STATEMENT OF

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ON

MEDICARE PAYMENTS FOR CLAIMS WITH IDENTIFICATION NUMBERS OF DEAD DOCTORS

BEFORE THE

SENATE COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS
PERMANENT SUBCOMMITTEE
ON INVESTIGATIONS

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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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Chairman Levin, Ranking Member Coleman, thank you for the opportunity to testify today regarding the Subcommittee's findings on Medicare payments for claims containing invalid or inactive provider identification numbers (PINs) of deceased physicians. The Centers for Medicare & Medicaid Services (CMS) appreciates the time and resources that the Subcommittee has invested in this study; we have carefully considered the preliminary findings shared verbally with us by Subcommittee staff, and we too are concerned. We look forward to an opportunity to review the complete findings and the Subcommittee's report.

With increasing expenditures, expanding Federal benefits, and a growing beneficiary population, the importance and the challenges of safeguarding CMS programs are greater than ever. Fraud, waste, and abuse schemes have become increasingly complex, and are quick to adapt and stump even the latest oversight strategies of Congress, CMS, and our law enforcement partners. With CMS' expansive role in the U.S. health care system comes a tremendous responsibility to protect our programs' integrity, promote efficient operations, and ensure safe and quality health care for all beneficiaries.

Responsible and efficient stewardship of taxpayer dollars is a critical goal of this Administration, as evidenced by a government-wide effort to improve financial management by way of the President's Management Agenda (PMA). Under the PMA, Federal agencies are mobilizing people, resources, and technology to identify improper

payments in high-risk programs; establish aggressive improvement targets; and implement corrective actions to meet those targets expeditiously. Consistent with these efforts, CMS is committed to identifying program weaknesses and vulnerabilities to help prevent fraud, waste, and abuse, and to improve quality of care.

As part of a sound financial management strategy, CMS has a long history of using improper payment calculations as a tool to monitor the fiscal integrity of Medicare. Improper payment calculations help identify the amount of money that has been inappropriately paid; the causes of the inappropriate payments; and strategies for strengthening internal controls to stop improper payments from continuing.

CMS has made great strides in significantly reducing the Medicare fee-for-service (FFS) error rate in recent years by educating providers about appropriate medical record documentation and methods to improve their accuracy and completeness. For example, in FY 2005, we strove for a Medicare FFS error rate of 7.9 percent and the actual error rate was 5.2 percent. For FY 2006, the goal was 5.1 percent and the actual error rate was 4.4 percent. The goal for FY 2007 was 4.3 percent and the actual error rate released in November 2007 was 3.9 percent, again improving upon the target. Paying claims right the first time ensures the proper expenditure of the Medicare trust funds and saves resources required to recover improper payments.

Durable Medical Equipment Fraud

CMS appreciates the Subcommittee's shared interest and goal of reducing waste, fraud, and abuse in the Medicare program, such as the apparent, continuing inappropriate use of PINs at issue today. As discussed in further detail below, CMS already has taken steps to implement policy changes and new procedures so that invalid or inactive PINs are not used by unscrupulous suppliers of Durable Medical Equipment, Orthotics, Prosthetics and Supplies (DMEPOS) or any other unscrupulous provider to bill Medicare in the future.

As you know, the topic of fraud and abuse in the context of Medicare-covered DMEPOS has been a focal point of CMS program integrity initiatives in recent years. The activity highlighted by the Subcommittee's recent findings is one troubling example of DMEPOS fraud and abuse, but in truth, the variations in this area are manifold.

Within the last 18 months, CMS and our law enforcement partners at the Department of Health & Human Services Office of Inspector General (OIG), the Department of Justice, and the Federal Bureau of Investigation have identified and documented significant fraudulent activity by DMEPOS suppliers in Miami and the Los Angeles metropolitan areas. While both regions of the country have high numbers of Medicare beneficiaries, there has been a tremendous spike in the number of suppliers and utilization: the number of DMEPOS suppliers in these areas has almost doubled and billing from the suppliers remains disproportionately high.

During FY 2006, the National Supplier Clearinghouse (NSC), the national enrollment contractor for DMEPOS suppliers, conducted 1,472 inspections of Miami DMEPOS suppliers. As of October 2006, the billing numbers of 634 DMEPOS suppliers had been revoked, including 143 suppliers that had been enrolled within the previous 12 months. This effort, which is still ongoing, resulted in a projected savings to the Medicare program of $317 million. The NSC spent approximately $3 million on all enrollment efforts in Miami, resulting in a return on investment of greater than 100:1 ($100 in savings for each dollar spent to conduct the project). A similar initiative was conducted in the Los Angeles area last year.

The types of fraud committed by the DMEPOS suppliers in Miami and the Los Angeles metropolitan areas included: (1) billing for services not rendered, which involved claims for power wheelchairs, scooters, nutritional products (e.g., Ensure), orthotics, prosthetics, hospital beds, etc.; and, (2) billing for services not medically necessary. CMS and its contractors have identified thousands of Medicare beneficiaries living in California and Florida who are receiving DMEPOS items that they did not require based upon their medical history and/or are receiving Medicare Summary Notices (MSNs) for items that

are not only unnecessary, but never ordered by their physician and never received by the beneficiary. CMS staff in Los Angeles and Miami have interviewed multiple physicians who have provided attestations that they never saw the patients for which DMEPOS was ordered and correspondingly never ordered the suspect DMEPOS items.

Fraud and Abuse Activities Involving Invalid Provider Identification Numbers

CMS shares the Subcommittee's concern with inappropriate use of invalid or inactive PINs on Medicare claims. We have taken steps internally and with our claims processing contractors to substantially curb and ideally eliminate this practice.

CMS processes claims and makes payments for FFS Medicare benefits through contracts with private companies called fiscal intermediaries (FIs), carriers, and Medicare Administrative Contractors (MACs). For 2008, CMS estimates that these claims administration contractors will process well over one billion claims from providers, physicians, and suppliers for items and services that Medicare covers. The contractors review claims submitted by providers to ensure payment is made only for Medicare-covered items and services that are reasonable and necessary and furnished to eligible individuals.

CMS issues more than 600 instructions annually to claims administration contractors and the process for reviewing and implementing those instructions is well documented by the Agency. After a detailed review and comment process, where implementing instructions are fine-tuned by CMS with its contractors, claims administration contractors are required to certify that they have implemented each final instruction and report back to CMS on a quarterly basis. CMS conducts regular oversight of each Medicare claims administration contractor and "spot checks" the implementation of new processing instructions. In addition, CMS conducts formal performance evaluations on an annual basis to assess individual contractor compliance with Agency requirements for implementation of Agency directives.

When concerns with use of invalid or inactive physician identification numbers were first brought to CMS' attention by the OIG in 2001, we concurred with their recommendations and took steps, working with our contractors, to ensure that identification numbers used on DMEPOS claims were valid and active. For example, contractors were instructed to research, update, correct and where necessary, deactivate PINs with invalid addresses and/or no claims activity for one year. In addition, the contractor responsible for maintaining our physician identification number registry subcontracted with the American Medical Association (AMA) to obtain provider data extract files containing physicians' dates of death on a bi-weekly basis. On a monthly basis, CMS' claims payment contractors were sent a deceased physician notification list and notified to update their physician records. This was intended to ensure that Medicare does not pay claims in both the circumstance where the physician (or other Medicare-recognized practitioner) is the rendering practitioner as well as where the physician or practitioner is the ordering or referring entity (as is usually the case with DMEPOS) and the date of the physician's death precedes the date of service. Notwithstanding the completion of these initiatives, CMS looks forward to the opportunity to review the Subcommittee's recent findings to determine what additional measures we might implement to further reduce improper payments of this nature.

Beginning in October 2006, CMS initiated a systematic deactivation of PINs where there has been no claims activity for 12 consecutive months. If any claim is received after the deactivation date, the Medicare contractor would reject the claim submission and require the physician or supplier to update their Medicare enrollment prior to receiving payment. To date, CMS has deactivated approximately 1.5 million PINs.

Fortunately, the recent conversion to the new National Provider Identifier (NPI), along with further documentation and data exchange improvements, significantly strengthen CMS' ability to combat fraud and abuse that rely on invalid provider identifiers. The Health Insurance Portability and Accountability Act of 1996 required the establishment of new, unique national identifiers to improve the efficiency and effectiveness of electronic transmission of health care administrative transactions. CMS achieved

compliance with this requirement on May 23, 2008, from which point all Medicare claims submitted by physicians and other practitioners, laboratories, ambulance suppliers, DMEPOS suppliers, and others who bill Medicare, are required to include only the new NPI in such transactions. Further, all providers and suppliers intending to bill Medicare are required to apply for and secure a new NPI – and to use the NPI exclusively on all forms, and in all electronic formats, when billing Medicare. Moreover, for all claims where a physician or other practitioner has ordered or referred the service or item (as in the case of DMEPOS), the billing entity must furnish the NPI of the ordering or referring physician or practitioner. Medicare program safeguard system edits, which had previously referenced PINs, now reference NPIs.

The mandate to use the NPI exclusively for all provider or supplier identifications in Medicare billing has the added benefit of eliminating invalid or inactive legacy PINs, which previously might have been used for illegitimate purposes such as those highlighted by the Subcommittee. As a result, CMS believes the vulnerability for further fraud and abuse relying on provider identifiers of deceased physicians is substantially smaller today than before full NPI implementation. To date, CMS has assigned approximately two million NPIs to individual practitioners such as physicians and non-physician practitioners.

Further, on January 25, 2008, CMS published in the Federal Register a proposed rule titled, "Medicare Program; Establishing Additional Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier Enrollment Safeguards" (CMS-6036-P). CMS proposed requiring DMEPOS suppliers to maintain ordering and referring documentation received from a physician or other non-physician practitioner (e.g., nurse practitioner, physician assistant, etc.) for seven years. We believe that this change, if adopted, will strengthen our ability to identify fraudulent billing during documentation reviews. We believe that requiring DMEPOS suppliers to maintain documentation from the ordering physician or non-physician practitioner will allow CMS to expand its efforts to identify and detect DMEPOS suppliers who are submitting claims that are not supported by the appropriate verifiable documentation.

CMS currently is reviewing public comments received on the proposed rule. On June 30, 2008, we proposed a similar requirement for physicians and non-physician practitioners when ordering or referring services for Medicare patients in the CY 2009 Medicare Physician Fee Schedule.

In addition, CMS finalized a new information exchange agreement with the Social Security Administration (SSA) on July 1, 2008 which will provide CMS with monthly updates of the SSA's Death Master file and unrestricted State death data beginning in August. CMS will then be able to match this information with information contained in the National Plan and Provider Enumeration System – the central system that maintains information about NPI – and our provider enrollment database, the Provider Enrollment, Chain and Ownership System. After confirming an individual practitioner is deceased, CMS will deactivate both the NPI and the practitioner's enrollment in the Medicare program.

Finally, while our current claims processing system allows any NPI to be used for the purpose of ordering and referring services to Medicare beneficiaries, we anticipate implementing changes in 2009 that will limit ordering and referring to individual practitioners enrolled in the Medicare program.

Conclusion

Thank you again for the opportunity to testify today. CMS appreciates the Subcommittee's ongoing efforts in support of fiscal and program integrity. We believe the initiatives described above will address many of the issues surrounding improper payments for claims relying on invalid or inactive provider identification numbers. We are continually considering initiatives to improve program integrity within Medicare and look forward to continued work with the Subcommittee and our partners represented here today to further strengthen our stewardship of the Medicare trust funds.