Makers that has very nearly put it out of business. Hopefully your report will point to practical reforms for the Commonwealth to take when its agents purport to spend its taxpayers' monies wisely and compassionately provide help to those who need it. An irony not lost to Boston Boot Makers, of course, is that there are many DMA recipients who do need custom-made shoes and are not getting them now. Perhaps they are hobbling along on mass-produced orthotic products. Perhaps that is what the General Court, in its wisdom, wishes for these people to do. Wouldn't it be more in accordance with the principles of our Commonwealth to have such decisions made by our legislators on their merits, and not as the result of self-serving bureaucratic manipulation?

Very truly yours,

Brian C. Broderick

BCB/ljb
cc: Ms.
Hon.

Appendix B: Examples of stylish Boston Boot Makers, Inc. shoes and boots

Review of BBM's case files by this Office demonstrate that its Medicaid clients often asked for and received stylish shoes and boots in accordance with the design preferences of the Medicaid recipient. BBM's shoe designers usually made a hand-drawn sketch of the shoe to the specifications of the Medicaid recipient, then made the shoes accordingly. This Office commonly observed apparent discrepancies between what the prescribing physician ordered and what the recipient received.

Record #1

Date of service: 1-10-94

Rx: 1 pair orthopedic shoes to accommodate toe deformities.

Dx: Hallux valgus.

Description: Lace front boots, kid leather, gray.

Cost: \$942.00



Record #2

Date of service: 8-12-93

Rx: Extra wide, orthopedic shoes.

Dx: Bunions, venous stasis.

Description: 12" zipper boots, kid leather, black.

Cost: \$942.00



Record #3

Date of service: 2-24-97

Rx: 1 pair of custom shoes, extra wide, extra depth.

Dx: Hallux valgus, rheumatoid arthritis.

Description: 14" zipper boots, calf leather, black.

Cost: \$942.00



Record #4

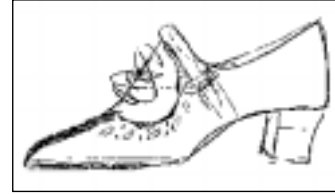
Date of service: 3/27/91

Rx: 1 pair of prescription shoes. Extra wide, arch support, extra depth.

Dx: Hallux valgus with deformity. Wide, flat feet.

Description: Soft white kid leather T-strap with buckle, 1 ½ to 1¾" heels.

Cost: \$921.00



Record #5

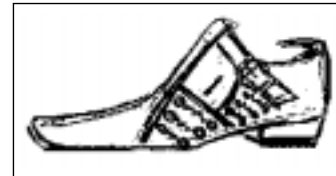
Date of service: 8-4-93

Rx: 1 pair of molded shoes.

Dx: osteoarthritis, severe pain, ulcerations.

Description: Instep strap shoes, kid leather, dark beige.

Cost: \$942.00



Record #6

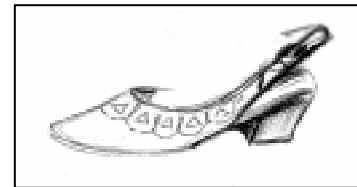
Date of service: 12-7-95

Rx: 1 pair of orthopedic shoes to accommodate pedal deformity.

Dx: Hallux valgus.

Description : Open back shoes, kid leather, black.

Cost: \$942.00



Record #7

Date of service: 2-19-97

Rx: Custom made molded shoes.

Dx: To accommodate pedal deformity.

Description: Open back summer shoes, kid leather, dark beige.

Cost: \$942.00



Record #8

Date of service: 9-12-96

Rx: Extra wide & extra deep orthopedic shoes.

Dx: Bunions, hammertoes.

Description: 1.5" heel, kid leather, burgundy.

Cost: \$942.00



Record #9

Date of service: 12-27-96

Rx: Extra depth shoe (wide width).

Dx: Bunion deformity.

Description: Open summer shoes, kid leather, white.

Cost: \$942.00



Record #10

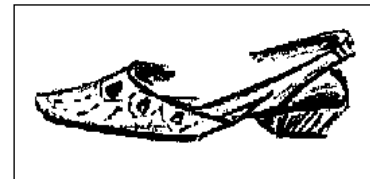
Date of service: 10-23-95

Rx: 1 pair extra width, extra depth custom shoes.

Dx: Hallux valgus, bunions, hammertoes.

Description: Open back shoes, kid leather, light beige.

Cost: \$942.00



Record #11

Date of service: 10-25-95

Rx: Hand-made footwear.

Dx: Flat foot and deformities.

Description: Open back and toe shoes, kid leather, light beige.

Cost: \$942.00



Record #12

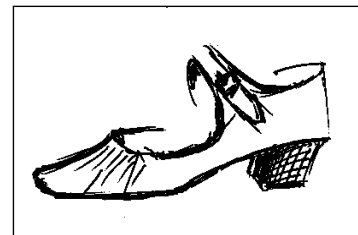
Date of service: 4-23-96

Rx: Extra wide and extra deep orthopedic shoes.

Dx: Bunions & hammertoes.

Description: Instep strap shoes, 3/4" heels, kid leather, beige.

Cost: \$942.00



Record #13

Date of service: 12-23-96

Rx: Right shoe.

Dx: As directed for edema.

Description: 1 pair 5" zipper boots, kid leather, black.

Cost: \$942.00



Record #14

Date of service: 5-8-92

Rx: 1 pair of prescription shoes. Extra wide, extra depth, arch support.

Dx: Hallux valgus with deformity.

Description: 5" zipper boots, kid leather, black.

Cost: \$942.00



Record #15

Date of service: 9-28-95

Rx: 1 pair of orthopedic shoes to accommodate pedal deformity.

Dx: Hallux valgus.

Description: 6" lace front boots, kid leather, black.

Cost: \$976.00



Record #16

Date of service: 3-14-97

Rx: Orthopedic shoes.

Dx: Bilateral hallux valgus, total hip replacement.

Description: Open toe and heel summer shoe, kid leather, white.

Cost: \$976.00



Record #17

Date of service: 11-29-96

Rx: Extra wide, extra deep orthopedic shoes.

Dx: Bunions, hammertoes.

Description: shoes, kid leather with wool, black.

Cost: \$942.00



Record #18

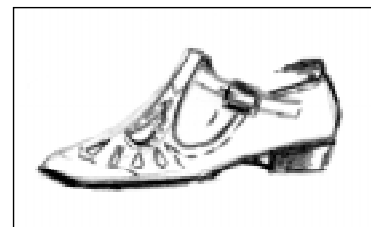
Date of service: 3-28-95

Rx: Extra wide & extra deep orthopedic shoes.

Dx: Bunions with hammertoes.

Description: T-strap shoes, kid leather, white.

Cost: \$942.00



Record #19

Date of service: 1-22-97

Rx: Custom made shoes.

Dx: Bunions.

Description: Open heel and toes shoes, kid leather, light beige.



Cost: \$942.00

Record #20

Date of service: 3-29-95

Rx: Diabetes mellitus, hammertoes, bunions.

Dx: Molded, extra depth shoe with removable plastizone inserts.

Description: T-strap shoes with buckle, kid leather, brown.

Cost: \$993.00



Record #21

Date of service: 2-28-97

Rx: Custom made shoes.

Dx: Bunions.

Description: Instep strap shoes, kid leather, light beige.

Cost: \$976.00



Record #22

Date of service: 4-10-95

Rx: Diabetes mellitus, hammertoes.

Dx: Extra depth, molded shoes to accommodate for hammertoe deformities.

Description: T-strap with buckle shoes, kid leather, light beige.

Cost: \$993.00



Record #23

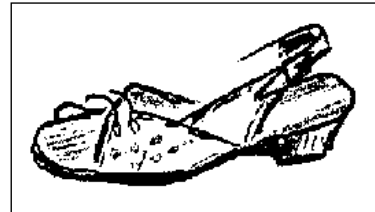
Date of service: 9-18-95

Rx: Extra wide & extra deep orthopedic shoes.

Dx: Hallux valgus, bunions, hammertoes.

Description: 1.5" open heel, open toe, kid leather, white.

Cost: \$942.00



Record #24

Date of service: 11-5-92

Rx: Extra wide, extra deep orthopedic shoes.

Dx: Bilateral bunions, venous stasis.

Description: T-strap shoes, kid leather, black.

Cost: \$942.00



Record #25

Date of service: 6-4-93

Rx: Misc. "contour" type extra depth shoe, custom-made, per patient's defect, laces, oxford.

Dx: Diabetes mellitus, PVD, painful bunions with hammertoes.

Description: Instep strap shoes, kid leather, black.

Cost: \$942.00



Record #26

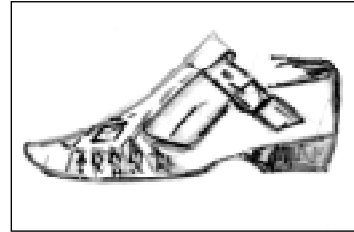
Date of service: 7-26-95

Rx: Orthopedic shoes.

Dx: To accommodate bunions and hammertoes.

Description: Sandals with instep strap, kid leather, dark beige.

Cost: \$942.00



Record #27

Date of service: 12-27-95

Rx: Extra wide orthopedic shoes.

Dx: Bunions, hallux valgus.

Description: Open back with front strap, 1.5" heel, kid leather, white.

Cost: \$976.00



Record #28

Date of service: 11-19-93

Rx: Custom molded orthopedic shoes with radial arch support.

Dx: Bunions, hammertoes.

Description: Instep strap shoes, kid leather, brown.

Cost: \$942.00



Record #29

Date of service: 3-29-96

Rx: 1 pair of custom shoes, extra width, extra depth.

Dx: Hallux valgus, rheumatoid arthritis.

Description: Instep strap shoes, 1" wedgie, kid leather, black.

Cost: \$942.00



Record #30

Date of service: 7-19-96

Rx: Custom-made leather shoes.

Dx: Hallux valgus with bunions, hammertoes.

Description: Instep strap shoes, kid leather, brown.

Cost: \$942.00



Record #31

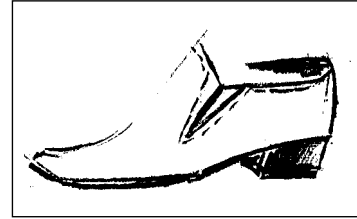
Date of service: 2-8-95

Rx: 1 pair of orthopedic shoes.

Dx: To accommodate foot deformity.

Description: Insert elastic shoes, kid leather, black

Cost: \$993.00



Record #32

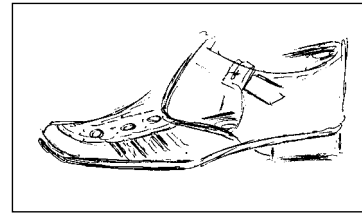
Date of service: 3-31-93

Rx: Custom-made, "orthopedic type" shoes.

Dx: Bunion deformities, hammertoes.

Description: Instep strap shoes, kid leather, light beige.

Cost: \$942.00



Record #33

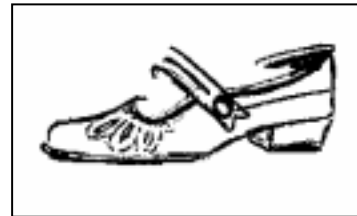
Date of service: 12-22-92

Rx: Extra wide & extra depth orthopedic shoes.

Dx: Bunions, hallux valgus, hammertoes.

Description: Instep strap shoes, kid leather, white.

Cost: \$993.00



Record #34

Date of service: 11-28-94

Rx: Extra depth shoes with arch and to accommodate bunions.

Dx: : Diabetes mellitus, hammertoes, bunions.

Description: Insert elastic shoes, kid leather, light beige.

Cost: \$942.00



Record #35

Date of service: 10-27-93

Rx: 1 pair of orthopedic shoes.

Dx: Hammertoes.

Description: Instep strap loafer, kid leather, light brown.

Cost: \$942.00



Record #36

Date of service: 4-3-96

Rx: 1 pair of orthopedic shoes to accommodate pedal deformity.

Dx: Fractured ankle.

Description: Instep strap shoes, kid leather, gray.

Cost: \$942.00



Record #37
Date of service: 12-17-93
Rx: PVD, hallux valgus, bunions
Dx: Extra depth shoes type (see previous pair)
Description: zipper boots, kid leather, black
Cost: \$942.00



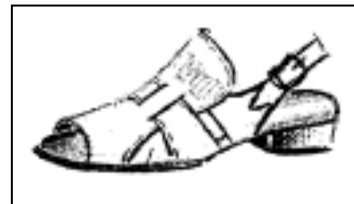
Record #38
Date of service: 10-20-94
Rx: Wholly customized footwear for patient with foot deformity.
Dx: Due to severe osteoarthritis. Medically necessary for safety of patient.
Description: 6" zipper boots, kid leather, brown
Cost: \$993.00



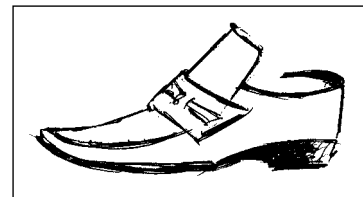
Record #39
Date of service: 10-13-95
Rx: 1 pair of orthopedic shoes to accommodate pedal deformities.
Dx: Severe PVD, Venous Stasis, Hammertoe
Description: Open back shoes, kid leather, beige
Cost: \$942.00



Record #40
Date of service: 7-11-95
Rx: Extra wide & extra deep orthopedic shoes.
Dx: Bunions, edema
Description: Open toe and heel sandal, kid leather, gray
Cost: \$942.00



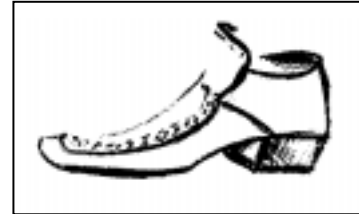
Record #41
Date of service: 6-8-94
Rx: None.
Dx: Hallux valgus on right foot, flat feet.
Description: Instep strap shoes, kid leather, brown.
Cost: \$942.00



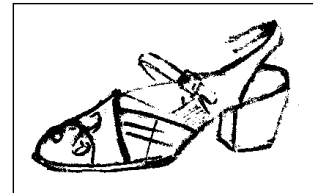
Record #42
Date of service: 2-11-97
Rx: Custom made shoes.
Dx: Flat feet.
Description: Loafer, kid leather, brown.
Cost: \$942.00



Record #43
Date of service: 6-23-94
Rx: Thomas heel.
Dx: Pes planus, hallux valgus.
Description: Shoes with kid leather, dark brown.
Cost: \$976.00



Record #44
Date of service: 3-3-94
Rx: Extra wide & extra deep orthopedic shoes.
Dx: Bunions & hammertoes.
Description: Open shoes, 1.7" heels, kid leather, bone color.
Cost: \$942.00



Record # 45
Date of service: 3-22-96
Rx: None.
Dx: Flat feet.
Description: 8" zipper boots, calf leather, black.
Cost: \$942.00



Record #46
Date of service: 11-27-95
Rx: None.
Dx: Bunions.
Description: Front lace boots, kid leather, brown.
Cost: \$942.00



Record #47
Date of service: 5-26-95
Rx: None.
Dx: Flat feet.
Description: Instep strap shoes, kid leather, gray.
Cost: \$942.00



Record #48
Date of service: 12-17-92
Rx: None.
Dx: Severe bunions, metatarsus, hammertoes.
Description: Instep strap shoes, kid leather, gray.
Cost: \$976.00



Record #49

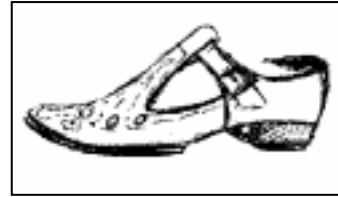
Date of service: 3-4-94

Rx: None.

Dx: Hallux valgus on right foot, coronary artery disease.

Description: Instep strap shoes, kid leather, gray.

Cost: \$942.00



Record #50

Date of service: 5-25-93

Rx: Custom molded orthopedic shoes with medial arch supports.

Dx: Pes planus, bunions, hammertoes.

Description: Boots, kid leather, black.

Cost: \$942.00



Record #51

Date of service: 12-18-96

Rx: Customized footwear.

Dx: Osteoarthritis, bunions.

Description: Ankle high boots, kid leather, black.

Cost: \$942.00



Record #52

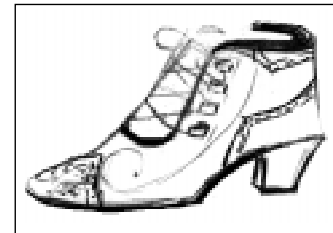
Date of service: 3-26-96

Rx: Extra wide, extra deep orthopedic shoes with built on medial arch support.

Dx: Pes planus, bunions, hammertoes.

Description: Front lace ankle shoes, 1 1/2" heel, kid leather.

Cost: \$ 942.00



Appendix C: Glossary of Medical Terms

Bilateral - of, or relating to, or affecting the right and left sides of the body or the right and left members of the paired organs; having bilateral symmetry; reference, bilateral bunions.

Bunion - an inflamed swelling of the small sac on the first joint of the big toe; reference, bilateral bunions.

Callus - a thickening of or a hard thickened areas around a break in a bone and is converted into bone in the healing of the break; reference, pre-ulcerative callus.

Capillary Artery - any of small blood vessels connecting arterioles (any of small terminal twigs of an artery that ends in capillaries) with venules (small veins) and forming networks throughout the body; reference capillary artery disease.

Clubfoot - any numerous congenital deformities of the foot in which it is twisted out of position or shape; reference, semi-clubfeet.

Coronary Artery - either of two arteries, one on the right and one on the left, that arise from the aorta immediately above the semi-lunar valves and supply the tissues of the heart itself; reference, coronary artery disease.

Deformity - the state of being deformed; physical blemish or distortion; reference, bunion deformity; pedal deformity.

Diabetes Mellitus - a familial constitutional disorder of carbohydrate metabolism characterized by inadequate secretion or utilization of insulin, by excessive urine production, by excessive amounts of sugar in the blood and urine, and by thirst, hunger, and loss of weight.

Edema - an abnormal excess accumulation of serous fluid in connective tissue or in a serous cavity; also called dropsy.

Flat Feet - a condition in which the arch of the instep is flattened so that the entire sole rests upon the ground; a foot affected with flatfoot; walking with a dragging or shambling gait (a walk, trot, pace, or canter).

Hallux Rigidus - restricted mobility of the big toe due to stiffness of the metatarsophalangeal (joint), especially when due to arthritic changes in the joint.

Hallux Valgus - an abnormal deviation of the big toe away from the midline of the body or toward the other toes of the foot that is associated especially with the wearing of ill-fitting shoes.

Hammertoes - a deformed claw-shaped toe and especially the second that results from permanent angular flexion between one or both phalangeal joints; also called claw toe.

Metatarsalgia - a cramping burning pain below and between the metatarsal bones where they join the toe bones.

Metatarsus - the part of the foot in man or the hind foot in quadrupeds that is between the tarsus and phalanges, contains when all the digits are present (as in man) five more or less elongated bones but is modified in many animals with loss or reduction of some bones or fusing of others, and in man forms the instep.

Neuropathy - an abnormal and usually degenerative state of the nervous system or nerves; reference, peripheral neuropathy.

Osteoarthritis - arthritis of middle-age characterized by degenerative and sometimes hypertrophic changes in the bone and cartilage of one or more joints and a progressive wearing down of apposing joint surfaces with consequent distortion of joint position usually without bony stiffening; also called, degenerative arthritis, degenerative joint disease, hypertrophic arthritis.

Pedal - of or relating to the foot; reference, pedal deformity.

Peripheral - of, or relating to, involving, forming, or being part of the nervous system; of or relating to blood circulation; located near a periphery or surface part; reference, peripheral neuropathy.

Pes - a distal segment of the hind limb of a vertebrate including the tarsus and foot; reference, pes planus.

Planus - flatfoot; a condition in which longitudinal arch is broken, and the sole is touching the ground; reference, pes planus.

PVD - (Peripheral Vascular Disease) - vascular disease affecting the blood vessels, especially of the extremities.

Rheumatoid Arthritis - chronic disease that is of unknown cause and is characterized especially by pain, stiffness, inflammation, swelling, and sometimes destruction of joints.

Stasis - a slowing or stoppage of the normal flow of the bodily fluid or semi-fluid; slowing of the current or circulating blood; reduced motility of the intestines with retention of feces; reference, venous stasis.

Ulcerate - to affect with or as if with an ulcer; to undergo ulceration; the process of becoming ulcerated; the state of being ulcerated; reference, pre-ulcerative callus.

Venous - full of or characterized by veins; made up of or carried on by veins; of relating, or performing the functions of a vein; of blood: having passed through the capillaries and given up oxygen for the tissues and become charged with carbon dioxide and ready to pass through the respiratory organs to release its carbon dioxide and renew its oxygen supply: dark red from reduced hemoglobin; reference, venous stasis.

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