FROM DRUGS TO WHEELCHAIRS:

NEW TECHNOLOGY FIGHTS THE GROWING MENACE OF ORGANIZED CRIME IN HEALTHCARE FRAUD

WHITE PAPER

CLEAR for Healthcare Fraud Investigations
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Drugs, prostitution, illegal gambling, money laundering, racketeering, wire fraud, mail fraud, extortion, and...healthcare fraud. Today's organized crime rings and gangs are following the money and it's leading them to two of our nation's most well-known, healthcare programs, Medicare and Medicaid. Weaving a sinister web that is victimizing doctors, nurses and patients, today's organized crime rings and gangs are siphoning off hundreds of millions of dollars through complex healthcare fraud schemes that are costing U.S. taxpayers billions.

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FROM DRUGS TO WHEELCHAIRS – WHO WOULD HAVE GUESSED?

Healthcare fraud in the United States is a big problem. Various sources estimate that between $60 billion to more than $230 billion is stolen each year from our nation's healthcare system through healthcare fraud, according to the National Healthcare Anti-Fraud Association (NHCAA), citing FBI information. Reuters, the international news agency, estimates the U.S. healthcare fraud tab is $150 billion annually (April 13, 2011). Based on these numbers, that amount of fraud represents "between 3 percent to 10 percent of the $2.6 trillion that the United States spent in 2010 on healthcare annually (all healthcare costs, public and private)." (2011, New York Times).

Most of the fraudulent activity targets three government programs serving the needs of more than 100 million Americans – Medicare, Medicaid and the Children's Health Insurance Program (CHIP). Combined, the U.S. government spends "$895.9 billion on these three programs annually," according to Reuters.

The majority of healthcare fraud plaguing our nation's healthcare system goes undetected. Billions of dollars are lost to healthcare providers fudging the system here and there, stealing unnoticeable little bits through a variety of fraudulent practices.

But what has many government and law enforcement officials from the federal to local levels especially concerned about is the growing presence over the past 10 years of organized crime syndicates and street gangs engaging in healthcare fraud.

David Botsko has seen the growing menace of the involvement of organized crime in the healthcare system firsthand. As the former inspector general for the State of Arizona's Medicaid program for 11 years, Botsko investigated the attempts of organized crime to defraud Arizona's Medicaid program.

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(2011, New York Times).

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And, organized crime is very successful in many cases, he noted.

"We worked closely with the FBI and the Drug Enforcement Agency to track the trail of money," Botsko said. "The mob got into it because it's easy to do, there's a low risk of serving jail time (because healthcare fraud is often treated as a white-collar crime), and because it's quite lucrative."

Imagine an episode of the Sopranos where Tony Soprano and his gang decide to open a storefront to sell wheelchairs, walkers and prosthetics in an out-of-the-way New Jersey suburb, and then they bill Medicare millions of dollars for medical equipment and devices that were never actually sold or delivered to any patients. In real life, international organized crime groups, experts at insurance fraud, wire fraud and money laundering, are operating healthcare fraud schemes in dozens of major cities across the country, schemes so sophisticated it would shock the gang at the Bada Bing.

"It's not easy to detect," said Lieutenant Mathew St. Pierre, officer in charge of the Fraud Section of the Los Angeles Police Department's Commercial Crimes Division, who has witnessed the growth of organized crime in healthcare fraud in the Los Angeles area. "They are very skilled at tapping sources of money. They start with one type of fraud, such as car insurance fraud, identify theft or real estate fraud, and they branch out into healthcare fraud. For example, we've even seen organized crime groups use the healthcare system, like setting up a fake medical supply company, to launder money from another scheme involving real estate."

"We're also seeing a growing trend of organized crime groups that have been doing healthcare fraud teaching street gangs known for drugs and prostitution how to do healthcare fraud and other white-collar crimes," St. Pierre added.
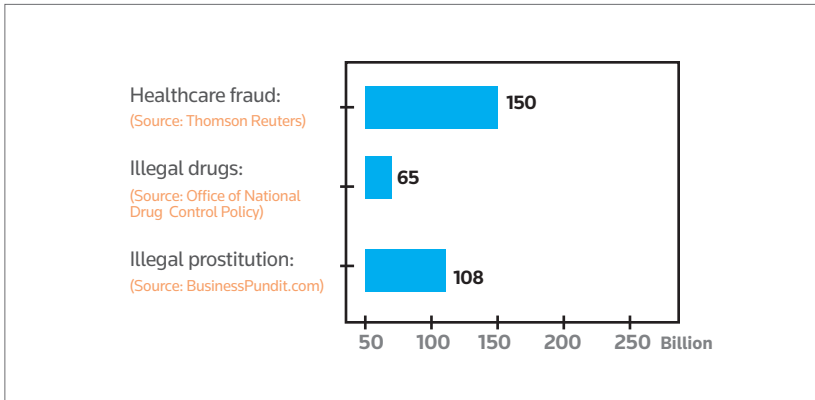
"They are very skilled at tapping sources of money. They start with one type of fraud, such as car insurance fraud, identify theft or real estate fraud, and they branch out into healthcare fraud."

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Drugs and prostitution traded in for wheelchairs, walkers and therapy sessions?

HEALTHCARE FRAUD VS. OTHER ILLEGAL ACTIVITIES (U.S. ONLY)

Healthcare fraud:
(Source: Thomson Reuters)   **150**

Illegal drugs:
(Source: Office of National
Drug Control Policy)   **65**

Illegal prostitution:
(Source: BusinessPundit.com)   **108**

50   100   150   200   250   **Billion**

"The volume (of money) that we're talking about is huge," Ann Rambusch, a Texas healthcare consultant, added. "The drug cartels, the mob – they're all in on it. If you're Al Capone and you're already very skilled at hiding things, you just have to learn the Medicare system and with a little patience, you're in the money."

To shine a light on how much can be stolen so easily, Botsko noted the case of a healthcare fraud bust in Baton Rouge, La. Seven people who ran two community mental health centers were accused of submitting more than $225 million in false claims for mental health services in a scheme that was launched in 2005.

"It's lucrative, not physically dangerous, and it only takes a small capital investment to get started," Botsko said. "For these, and other reasons, organized crime groups appear to be shifting into high gear to get into healthcare fraud."

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And the problem is only predicted to become worse in the years ahead. According to the FBI and other sources, healthcare fraud is projected to increase dramatically as healthcare spending rises, due to an enormous wave of Baby Boomers set to become eligible to receive Medicare and Medicaid benefits in the future. Additionally, as Americans live longer, a greater strain will be placed on the need for Medicare and Medicaid-provided healthcare services.

Consequently, the amount of money expected to flow through Medicare and Medicaid in the coming years, an estimated $4.14 trillion by 2016 according to the Centers for Medicare & Medicaid (CMS), makes these programs an enticing target for individuals and organized crime organizations intent on ripping off the country.

THE PROBLEM IS EVERYWHERE

While there are many different schemes used to defraud Medicare and Medicaid of billions each year, most fraud can be organized into two categories, soft healthcare fraud and hard healthcare fraud, says Rambusch.

Soft healthcare fraud is ubiquitous throughout the system and refers to healthcare providers who fudge on the coding of healthcare services provided to Medicare and Medicaid patients.

Coding refers to the system that healthcare providers (including medical equipment and prescription drug providers) use to electronically submit, and be reimbursed for, services provided to a patient covered under Medicare, Medicaid and CHIP insurance programs.

Billions are siphoned from Medicare and Medicaid/CHIP each year by healthcare providers who manipulate the coding system to claim more funds than what they are actually entitled to. This manipulation of the reimbursement system is so engrained into the fabric of Medicare and Medicaid that the fight to identify and

"It's treatable, but it shouldn't take years to bring an indictment or to send the message that something is wrong, like it does now. We have to be proactive to keep it under control."

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prosecute this type of fraud is exceedingly difficult, or next to impossible, according to Rambusch.

"It's like someone with heart disease," Rambusch said. "It's treatable, but it shouldn't take years to bring an indictment or to send the message that something is wrong, like it does now. We have to be proactive to keep it under control. If we don't, the arteries get clogged and we end up having a stroke or heart attack. It's going to take some dieting and good medicine to fix."

It's estimated that hospitals, clinics and medical professionals are responsible for 80 percent of healthcare fraud, according to the American Society of Business and Behavioral Sciences (ICD10Watch, Feb. 9, 2012), primarily through the manipulation of the Medicare and Medicaid coding system.

But it's that other 20 percent that has caught the eye of many dedicated to fighting healthcare fraud, primarily because of the growing presence of organized crime syndicates and gangs.

These criminals are shifting their efforts from "traditional" illegal activities to healthcare fraud – because it can be much easier, safer and cleaner than, for instance, trafficking narcotics.

"Remember, they don't break your kneecaps or beat you up (too much). It doesn't take a whole lot of people (unlike prostitution). And if you get caught, you are more likely to go to federal prison, not state, and be jailed with the likes of Bernie Madoff – and that's only if you get caught," said Rambusch.

HHS Inspector General Daniel R. Levinson, in testimony before the United States Senate Finance Committee in May 2011 noted: "The Medicare program is increasingly infiltrated by violent and organized crime networks. For example, the government recently charged 73 defendants with various healthcare fraud-related crimes involving more than $163 million in fraudulent billings."

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"Some believe that organized crime is a thing of the past," said FBI Director Robert S. Mueller, III before the Senate Judiciary Committee in March 2011. But earlier that year, he noted, "the FBI arrested nearly 130 members of La Cosa Nostra in New York, New Jersey, Philadelphia and New England on a number of accounts of illegal activity, including healthcare fraud."

Two years earlier, according to an Associated Press news story, 11 members of the Bonanno crime family, based in New York, were arrested in a Medicare fraud scheme in south Florida, accused of stealing Medicare patient numbers and billing Medicare for services that were never rendered.

ORGANIZED CRIME FRAUD SCHEMES

So how are organized crime rings doing it – defrauding Medicare and Medicaid?

According to the FBI (Financial Crimes Report to the Public, Financial Crimes Section, Fiscal Years 2010-2011), organized crime use many types of schemes to bilk the Medicare and Medicaid reimbursement system. Here are a few of the most common schemes:

- Billing for Services not Rendered: This includes schemes such as billing for a service when no medical service of any kind was provided; billing for a service that was not provided as described in the claim for payment; or billing for a service that was previously billed and the claim had already been paid.

- Upcoding of Services: This involves submitting a bill to Medicare or Medicaid using a code that offers a higher payment than the code for the service that was actually rendered. An example of upcoding would be assigning a code for particular type of virulent pneumonia, which reimburses at a much higher rate, instead of general pneumonia, or coding for a far more complex trauma wound when the patient actually just has a minor abrasion or scrape, according to Rambusch.

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- Upcoding of Items (such as a wheelchair or other durable medical equipment or supplies): A patient receives a hand-propelled wheelchair from a medical supplier, but Medicare or Medicaid sees a reimbursement claim for a more expensive motorized version of the wheelchair.

- Unbundling: The fraudster submits bills to Medicare in fragments to maximize the reimbursement for tests, procedures or services that should be billed together at a reduced cost.

- Excessive Services: This is billing Medicare or Medicaid for services in excess of what a patient actually needs. An example would be a medical supply company billing for 30 wound care kits per week for a nursing home patient who only requires a change of dressings once per day, or billing for a daily office visit when a monthly office visit would be adequate.

- Unnecessary Services: In this situation, a fraudster may bill Medicare or Medicaid for a service that a patient doesn't need based on the patient's medical condition. For example, billing for an x-ray when a patient comes in for a flu shot.

After understanding how Medicare and Medicaid reimburse claims for medical services, medical equipment and prescription drugs, organized crime rings need the data or information to submit those claims – in other words, the identification numbers of doctors and patients.

Organized crime groups are constantly inventing and implementing new and more complex schemes that often involve multiple fraud methods, and that leverage their experience with other types of fraud, such as direct mail fraud, wire fraud, identity theft and insurance fraud to get the information they need to submit lucrative Medicare and Medicaid claims. In the past few years, some of the biggest healthcare fraud busts involving organized crime include:

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- A $250 million fraud scheme run by an organized crime ring in Brighton Beach, N.Y., involved nine clinics in the Bronx, Brooklyn and Queens, that provided unnecessary and excessive medical treatments, including physical therapy, pain management, psychological services, X-rays, MRIs and other services (New York Times, Feb. 29, 2012).

- Nine members of a southern California street gang fleeced Medicare out of $11 million by setting up a fake medical device company and billing the government for high-ticket, durable medical equipment items in 2010, according to the Center for Investigative Reporting (California Watch, Sept. 16, 2010).

- Mirzoyan-Terdjanian, an international crime syndicate, conducted a large-scale, nationwide scam that billed Medicare for more than $100 million in unnecessary medical treatments using phantom clinics. Seventy-three members of the crime group were charged in the fraud scheme, which involved stealing the identities of doctors and Medicare beneficiaries. Invoices were sent to Medicare for services that were never performed by non-existent doctors to non-existent patients, according to Kevin Perkins, FBI assistant director of the Criminal Investigation Division, as reported in Forbes magazine (Health Leaders, Oct. 14, 2010).

FIGHTING ORGANIZED CRIME WITH TECHNOLOGY

As organized crime syndicates and gangs become more brazen and more sophisticated in their efforts to defraud Medicare and Medicaid/CHIP, local, state and national law enforcement officials are stepping up their efforts by putting more boots on the ground in healthcare fraud hotspots.

They're also leveraging new, advanced technologies to more accurately identify potential fraudsters applying to get into the Medicare and Medicaid reimbursement systems; identify false claims faster, before they're paid out; and identify criminals

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and links to others in their fraud scheme networks to recapture lost funds and to prevent a fraud from spreading or morphing into new schemes.

At the heart of the fight on healthcare fraud, the Centers for Medicare & Medicaid Services (CMS), through the Department of Health and Human Services (HHS), have instituted a "Twin Pillars" strategy to shut down schemes before the criminals skip town, taking all of their fraudulent billings with them. This strategy, as revealed by Ted Doolittle, deputy director for policy with CMS before a U.S. Senate subcommittee on crime and terrorism (March 26, 2012), is part of a national, collaborative effort that involves multiple government agencies at all levels, including the FBI, which serves as the lead investigative agency in fighting healthcare fraud, as well as the Office of Inspector General (OIG) of HHS, the Department of Justice (DOJ), the Food & Drug Administration, the Drug Enforcement Administration, the Internal Revenue Service, and state and local law enforcement agencies, such as the Los Angeles Police Department.

The first pillar is CMS' Fraud Prevention System (FPS), a system based on predictive analytic technology designed to detect unusual billing patterns by running predictive algorithms against Medicare Part A, Part B and Durable Medical Equipment (DME) claims before a payment is made. The system is similar to what credit card companies use to identify stolen credit cards.

The second pillar is a new, enhanced provider enrollment initiative called the Automated Provider Screening (APS) system, which performs rapid and automated review of all providers and suppliers seeking to enroll or validate their enrollment in Medicare. The system also conducts ongoing monitoring of the eligibility status of currently enrolled providers and suppliers.

The intent of the two pillars system is to continuously feed information into one another regarding suspect providers or claims, creating a truly integrated data management and analysis capability.

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The "Holy Grail" in the fight against healthcare fraud is thwarting the attempts of crime organizations from getting into Medicare and Medicaid systems in the first place, and putting a hard stop on fraudulent claims before they're paid.

Communication between law enforcement and various healthcare systems, and sharing information about healthcare fraud suspects, is critical to achieving this, and to pinpointing the latest fads in healthcare fraud schemes, such as the "Time Bandit" fraud in which a healthcare practice, such as a physical therapist, bills Medicare or Medicaid for more services than can be physically billed in a 24-hour period.

In 2009, to foster closer working relationships and communication, the DOJ and HHS came together to form the Health Care Fraud Prevention and Enforcement Action Team (HEAT) program, which elevated the fight on healthcare fraud to the cabinet level of President Obama's administration.

The intent of HEAT, according to Jean Stone, a director with CMS, in a presentation to the HCCA Upper Northeast Regional Annual Conference, is to "gather resources across government to help prevent waste, fraud and abuse in the Medicare and Medicaid programs and to crack down on fraud perpetrators abusing the system and costing U.S. taxpayers billions of dollars."

In line with HEAT's mission, CMS developed a web-based application that allows state Medicaid agencies to exchange information about terminated providers and to view information on providers and suppliers that have been terminated by Medicare, noted Peter Budetti, M.D., J.D., director for CMS' Center for Program Integrity, before a U.S. Senate Finance Committee (April 12, 2012).

This tool reflects a growing realization that when federal agencies and state Medicaid agencies integrate technology and share relevant information in a collaborative effort, they can be more effective in fighting healthcare fraud.

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With better interagency communication and cooperation, government agencies can get down to the important business of sifting through the incredibly vast amount of data that flows through the Medicare, Medicaid/CHIP systems, which serve more than 100 million Americans.

Moving detection up earlier in the payment processing cycle to find fraud before the claim is paid is critical to eliminating the wasteful cycle of paying a claim and then chasing down the money. CMS and the DOJ are both dedicating greater portions of their fraud-fighting dollars to implement powerful data mining tools to identify fraud faster, suspend questionable payments and seize Medicare and Medicaid reimbursement funds before organized crime rings have the chance to transfer those funds offshore.

To put more heat on healthcare fraud, in 2007 the U.S. Attorney's Offices formed a strike force dedicated to fighting healthcare fraud in selected areas such as Miami-Dade County, according to Stone. Each Medicare Fraud Strike Force includes an HHS-OIG agent, an FBI agent, a representative from a state Medicaid inspector general's office, and participation from local law enforcement.

The Medicare Fraud Strike Force uses data analysis "to pinpoint fraud hotspots throughout the country by identifying suspicious billing patterns as they occur," noted HHS Inspector General Levinson before Congress in May 2011. Medicare Fraud Strike Force field agents are supported by a team of data experts, composed of special agents, statisticians, programmers and auditors, who use sophisticated data analysis tools, combined with criminal intelligence gathered directly from special agents in the field, to identify healthcare fraud trends and patterns among organized crime groups, including new healthcare fraud schemes, and schemes that migrate among organized crime groups, from one part of the country to another.

U.S. CITIES TARGETED FOR HEALTHCARE FRAUD BY THE HHS-DOJ HEAT MEDICARE STRIKE FORCE

YEAR:	
2007	Miami-Dade County
2008	Los Angeles
2009	Detroit, Houston, Brooklyn
2010	Baton Rouge , Tampa
2011	Chicago, Dallas

Source: CMS, May 20, 2011, Jean Stone, director of Northeast Program Integrity Office, Center for Program Integrity, Centers for Medicare & Medicaid Services

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According to a DOJ statement released on Feb. 14, 2012, in 2011, the Medicare Fraud Strike Force, managed by Medicare in partnership with the HHS-DOJ HEAT Program, "charged a record number of 323 defendants, who collectively billed Medicare more than $1 billion." Overall, according to the statement, the HEAT program recovered $4.1 billion in 2011, the highest amount ever recovered by the U.S. government in a single year through its healthcare fraud investigative efforts.

In addition to mining Medicare and Medicaid reimbursement data, government and law enforcement agencies are tapping into information that is already publicly available to find unusual patterns and disturbing links between people, businesses, residences and other data points that can be linked with potential healthcare fraud.

One powerful new tool for finding and preventing medical fraud is CLEAR for Healthcare Fraud Investigations, which was launched in March 2011 by Thomson Reuters. CLEAR is a next-generation investigative suite that is helping to increase the effectiveness of law enforcement fighting healthcare fraud by providing more accurate potential leads to investigate through its powerful search utility.

An example of CLEAR's powerful, next-generation capabilities is its innovative link feature. When looking up information about a potential lead or suspect, CLEAR shows easy-to-read graphical links to other people in its system as well as links to property or businesses. This feature offers the kind of detail that's needed to bust an organized crime ring.

"CLEAR is really good at showing you gaps in information," said former inspector general Botsko. "It's like when a police officer pulls you over – he or she expects you to be nervous. When the officer doesn't see that nervousness, it's a red flag. With CLEAR, we expect to see certain data points and patterns. When we don't see something, we know that's a sign that something may not be quite right."

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CLEAR uses industry data and key provider content such as NPI (National Provider Identifier) numbers, sanctions data and professional licensing information, to conduct a deep search of utility records, cell phone data and other public records. The tool finds not just minor data aberrations, but real inconsistencies to flag for investigation. The results of those investigations can help to find fraudulent healthcare providers, such as those run by organized crime rings, and thereby save Medicare and Medicaid billions of dollars.

"Our goal is to assist government, corporate healthcare and healthcare insurance providers in combating the multi-billion dollar fraud problem," said Steve Rubley, managing director, Government, Thomson Reuters. "We want to make it easier for investigators to find the right information by providing a one-stop shop."

The data accessed by CLEAR can also be directly integrated into an organization's workflow systems to help identify potential risk indicators as a provider is enrolling for reimbursement. Through integration such as this, an organization can more efficiently allocate their investigative resources to those applicants with the highest risk indicators, while efficiently clearing the low risk applicants for enrollment in a more timely manner.

The CLEAR online record search platform reaches across tens of millions of public records and delivers aggregated results that provide a meaningful look into the subject (person, business, residence, etc.) being investigated. There are three ways it works, explained Rubley:

• During the enrollment process (as a healthcare provider at tempts to enter into the Medicare or Medicaid system), CLEAR can find information that might indicate past or possibly future fraudulent behavior, including activities in a different state.

• Information identified with CLEAR can complement other data-mining techniques and predictive analytics, such

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as looking for aberrations in claims patterns that might indicate fraudulent billing.

- If you suspect that a healthcare provider may be engaged in fraudulent activities, CLEAR provides the full picture of the subject under investigation, such as links to other individuals who may have potential knowledge of the fraud, based on their relationship to the suspected healthcare provider.

The bottom line: Combining advanced technology such as CLEAR and other data-mining technology with more investigators on the ground who are working with more intelligent data is a powerful one-two punch in the fight against organized crime involvement in healthcare fraud.

FORECAST: THE FIGHT HAS ONLY JUST BEGUN

The good news is that federal and state legal officials and investigators are making substantial, visible progress in what can be appropriately dubbed the "War on Healthcare Fraud."

According to FBI statistics (Financial Crimes Report to the Public, Fiscal Years 2010-2011), between Oct. 1, 2010 and Sept. 30, 2011 (FY 2011), 2,690 healthcare fraud cases were investigated by the FBI, resulting in 1,676 indictments and 736 convictions. From a financial perspective, the FBI obtained $1.2 billion in restitution, $1 billion in fines, $96 million in seizures, $320 million in civil restitution and $1 billion in civil settlements.

The bad news is that the growing number of healthcare fraud prosecutions also demonstrates the extent of the problem. Government officials and healthcare industry experts alike admit that this is only the tip of the iceberg. The cancer of fraud is spreading and without more resources, stemming its growth will continue to be a daunting task.

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"I believe we are just starting to scratch the surface on the growing problem of organized crime in healthcare fraud," Botsko noted. "Why? For one reason, most healthcare fraud [investigative] units are less than five years old, according to the Health Care Finance Authority (HCFA). After all, it was only considered a 'white-collar crime.'"

New advancements and more resources dedicated to the surveillance and investigation of healthcare fraud are leading to significant progress in prosecutions and the recovery of Medicare and Medicaid funds. The key is to thwart organized crime from entering into healthcare fraud by increasing the screening of healthcare providers seeking reimbursement from Medicare and Medicaid.

Anticipating that expenditures for Medicare and Medicaid will double over the next 10 years, as well as continued pressure to increase the effectiveness and efficiency of these programs as federal and state budgets grow increasingly tight, the challenge will be to protect the integrity of these programs. If organized crime continues unabated its attacks on Medicare and Medicaid, their integrity will continue to be compromised and healthcare costs will continue to rise.

To stop organized crime and its role in bilking Medicare and Medicaid, we believe that the following factors should be given careful consideration:

- **Fight fire with fire** – more federal funding to fight healthcare fraud. The return-on-investment of current initiatives to fight healthcare fraud shows great promise: For every $1 spent on healthcare fraud, the U.S. government has retrieved $7, according to Inspector General Levinson before the U.S. Senate Committee on Finance (April 2012).

"I believe we are just starting to scratch the surface on the growing problem of organized crime in healthcare fraud,"

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- **Broaden the fight** – expand Medicare Fraud Strike Force to more cities. Focus on markets where all of the conditions are right for healthcare fraud – the presence of organized crime groups and gangs, growing populations of baby boomers (Medicare beneficiaries) and low-income households (Medicaid beneficiaries), and counties/states where there are low hurdles for individuals and organizations to enter into the healthcare business.

- **Let's talk more.** Accelerate the fight on healthcare fraud by increasing more inter-agency communications and sharing of technology and data. The HEAT program and the Medicare Fraud Strike Force have clearly demonstrated that the more we work together, the more powerful our results will be.

- **Stop the problem at its source.** Shift investment of limited resources to prevent criminals from getting into the Medicare and Medicaid systems in the first place, rather than chasing them after they've already robbed the bank (pay and chase model). This includes the screening of individuals or companies that purchase an existing business that is already approved for Medicare and Medicaid reimbursements, a commonly used scheme by organized crime groups.

- **It's every American's problem.** Educate the public about the growing threat of healthcare fraud. Help U.S. taxpayers understand why federal and state governments need to invest more in the fight. Build understanding among consumers about how to spot and report healthcare fraud to generate more leads for law enforcement.

Thomson Reuters offers solutions that pull together extensive public and proprietary records and allows users to access the records via the CLEAR online interface, batch services or directly through system-to-system integration.

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CLEAR for Healthcare Fraud Investigations is a next-generation investigative platform designed for professionals who need information about people and companies. With a robust collection of both public and proprietary records, CLEAR makes investigative work easier by offering a one-stop source with live gateways that provide real-time data for the most current information – as well as historical information on individuals and businesses; integrated provider content, including NPI numbers, state and federal sanctions, and expanded professional licenses – across all states; access to all data from one search, reducing time spent running redundant searches; expanded search capabilities across the Web, including social network sites; graphical connections between people, businesses, addresses, and phone numbers; and customizable Provider Comprehensive Reports to create and save for later use or share with others on your team. For questions on purchasing CLEAR or more product information, please contact us at 1.800.262.0602 or contact clear@thomsonreuters.com.

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