



Testimony before the

Permanent Subcommittee on Investigations
Committee on Homeland Security & Governmental Affairs
U.S. Senate

**“Medicare Payments for Claims
with Identification Numbers of
Dead Doctors”**

Testimony of
Robert Vito
**Regional Inspector General for
Evaluation and Inspections**

Office of Inspector General
Department of Health and Human Services

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Good morning, Mr. Chairman and Members of the Subcommittee. I am Robert Vito, Regional Inspector General for Evaluation and Inspections in Philadelphia at the U.S. Department of Health and Human Services' (HHS) Office of Inspector General (OIG). Consistent with its statutory mandate, OIG has devoted considerable resources toward fighting fraud, waste, and abuse involving Medicare coverage and payment for durable medical equipment (DME), prosthetics, orthotics, and related supplies. OIG has performed evaluations, investigations, and audits on an array of DME-related issues; made recommendations to the Centers for Medicare & Medicaid Services (CMS) to help correct vulnerabilities that make the DME area so susceptible to fraud, waste, and abuse; and performed targeted follow-up work to ensure that corrective actions have been taken to eliminate or minimize these vulnerabilities.

One issue—the Medicare requirement that a supplier include on a DME claim the unique physician identification number (UPIN) of the physician who ordered the DME—is the subject of my testimony today. OIG has found that the lack of edits or other reviews that validate the UPIN listed on DME claims presents a vulnerability that has allowed millions of dollars in questionable claims to be paid. OIG studies have uncovered: (1) the use of UPINs that were invalid or inactive, (2) the use of UPINs that belonged to physicians who had died prior to the dates of service, (3) the improper use of surrogate UPINs, and (4) the use of legitimate UPINs that were associated with an unusually large number of claims.

It should be noted that effective May 23, 2008, CMS began requiring the use of national provider identifiers (NPIs) rather than UPINs on supplier claims, as mandated by the Health Insurance Portability and Accountability Act of 1996. However, OIG remains concerned that the vulnerabilities identified in our UPIN studies, as well as other NPI-specific challenges, may affect the integrity of the new system.

My testimony today provides a brief overview of OIG and our work related to DME. It then specifically focuses on studies involving the use of UPINs on DME claims. Finally, I will discuss issues to be considered by CMS now that the NPI requirement has been implemented, as well as OIG's future plans to provide oversight on this important issue.

Role and Responsibilities of HHS OIG

HHS OIG was created in 1976 and was the first statutory OIG in the Federal Government. Two years later, the Inspector General Act of 1978 (IG Act) established OIGs at other Cabinet-level departments of the Federal Government, as well as at some independent Government agencies.

Congress created OIGs to be independent and objective units within Federal departments and agencies for the purpose of: (1) conducting audits and investigations of programs and operations; (2) coordinating and recommending policies to promote economy, efficiency, and effectiveness in the administration of programs; (3) preventing and detecting fraud and abuse; and (4) keeping the Department Secretary or Agency Administrator and Congress informed about the necessity for corrective action.

To achieve these objectives, our office reviews departmental programs to identify systemic vulnerabilities and makes recommendations to improve their efficiency and effectiveness; investigates specific instances of fraud, waste, or abuse and takes appropriate enforcement actions; audits specific payments, providers, and programs to identify and recover overpayments; and promotes voluntary compliance by issuing guidance to health care providers and the health care industry.

Although the Medicare program relies on providers to submit accurate and appropriate claims for payment, and the vast majority of providers are honest and trustworthy, provider efforts alone are not sufficient to ensure the integrity of the program. OIG plays a key role in protecting public funds and the health and welfare of beneficiaries. Our effectiveness relies heavily on coordination and cooperation with our law enforcement partners, including the Department of Justice's (DOJ) Civil, Criminal, and Civil Rights Divisions, U.S. Attorneys' Offices, and the Federal Bureau of Investigation (FBI). As the administrator of Medicare, CMS is also a key partner and plays an important role in our efforts to protect the program and its beneficiaries.

Our staff expertise, national presence, organizational structure, and collaboration with law enforcement partners enable OIG to leverage scarce resources to achieve maximum return for the oversight dollars invested. In the 6-month period from October 1, 2007, to March 31, 2008, OIG conducted audits and investigations that resulted in anticipated recoveries of \$2.2 billion; exclusions of 1,291 individuals and entities from participation in Federal health care programs; 293 criminal prosecutions for crimes against HHS programs; and 142 civil or administrative monetary recoveries pursuant to False Claims Act cases, unjust enrichment suits, civil money penalty cases and administrative recoveries related to provider self disclosure matters. For fiscal years 2004–2006, our average return on investment was nearly \$13 for every \$1 in funding.

Each year, to help ensure that we achieve maximum effectiveness and impact, OIG develops a work plan to guide our activities.¹ Although resource constraints preclude us from annually reviewing all 300-plus programs administered by the Department, OIG engages in this comprehensive work-planning process to identify the most important and timely issues for the upcoming fiscal year and to direct our resources accordingly. Among the things that OIG considers in setting its work priorities are findings from previous OIG and external reviews, the size of the program (e.g., expenditures, number of beneficiaries served), specific requests for work from Congress and the Department, the need to revisit program areas with identified vulnerabilities, and the need to review new and emerging issues.

¹ Available online at <http://www.oig.hhs.gov/publications/workplan.html>.

In addition to our work-planning process, and consistent with the requirements of the IG Act, OIG reports to Congress semiannually on our activities. OIG's semiannual report provides a 6-month summary of OIG's completed work during the reporting period and covers the spectrum of OIG audit, evaluation, and enforcement accomplishments. Each semiannual report identifies significant recommendations described in previous semiannual reports for which corrective action has not been completed. Appendixes to each semiannual report list significant unimplemented recommendations.

Because of the abbreviated nature of the appendixes to the semiannual reports, OIG also issues a "Compendium of Unimplemented Office of Inspector General Recommendations."² This document serves as a useful tool for Congress, the Administration, and the Department in their respective efforts to identify ways to contain costs, maximize the effectiveness of programs and services, and improve the efficiency of departmental programs. Implementation of the recommendations in this document could result in substantial savings and increased effectiveness in the operation of the Medicare program.

OIG Work Related to DME

OIG work related to UPINs was undertaken within the broader context of our oversight efforts involving Medicare coverage and payment for DME. Because Medicare's DME benefit has proven to be particularly susceptible to fraud, waste, and abuse, it has been a focal point of a number of OIG activities, initiatives, and recommendations. Medicare Part B expenditures for DME and related supplies totaled more than \$10 billion in 2007, of which beneficiaries paid more than \$2 billion in the form of copayments and deductibles. OIG evaluations, audits, and investigations have demonstrated that: (1) Medicare pays too much for certain DME and supplies; (2) Medicare pays for some DME claims that do not meet coverage requirements; and (3) a number of DME suppliers have been able to circumvent the existing controls and defraud the program, costing Medicare millions of dollars a year. I will discuss each of these in turn.

Pricing of DME and Related Supplies

OIG's evaluations involving power wheelchairs, hospital beds, diabetic supplies, home oxygen equipment, and inhalation drugs used with nebulizers, among other items, have consistently found that Medicare pays too much for certain pieces of DME and related supplies. In many cases, we have performed additional studies on a subject in an attempt to ensure that our recommendations were implemented and outstanding issues were resolved.

For example, OIG issued its first report on excessive Medicare payments for home oxygen equipment in 1987.³ We released a second report on the issue in 1991, again

² Available online at <http://www.oig.hhs.gov/publications/compendium.html>.

³ "Medicare Reimbursement for At-Home Oxygen Care" (OAI-04-87-00017). December 1987.

finding that Medicare paid substantially more than other payers.⁴ We revisited the subject of oxygen reimbursement in a 2005 report, which found that Medicare allowances for home oxygen equipment were substantially higher than the Federal Employee Health Benefit program rates.⁵ Information from our report was used to reduce Medicare payment rates by an average of 8.6 percent for stationary oxygen equipment and 8.1 percent for portable oxygen equipment. To assess the impact of these changes, in December 2006, OIG released another report, which found that Medicare payment levels for oxygen concentrators were still several times higher than their actual cost.⁶

In addition, OIG issued eight reports between 1996 and 2004 that focused on Medicare payments for inhalation drugs used with nebulizers (e.g., albuterol, ipratropium bromide) that are covered under the DME benefit.⁷ We repeatedly found that Medicare reimbursement amounts for these drugs greatly exceeded other pricing points (i.e., Medicaid, supplier acquisition costs, and retail prices), and made numerous recommendations calling for Medicare payments to be lowered. These recommendations were implemented by the new drug reimbursement methodology established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

DME Coverage Requirements

OIG has also performed numerous reviews to determine whether the DME claims paid under Medicare conformed to coverage requirements. For example, in a 2004 evaluation, we sought to determine whether power wheelchair claims met Medicare's coverage and documentation requirements.⁸ We found that most of the reviewed claims did not meet Medicare's coverage criteria for the wheelchair that was provided; however, some claims may have met coverage criteria for a less expensive mobility device. For over half of the claims we reviewed, required documentation was missing, incomplete, or dated after the date of service listed on the claim. We recommended that CMS improve compliance with Medicare's coverage criteria for power wheelchairs and suggested several specific steps to help accomplish that goal.

CMS implemented many of OIG's recommendations through its power wheelchair workgroup, which was established to develop a plan of action to ensure that Medicare payments are only made for power wheelchairs that are reasonable and necessary. We recently started another study on power wheelchairs that will determine the effect of CMS's actions.

OIG has also investigated cases in which DME suppliers billed for services not rendered or medically unnecessary services. For example, OIG, in coordination with its partners at

⁴ "Oxygen Concentrator Reimbursement: Medicare and the Department of Veterans Affairs" (OEI-03-91-00711). August 1991.

⁵ "Medicare Payment Rates for Home Oxygen Equipment" (OEI-09-03-00160). March 2005.

⁶ "Home Oxygen Equipment: Cost and Servicing" (OEI-09-04-00420). December 2006.

⁷ For example, see "Update: Excessive Medicare Reimbursement for Albuterol" (OEI-03-03-00510). January 2004, and "Update: Excessive Medicare Reimbursement for Ipratropium Bromide" (OEI-03-03-00520). January 2004.

⁸ "Medicare Payments for Power Wheelchairs" (OEI-03-02-00600). April 2004.

the Texas Medicaid Fraud Control Unit and FBI, recently completed an investigation involving inappropriate DME claims submitted by The Scooter Store, Inc. The Government alleged that the company submitted false claims to Medicare and Medicaid for power wheelchairs that beneficiaries did not want, did not need, or could not use; submitted claims for used power wheelchairs, scooters, and accessories as though the equipment were new; submitted claims for power wheelchair accessories that were not ordered by a physician; and improperly induced beneficiaries by promising free mobility equipment. In 2007, The Scooter Store entered into a settlement agreement with the Government to resolve its False Claims Act liability. The Scooter Store agreed to pay \$4 million and relinquish its right to approximately \$13 million in claims initially denied for payment by CMS. The Scooter Store and its individual owner also agreed to enter into a 5-year corporate integrity agreement.

Controls To Ensure Appropriate DME Payment

OIG has also focused on DME suppliers and, in some cases, ordering physicians, who circumvent existing controls in order to defraud the program. Many of these efforts addressed the three basic controls employed by Medicare to ensure that claims are legitimate. These three controls validate that: (1) the beneficiary is enrolled in the Medicare program; (2) the DME supplier meets the Medicare standards and has received a Medicare billing number; and (3) the DME or supplies have been ordered by a physician or other approved health care practitioner. I will address each of these in more detail below.

OIG Work on Beneficiary and Supplier Controls

Beneficiaries

As part of many DME-related studies, OIG has contacted beneficiaries to gather their experiences with certain pieces of equipment or particular suppliers. We have also analyzed claims data to identify payments made to suppliers for ineligible beneficiaries.

For example, as part of a study published in 2000, we found that Medicare paid \$9.2 million in 1997 for DME and related supplies provided after the beneficiary was deceased.⁹ We recommended that CMS conduct prepayment edits and postpayment reviews to ensure that payments are not made for these types of claims. In response, CMS created a prepayment edit to deny payments when the beneficiary is deceased. In addition, CMS instructed its contractors to conduct annual postpayment reviews to identify and recover payments for items and services furnished and claimed after a beneficiary's date of death.

Suppliers

DME suppliers must enroll in the Medicare program to sell or rent items to Medicare beneficiaries and, in turn, submit claims to Medicare for reimbursement. Currently,

⁹ "Medicare Payments for Services After the Date of Death" (OEI-03-99-00200). March 2000.

DME suppliers must comply with 24 supplier standards to receive and maintain a Medicare billing number. For more than 10 years, OIG has reported on weaknesses in CMS's oversight of DME suppliers' compliance with Medicare's enrollment standards.

In a 1997 report, OIG recommended that CMS conduct site visits of DME suppliers specifically at the time of enrollment in the Medicare program.¹⁰ Subsequently, CMS incorporated initial site visits into the supplier enrollment process. In a second report issued in 2001, we recommended that CMS institute random, unannounced site visits of suppliers in addition to the initial enrollment and reenrollment visits.¹¹ In response, CMS stated that it would increase site visits to suppliers that did not pass inspection.

We have recently expanded efforts to identify suppliers who were not in compliance with Medicare enrollment standards. In 2005, we conducted out-of-cycle site visits to 169 DME suppliers to determine whether they met the Medicare requirements of maintaining a physical facility and being open to conduct business during posted hours.¹² We found that 10 of these suppliers were not in operation at their business address, yet still billed Medicare almost \$393,000 in the 2 months after we had determined they did not maintain facilities at their address of record.

Further, based on evidence of concentrated problems with supplier enrollment in certain areas of the country, we conducted unannounced site visits to 1,581 DME suppliers in South Florida in late 2006.¹³ We found that 31 percent of these DME suppliers did not maintain physical facilities or were not open and staffed during their posted business hours. Another 14 percent of suppliers were open and staffed but did not meet additional requirements we reviewed. We recommended several steps that CMS could take to address the concerns highlighted in these reports, including conducting random unannounced site visits, strengthening the provider enrollment process, and limiting the ability of fraudulent suppliers to obtain Medicare billing numbers. In response, CMS implemented a 2-year demonstration project involving the enrollment of DME suppliers into Medicare.¹⁴

In 2007, OIG expanded its review of supplier enrollment by conducting unannounced site visits to 905 suppliers in Los Angeles County.¹⁵ We found that 13 percent of suppliers did not maintain a physical facility or were not open when we visited, and an additional 9 percent did not meet additional standards we reviewed. We again recommended that CMS strengthen the supplier enrollment process and ensure that suppliers meet Medicare

¹⁰ "Medical Equipment Suppliers: Assuring Legitimacy" (OEI-04-96-00240). December 1997.

¹¹ "Medical Equipment Suppliers: Compliance with Medicare Standards" (OEI-04-99-00670). August 2001.

¹² "Medical Equipment Suppliers: Compliance With Medicare Enrollment Requirements" (OEI-04-05-00380). March 2007.

¹³ "South Florida Suppliers' Compliance With Medicare Standards: Results From Unannounced Visits" (OEI-03-07-00150). March 2007.

¹⁴ Available online at

<http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/DME%20Fact%20Sheet.pdf>.

¹⁵ "Los Angeles County Suppliers' Compliance With Medicare Standards: Results from Unannounced Site Visits" (OEI-09-07-00550). February 2008.

supplier standards. In response to our recommendations, CMS stated that, among other actions, it had increased the frequency of unannounced site visits, begun targeted background checks of suppliers in high-fraud areas, and announced a mandatory accreditation process for DME suppliers.

Recent investigations by OIG, DOJ, and other law enforcement agencies have also identified and pursued enforcement actions against fraudulent DME suppliers. In March 2007, OIG and DOJ formed a Medicare Fraud Strike Force composed of Federal, State, and local investigators to combat the fraudulent activities of medical equipment suppliers in South Florida through the analysis of Medicare billing data. During a 3-month period in 2007, 56 individuals were charged in South Florida with fraudulently billing Medicare more than \$258 million. As of March 2008, the Strike Force had brought charges against 120 defendants, resulting in 101 convictions. Our investigation included one case in which a Medicare DME company billed Medicare over \$14 million (and paid more than \$1 million) for wound care, enteral nutrition products, and wheelchairs that were neither prescribed nor delivered. In this case, certain claims listed two prescribing physicians who were deceased prior to the incorporation of the company.

OIG Work on UPINs and Physician Controls

OIG has conducted evaluations, audits, investigations, and additional data analysis focusing on the ordering physicians listed on DME claims. The Consolidated Omnibus Budget Reconciliation Act of 1985 required CMS to establish UPINs for all physicians who provide services to Medicare beneficiaries. Information on UPINs is stored in a national database known as the UPIN Registry.

Prior to the recent implementation of the NPI, Medicare regulations required DME suppliers to provide the UPIN of the physician who ordered the equipment on the claim form. Medicare relies on physicians and other health care practitioners to act as gatekeepers to ensure that only medically necessary equipment and supplies are ordered. When a DME supplier puts a UPIN (or NPI) in the appropriate field on the claim form, the supplier is indicating that a physician has verified the need for the equipment. In addition, the presence of the UPIN or NPI enables CMS to determine who prescribed the equipment and/or supplies as part of any postpayment reviews.

Payments for DME Claims With Invalid and Inactive UPINs

In conducting our DME-related work, we learned that Medicare claims-processing systems verified only that the UPIN listed on a claim met certain format requirements. Computer system edits were not performed to ensure that the UPIN listed on a claim had been assigned or was active. To assess the impact of this vulnerability, OIG determined the prevalence of invalid and inactive UPINs listed on Medicare claims in 1999, and released a report on the issue in 2001.¹⁶

¹⁶ "Medical Equipment and Supply Claims With Invalid or Inactive Physician Numbers" (OEI-03-01-00110). November 2001.

We compared the UPINs listed on Medicare DME claims in 1999 to information contained in the UPIN Registry. We then identified Medicare payments for claims for which the listed UPIN was either invalid or inactive on the date of service. An invalid UPIN is one that has never been assigned; an inactive UPIN has been assigned but all the practice settings associated with the UPIN have been deactivated.

We found that Medicare and its beneficiaries paid \$32 million for DME claims with invalid UPINs in 1999. One-quarter of the invalid UPINs began with a letter for which no UPINs had ever been issued, meaning that the UPIN could easily be identified as one which was never assigned. Approximately 100 of the invalid UPINs were each associated with more than \$50,000 in Medicare DME payments. A single invalid UPIN was listed as the ordering physician by seven different suppliers on \$1.1 million in paid Medicare DME claims.

Furthermore, Medicare and its beneficiaries paid an additional \$59 million in 1999 for DME claims listing UPINs that were inactive on the date of service. Almost \$8 million of this amount involved UPINs for physicians who were deceased prior to the dates of service entered on the claims. Over 30 percent of the inactive UPINs listed on the claims had been inactive for at least 3 years.

Finally, we found that a small number of suppliers accounted for a significant share of the \$91 million in Medicare payments for DME claims with invalid or inactive UPINs. One hundred suppliers were reimbursed for \$17 million of that total. One supplier was responsible for \$1.2 million in Medicare claims, using over 1,700 different invalid or inactive UPINs on medical equipment and supply claims that year. Another supplier had 62 percent of its Medicare reimbursement associated with one invalid UPIN.

To address the issues identified by this report, OIG recommended that CMS: (1) revise claims-processing edits to ensure that UPINs listed on DME claims are valid and active and (2) emphasize to suppliers the importance of using accurate UPINs when submitting claims to Medicare. In responding to our recommendations, CMS indicated that it had developed instructions, system changes, and edits which would reject claims listing a deceased physician's UPIN. CMS also stated that it planned to expand the edits to include all invalid and inactive UPINs. In November 2001 and April 2002, CMS issued instructions to its carriers stating that DME claims listing a deceased physician's UPIN would be denied.¹⁷ We are unaware of any further CMS action taken to address the presence of invalid and inactive UPINs on DME claims. Therefore, we continued to promote our recommendations addressing the invalid and inactive UPIN issue by including them through 2007 in our annual publications listing unimplemented OIG recommendations.¹⁸

¹⁷ Available online at <http://www.cms.hhs.gov/transmittals/downloads/B0173.pdf> and <http://www.cms.hhs.gov/Transmittals/downloads/B02024.pdf>

¹⁸ "Compendium of Unimplemented Office of Inspector General Recommendations" May 2007, page 21.

Accuracy of the UPIN Registry

To ensure effective edits that prevent payments for DME claims with invalid and inactive UPINs, CMS needs to maintain accurate information in the UPIN Registry. However, in a 1999 report, we found that although CMS had taken steps to enhance the accuracy of UPIN data, some problems still persisted.¹⁹ These problems included UPINs with no recent claim activity still being listed as active, inaccurate physician information in UPIN Registry fields, and format-related issues. Further, in 2002, we issued a report to CMS that noted issues with the physician addresses listed in the UPIN registry that we identified during a study involving Medicare mental health services.²⁰

In 2003, OIG issued another report on the accuracy of CMS's UPIN data.²¹ For this study, we contacted providers and asked them to verify information contained in the UPIN database for each of their active practice settings. We also reviewed the universe of active UPIN registry records to identify inconsistent, missing, and questionable information.

OIG found that 52 percent of providers listed in the active UPIN database had inaccurate information in at least one of their practice setting records. Seventeen percent of providers no longer billed Medicare from any of the practice settings listed in the active UPIN file. Of that number, 14 percent were deceased, and 26 percent indicated they had retired. Another 9 percent of providers could not be contacted by mail at the addresses listed in the UPIN Registry.

We noted that when information housed in the UPIN Registry is unreliable, CMS's ability to conduct effective oversight is jeopardized. For instance, inaccurate UPIN data limits CMS's ability to identify unusual billing activity, both in the performance of services and the ordering of services, and also inhibits CMS from verifying that sanctions are correctly imposed.

Therefore, OIG recommended that CMS: (1) correct inaccurate and incomplete information in the UPIN Registry and deactivate practice settings that have never been or are no longer used by Medicare providers; (2) review data contained in the UPIN Registry to ensure that they are complete, accurate, and consistent; (3) conduct a review of providers who billed Medicare for Part B services in 2000 but could not be contacted by mail; and (4) review and revise existing UPIN Registry data entry guidelines. CMS concurred with our recommendations and indicated that it was taking steps to correct the issues.

¹⁹ "Accuracy of Unique Physician Identification Number Data" (OEI-07-98-00410). October 1999.

²⁰ "Inaccuracies in the Unique Physician Identification Number Registry: Incorrect Addresses for Mental Health Service Providers" (OEI-03-99-00131). May 2002.

²¹ "Accuracy of Unique Physician/Practitioner Identification Number Registry Data" (OEI-03-01-00380). May 2002.

Use of Surrogate UPINs

In 2002, OIG issued a report examining the use of surrogate UPINs on DME claims.²² Under Medicare guidelines, surrogate UPINs are temporary UPINs that may be used until an individual UPIN has been assigned. If the ordering physician for a DME item does not have a permanent UPIN, the supplier must use a surrogate UPIN when submitting the claim. At the time of our review, CMS had established four specific surrogate UPINs, as well as guidelines for their use.

We selected a sample of DME claims from 1999 that listed surrogate UPINs. We found that 61 percent of reviewed claims should have listed a permanent UPIN rather than a surrogate, because the ordering physician had a permanent UPIN at the time the service was provided. Furthermore, nearly half of the DME ordered with a surrogate UPIN (45 percent) had either: (1) no written order or certificate of medical necessity to support the service or (2) a written order or certificate of medical necessity with one or more items missing. Medicare paid an estimated \$61 million for these services that year.

We noted that the use of surrogate UPINs on medical equipment claims enables them to be processed automatically whether the equipment has been ordered by a physician or not. If the inappropriate use of surrogate UPINs by suppliers goes unchecked, the Medicare program becomes vulnerable to fraudulent billings and inappropriate payments. Therefore, OIG recommended that CMS: (1) perform targeted reviews of claims for DME ordered with surrogate UPINs and (2) continue to educate suppliers and physicians that accurate UPINs must be used on claims. CMS concurred with OIG's recommendations.

Additional Work on UPINs

OIG has also identified numerous UPINs that were used to order unusually high dollar amounts of DME. For example, in 2006, through the coordinated effort of OIG, DOJ, and others, a South Florida physician pleaded guilty to violating the anti-kickback and false claims statutes. According to the press release issued by the U.S. Attorney's Office for the Southern District of Florida,

Beginning in approximately April 1999, [the physician] established referral relationships with the owners of numerous medical equipment companies. The owners would bring "patients" to [the physician's] office and specify which types of equipment and medications they wanted her to prescribe. Defendant would conduct a cursory examination of the patients

²² "Durable Medical Equipment Ordered with Surrogate Physician Identification Numbers" (OEI-03-01-00270). September 2002.

and then sign the requested prescriptions, regardless of whether they were medically necessary.²³

The UPIN belonging to this physician was used on almost \$8 million in DME claims in 1999. This dollar amount equates to the physician ordering more than \$20,000 in DME each day of the year.

In other cases, it is likely that the physician did not know his or her UPIN was being used to order the DME. Our audits of DME suppliers identified several situations in which the physicians whose UPINs were listed on Medicare claims said that they had not ordered the equipment or supplies. In most cases, the physicians had no medical records for these beneficiaries, and/or stated that the beneficiaries were not their patients. The suppliers identified in these audits were then forwarded to OIG's Office of Investigations for further review.

More recently, we have identified additional UPINs that are associated with questionable billing levels in South Florida for inhalation drugs used with DME. According to CMS, its local Miami office has begun to actively monitor UPIN usage and is now working with the physicians, most of whom did not know about the billings, to limit fraudulent claims.

These cases illustrate that using UPINs (or NPIs) as a control to prevent fraud is more complicated than simply performing edits to ensure that the identifier is valid and active. Because UPINs and NPIs are readily available to the public, fraudulent suppliers can easily obtain a valid number from their geographic area and use that number on their DME claims.

National Provider Identifier

The Health Insurance Portability and Accountability Act of 1996 requires issuance of an NPI to each physician, supplier, and other provider of health care. To comply with this requirement, CMS began to accept applications for NPIs on May 23, 2005. Beginning May 23, 2008, the NPI must be used in lieu of legacy provider identifiers, such as supplier numbers and UPINs.

To determine whether CMS addressed the problems identified with invalid and inactive UPINs in the months directly prior to the full implementation of the NPI, we are in the process of analyzing DME claims from 2007. Based on our preliminary analysis and discussions with CMS staff, we have found evidence that issues with invalid and inactive UPINs still existed in 2007, and may be a continuing problem with the NPI. According to CMS documents, edits will be established to verify that the NPI is in the correct format.²⁴ However, it is unclear whether there will be any edits to identify NPIs that have not been assigned or that correspond to inactive physicians.

²³ Available online at <http://149.101.1.32/usao/fls/PressReleases/060825-03.html>.

²⁴ Available online at <http://www.cms.hhs.gov/MLNMArticles/downloads/MM4320.pdf>.

Furthermore, according to a CMS communication published on its Web site and dated June 2, 2008, CMS is temporarily allowing DME suppliers to use their own NPIs rather than the NPIs of the ordering physicians:

To assist those billing providers, which, after reasonable effort, are still unable to obtain NPIs for secondary providers, Medicare has instituted a temporary measure that allows billing providers to use their own NPI in secondary identifier fields.²⁵

The communication does not indicate the date when this policy will be discontinued. However, as long as DME suppliers are allowed to enter their own NPIs rather than the NPIs of the ordering physicians, a major control for preventing fraud, waste, and abuse will not exist.

Because of our concerns with various aspects of the NPI, OIG is planning additional studies on the subject. Therefore, we expect to conduct several evaluations on the NPI during fiscal year 2009.

Conclusion

OIG has devoted considerable resources to identifying fraud, waste, and abuse involving DME claims. From large-scale reviews involving supplier site visits to data analysis involving the UPINs listed on DME claims, OIG has worked to safeguard taxpayer dollars and protect Medicare and its beneficiaries. OIG will continue to focus its attention on the integrity of Medicare payments for DME, make recommendations to resolve potential vulnerabilities, and conduct targeted follow-up work as warranted.

One of the best ways to combat fraud, waste, and abuse is to ensure that the safeguards put in place to protect the program are operating effectively. One such safeguard, the requirement that an identifier for the physician ordering the equipment be listed on the claim, can be bolstered through the appropriate use of prepayment edits. However, despite our earlier recommendations, CMS never implemented edits that would ensure that the UPINs listed on DME claims were valid and active. As a result, we remain concerned that the vulnerabilities highlighted by our earlier work, as well as new challenges, may affect the integrity of the NPI system.

Unfortunately, edits like those we previously recommended will not completely prevent fraud, waste, and abuse. As our work has shown, some suppliers will use valid identifiers (often without the physicians' knowledge) when submitting their claims. In those cases, CMS must work to identify cases when there are spikes in the use of a particular NPI, when the NPI is consistently associated with an aberrant number of claims, or when the NPI used on claims is not in the geographic vicinity of the beneficiary. These postpayment reviews would require not only data analysis, but also outreach to the physicians whose NPIs are being abused. To that end, OIG is available to assist CMS in

²⁵ Available online at http://www.cms.hhs.gov/NationalProvIdentStand/02_WhatsNew.asp.

monitoring the use of NPIs on DME claims as well as developing effective methods for increasing the awareness of NPI-related issues among the supplier and physician community.

This concludes my statement. Thank you for the opportunity to testify today. I would be pleased to answer your questions.