Testimony of:
Robert A. Vito
Acting Assistant Inspector General
Centers for Medicare & Medicaid Audits
Office of Inspector General
U.S. Department of Health & Human Services

Good morning, Mr. Chairman and members of the Subcommittee. I am Robert Vito, Acting Assistant Inspector General for the Centers for Medicare & Medicaid Audits at the U.S. Department of Health & Human Services' (HHS) Office of Inspector General (OIG). In March of this year, I testified before this Subcommittee regarding OIG's body of work on program integrity and payment accuracy safeguards in the Medicare Part D prescription drug program (Medicare Part D).[1] At that hearing, I stated that oversight by the Centers for Medicare & Medicaid Services (CMS) and its contractors had been limited and that as a result, the Medicare Part D program was vulnerable to fraud, waste, and abuse.

Recent OIG work illustrates that because of such vulnerabilities, Medicare has paid for substantial numbers of questionable claims for prescription drugs under Part D. OIG's June 2010 report, *Invalid Prescriber Identifiers on Medicare Part D Drug Claims*, reveals that CMS and its plan sponsors have not adequately performed one of the most basic oversight checks in Medicare Part D – ensuring that a drug was prescribed by a physician.[2] As a result, Part D sponsors and beneficiaries paid pharmacies $1.2 billion in 2007 for claims in which the prescriber identifiers listed on the claims did not correspond to practicing physicians. Because prescriber identifiers are a key indicator on Part D claims that link prescribing physicians, dispensing pharmacies, and Medicare beneficiaries, they play a critical role in program integrity efforts. Without a valid prescriber identifier, CMS and its contractors cannot determine if a physician even prescribed a drug, much less verify that the physician was appropriately licensed or had not been excluded from the Medicare program. Furthermore, invalid prescriber identifiers inhibit OIG investigations by making it more difficult to identify questionable prescribing patterns and the parties responsible for potential fraud.

In my testimony, I will provide more details about the findings of our June 2010 study related to invalid prescriber identifiers on Part D claims and offer recommendations to help prevent potentially improper payments associated with this vulnerability in the future. Unfortunately, this is not the first time that OIG has identified problems with

[1] OIG, *Oversight Challenges in the Medicare Prescription Drug Program.* Testimony of Robert A. Vito before the Senate Committee on Homeland Security and Government Affairs Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security. March 3, 2010.
[2] OIG, *Invalid Prescriber Identifiers on Medicare Part D Drug Claims*, OEI-03-09-00140, June 2010.

invalid prescriber identifiers, and my testimony will also describe earlier OIG work on the issue involving Medicare claims for durable medical equipment (DME).

Use of Invalid Prescriber Identifiers on Part D Claims Is a Significant Program Vulnerability

One of the most basic safeguards in paying for medical care – be it Medicare, Medicaid, or private payers – is ensuring that an item or a service was performed, provided, or prescribed by an appropriate medical professional. However, a recent OIG study, *Invalid Prescriber Identifiers on Medicare Part D Drug Claims*, found that this basic safeguard is not always operating effectively.

CMS contracts with plan sponsors to administer the Medicare Part D benefit and pay Part D claims. Sponsors must submit an electronic record, called a prescription drug event (PDE) record, to CMS for any covered prescription that is filled. CMS requires that most PDE records contain an identifier for the drug's prescriber, which is to be entered by the dispensing pharmacy when the claim is submitted to the sponsor.[3] This requirement not only helps to ensure that a physician, and not an unqualified provider, prescribed the drug, but also is fundamental to successful program integrity efforts, including:

- verifying a prescribing physician's licensing or disciplinary information,
- examining unusual prescribing patterns by a physician,
- verifying that a beneficiary has had an office visit with a prescribing physician,
- comparing the geographic location of a prescribing physician to the location of a beneficiary to determine if they are in the same area,
- determining whether the specialty of a prescribing physician matches the indications of a prescribed drug, and
- requesting a beneficiary's medical records from a prescribing physician to determine whether a drug was medically necessary.

Beneficiaries and Medicare Part D paid for $1.2 billion in prescription drug claims containing invalid prescriber identifiers in 2007

In our June 2010 report, we found that more than 18 million PDE records contained invalid prescriber identifiers in 2007, representing 2 percent of the nearly 1 billion PDE records submitted to CMS that year.[4] These identifiers either were not listed in the appropriate provider identifier directories or had been deactivated or retired before

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[3] CMS does not require a prescriber identifier on Part D drug claims submitted to plans in nonstandard formats, such as beneficiary-filed claims and paper claims.

[4] Given that the new national provider identifier (NPI) initiative had yet to be fully implemented in 2007, almost all of these records (95 percent) had the prescriber identifiers coded as Drug Enforcement Administration numbers. Of the remaining 5 percent, 3.6 percent were coded with NPIs, 1.3 percent were coded with State medical license numbers, and less than one-tenth of 1 percent were coded as unique physician identification numbers.

January 1, 2006. Part D sponsors and Medicare beneficiaries paid pharmacies $1.2 billion in 2007 for claims containing these invalid prescriber identifiers.

Identifiers on 17 percent of the drug claims with invalid prescriber identifiers did not conform to format specifications

Based on our analysis of claims data from 2007, CMS and plans were not successfully verifying that prescriber identifiers on Part D claims were in the proper format. In 17 percent of cases, the invalid prescriber identifiers listed on PDE records did not have the correct number of characters and/or contained inappropriate letters, numbers, punctuation marks, or symbols. These PDE records represented $213 million in payments by sponsors and beneficiaries in 2007. One invalid prescriber identifier that did not meet format specifications was a string of nine zeros (000000000). This single invalid identifier accounted for almost 40,000 PDE records worth $3.7 million in 2007.

Ten invalid identifiers accounted for 17 percent of the drug claims with invalid prescriber identifiers

In total, approximately 0.50 million different invalid prescriber identifiers were used on paid Part D claims in 2007. However, just 10 of these invalid identifiers accounted for almost one-fifth of the questionable PDE records. In fact, one invalid prescriber identifier (AA0000000) was recorded on almost 1.8 million PDE records in 2007, representing $105 million in paid claims for 151,269 beneficiaries who were enrolled with 248 different Part D sponsors. In other words, 10 percent of all PDE records with invalid prescriber identifiers contained this one invalid identifier.

Furthermore, although most of the top 10 invalid prescriber identifiers were submitted on claims by thousands of pharmacies in 2007, one particular invalid identifier, ZZ4567890, was used on drug claims submitted by just 37 different pharmacies. In 2007, virtually all of the PDE records that listed ZZ4567890 as the prescriber identifier were associated with a single company (a large pharmacy benefit manager and mail-order pharmacy) under multiple provider numbers that reflect a number of the company's locations across the country.

It is important to note that an invalid prescriber identifier does not automatically indicate that a prescription was inappropriate or that a pharmacy claim was unnecessary. However, without valid prescriber identifiers, CMS and plan sponsor efforts to determine the validity, medical necessity, or appropriateness of Part D claims will be limited, as it can be difficult to determine the name of, or any details about, the physician who prescribed the drug in question.

Part D Claims With Invalid Prescriber Identifiers Should Be Subjected to Further Review

OIG recognizes the difficult balancing act CMS faces in trying to ensure beneficiary access while also preventing improper payments. Therefore, we recommended that rather than implementing prepayment edits (which could at times prevent beneficiaries from getting needed medication), CMS conduct periodic reviews to ensure the validity of prescriber identifiers used on PDE records. CMS could also require sponsors to institute procedures that would identify and flag for review any Part D claims with invalid identifiers in the prescriber identifier field. The success of these intermediate steps would depend on whether CMS, the sponsors, and program integrity contractors take appropriate actions when questionable claims are identified.

CMS concurs with these recommendations, and in response to our June 2010 report, acknowledged that issues with invalid prescriber identifiers are hindering oversight efforts. However, CMS also emphasized that there have been significant improvements in the use of prescriber identifiers since the period covered by our analysis. According to CMS, a major reason for these improvements is the implementation of National Provider Identifiers (NPI) as the standard method for identifying prescribing physicians on Part D claims.[5] OIG recognizes that the movement toward NPIs is a positive step, as the use of a single identifier, rather than the multiple types of identifiers previously used, will facilitate efforts by sponsors and CMS to validate prescriber identifiers listed on claims. Nevertheless, we believe that NPIs will not completely eliminate the vulnerabilities identified in our report. In fact, although only about 35 million PDE records (3.6 percent) were coded with NPIs in 2007, we found that over 300,000 of them (almost 1 percent) contained invalid prescriber identifiers. Therefore, the recommendations listed above apply equally to Part D claims containing NPIs, and CMS must remain vigilant in the invalid identifier issue.

Ongoing OIG Work on Invalid Prescriber Identifiers Is Focusing on Specific Geographic Areas and Schedule II Drugs

Recognizing the importance of the prescriber identifier issue, OIG has provided to CMS data from our report on invalid identifiers in Part D. In addition, OIG is conducting additional analysis on invalid prescriber identifiers, and we have identified specific geographic areas with unusually large numbers of questionable claims.

OIG is further reviewing invalid prescriber identifiers related specifically to Schedule II

[5] NPIs are unique 10-digit identification numbers intended to be a single identifier to replace multiple other identification numbers (such as Drug Enforcement Administration numbers, State medical license numbers, etc.) used by providers on claims.

drugs, like Oxycontin, which are highly susceptible to abuse and fraudulent activity.[6] Claims for this type of drug containing invalid identifiers should be considered highly suspect. Our review focuses not only on whether PDE records contain invalid prescriber identifiers, but also on what steps CMS and sponsors undertake to ensure that the valid identifiers are listed on Part D claims.

Invalid Prescriber Identifiers Have Also Presented Vulnerabilities for Part B Claims

Vulnerabilities with prescriber identifiers have not been confined to Medicare Part D claims. OIG has identified similar problems in claims for durable medical equipment, such as wheelchairs and diabetic supplies, covered under Medicare Part B. In July 2008, I testified before the Permanent Subcommittee on Investigations and discussed two OIG reports that found Medicare paid for millions of dollars in questionable claims that did not accurately identify the physicians that supposedly ordered the items, including many claims that listed deceased doctors as the prescribers.[7]

Medicare regulations require DME suppliers to provide on the claim form the identifier of the physician who ordered the equipment.[8] As with prescription drugs, Medicare relies on physicians to act as gatekeepers to ensure that only medically necessary equipment and supplies are ordered. In conducting our DME-related work, OIG learned that Medicare claims-processing systems verified only that the physician identifier listed on a claim met certain format requirements – automated checks were not performed to ensure that the identifier listed on a claim was valid and active. A November 2001 OIG report OIG found that as a result, Medicare and its beneficiaries paid $91 million for DME claims with invalid or inactive physician identifiers in 1999.[9] Almost $8 million of the $91 million involved identifiers for physicians who were deceased prior to the dates

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[6] The Controlled Substances Act of 1970 classifies certain federally regulated drugs as controlled substances and divides them among five schedules based on their medical use and potential for abuse and addiction. Schedule II drugs have high abuse risk, but also have safe and accepted medical uses in the United States. These drugs can cause severe psychological or physical dependence. Schedule II drugs include certain narcotic, stimulant, and depressant drugs.

[7] OIG, *Medicare Payments for Claims with Identification Numbers of Dead Doctors.* Testimony of Robert A. Vito before the Senate Committee on Homeland Security and Government Affairs Permanent Subcommittee on Investigations. July 9, 2008.

[8] On May 5, 2010, CMS issued a rule that institutes new requirements for DME suppliers billing Medicare. According to this rule, to receive payment for certain types of Part B items and services, a provider or supplier must meet all of the following requirements: (1) the items and services must have been ordered or referred by a physician or, when permitted, an eligible professional; (2) the claim from the part B provider or supplier must contain the legal name and the National Provider Identifier (NPI) of the physician or the eligible professional who order or referred the item or service; and (3) the physician or the eligible professional who ordered or referred the item or service must have an approved enrollment record or a valid opt-out record in the Provider Enrollment, Chain and Ownership System.

[9] OIG, *Medical Equipment and Supply Claims with Invalid or Inactive Physician Numbers*, OEI-03-01-00110, November 2001. For this study, OIG defined an invalid identifier as one that had never been assigned by Medicare; or an inactive identifier had been assigned but all the practice settings associated with it had been deactivated.

of service entered on the claims. OIG recommended that CMS (1) revise claims-processing edits to ensure that the physician identifiers listed on DME claims are valid and active and (2) emphasize to suppliers the importance of using accurate physician identifiers when submitting claims.

Although CMS informed us that it had taken steps to address these recommendations, a followup OIG report in February 2009 showed that invalid and inactive identifiers on DME claims were still a problem almost a decade later.[10] OIG found that Medicare paid almost $34 million in 2007 for medical equipment and supply claims with physician identifiers that had never been issued or had been deactivated by CMS. This figure included $5 million for claims with dates of service after the physicians identified on the claims had died.

Other Recent OIG Oversight Work Has Focused on the Error Rate and Recovery Audit Contractors

Comprehensive Error Rate Testing (CERT) Program

OIG issued a report just yesterday analyzing data from CMS's CERT program.[11] CMS established the CERT program to determine the error rate for Medicare fee-for-service claims. The national paid claim error rate for fiscal year (FY) 2009 was 7.8 percent ($24.1 billion), a significant increase over the FY 2008 error rate of 3.6 percent ($10.4 billion). According to CMS's FY 2009 Improper Medicare Fee-for-Service Payments Report, the increase in the error rate was attributable to substantial changes in the CERT medical record review methodologies.

OIG analyzed the CERT data and identified the types of providers that caused the majority of improper payments and the most significant types of payment errors made by these providers in FY 2009. Our results indicate that six types of providers accounted for 94 percent of the improper payments. These provider types were inpatient hospitals, durable medical equipment suppliers, hospital outpatient departments, physicians, skilled nursing facilities, and home health agencies. The most significant types of payment errors attributable to these six provider groups were: (1) insufficient documentation, (2) miscoded claims, and (3) medically unnecessary services and supplies.

Recovery Audit Contractors (RACs)

In February 2010, OIG issued a report that determined the extent to which RACs referred cases of potential fraud to CMS.[12] CMS contracts with RACs to identify improper

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[10] OIG, *Medicare Payments in 2007 for Medical Equipment and Supply Claims With Invalid or Inactive Referring Physician Identifiers,* OEI-04-08-00470. February 2009.
[11] OIG, *Analysis of Errors Identified in the Fiscal Year 2009 Comprehensive Error Rate Testing Program,* A-01-10-01000, July 2010.
[12] OIG, *Recovery Audit Contractors' Fraud Referrals*, OEI-03-09-00130, February 2010.

payments of Medicare Part A and Part B claims. From March 2005 through March 2008, CMS conducted a RAC demonstration project that was designed to (1) detect and correct past improper payments in the Medicare fee-for-service program and (2) provide information to CMS and the Medicare claims-processing contractors that could help protect the Medicare trust funds by preventing future improper payments.

According to CMS, the RACs' primary focus is the identification and correction of improper payments, not the identification of potential fraud. In fact, RACs receive payment based on the amount of improper payments identified. However, given the nature of the RAC reviews, fraudulent payments could also potentially be identified and referred to CMS or OIG. In our February 2010 report, OIG found that during the 3-year demonstration project, RACs identified over $1 billion in improper payments. However, RACs referred only two cases of potential fraud to CMS during that time period. Because RACs do not receive their contingency fees for fraud referrals, there may be a disincentive for the RACs to refer these types of cases. In addition, during the demonstration project, CMS did not provide the RACs with any formal training regarding the identification and referral of potential fraud.

To address the issues identified in the report, we recommended that CMS follow up on the two referrals, implement a database system to track fraud referrals, and require that RACs receive mandatory training on the identification and referral of fraud. CMS concurred with our recommendations.

Conclusion

Ensuring that Part D claims contain valid prescriber identifiers is fundamental to successful program oversight. Without valid and accurate prescriber identifiers, CMS and its contractors have difficulty performing oversight functions, such as verifying the prescriber's licensing information, determining whether the prescriber has been the subject of disciplinary actions for inappropriate activities, or tracking potential over-prescribing issues. OIG's recent work has shown that safeguards for identifying claims with invalid identifiers have not functioned effectively for Part D claims, and these problems in Medicare Part D parallel those we have identified with respect to Part B DME claims over the past decade. However, CMS's implementation of NPI and its agreement to take steps to address the recommendations of our most recent report indicate that the agency plans to address these vulnerabilities. To ensure this is the case, OIG will continue to monitor the use of invalid identifiers on Part D claims. I would be happy to answer any questions at this time.