Geoffrey Mangers Vs.
~~The County of Santa Clara Et. Al.~~
(***caption in dispute:*** that's not how I filed it, the county is also a victim in all this)

The LPS ("Mental Health") $Malpractice$ Complex

The New York Times

National Medical Enterprises

	Page
Chain of Mental Hospitals Faces Inquiry in 4 States (10-22-91) By PETER KERR	2
Paying for Fraud/A special report.; (11-24-91) By PETER KERR Mental Hospital Chains Accused of Much Cheating on Insurance (6 pages)	6
8 Big Insurers Sue National Medical Enterprises (7-31-92) By PETER KERR	12
National Medical Faces Second Suit by Insurers (9-15-92) By PETER KERR	13
Nearly Half of Suits Settled, Medical Enterprises Says (11-17-93) By MICHAEL QUINT	14
National Medical Enterprises Selling 28 Hospitals (12-4-93) By MILT FREUDENHEIM	15

"You can't fix it.."

Dr. Florence Keller told me in a moment of honest candor *".. or maybe you can".*
"You know it's broken" I told Michael Fitzgerald (El Camino Hospital Behavioral Health Director) who never disputed it.

Everyone knows it's broken.
And it's wrong, just plain ***Wrong***.

The old "shortage of beds" shibboleth. That the 2003 Civil Grand Jury Report made short shrift of:
"It was found that there was no lack of beds but a problem of discharging patients to appropriate levels of care"
(a euphemism for a misdiagnosis)

It just keeps going up .. and up .. and up..
"National Medical Enterprises Inc, … selling 28 hospitals and 45 satellite outpatient clinics to the Healthsouth Rehabilitation Corporation for about $300 million in cash. .. Healthsouth, .. , **rose $3.25, to $20 a share**.."

"A private psychiatric hospital is a dangerous thing" (author unknown)

Any royalties the New York Times is due for this splendid series of articles they are certainly more than welcome to.
Geoffrey Mangers

COMPANY NEWS

Chain of Mental Hospitals Faces Inquiry in 4 States

By PETER KERR

Published: October 22, 1991

Law enforcement officials in several states have begun investigations of one of the nation's largest private psychiatric-hospital chains on charges that it systematically misdiagnosed, mistreated and abused patients to increase its profits from insurance claims.

Over the last decade, the company at the center of the investigations, Psychiatric Institutes of America, the operator of 73 hospitals and treatment centers across the nation, has been regarded as one of the most modern, profitable and prestigious enterprises in the fast-growing industry of private psychiatric hospitals.

Its Fair Oaks Hospital in Summit, N. J., for example, is widely known as a center for research and treatment of drug addiction. In the 1980's, celebrities praised their treatment there and its doctors were models to many health professionals of a new generation of psychiatrists as entrepreneurs.

The investigations, under way in New Jersey, Texas, Florida and Alabama, involve complaints from those and other states, law enforcement officials say.

The company says that complaints against its hospitals and drug and alcohol treatment centers are overblown or inaccurate. It says they are not guilty of any wrongdoing.

But health authorities say that questions about these institutions are part of a broad, accelerating crisis in the private, for-profit psychiatric-hospital industry, an enterprise that has grown rapidly in the last decade. At its heart is a fierce argument about their quality of care, rising costs and attempts to balance the needs of patients with the search for profits.

Concern about the possible abuse or overuse of mental-health services is especially great now because the costs associated with these practices have become an important factor in driving up the nation's overall health costs -- now 12 percent of the gross national product.

"One of the big questions facing American psychiatry is whether or not the profit motive in hospitals drives people to do things that are unacceptable ethically," said Dr. Paul Fink, a former president of the American Psychiatric Association. "That doesn't mean every private psychiatric hospital is bad. It means that some people who tie their jobs and their world to the bottom line are going to seek patients in every way they can."

In more than 200 complaints to law enforcement officials in New Jersey, Florida, Texas and Alabama, and in an extensive series of interviews, former patients, their relatives and former staff members made these charges, among others:

*The company's hospitals in New Jersey, Florida and Texas admitted patients who did not need hospitalization. In Texas, the State Attorney General says the hospitals hired "bounty hunters" who "kidnapped" patients with medical insurance.

*In Florida, former patients and their families charged in lawsuits that the hospitals kept patients against their will, or even against the wishes of their families, including, in one case, a 3-year-old child.

*The company's hospitals in New Jersey and Florida crafted diagnoses to meet patients' insurance coverage, investigators said.

*In some cases, the hospitals kept patients until their insurance ran out, whether they needed such hospitalization or not, according to law suits and former staff members in New Jersey, Florida and Alabama. In other cases, the hospitals are said to have released patients as soon as their insurance was exhausted whether they were ready to be discharged or not.

*Hospitals in a number of states awarded bonuses to top staff members as incentives to keep patients for longer stays, former staff members said.

Company Defends Treatment

A spokesman for the company, which is a subsidiary of National Medical Enterprises Inc. of Santa Monica, Calif., said that charges against the hospitals were made by a small number of former employees and that treatment at most of the chain's hospitals was beyond reproach.

"Patients are admitted by physicians when physicians determine that it is medically necessary to do so," said the spokesman, David Olson. "The overwhelming majority of patients are the subject of outside third-party utilization review or case management."

Charges of kidnapping, altering diagnosis, or any altering of medical tally false, he said, adding that it is ending the practice of paying staff bonuses on the basis of the number of patients in hospitals.

Nonetheless, Mr. Olson said, the company recently hired two law firms to conduct a review of practices at all its hospitals, and the top executive overseeing the psychiatric hospital subsidiary, Norman A. Zober, left his post on paid leave earlier this month.

Mr. Olson said that National Medical Enterprises did not comment on cases of individuals. In Florida, dozens of former patients from the company's two hospitals in Palm Beach County have registered their complaints, often in public demonstrations outside the hospitals. Bill Coakley, an organizer of the demonstrations, pointed to a number of examples. These and other former patients made themselves available for interviews after several of them found they had had similar experiences, formed patients' advocacy groups and decided their stories should be made public.

Admitted for Anorexia

Kelly Dewald, a Palm Beach County resident, said she voluntarily admitted herself to the company's Lake Hospital of the Palm Beaches in Lake Worth for treatment of anorexia four years ago when she was l7 years old. She said she received little treatment for the eating disorder but instead was put on antidepressants that brought on hallucinations and paranoia. After 34 days, when her insurance ran out, she said she was summarily discharged and told her treatment was over.

"At this point I was left with nothing," she said. "But one week after I stopped taking medication, the violence, the fear and paranoia disappeared."

Her bill, for nearly $26,000, included charges of $3.75 for one Bufferin tablet and 30 biofeedback sessions at $150 each. She said that she had been unable to get anyone at the hospital to take her complaints seriously, and that she had talked to a lawyer who said she would probably lose if she went to court.

Charges at Psychatric Institute hospitals in Florida and New Jersey often run from $700 to $1,000 a day. The costs of residential treatment vary greatly at other hospitals, but according to Dr. Charles E. Riordan, a clinical professor of psychatry at Yale University, public or not-for-profit private hospitals often charge $400 to $500 daily.

In another Florida case, Eileen Vinsand, the wife of a Palm Beach County firefighter, said the stay of her 10-year-old son, Jimmy, in the company's Fair Oaks Hospital in Boca Delray turned into the worst conceivable family horror. A school guidance counselor recommended that Fair Oaks evaluate the boy in 1988 for hyperactivity and behavioral problems.

Asked About Insurance

She said the hospital's first question was whether he was covered by insurance and when that was confirmed he was promptly admitted Mrs. Vinsand, who had been trained as a nurse, said she was subsequently told that she could not visit her son. But she said she forced her way into his room and that what she saw were actions unlike anything she had seen in him before: "He was having what looked like grand mal seizures. He was terrified. He was flipping his head back and stuttering and his eyes were running back into his head."

She said she demanded his release but the doctor in charge told her that her son had brain damage and if she removed him the hospital could have her rights of custody to the child taken away.

"I believed it," she said. "They play off your emotions. They have M.D.'s after their names. They are God."

Her son was released several days before his insurance ran out. She said Jimmy soon regained his normal health and has now outgrown his hyperactivity.

Why did she not sue? Because the child got better so quickly and "you don't sue God."

Threat Is Reported

Last January in Anniston, Ala., W.T. Gable, a retired insurance agent, said he took his 73-year-old wife, Elsie, who was having repeated nightmares, to the psychiatric ward at the Regional Medical Center. The ward is operated by Psychiatric Institutes of America.

Mr. Gable said that after a week he wanted to take her out of the hospital but that the doctor in charge refused to allow her to leave and quoted him as saying: "If you do, I'll fix it so that no a doctor in town will touch her."

Mr. Gable said, "I have witnesses who heard that." Mr. Gable said from the day of admission, a chart listed Mrs. Gable's release date as Feb. 6 -- the day her insurance ran out.

"Their intention was to keep her until the 6th," he said, "even before they knew what was wrong with her."

Last year, the medical director and the head psychologist on the ward resigned, saying patients were kept until their insurance ran out.

Psychiatric Institutes of America is one of several major companies that rapidly developed chains of investor-owned psychiatric hospitals in the 1980's. The number of beds in for-profit psychiatric hospitals in the United States grew to 37,500 in 1990 from 21,400 in 1984. The total number of such hospitals grew to 440 in 1988 from 220 in 1984.

Increased Public Acceptance

The growth came as a result of increased public acceptance of psychiatric care, the growth of health insurance plans that paid for psychiatric treatment and the widespread deregulation of the hospitals in several states.

In places like Palm Beach County, one of Florida's affluent vacation spots, for example, the number of free-standing private psychiatric hospitals grew from one to seven, while other general-care hospitals also opened up psychiatric and drug and alcohol units. The same increase, from one to seven, took place in Dallas.

Although scattered complaints have been made about other companies, officials say they have not identified other for-profit hospitals for investigation.

And medical authorities are quick to point out that some of the new entrepreneurial hospitals are providing excellent care. Still, many psychiatrists said they were troubled by the companies' generally aggressive advertising campaigns and the premiums they put on getting and keeping patients with insurance.

Florida Investigations

A spokesman for the Florida Attorney General's office said yesterday that his state's investigation was being handled by the its consumer litigation division, focusing on Fair Oaks and Lake Hospitals. The state insurance company's fraud division said it had begun its own investigation.

In Texas, where Psychiatric Institutes of America operates 13 hospitals, the Attorney General's office is suing the company to stop payment of $3.1 million in funds from a crime victim's compensation fund, which pays for victims' psychiatric services. The suit involves at least 125 patients.

In the suit, the state charges that patients were "subjected to unnecessary and expensive treatment programs, some of which are administered by persons not trained to safely conducte such programs." The state says it is also investigating charges that the company hired people it called bounty hunters to "infiltrate" meeting of Alcoholics Anonymous to find patients.

"They would simply kidnap various persons who didn't need treatment of any kind," said Ron Dusek, a spokesman for the Attorney General's office. "And once they got them into the hospital they held them against their will until the insurance claims ran out."

Settlement in New Jersey

In New Jersey this summer, Psychiatric Institutes of America, which owns Fair Oaks Hospital in Summit, together with doctors there, agreed to pay a $400,000 fine to the state, the largest such settlement in state history.

Both sides agreed not to discuss the basis for the payment but the state said the investigation came in response to complaints from patients and staff members.

Officials familiar with the New Jersey inquiry said that in recent weeks Federal agents and the United States Attorney's office in Newark had joined a new investigation of Fair Oaks that involved charges of criminal insurance fraud.

Louis Parisi, who heads the New Jersey Insurance Department's investigation division, said the department had received more than 300 complaints from around the country about hospitals owned or operated by Psychiatric institutes of America.

Among the charges being investigated in New Jersey, state officials say, are those of Dr. Robert Stuckey, a psychiatrist who served as the medical director of the alcoholic unit at Fair Oaks from 1975 to 1985.

In an interview yesterday, Dr. Stuckey said patients were admitted who did not need treatment and that their diagnoses were shaped to take advantage of insurance coverage.

'Analysis of Insurance'

"The starting point was always their remarkable analysis of insurance," Dr. Stuckey said. "They were geniuses at assessing and diagnosing insurance."

He added: "They took people who didn't need psychiatry. "They took people who couldn't defend themselves and kept them in hospitals for months."

Critics of the hospitals in Florida say that the plight of patients may be best illustrated by the case of three children whose parents were divorced and who were were being confined unnecessarily at Fair Oaks at Boca Delray.

The children's father, George Pallay, has sued the hospital, saying that his children, aged 3, 8 and 9, had been held for six weeks until their insurance coverage ran out.

Mr. Pallay's lawyer, Theresa DiPaolo, said an investigation by insurance companies later found that the children did not need psychiatric hospitalization.

NEXT: Managed care controversy.

Photos: Psychiatric Institutes of America is at the center of charges that its hospitals systematically misdiagnosed, mistreated and abused patients to increase its profits from insurance claims. One of its hospitals, Fair Oaks Hospital in Summit, N.J., is widely known as a center for treatment of drug addiction. (F. N. Kinney for The New York Times) (pg. D4) Graph: "A Growing Number of Beds" shows number of beds at the largest for-profit, short-term psychiatric and alcohol-rehabilitation hospitals, 1984-91; notes the number of for-profit psychiatric hospitals rose to 444 in 1988, from 220 in 1984. (Source: Sanford C. Bernstein & Company) (pg. D4)

Paying for Fraud/A special report.;
Mental Hospital Chains Accused of Much Cheating on Insurance

By PETER KERR

Published: November 24, 1991

Investigators looking into psychiatric hospitals that are operated for profit have uncovered evidence of fraud and abuse in the filing of insurance claims that could run into millions of dollars.

The authorities say these investigations, coupled with earlier findings, suggest that insurance fraud and abuse may permeate the entire medical field and contribute significantly to the country's soaring health-care costs.

Officials in the Federal Government and six states initially focused on complaints of patients at one leading chain, Psychiatric Institutes of America. But Texas officials have now named three other national chains. The investigators say the complaints under review are essentially about private for-profit hospitals as opposed to the nonprofit private or public institutions.

At Psychiatric Institutes of America, investigators say they have identified the following types of practices:

*Inflated bills for medications and services -- $1,100 a person for three hours of group therapy, or $4.15 for a single Advil tablet that costs 11 cents in drugstores.

*Billing for services never rendered, as in the case of a woman who says she was charged for group therapy at $80 an hour when she was at lunch, at dinner, or was being inspected for lice.

*Diagnoses and treatments altered to match insurance coverage.

*Admitting children to psychiatric hospitals even though experts say they do not need hospitalization.

Psychiatric Institutes acknowledges isolated instances of abuse but says the practices are not widespread.

The cases raise questions, experts say, of why in even the most extreme examples of general medical insurance abuse, the institutions that should be responsible for preventing or correcting it -- the insurance companies, regulatory agencies and professional medical societies -- have appeared either unwilling or unable to do so.

And they come to light as members of Congress and some leaders in the insurance industry and medical profession express growing concern.

"Insurance fraud and abuse are weeds that are growing fast, and if they are not stopped they will suffocate the health care garden," said James L. Garcia, the director of Health Plans for the Aetna Insurance Company and one of the nation's leading experts on insurance fraud. "The whole system is in dire need of reform."

Patients and former employees have described their experiences to investigators in Texas, New Jersey, Florida, Alabama, Louisiana and California and in interviews with The New York Times. Major L. Harper of Fort Worth, for one, told how his 70-year-old wife, Jean, received a $5,000 pharmacy bill after a one-month hospital stay. She was charged $3.75 a tablet for Tylenol with codeine, a drug that sells wholesale to pharmacies for 42 cents a tablet.

"The testimony we have heard from hundreds of members of the public indicates that fraud and abuse in the medical field can be extremely blatant and may be extraordinarily widespread," said State Senator Mike Moncrief, a Texas Democrat and the chairman of an investigative committee that has heard testimony from more than 200 witnesses in the past six weeks. "This is one of the major reasons that health-care costs are going through the roof while insurance companies just continue to raise our rates."

Psychiatric Institutes is a subsidiary of National Medical Enterprises Inc. of Santa Monica, Calif., which operates 74 psychiatric and substance abuse centers nationally. At least 25 hospitals or treatment centers are under investigation, officials said.

A spokesman for Psychiatric Institutes of America, David Olson, said troubling practices did exist at a small number of its hospitals, but he insisted that the chain was devoted to high-quality care and high ethical standards. "A few instances of difficulty have been magnified into larger problems that simply don't exist," he said, adding that the company has begun its own audit and investigation. "If we find anything wrong, we're going to fix it."

On Friday, the Attorney General of Texas, Dan Morales, disclosed that his investigation had expanded to include the hospitals of three other chains, the Charter Medical Corporation, the Hospital Corporation of America and the Community Psychiatric Centers. A spokesman for the Attorney General, Gray McBride, said the state was examining significant evidence of "fraudulent activity, misapplication of funds and fundamental errors in the provider-patient relationship."

Spokesmen for the three companies said they were not aware of any wrongdoing or serious allegations against their hospitals. They said they would cooperate with Texas investigators.

Robert Thomas, executive director of the 325-member National Association of Private Psychiatric Hospitals, which includes both for-profit and nonprofit institutions, said: "Most of our hospitals are fine medical institutions, providing upstanding medical service and high quality. This is an honorable, care-giving industry."

What follows is a look at categories of complaints under investigation and some specific cases.

Huge Markups A 42-Cent Tablet That Costs $3.75

Shortly after Mr. Harper's wife, Jean, came home from the hospital, Psychiatric Institutes of Fort Worth, Mr. Harper examined her itemized bill and blew up. The hospital, he said, told him not to worry, that his insurance would cover the bill. But Mr. Harper, a retired state nursing-home investigator, told the Texas State Senate that he remained perplexed and enraged.

And he was not alone.

Dozens of patients this fall have complained to investigators and a Congressional subcommittee looking into the markups of drugs and supplies often by more than 10 times the cost.

In another example of such markups at another Psychiatic Institutes hospital in Florida, Fred Flintstone vitamins were billed at $3.60 a pill, compared with 13 cents in a drug store, and Advil at $4.15, compared with 11 cents, a markup of 37 times the cost. High markups are not illegal. But experts say they are common and hurt everyone because they are passed along in higher premiums, or in expenses for employers and in turn in reduced income for employees or lower earnings for shareholders.

Mr. Harper said his wife was overcharged for services, too, billed $1,100 for a three-hour session of family therapy, for instance. "That just about made my eyes fall out," said Mr. Harper, who is 73 years old.

The therapy was said to be part of a two-day program in April when patients and their families met with a social worker and a counselor, according to the company that provided the therapy for the hospital, Metro & McGee Associates. Metro & McGee said it had been paid only $105.21 a patient for each three hours of treatment. Spokesmen for Psychiatric Institutes, as well as other health care companies, say the high markups at hospitals are used to offset the sharply increasing costs of running a hospital, ranging from staff salaries to supplies. They say, too, that the majority of patients do not pay the full charges because so many insurance plans have discounting agreements with hospitals.

In Mrs. Harper's case, the Psychiatric Institutes spokesman said, the $1,100 entries for three hours of family therapy were the result of a billing error, which the spokesman said had later been corrected. Mr. Harper said he had received no such correction. The charge was $1,100 for six hours of therapy, the company spokesman said.

The chain's markup of drugs, he said, is no different from that at other hospitals.

Though the hospitals and doctors are known to try to reassure patients about the high bills, saying the insurance companies will pay, the markups disturb some officials. "A $1 Tylenol, that certainly troubles me," said Larry D. Morey, the deputy inspector general for the Federal Department of Health and Human Services and the president of the National Health Care Anti-Fraud Association. "In many cases, you are paying for greed."

Disputed Bills Did Treatment Last 12 Hours?

On Sept. 6, Mindy Jo Horvath spent the morning with other female patients at Willowbrook Hospital in Waxahachie, Tex. They were taken, she said, into a padded room and searched for lice.

Ms. Horvath, a 34-year-old electronic technician who was being treated for depression, said she went to lunch that day at noon, and at 1 P.M. entered group therapy that lasted until 9:30 P.M., with a one-hour break for dinner. She was in therapy, she said, for a total of no more than seven and a half hours.

But Ms. Horvath said later that she was overwhelmed by a $32,538 bill for her 28-day stay; that the charges included 10 hours of group therapy on Sept. 6, at $80 an hour; a $1,600 battery of tests by a psychologist she says she never met, and $160 an hour for individual therapy she says she was never given.

"I may be crazy, but I'm not stupid," Ms. Horvath said. "How could anyone believe that I got all these treatments in just one day?"

Although Mr. Olson said his company was limited by law from commenting on patient cases, he said Psychiatric Institutes did not purposely charge for any service not given.

A recent study by the Health Insurance Institute of America of 50,000 cases of medical and psychiatric cases investigated by the insurance industry between 1987 and 1989 found that claims for services not rendered and changed dates of treatment were the most common type of fraud, making up 43.4 percent of the cases.

Ms. Horvath's bill was reviewed by the president of the Texas Society of Psychiatric Physicians, Dr. Deborah Peele, at a state Senate hearing. "This is clearly abusive corporate practice," she said. "I'm puzzled that insurance companies don't challenge these kinds of things."

Blue Cross paid a total of $14,723, the full amount that its policy covered. Under a contract with Blue Cross, the hospital accepted the money as payment in full. The company made no inquiry into the claim, though experts say the combination of more than 12 hours of group therapy, individual therapy and tests was highly unusual.

Dr. Rogers Coleman, Blue Cross president, said that Ms. Horvath did not complain before the company paid its share of the bill, and that insurance companies had no resources to investigate every claim. They cannot, he said, "be policemen for society."

A Diagnosis To Fit the Policy

In April 1987, Cinde Allen took her 13-year-old daughter, Jennifer, to Fair Oaks Hospital, a Psychiatric Institutes hospital in Delray Beach, Fla., with a drug problem. Jennifer wrote on a hospital questionnaire that she smoked six marijuana cigarettes a day and had used alcohol, pills, LSD and PCP, a horse tranquilizer. One document showed that she tested positive for marijuana use.

The psychiatrist at Fair Oaks told Mrs. Allen not to worry about the questionnaire, she said, because the daughter's drug problem was not serious. Mrs. Allen told investigators that the hospital classified Jennifer as a psychiatric patient, gave her virtually no drug treatment, put her on anti-depressants and released her after 15 weeks. The bill, Mrs. Allen said, was $82,000.

The child then went back to using drugs, including crack, and was later arrested on drug charges.

Mrs. Allen wrote her insurance company and the state Department of Professional Regulation, saying that despite strong evidence of drug abuse, the daughter received little drug abuse treatment. And in testimony at a state public hearing in Palm Beach County, Mrs. Allen noted that with a drug diagnosis her daughter had only $10,000 in insurance coverage, but that as a psychiatric patient, the coverage went up to $1 million.

Deliberate misdiagnosis and changing of dates of service are among the more common types of all medical-insurance fraud, according to the Health Insurance Association. But proving a diagnosis was altered to increase insurance reimbursement is often extremely difficult, particularly in psychiatry, where definitions are vague.

The Florida Department of Professional Regulation said it could find no proof of misdiagnosis in the Allen case, and Mutual of Omaha said it had not investigated it.

The spokesman for Psychiatric Institutes said it had reviewed the case and reaffirmed that its original diagnosis was correct. Mr. Olson said that in 53 percent of all substance abuse cases, the patients had serious psychiatric problems and that often psychiatrists find patients and families resist and deny the need to treat underlying psychological problems.

Psychiatric Institutes hospitals, he said, never alter diagnoses to fit insurance coverage.

But a dozen former and present employees of Psychiatric Institutes in New Jersey and Texas have disputed that contention. They have told state and Federal investigators that their hospitals systematically made diagnoses on the basis of insurance coverage.

One of them, Dr. Robert F. Stuckey, the medical director of the Alcoholism Unit at Fair Oaks Hospital in Summit, N.J., from 1975 until 1985, told New Jersey state insurance investigators that the hospital frequently gave patients the diagnoses that matched the highest insurance coverage, officials in Trenton said.

In Texas, Susan Alderson, a former patient at a Psychiatric Institutes center in Farmers' Branch, Tex., said the staff had told her they were trying to change her diagnosis from psychiatric to medical to increase her coverage to $1 million from $50,000 and prolong her stay. Ms. Alderson told a legislative committee that when she protested, the hospital punished her by taking away privileges and telling her she would be in a mental hospital the rest of her life. Again, a chain spokesman said, it does not engage in any such practices.

Investigators say an incident in Texas in April illustrates the unwarranted hospitalization of children.

Two stocky private security agents working for another Psychiatric Institutes hospital, Colonial Hills in San Antonio, arrived at the home of Sid Harrell, an Army retiree, and, he said, they told him that they had a signed court order to commit his 14-year-old grandson Jeremy as a patient. The boy's grandmother became hysterical as the guards took him away for a five-day stay that ended only after a state senator obtained a court order.

Investigators said they had later determined that the boy had been committed solely on the basis of comments by his 12-year-old brother. The doctor who had ordered Jeremy's admission had forged medical credentials and has since been stripped of his license.

In a Florida law suit, George Pallay of Boca Raton charges that Psychiatric Institute's Fair Oaks Hospital held his three children, ages 9, 8, and 3, against his will for more than five weeks in 1987 at a cost of more than $70,000. The suit charges that the children, committed by Mr. Pallay's ex-wife during a custody battle, were held unnecessarily as an insurance company also found in a later review.

The number of Americans between the ages of 10 and 19 who were committed to psychiatric units, at public as well as private hospitals, ballooned between 1980 and 1987 by 43 percent to 180,000 from 126,000, according to the National

Center for Health Statistics. A study of 20,000 hospitalized children, conducted by Ira M. Schwartz, a social worker at the University of Michigan, found that up to 75 percent of the admissions were unnecessary.

All of the large psychiatric hospital chains insist that their doctors are highly cautious and professional in determining whether treatment is necessary, particularly for young people.

But recent disclosures in Texas indicate that at least some hospitals have gone to great lengths to find and admit children. School officials have testified that private hospitals run aggressive drives for referrals from the public schools. Attorney General Morales has subpoenaed school records after receiving allegations that financial relationships exist between the hospitals and school personnel.

In court papers, Psychiatric Institutes said its hospital reasonably believed that Mr. Pallay abused his children. In the Harrell case, the company said, its comments were limited by pending litigation, but Richard Eamer, chairman and chief executive of National Medical Enterprises, said some of its Texas hospitals had used unacceptable marketing methods under a manager who has left the company to work for another hospital.

Policing the System The Proper Role For Insurers

As part of the efforts to determine the extent of insurance fraud throughout the medical field, both the National Health Care Anti-Fraud Association, an insurance industry and law enforcement group, and the Federal Trade Commission said they found in studies that 5 percent of doctors routinely submit fraudulent claims and that 30 to 40 percent occasionaly do so. Much of this may be relatively mild; a doctor may list the reason for an office visit as a cough rather than a checkup because one is covered by insurance and the other is not. Or falsify a date of treatment so that it falls within the period of coverage.

In the past, estimates have put fraud and abuse at about 10 percent of the nation's health care costs, between $60 billion and $80 billion. But law enforcement officials and fraud specialists like Edward J. Kuriansky, New York State Deputy Attorney General, say the percentage is probably much higher because the accumulating evidence, including new multimillion-dollar Medicaid-fraud cases, indicates that fraud is growing and that much abuse goes undetected or unreported.

Dr. James S. Todd, the executive vice president of the American Medical Association, said only a small fraction of doctors violate the law or codes of medical ethics. "But even that is not reassuring," Dr. Todd said. "One doctor is too many."

Although the insurance industry has increased its fraud investigations by more than 50 percent in recent years and although managed-care programs that oversee medical charges have had an impact, experts say much more needs to be done.

Dr. Walter E. Afield, the president of the Mental Health Programs Corporation, a company that monitors mental health claims for more than 36 leading insurance companies, said the overuse of tests, services or drugs is extremely widespread at private psychiatric hospitals across the nation.

Doctors, he said, often prescribe thousands of dollars in expensive but uncalled for tests, like Magnetic Resonance Imagining at $600 to a $1,000 a test.

Another form of overuse, he said, is keeping patients in hospitals longer than necessary. According to internal documents from Psychiatric Institutes in Oklahoma, Arkansas, Missouri, Wisconsin and Texas, the official goals and objectives of the hospitals stipulated the average stay for patients on each unit, and directed the staff not to permit the patient "census," or number of patients on each ward, to vary by more than a specified number per week.
"The whole place was census driven," said Dr. Durad Bok, a former attending physician at Psychiatric Institutes of Fort Worth who was fired after complaining and is suing the hospital. Referring to staff members, he said, "If your census dropped and stayed that way, you were out the door."

Mr. Olson of Psychiatric Institutes said the contentions by Dr. Bok and the other employee about their being census driven were simply not true. And, he said, all good institutions have operational goals.

Ignored Complaints Insurers Don't Seem Interested

Jean Harper's husband, the retired state nursing-home inspector, wrote the Federal Medicare office in Dallas, complaining about his bill and asking for a detailed audit.

Mutual of Omaha, a private insurance company that processes claims for Medicare, said it would not comment on the case but acknowledged that no investigation into the Harper bill had ever been made.

"My question is," Mr. Harper said, "with a bill like ours and my letter to them, why didn't Mutual of Omaha start an investigation?"

Mr. Harper's concern is shared by the General Accounting Office, the investigative arm of Congress. It reported last month that insurance companies that process Medicare claims all too often disregard complaints of possible fraud and abuse and proceed with payments. The G.A.O. studied 1,000 complaints made in five states and found that the companies failed to refer more than half of the calls containing allegations of serious abuse or fraud to investigative units. Among the cases that were handed to investigators, less than a third were looked into.

"The insurance carriers," said John Hansen, a spokesman for the G.A.O., "didn't seem terribly interested."

The nation's large insurance companies say they have started campaigns to ferret out offenders, complete with computerized fraud-detection systems and toll-free hot-lines for consumers.

But many say this is not their primary responsibility. "Insurance companies can't keep everybody honest," said James Panella, the second vice president in charge of special investigations with Mutual of Omaha. "We are not law enforcement agencies."

Others contend that the lack of a Federal insurance fraud statute has made it a particularly hard crime to prosecute; that state prosecutors have been preoccupied with other crimes to which they attach priority; that public licensing agencies and medical societies are reticent about punishing medical professionals who cheat the system, and that the insurance companies themselves are hampered by laws that prevent them from sharing information on fraud cases. Still, some insurance executives and state insurance officials say that a good deal of the responsibility rests in the industry itself and that the insurers and Federal and state law-enforcement and regulatory agencies have to share the job of correcting the abuses.

The current system gives the insurance companies no financial incentive to investigate the millions of questionable claims they receive each year, Mr. Garcia of Aetna said. They simply pass the costs along to the public, he said.

Among the complaints of insurance fraud in many for-profit psychatric hospitals under investigation is a $5,000 bill Jean Harper received for Tylenol with codeine that she took during a one-month hospital stay. At rear was her husband, Major. (John R. Fulton Jr. for The New York Times) (pg. 28) Graphs: Shows a breakdown by type of fraud of 50,000 cases investigated for fraud by insurance companies (Source: Health Insurance Association of America) (pg. 1); "Rising Claims," tracks combined private health insurance claims to insurance companies, Blue Cross-Blue Shield, self-insured individuals and those with H.M.O. plans, 1981-1989 (Source: Health Insurance Association of America); "Charges for a Patient," show figures for three of the drugs prescribed for Jean Harper during her stay at the Psychiatric Institute of Fort Worth; figures include compare what a hospital pays, what a durgstore pays, what a customer pays to a drugstore and what a patient was charged by the hospital (Sources: 1991 Redbook Annual Pharmacits' Reference; Village Apothecary; bill issued to Jean Harper) (pg. 28)

8 Big Insurers Sue National Medical Enterprises

By PETER KERR

Published: July 31, 1992

Eight leading insurance companies filed suit yesterday in Federal court charging National Medical Enterprises, one of the nation's largest operators of psychiatric hospitals, with a "massive" scheme to commit insurance fraud by admitting thousands of patients who did not need hospitalization and treating them at inflated prices.

The insurers, including Prudential and Travelers, contend that National Medical Enterprises systematically manipulated the diagnoses of patients to keep them in hospitals until their health insurance coverage was exhausted. The insurers, lawyers say, will seek hundreds of millions of dollars in damages.

The suit, filed in Washington, echoed allegations made against National Medical Enterprises in Congressional hearings last April and in State Senate hearings in Texas last year. But the suit represents the first action against the company by the nation's leading insurers and the first public charges that National Medical systematically committed insurance fraud in most of the 22 states in which it operates.

A lawyer for the insurance companies, Thomas Brunner, said the suit marked a substantial initiative on the part of the giant insurers to crack down on fraud as a way to help bring spiraling health-care costs under control.

"This suit clearly signals that these insurers intend to take an active role in ferreting out and halting insurance fraud," Mr. Brunner said. "Fraud is a significant factor in the upward pressure on health-care costs."

But in a written statement, National Medical said that the insurance companies were trying to avoid facing what it said was the real issue: a failure to pay for medically necessary psychiatric care. On July 20, National Medical filed its own suit against three of the insurers -- Massachusetts Mutual, Mutual of Omaha and Travelers -- saying they failed to pay claims.

"It is clearly a response, which we expected, to our earlier suit seeking $45 million for their failure to pay for care." the statement said.

Between 1988 and 1991, the insurers' suit charges, National Medical and its psychiatric hospital division, Psychiatric Institutes of America, received more than $490 million from the eight insurers. Although Mr. Brunner said he would not estimate how much of that money was obtained fraudulently, he said it amounted to hundreds of millions of dollars and that his clients were seeking triple damages.

Based on sworn testimony and documents obtained from National Medical, Mr. Brunner said, the insurers will be able to prove that the management ordered hospitals to disregard the medical needs of patients and admit them to tap their insurance benefits. The suit contends that the patients, including those who did not need hospitalization, were not released until their insurance coverage ran out.

A Defense Department study of private psychiatric hospital cases, released in April, found that in 64 percent of the cases, patients -- mostly relatives of military personnel -- should never have been admitted, were kept longer than necessary or had medical histories for which the hospitals could not justify treatment. National Medical has acknowledged that its staff in its Texas hospitals engaged in practices that appalled the company's management at its Santa Monica, Calif., headquarters. But the company has steadfastly denied that it committed insurance fraud or that problems existed in the other 21 states where it operates.

The other companies involved in the suit are Northwestern National Life, United of Omaha Life, Time Insurance, and Phoenix Home Life.

National Medical Faces Second Suit by Insurers

By PETER KERR

Published: September 15, 1992

The Metropolitan Life Insurance Company and Aetna Life Insurance Company filed suit yesterday, charging that National Medical Enterprises, which operates a chain of more than 70 psychiatric hospitals, committed a $500 million insurance fraud.

The suit follows by five days the seizure of documents by Federal and state law-enforcement officials at a National Medical Enterprises hospital in Wisconsin, where the agencies said they had found evidence of fraud in Medicaid billings.

In its suit, Metropolitan and Aetna contended that National Medical illicitly recruited patients through kickback schemes with referring physicians, patient-assessment services and public school guidance counselors.

'This Is Patient Abuse'

The suit, filed in Federal court in Dallas, also charged that National Medical used direct-marketing techniques to screen for prospective patients with insurance coverage and tried to keep patients hospitalized until their insurance was exhausted. Earlier this summer, eight other large insurers sued National Medical, making similar charges.

"We expect evidence at trial to demonstrate an elaborate scheme by N.M.E. to admit patients, regardless of medical need, to its affiliated hospitals and to bill for treatments that were never provided or were provided without medical justification," said James L. Garcia, director of Aetna's Health Insurance Tracking Unit.

Ann Browne, who manages Metropolitan Life's health-care fraud and abuse unit, said she had reviewed hundreds of bills from National Medical psychiatric hospitals around the nation and found that fraudulent practices were not centered in any one state or region. National Medical had said that problems existed in individual hospitals in Texas but that they were limited to that state.
"I think this is more than fraud," Ms. Browne said. "This is patient abuse."

'We Believe We Can Prevail'
A spokesman for National Medical Enterprises, David Olson, said the suit grew out of the common tension between providers of health care and the insurance companies that pay them. He denied the charges.

"It is a manifestation of the conflict in today's health-care environment between providers and payers," Mr. Olson said. "We very strongly believe that we can prevail, but we always have been willing to discuss any legitimate issues."

In an unrelated action in Prescott, Wis., last week, agents of the inspector general's office of the Federal Department of Health and Human Services and of the state Justice Department spent 12 hours seizing records and documents at Riverhills Hospital, which is operated by National Medical. The search warrant contended that the hospital submitted fraudulent bills to Blue Cross and Blue Shield and to Medicaid.

Mr. Olson said he had not seen the accusations in the search warrant and had no comment on the Wisconsin investigation.

The eight other large insurers who filed suit against National Medical Enterprises contended they were defrauded of $490 million. Those companies were Prudential Insurance; Travelers; Mutual of Omaha as well as its United Of Omaha Life unit; Massachusetts Mutual; the Northwestern National Life unit of the NWNL Companies; the Time Insurance unit of AMEV N.V. and Phoenix Home Life.

Both suits were filed under a Federal racketeering law that permits plaintiffs to seek triple the damages they sustained. In New York Stock Exchange trading yesterday, National Medical's shares slipped 37.5 cents, to $13.50.

COMPANY NEWS

Nearly Half of Suits Settled, Medical Enterprises Says

By MICHAEL QUINT

Published: November 17, 1993

National Medical Enterprises, a hospital operator accused of fraud and improper medical treatment in lawsuits by more than a hundred former patients, said yesterday that it had settled nearly half the lawsuits for $15 million.

The settlement covers 66 patients at psychiatric hospitals in Texas who said the company conspired to hold them against their will. They also said that they were given treatments without regard to their medical needs but rather the the terms of their insurance coverage.

Most of the patients were adolescents when they were in National Medical's hospitals from 1985 to 1987 for periods ranging from five days to three years.

70 Suits Pending

All the patients who agreed to the settlement were clients of Robert Andrews, a Fort Worth lawyer. The amount of each settlement will vary with each of the former patients. The patients did not say in their lawsuits how much they sought in damages.

National Medical has not yet settled 70 similar lawsuits by former patients, and it still faces possible charges by Federal officials who have been scrutinizing the company for more than two years.

In August, agents of the Federal Bureau of Investigation and other Federal officials seized records at the headquarters of the company in Santa Monica, Calif., and 11 of its psychiatric hospitals.

National Medical is also being sued by a group of insurance companies, led by Travelers, which contend the company fraudulently collected on the insurance policies of patients. Similar lawsuits by two other groups of insurers were tentatively settled last month for a total of $125 million.

News of the $15 million settlement had little impact on National Medical's stock, which fell 12.5 cents yesterday, to $11.125, well below its high last year of $18.125.

To settle the lawsuits of former patients and insurance companies and to cover the legal costs of defending itself against any Government charges, National Medical last month set aside $250 million.

In the midst of its legal problems, National Medical has changed much of its management and announced its desire to concentrate on its general hospital business and sell more than 20 of its psychiatric hospitals.

COMPANY NEWS

National Medical Enterprises Selling 28 Hospitals

By MILT FREUDENHEIM
Published: December 4, 1993

National Medical Enterprises Inc, the troubled hospital chain, announced yesterday that it was selling 28 hospitals and 45 satellite outpatient clinics to the Healthsouth Rehabilitation Corporation for about $300 million in cash.

The shares of both companies rose yesterday in heavy trading on the New York Stock Exchange. Healthsouth, based in Birmingham, Ala., rose $3.25, to $20 a share; National Medical Enterprises, based in Santa Monica, Calif., gained 62.5 cents, closing at $12.50, a high for the year.

National Medical Enterprises, which has been fighting suits accusing it of insurance fraud and patient abuse in its psychiatric division, agreed to pay Healthsouth to settle any charges of improper behavior at its rehab units, Healthsouth said.

The sale, subject to Federal antitrust and other regulatory approval, is expected to close by Dec. 31.

Richard M. Scrushy, chairman of Healthsouth, said that with the acquisition it would be "the nation's largest provider of rehabilitative health services." Healthsouth would have 45 rehabilitation hospitals and 216 out-patient clinics in 32 states.

Analysts said the purchase made sense for both companies. Joyce Albers of CS First Boston said Healthsouth expected the deal to add 6 percent to profits next year and 16 percent in 1995.

"They can turn around hospitals that were losing money and get back the insurance company business that N.M.E. lost after the lawsuits," Ms. Albers said.

The company is being sued by the Travelers Corporation and 12 other insurers and dozens of former patients. It also faces possible Federal charges. In August, F.B.I. agents seized company records in Santa Monica and at 11 psychiatric hospitals.
Focusing on Acute Care

Jeffrey Barbakow, chairman of National Medical Enterprises, said the deal "underscores our determination to concentrate N.M.E.'s resources in our acute-care markets."

National Medical Enterprises has 34 acute-care hospitals and 61 psychiatric hospitals. It is also keeping six rehabilitation units next to its community hospitals.

"N.M.E. is strapped for cash," said Todd Richter at Dean Witter Reynolds. "It is raising money so it can try to settle the lawsuits and reposition the company. This is a step in the right direction, but they still have to settle with the Federal Government" and get out of the psychiatric business.

Edwin Gordon at Morgan Stanley & Company said N.M.E. might "have a buyer for the psychiatric hospitals" at a sharply marked-down price of about $200 million to $250 million. He said they were carried on the company's books at $450 million.