

September 2009

MEDICAID

Fraud and Abuse Related to Controlled Substances Identified in Selected States



GAO

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Highlights of [GAO-09-957](#), a report to congressional requesters

Why GAO Did This Study

One significant cost to Medicaid is prescription drugs, which accounted for over \$23 billion in fiscal year (FY) 2008, or about 7 percent of total Medicaid outlays. Many of these drugs are susceptible to abuse and include pain relievers and stimulants that are on the Drug Enforcement Administration’s (DEA) Schedule of Controlled Substances. As part of the American Recovery and Reinvestment Act of 2009 (ARRA), the Medicaid program will receive about \$87 billion in federal assistance based on a greater federal share of Medicaid spending.

GAO was asked to determine (1) whether there are indications of fraud and abuse related to controlled substances paid for by Medicaid; (2) if so, examples of fraudulent, improper, and abusive activity; and (3) the effectiveness of internal controls that the federal government and selected states have in place to prevent fraud and abuse related to controlled substances. To meet these objectives, GAO analyzed Medicaid controlled substance claims for fraud and abuse indications for FY 2006 and 2007 from five selected states. GAO also interviewed federal and state officials and performed investigations.

What GAO Recommends

GAO makes four recommendations to the Centers for Medicare and Medicaid Services (CMS) to issue guidance to states to better prevent fraud of controlled substances in Medicaid. CMS generally agreed with GAO’s recommendations.

[View GAO-09-957](#) or [key components](#). For more information, contact Greg Kutz at (202) 512-6722 or kutzg@gao.gov.

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What GAO Found

GAO found tens of thousands of Medicaid beneficiaries and providers involved in potential fraudulent purchases of controlled substances, abusive purchases of controlled substances, or both through the Medicaid program in California, Illinois, New York, North Carolina, and Texas. About 65,000 Medicaid beneficiaries in the five selected states acquired the same type of controlled substances from six or more different medical practitioners during fiscal years 2006 and 2007 with the majority of beneficiaries visiting from 6 to 10 medical practitioners. Such activities, known as doctor shopping, resulted in about \$63 million in Medicaid payments and do not include medical costs (e.g., office visits) related to getting the prescriptions. In some cases, beneficiaries may have justifiable reasons for receiving prescriptions from multiple medical practitioners, such as visiting specialists or several doctors in the same medical group. However, GAO found that other beneficiaries obtained these drugs to support their addictions or to sell on the street. In addition, GAO found that Medicaid paid over \$2 million in controlled substance prescriptions during fiscal years 2006 and 2007 that were written or filled by 65 medical practitioners and pharmacies barred, excluded, or both from federal health care programs, including Medicaid, for such offenses as illegally selling controlled substances. Finally, GAO found that according to Social Security Administration data, pharmacies filled controlled substance prescriptions of over 1,800 beneficiaries who were dead at that time.

GAO performed in-depth investigations on 25 Medicaid cases and found fraudulent, improper, or abusive actions related to the prescribing and dispensing of controlled substances. These investigations uncovered other issues, such as doctors overprescribing medication and writing controlled substance prescriptions without having required DEA authorization.

Examples of Fraudulent, Improper, and Abusive Controlled Substance Activity in Medicaid

| Nature of activity | State | Type(s) of controlled substance(s) | Case details |
|---|-------|---|--|
| Fraudulent enrollment using identify of dead individual | CA | Vicodin, MS Contin, Dilaudid, and Ativan | Individual used identity of deceased individual to enroll in Medicaid program and was prescribed thousands of pills. Medicaid paid over \$200,000 for services rendered while individual was in the program. |
| Doctor shopping | IL | Concerta, Ritalin, and Adderall | Beneficiary’s mother was addicted to her son’s attention-deficit/hyperactivity disorder medication, and regularly took her son to multiple physicians to obtain additional prescriptions, which Medicaid paid. |
| DEA noncompliance | NY | Oxycodone, Fentanyl, Vicodin, Ambien, and Xanax | Physician prescribed over 10,600 pills of DEA Schedules II, III, and IV drugs to about 100 Medicaid beneficiaries without DEA authorization. |

Source: GAO analysis of CMS, public, and other records.

States are primarily responsible for the fight against Medicaid fraud; however, the selected states did not have a comprehensive fraud prevention framework to prevent fraud and abuse of controlled substances. CMS is responsible for overseeing state fraud and abuse control activities but has provided limited guidance to the states to prevent fraud and abuse of controlled substances.

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Abbreviations

| | |
|------|--|
| ADHD | attention-deficit/hyperactivity disorder |
| CMS | Centers for Medicare & Medicaid Services |
| CSA | Controlled Substances Act of 1970 |
| DEA | Drug Enforcement Administration |
| DMF | Death Master File |
| DRA | Deficit Reduction Act of 2005 |
| DUR | Drug Utilization Review |
| EPLS | Excluded Parties List System |
| FMAP | Federal Medical Assistance Percentage |
| GSA | General Services Administration |
| HHS | Department of Health and Human Services |
| LEIE | List of Excluded Individuals/Entities |
| MFCU | Medicaid Fraud Control Unit |
| MIC | Medicaid integrity contractor |
| MIP | Medicaid Integrity Program |
| MMIS | Medicaid Management Information Systems |
| OIG | Office of Inspector General |
| PDMP | prescription drug monitoring program |
| SSA | Social Security Administration |
| SSN | Social Security number |

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United States Government Accountability Office
Washington, DC 20548

September 9, 2009

The Honorable Thomas Carper
Chairman
The Honorable John McCain
Ranking Member
Subcommittee on Federal Financial Management, Government
Information, Federal Services, and International Security
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Tom Coburn
United States Senate

Medicaid is a joint federal-state program that finances health care for certain categories of low-income individuals, including children, families, persons with disabilities, and persons who are elderly. The federal government matches state spending for Medicaid services according to a formula based on each state's per capita income in relation to the national average per capita income. The amount of federal assistance states receive for Medicaid service expenditures is known as the Federal Medical Assistance Percentage (FMAP).

As part of the American Recovery and Reinvestment Act of 2009,¹ Congress recently increased the federal share of the FMAP for eligible states through December 2010. Generally, for fiscal year 2009 through the first quarter of fiscal year 2011, the increased FMAP, which is calculated on a quarterly basis, provides for (1) the maintenance of states' prior year FMAPs; (2) a general across-the-board increase of 6.2 percentage points in states' FMAPs; and (3) a further increase to the FMAPs for those states that have a qualifying increase in unemployment rates. The estimated total increase in the federal share of Medicaid spending is about \$87 billion. One significant cost to the Medicaid program is prescription drugs. During fiscal year 2008, prescription drugs accounted for over \$23 billion of the costs in the Medicaid program, or about 7 percent of total federal and state Medicaid outlays.

¹ Pub. L. No. 111-5, § 5001, 123 Stat. 306, 496-497.

Prescription drug abuse is a serious and growing public health problem. According to the Centers for Disease Control and Prevention drug overdoses, including those from prescription drugs, are the second leading cause of deaths from unintentional injuries in the United States, exceeded only by motor vehicle fatalities. Unlike addiction to heroin and other drugs that have no accepted medical use, addiction to some controlled substances can be financed by insurance and public programs such as Medicaid.² There are reports and allegations that criminals and drug abusers are able to illegitimately acquire controlled substances by filing fraudulent Medicaid claims, seeking treatment from medical practitioners for feigned injuries and illnesses, and perpetrating other fraudulent activities. The cost associated with controlled substance fraud and abuse is more than the cost of drug purchases since there are related medical services, such as doctor and emergency room visits, that precede the dispensing of these medications. Several criminal cases highlight Medicaid fraud and abuse related to controlled substances.

- An Ohio physician was convicted in 2006 for filing \$60 million in fraudulent Medicaid, Medicare, and other insurance claims. The physician, a pain management specialist, prescribed multiple injections of controlled substances for his patients. He then billed Medicaid and the other insurance plans for those treatments. The physician was found to have fostered an addiction to controlled substances in his patients so that he could profit from their habit and increase the income he received from their medical claims. Two patients who regularly saw him died under his care, one from a multiple-drug overdose in the physician's office and one from an overdose of OxyContin taken on the same day that the prescription was written. The physician was sentenced to life in prison.
- In 2006, a Florida physician was sentenced to life in prison following his conviction on multiple charges, including wire fraud, illegal distribution of controlled substances, and Medicaid fraud. The physician, a general practitioner, wrote excessive prescriptions to patients for controlled substances without giving them physical examinations or additional follow-up treatments. The physician directed patients to have their prescriptions filled at specific pharmacies and warned them against filling their prescriptions at pharmacies that would ask too many questions about the quantity and

² For purposes of this report, "controlled substance abuse" refers only to abuse related to drugs or substances that are regulated by the Drug Enforcement Administration (DEA).

combination of controlled substances prescribed. In fact, the physician was found to have known some of his patients were addicts feeding their drug habits. Five of his patients died from taking drugs he prescribed.

- During 2004 to 2005, a pharmacist created false telephone prescriptions for Vicodin, an addictive narcotic pain reliever that combines hydrocodone and acetaminophen, and provided thousands of the pills to at least two purported customers. The pharmacist also submitted false claims for the drugs to Medicaid and other insurance companies, stating that they were prescribed for legitimate patients. The customers were actually friends of the pharmacist who sold the drugs and split the profits with him. In 2009, the pharmacist was convicted of health care fraud, Medicaid fraud, and distribution of dangerous controlled substances.

You asked us to determine whether there is fraud and abuse related to controlled substances in the Medicaid program. Specifically, this report discusses (1) continuing indications of fraud and abuse related to controlled substances paid for by Medicaid; (2) specific case study examples of fraudulent, improper, and abusive controlled substance activity; and (3) the effectiveness of internal controls that the federal government and selected states have in place to prevent and detect fraud and abuse related to controlled substances.

To identify whether there are continuing indications of fraud and abuse related to controlled substances paid for by Medicaid, we obtained and analyzed Medicaid claims paid in fiscal years 2006 and 2007 from five states: California, Illinois, New York, North Carolina, and Texas. Prescription drug payments to these states constituted over 40 percent of all Medicaid prescription drug payments made during fiscal years 2006 and 2007. These states were primarily selected based on the magnitude of Medicaid payments for prescription drugs. To identify indications of fraud and abuse related to controlled substances paid for by Medicaid, we obtained Medicaid prescription claims data for these five states from the Centers for Medicare & Medicaid Services (CMS). For indications of doctor shopping, we selected 10 types of controlled substances and the criteria of using at least six different medical practitioners based on our review of drug diversion literature and discussions with a criminal investigator whose recognized expertise is drug diversion. To determine the total number of different prescribers a beneficiary visited, we identified and totaled the number of different prescribers shown on each beneficiary's claims data. Because the Medicaid prescription claims databases did not track doctors who practiced in groups, we could not

determine the amount of duplication caused by this factor. To identify other potential fraud and improper payments, we compared the beneficiary and prescriber shown in the Medicaid claims data to the death master files from the Social Security Administration (SSA) to identify deceased beneficiaries and prescribers. To identify claims that were improperly processed and paid by the Medicaid program because the federal government had banned these prescribers and pharmacies from prescribing or dispensing to Medicaid beneficiaries, we compared the Medicaid prescription claims to the exclusion and debarment files from the Department of Health and Human Services' (HHS) Office of Inspector General (OIG) and the General Services Administration (GSA).

To develop specific case study examples in selected states, we identified 25 cases that illustrate the types of fraudulent, improper, and abusive controlled substance activity we found in the Medicaid program. To develop these cases, we interviewed pharmacy employees, prescribers, law enforcement officials, and beneficiaries, as appropriate. We also obtained and reviewed registration and enforcement action reports from the Drug Enforcement Administration (DEA) and HHS.

To identify the effectiveness of internal controls that the federal government and selected states have in place to prevent and detect fraud and abuse related to controlled substances, we interviewed Medicaid officials from the selected state offices and CMS. In addition, we obtained and reviewed the appropriate policies and procedures related to controlled substances at the selected states. As part of this review, we identified the types of investigations and audits performed by the state Medicaid Fraud Control Units (MFCU) and the state Medicaid offices of inspector general.

To determine the reliability of the data in Medicaid claims and exclusion and debarment files from HHS OIG and GSA, we interviewed officials responsible for their respective databases. In addition, we performed electronic testing to determine the validity of specific data elements in the databases that we used to perform our work.³ Based on our discussions with agency officials and our own testing, we concluded that the data elements used for this report were sufficiently reliable for our purposes.

³ Data validation edits include (1) tests to see if numeric fields contain non-numeric data, (2) tests on a value to see if it falls within the range established for the data element, and (3) relational tests that compare values of two or more data elements for consistency or according to a rational or formula.

We conducted this forensic audit from July 2008 to September 2009 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. We conducted our related investigative work in accordance with standards prescribed by the Council of the Inspectors General on Integrity and Efficiency.

Background

Medicaid

Title XIX of the Social Security Act⁴ establishes Medicaid as a joint federal-state program to finance health care for certain low-income, aged, or disabled individuals. Medicaid is an entitlement program, under which the federal government is obligated to pay its share of expenditures for covered services provided to eligible individuals under each state's federally approved Medicaid plan. States operate their Medicaid programs by paying qualified health care providers for a range of covered services provided to eligible beneficiaries and then seeking reimbursement for the federal share of those payments.

Although the federal government establishes broad federal requirements for the Medicaid program, states can elect to cover a range of optional populations and benefits. CMS, within HHS, is responsible for administering legislation and regulations affecting the Medicaid program, including disbursement of federal matching funds. CMS also provides guidelines, technical assistance, and periodic assessments of state Medicaid programs.

Title XIX of the Social Security Act allows flexibility in the states' Medicaid plans. Guidelines established by federal statutes, regulations, and policies allow each state some flexibility to (1) broaden its eligibility standards; (2) determine the type, amount, duration, and scope of services; (3) set the rate of payment for services; and (4) administer its own program, including enrollment of providers and beneficiaries, processing and

⁴ 42 U.S.C. § 1396.

monitoring of medical claims, payment of claims, and maintenance of fraud prevention programs.

Controlled Substances Act

The Controlled Substances Act of 1970 (CSA)⁵ established a classification structure for certain drugs and chemicals used in drug manufacturing. Controlled substances are classified into five schedules on the basis of their currently accepted medical use and potential for abuse and dependence. Schedule I drugs—including heroin, marijuana, and hallucinogens such as LSD—have a high potential for abuse, no currently accepted medical uses in treatment in the United States, and a lack of accepted safety for use under medical supervision. Schedule II drugs—including methylphenidate (Ritalin) and opiates such as morphine and oxycodone—have high potential for abuse and abuse may lead to severe psychological or physical dependence, but have currently accepted medical uses. Drugs on Schedules III through V have medical uses and successively lower potentials for abuse and dependence. Schedule III drugs include anabolic steroids, codeine, hydrocodone in combination with aspirin or acetaminophen, and some barbiturates. Schedule IV contains such drugs as the anti-anxiety medications diazepam (Valium) and alprazolam (Xanax). Schedule V includes preparations such as cough syrups with codeine. All drugs but those in Schedule I are legally available to the public with a prescription.

CSA mandates that DEA establish a closed system of control for manufacturing, distributing, and dispensing controlled substances. Any person who manufactures, dispenses, imports, exports, or conducts research with controlled substances must register with DEA (unless exempt), keep track of all stocks of controlled substances, and maintain records to account for all controlled substances received, distributed, or otherwise disposed of. Although all registrants, including pharmacies, are required to maintain records of controlled substance transactions, only manufacturers and distributors are required to report their Schedule I and II drugs and Schedule III narcotics drug transactions,⁶ including sales to the retail level, to DEA. The data provided to DEA are available for use in investigations of illegal diversions. The act does not require pharmacies to report dispensing information at the patient level to DEA.

⁵ 21 U.S.C. §§ 801 and 812.

⁶ Registrants are also required to report certain other drugs, such as gamma-hydroxybutyric products listed in Schedule III.

Fraud, Waste, and Abuse of Controlled Substances in Medicaid Program in Selected States

We found tens of thousands of Medicaid beneficiaries and providers involved in potential fraudulent, wasteful,⁷ and abusive purchases of controlled substances through the Medicaid program in the selected states during fiscal years 2006 and 2007. The fraud, waste, and abuse activities that we examined in our analysis include the following: beneficiaries acquiring addictive medication from multiple medical practitioners, known as doctor shopping, to feed their habits, sell on the street, or both; medical practitioners and pharmacies barred from receiving federal funds nevertheless writing and filling Medicaid prescriptions; and prescriptions being paid for with Medicaid funds for dead beneficiaries and for prescriptions attributed to dead doctors by pharmacies.

Tens of Thousands of Medicaid Beneficiaries Visit Multiple Medical Practitioners to Obtain Controlled Substances

Approximately 65,000 Medicaid beneficiaries in the five states investigated visited six or more doctors to acquire prescriptions for the same type of controlled substances in the selected states during fiscal years 2006 and 2007.⁸ These individuals incurred approximately \$63 million in Medicaid costs for these drugs, which were painkillers, sedatives, and stimulants.⁹ In some cases, beneficiaries may have justifiable reasons for receiving prescriptions from multiple medical practitioners, such as visiting specialists or several doctors in the same medical group. However, our analysis of Medicaid claims found that at least 400 of them visited 21 to 112 medical practitioners and up to 46 different pharmacies for the same controlled substances. In these situations, Medicaid beneficiaries were likely seeing several medical practitioners to support and disguise their addiction or to obtain drugs to fraudulently sell.

Our analysis understates the number of instances and dollar amounts involved in the potential abuse related to multiple medical practitioners. First, the total we found does not include related costs associated with obtaining prescriptions, such as visits to the doctor's office and emergency room. Second, the selected states did not identify the prescriber for many Medicaid claims submitted to CMS. Without such identification, we could

⁷ For purposes of this report, we consider wasteful purchases to be situations where a drug is dispensed and paid for by Medicaid, but the drug is not utilized by Medicaid beneficiaries (e.g., drugs dispensed to individuals in long-term care facilities who have already died).

⁸ The approximately 65,000 Medicaid beneficiaries make up less than 1 percent of the total number of Medicaid beneficiaries in these five states.

⁹ The \$63 million makes up about 6 percent of the 10 controlled substances that we analyzed in these five states.

not always identify and thus include the number of unique doctors for each beneficiary who received a prescription. Third, our analysis did not focus on all controlled substances, but instead targeted 10 types of the most frequently abused controlled substances, as shown in table 1.

Table 1: Ten Frequently Abused Controlled Substances

| Controlled substance | Other name(s) | DEA schedule ^a | Description |
|---|--|---------------------------|-------------------------|
| Amphetamine derivatives | Adderall | II | Non-narcotic stimulant |
| Benzodiazepines (e.g., Diazepam, Alprazolam, Lorazepam, Clonazepam, Temazepam, and Triazolam) | Valium, Xanax, Klonopin, Ativan, Restoril, and Halcion | IV | Non-narcotic depressant |
| Fentanyl | Duragesic and Actiq | II | Narcotic painkiller |
| Hydrocodone combinations | Lorcet, Lortab, Norco, and Vicodin | III | Narcotic painkiller |
| Hydromorphone | Dilaudid | II | Narcotic painkiller |
| Methadone | Methadose and Dolophine | II | Narcotic painkiller |
| Methylphenidate | Ritalin, Concerta, and Methylin | II | Non-narcotic stimulant |
| Morphine | MS Contin, Roxanol, Avinza, and Kadian | II | Narcotic painkiller |
| Non-Benzodiazepine sleep aids (e.g., Zolpidem, Zopiclone, and Zaleplon) | Ambien, Sonata, and Lunesta | IV | Non-narcotic sedative |
| Oxycodone | OxyContin, Roxicodone, Percocet, Endocet, and Roxicet | II | Narcotic painkiller |

Source: GAO.

^aDEA classifies controlled substances in schedules I through V. Schedule I drugs—including heroin, marijuana, and hallucinogens such as LSD—have a high potential for abuse and no federally accepted medical uses. Schedule II drugs have high potential for abuse and may lead to severe psychological or physical dependence, but have currently accepted medical uses. Drugs on Schedules III through V have medical uses and successively lower potentials for abuse and dependence.

Table 2 shows how many beneficiaries received controlled substances and the number of medical practitioners who prescribed them the same type of drug.

Table 2: Number of Beneficiaries That Received 1 of 10 Controlled Substances from Six or More Prescribers in Fiscal Year 2006 and Fiscal Year 2007

| Controlled substance | Number of prescribers in selected states | | | | | Total | Medicaid amount paid |
|--|--|--------------|------------|------------|----------|---------------|----------------------|
| | 6-10 | 11-15 | 16-20 | 21-50 | 51+ | | |
| Amphetamine derivatives (e.g., Adderall) | 2,877 | 55 | | | | 2,932 | \$6,616,000 |
| Benzodiazepine (e.g., Valium and Xanax) | 14,006 | 669 | 85 | 22 | | 14,782 | 7,266,000 |
| Fentanyl (e.g., Duragesic) | 777 | 41 | 6 | 1 | | 825 | 7,810,000 |
| Hydrocodone (e.g., Vicodin and Lortab) | 31,364 | 3,518 | 723 | 340 | 9 | 35,954 | 9,172,000 |
| Hydromorphone (e.g., Dilaudid) | 590 | 67 | 14 | 11 | | 682 | 983,000 |
| Methadone (e.g., Dolophine and Methadose) | 824 | 76 | 9 | 2 | | 911 | 546,000 |
| Methylphenidate (e.g., Ritalin and Concerta) | 4,821 | 106 | 3 | 1 | | 4,931 | 10,866,000 |
| Morphine (e.g., MS Contin and AVINZA) | 810 | 50 | 8 | 1 | | 869 | 4,119,000 |
| Non-Benzodiazepine sleep aids (e.g., Ambien and Lunesta) | 2,821 | 49 | 5 | | | 2,875 | 5,739,000 |
| Oxycodone (e.g., OxyContin and Percocet) | 5,349 | 435 | 73 | 18 | | 5,875 | 10,163,000 |
| Total | 64,239 | 5,066 | 926 | 396 | 9 | 70,636 | \$63,280,000 |

Source: GAO.

Note: The numbers in the column totals do not necessarily represent unique beneficiaries. A single beneficiary could have been prescribed more than one type of controlled substance by more than one doctor. The number of unique beneficiaries represented in this table is 64,920. The maximum number of doctors from which a beneficiary received one of the 10 types of controlled substance prescriptions was 112.

Controlled Substances Prescribed or Filled by Banned Providers

We found that 65 medical practitioners and pharmacies in the selected states had been barred from federal health care programs, excluded from these programs, or both, including Medicaid, when they wrote or filled Medicaid prescriptions for controlled substances during fiscal years 2006 and 2007. Nevertheless, Medicaid approved the claims at a cost of approximately \$2.3 million. The offenses that led to their banishment from federal health programs included Medicaid fraud and illegal diversion of controlled substances. Our analysis understates the total number of excluded substances because the selected states either did not identify the prescribing medical practitioner for many Medicaid claims (i.e., the field

was blank) or did not provide the taxpayer identification number for the practitioner, which was necessary to determine if a provider was banned.

The banned providers we identified had been placed on one or both of the following exclusion lists, which Medicaid officials must check before paying for a prescription claim: the List of Excluded Individuals/Entities (LEIE), managed by HHS, and the Excluded Parties List System (EPLS), managed by GSA. The LEIE provides information on health care providers that are excluded from participation in Medicare, Medicaid, and other federal health care programs because of criminal convictions related to Medicare or state health programs or other major problems related to health care (e.g., patient abuse or neglect). The EPLS provides information on individuals or entities that are debarred, suspended, or otherwise excluded from participating in any other federal procurement or nonprocurement activity. Federal agencies can place individuals or entities on the GSA debarment list for a variety of reasons, including fraud, theft, bribery, and tax evasion.

Medicaid Paid for Controlled Substance Prescriptions Filled for Dead Beneficiaries or “Written” by Dead Doctors

Our analysis of matching Medicaid claims in the selected states with SSA’s Death Master File (DMF) found that controlled substance prescription claims to over 1,800 beneficiaries were filled after they died. Even though the selected state programs assured us that beneficiaries were promptly removed from Medicaid following their deaths based on either SSA DMF matches or third-party information, these same state programs paid over \$200,000 for controlled substances during fiscal years 2006 and 2007 for postdeath controlled substance prescription claims. In addition, our analysis also found that Medicaid paid about \$500,000 in Medicaid claims based on controlled substance prescriptions “written” by over 1,200 doctors after they died.¹⁰

The extent to which these claims were paid because of fraud is not known. For example, in the course of our work, we found that certain nursing homes use long-term care pharmacies to fill prescriptions for drugs. One long-term care pharmacy dispensed controlled substances to over 50 beneficiaries after the dates of their deaths because the nursing homes did not notify the pharmacy of their deaths before delivery of the drugs. The

¹⁰ Certain Medicaid claims did not capture the date of the prescription. If the prescribing date was unknown, we based our calculations on the 6-month period before the order was filled. This proxy was used as a reasonable estimate to be consistent with the 6-month period allowed for valid refills and partial fillings for certain controlled substances.

nursing homes that received the controlled substances, which included morphine, Demerol, and Fentanyl, were not allowed to return them because, according to DEA officials, CSA does not permit such action. Officials at two selected states said that unused controlled substances at nursing homes represent a waste of Medicaid funds and also pose risk of diversion by nursing home staff. In fact, officials from one state said that the certain nursing homes dispose of these controlled substances by flushing them “down the toilet,” which also poses environmental risks to our water supply.

Examples of Fraud, Waste, and Abuse of Controlled Substances in Medicaid

In addition to performing the aggregate-level analysis discussed above, we also performed in-depth investigations for 25 cases of fraudulent, improper, and abusive actions related to the prescribing and dispensing of controlled substances through the Medicaid program in the selected states. Table 3 shows a breakdown of the types of cases that we identified from our analysis and confirmed through our investigations.

Table 3: Types of Fraudulent, Improper, and Abusive Activities Used to Obtain Controlled Substances through the Medicaid Program

| Type | Number |
|---|--------|
| Doctor shopping | 8 |
| Dead doctors “writing” or dead beneficiaries “receiving” prescriptions | 4 |
| Barred medical practitioners and pharmacies prescribing or dispensing drugs | 5 |

Source: GAO.

In the course of our investigation, as we pursued leads produced from our data mining, we also found two other types of fraudulent, improper, and abusive actions, as shown in table 4.

Table 4: Additional Types of Fraudulent, Improper, and Abusive Activities Used to Obtain Controlled Substances through the Medicaid Program

| Type | Number |
|---|--------|
| Doctors prescribing beneficiaries a schedule of controlled substance that the doctors are not registered to prescribe | 6 |
| Doctors overprescribing controlled substances to beneficiaries | 2 |

Source: GAO.

As noted in table 4, we are highlighting six examples where a doctor’s DEA registration did not authorize the doctor to prescribe a particular schedule of controlled substance. Under CSA,¹¹ controlled substances are classified into five schedules based on the extent to which the drugs have an accepted medical use and their potential for abuse and degree of psychological or physical dependence. Schedule II includes what are considered by DEA to be the most addictive and abused drugs that legally can be prescribed.¹² Schedule V, meanwhile, covers those that are least likely to cause such problems.

Each provider must obtain a valid registration from DEA that reflects the schedule(s) of controlled substances the provider is authorized to store, dispense, administer, or prescribe. For example, if a physician wants the authority to prescribe Schedule II drugs, the physician must register and be granted authority by DEA to do so.¹³

As noted in table 4, we also found two cases where the physician prescribed controlled substances in excess of medical need. In one of these cases, our investigators found that the physician prescribed a controlled substance in a manner intended to circumvent Medicaid’s dosage limitations. In the other, the beneficiary sold excess controlled substances (in this case, painkillers).

Table 5 summarizes 15 of the 25 cases we developed of fraudulent, improper, and abusive controlled substance activities in the Medicaid

¹¹ 21 U.S.C. § 822.

¹² Schedule I drugs—including heroin, marijuana, and hallucinogens such as LSD—have a high potential for abuse and no currently accepted medical uses.

¹³ Schedule II drugs include opiates—such as morphine, oxycodone, and methadone—that have currently accepted medical uses as well as high potential for abuse and may lead to severe psychological or physical dependence.

program. Appendix I provides details on the other 10 cases we examined. We have referred certain cases to DEA and the selected states for further criminal investigation.

Table 5: Fraudulent, Improper, and Abusive Controlled Substance Activity in Medicaid

| Case | State | Nature of activity | Type of controlled substance(s) ^a | Case details |
|------|-------|---|--|--|
| 1 | IL | Overprescribing | Vicodin and Duragesic | <ul style="list-style-type: none"> Beneficiary received 4,500 pills of Vicodin and 200 Duragesic patches over 22 months. Beneficiary was prescribed pain medication for injuries sustained in an automobile accident in 1999. Beneficiary began receiving pain medication in excess of her need in 2005. Beneficiary sold excess prescriptions paid by Medicaid for at least \$400 each for a 1-month supply. User of the prescriptions she sold later died of an overdose. Prescribing physician has been indicted for overprescribing painkillers and contributing to the fatal overdoses of at least three individuals. The state placed the beneficiary on a restricted recipient program from January 2002 through March 2005. The state released her from the program in March 2005 and subsequently restricted her again in March 2007, and she remains restricted today. Beneficiary received prescriptions linked to a person's death while beneficiary was enrolled in restricted recipient program. |
| 2 | CA | Fraudulently enrolled using identity of deceased individual | Vicodin, MS Contin, Dilaudid, and Ativan | <ul style="list-style-type: none"> Beneficiary submitted Medicaid application with Social Security number (SSN) of a deceased individual. Medicaid office provided beneficiary with Medicaid card, which was used by beneficiary for medical services and controlled substance prescriptions. Beneficiary received almost 1,200 pills of Dilaudid, 900 pills of Morphine, and 300 pills of Vicodin over 10 months. Medicaid accepted the beneficiary's enrollment application although the program was aware of discrepancies with the submitted SSN. Medicaid paid over \$200,000 for services rendered from 2004 through 2007 before removing beneficiary from program for not submitting required paperwork. |

| Case | State | Nature of activity | Type of controlled substance(s) ^a | Case details |
|------|-------|--|--|--|
| 3 | NY | Doctor shopping | Ambien | <ul style="list-style-type: none"> Beneficiary received almost 1000 pills of Ambien for a nearly 3-year supply of the drugs over a 23-month period. Beneficiary received prescriptions of Ambien from at least 10 prescribers that were then filled by at least six pharmacies. Beneficiary routinely had overlapping prescriptions from multiple physicians. Beneficiary requested additional prescriptions by telling physicians that she lost her pills while using public transportation. Beneficiary acknowledged addiction to Ambien. The state has never placed the beneficiary on a restricted recipient program because the state did not identify beneficiary as a doctor shopper. |
| 4 | CA | Prescriptions "written" by a dead prescriber | Methadone, Dilaudid, Kadian, Demerol, and Klonopin | <ul style="list-style-type: none"> Pharmacy filled 23 Medicaid prescriptions of controlled substances for three beneficiaries. The claims indicated that the prescriptions were written by a deceased prescriber. Pharmacy surrendered its license following disciplinary action by the California Board of Pharmacy. Violations included filling of erroneous prescriptions, failure to maintain current inventory for dangerous drugs, and filling excessive prescriptions for a patient on the same day, for the same medication, from two different physicians. |
| 5 | TX | DEA noncompliance | Ritalin, Concerta, Adderall, and Focalin | <ul style="list-style-type: none"> According to DEA, physician was only authorized to prescribe Schedule IV drugs. Physician prescribed over 6,000 pills of DEA Schedule II drugs to over 50 Medicaid beneficiaries in violation of DEA regulations. |
| 6 | NC | Doctor shopping | Oxycodone | <ul style="list-style-type: none"> Beneficiary received 1,300 pills of oxycodone over 24 months. Beneficiary received prescriptions of oxycodone from 25 prescribers that were then filled by nine pharmacies. Employee at one pharmacy stated that the beneficiary was known as an abuser of controlled substances. According to police official, beneficiary partnered with another Medicaid beneficiary. The partner drove the beneficiary and other individuals to physicians to receive Medicaid prescriptions. The prescriptions were later filled at a pharmacy and sold on the street. The state has never placed the beneficiary on a restricted recipient program because the state did not identify beneficiary as a doctor shopper. |

| Case | State | Nature of activity | Type of controlled substance(s) ^a | Case details |
|------|-------|--|---|--|
| 7 | CA | Prescribing controlled substances to Medicaid beneficiaries while on sanction list | OxyContin, Vicodin, Phenobarbital, Tylenol with Codeine, Xanax, Ambien, Restoril, Klonopin, Valium, Ativan, and Halcion | <ul style="list-style-type: none"> Physician has been excluded from prescribing to Medicaid beneficiaries since 1999 as a result of incompetence, malpractice, and negligence. Physician prescribed at least 142,000 pills of controlled substances to over 600 Medicaid beneficiaries during exclusion period. Medicaid paid \$109,228 for 3,944 claims during fiscal years 2006 and 2007 even though the physician was excluded from the Medicaid program. Physician surrendered medical license in 1999 after violating terms and conditions of probation, and was later reinstated in 2002. Physician currently maintains a valid medical license, but is still excluded from prescribing to Medicaid beneficiaries. |
| 8 | NY | Receiving prescriptions using identity of deceased individual | Methadone, Klonopin, and Xanax | <ul style="list-style-type: none"> Beneficiary was prescribed almost 1,000 pills of controlled substances after her death. Pharmacy employee stated that the beneficiary's husband picked up her controlled substances because she was too sick to pick them up herself. Medicaid paid for all these prescriptions. After becoming aware of the beneficiary's death 4 months after she died, the pharmacy did not fill any more prescriptions. Prescriber stated that physicians will sometimes prescribe medication for patients with chronic pain without requiring an examination. |
| 9 | IL | Doctor shopping | Concerta, Ritalin, and Adderall | <ul style="list-style-type: none"> Over the course of the 2 fiscal years, beneficiary received 3,200 pills of controlled substances used to treat attention-deficit/hyperactivity disorder (ADHD), equivalent to over a 6-year supply. Beneficiary received prescriptions of Concerta and Ritalin from 25 prescribers that were then filled by 11 pharmacies. Beneficiary's mother stated that she was addicted to Ritalin, a controlled substance prescribed to her son, and regularly took her child to multiple physicians to obtain additional prescriptions, which Medicaid paid. Beneficiary and his mother were banned from several medical practices as a result of doctor shopping. Beneficiary's mother has an extensive criminal history involving unlawful acquisition of controlled substances with stolen prescription forms. The state has never placed the beneficiary on a restricted recipient program because the state did not identify beneficiary as a doctor shopper. |

| Case | State | Nature of activity | Type of controlled substance(s) ^a | Case details |
|------|-------|--|--|--|
| 10 | TX | Doctor shopping | Vicodin | <ul style="list-style-type: none"> Over the course of the 2 fiscal years, beneficiary received 4,700 pills of Vicodin. Beneficiary received prescriptions of Vicodin from over 70 prescribers that were then filled by at least 40 pharmacies. Beneficiary routinely received prescriptions at multiple hospital emergency rooms. Beneficiary is currently on parole following a felony controlled substance conviction in the 1990s. Medicaid paid over \$60,000 over the 2 years for medical services rendered, including prescription drugs. The state has never placed the beneficiary on a restricted recipient program because the state did not identify beneficiary as a doctor shopper. |
| 11 | TX | Prescriptions "written" by a dead prescriber | Vicodin and Ativan | <ul style="list-style-type: none"> Three pharmacies filled Medicaid prescriptions of controlled substances for three beneficiaries. The claims indicated that the prescriptions were written by the same deceased prescriber. Most of the actual prescriptions were written and signed by a physician assistant who previously worked for the deceased prescriber. The physician assistant is not a DEA registrant and thus does not have the authority to write prescriptions for controlled substances. Another physician who works with the physician assistant is being investigated, as of June 2009, for prescribing the exact same regimen of medication to 13 patients, using preprinted prescription pads for prescribing Vicodin and Soma, charging each patient the same amount, and reporting seeing 300 to 400 patients per week. |

| Case | State | Nature of activity | Type of controlled substance(s) ^a | Case details |
|------|-------|--|--|---|
| 12 | NY | Doctor shopping | Ambien | <ul style="list-style-type: none"> Beneficiary used two different Medicaid IDs to doctor shop Ambien at two pharmacies and three prescribers. Beneficiary admitted to using different doctors and pharmacies in an effort to elude detection and acknowledged his wrongdoing. New York Medicaid program did not detect error for several years although the same name and SSN were associated with both Medicaid IDs. Beneficiary received 1,200 pills of Ambien, which cost Medicaid \$4,400. This represented a 3.4 year supply obtained within 2 years. Medicaid paid over \$440,000 for medical services rendered during fiscal years 2006 and 2007, including prescription drugs. The state has never placed the beneficiary on a restricted recipient program because the state did not identify beneficiary as a doctor shopper. |
| 13 | NY | DEA noncompliance | Oxycodone, Fentanyl, Vicodin, Tylenol with Codeine, Ambien, Xanax, Klonopin, Provigil, and Lunesta | <ul style="list-style-type: none"> According to DEA, physician was only authorized to prescribe Schedule V drugs. Physician prescribed over 10,600 pills of DEA Schedules II, III, and IV drugs to 100 Medicaid beneficiaries in violation of DEA regulations. Physician said that he thought that Schedule V was the highest and most restrictive DEA schedule, and by having that authorization, he assumed he did not need separate authorizations for Schedules II, III, and IV. |
| 14 | TX | Prescribing controlled substances to Medicaid beneficiaries while on sanction list | Oxycodone, Dilaudid, Vicodin, and Ambien | <ul style="list-style-type: none"> Physician has been excluded from prescribing to Medicaid beneficiaries since 2005 as a result of a felony controlled substance conviction. Physician was found guilty of a felony count of writing fraudulent controlled substance prescriptions. Subsequent to conviction, physician prescribed 2,500 pills of controlled substances to 10 Medicaid beneficiaries. Many of the prescriptions were also in violation of the physician's DEA authority, which was restricted as a result of the physician prescribing medication to himself. Medicaid paid for 36 claims during fiscal years 2006 and 2007 even though the physician was excluded from the Medicaid program. |

| Case | State | Nature of activity | Type of controlled substance(s) ^a | Case details |
|------|-------|--------------------|--|---|
| 15 | IL | Overprescribing | Adderall XR | <ul style="list-style-type: none"> Physician prescribed one patient 64,200 mg of Adderall XR over a 2-year period, or a daily average of 88 mg per day, almost three times the daily maximum recommended dose of 30 mg per day. Physician circumvented Medicaid restrictions on the amount of Adderall XR that could be prescribed by concurrently prescribing multiple dosages. Physician stated that he prescribed Adderall XR to the same patient in patterns of 10, 15, 25, and 30 mg “to get the prescriptions through Medicaid” because he knew Medicaid would not fill three 30 mg prescriptions. Medicaid paid over \$11,000 for 115 prescriptions of Adderall XR from 2005 through 2007. |

Source: GAO.

^aThe type of controlled substance is the prescribed brand-name drug, which may have been filled with a generic version of the drug.

The following provides illustrative detailed information on four cases we investigated.

- Case 2:** The beneficiary used the identity of an individual who was killed in 1980 to receive Medicaid benefits. According to a state Medicaid official, he originally applied for Medicaid assistance at a California county in January 2004. During the application process, the man provided a Social Security card to a county official.¹⁴ When the county verified the SSN with SSA, SSA responded that the SSN was not valid. The county enrolled the beneficiary into Medicaid provisionally for 90 days under the condition that the beneficiary resolve the SSN discrepancy with SSA within that time frame. Although the beneficiary never resolved the issue, he remained in the Medicaid program until April 2007. From 2004 through 2007, the Medicaid program paid for over \$200,000 in medical services. This included at least \$2,870 for controlled substances that he received from the pharmacies.¹⁵ We attempted to locate the beneficiary but could not locate him.
- Case 8:** The physician prescribed controlled substances to the beneficiary after she died in February 2006. The physician stated that the beneficiary had been dying of a terminal disease and became

¹⁴ In California, Medicaid applications are submitted to the county, which are then forwarded to the state following a review.

¹⁵ The controlled substance amount is for fiscal years 2006 and 2007.

unable to come into the office to be examined. The physician stated that in instances where a patient is compliant and needs pain medication, physicians will sometimes prescribe it without requiring an examination. A pharmacy eventually informed the physician that the patient had died and the patient's spouse had continued to pick up her prescriptions for Methadone, Klonopin, and Xanax after her death. According to the pharmacy staff, the only reason they became aware of the situation was when an acquaintance of the spouse noticed him picking up prescriptions for a wife who had died months ago. The acquaintance informed the pharmacy staff of the situation. They subsequently contacted the prescribing physician. Since this incident, the pharmacy informed us that it has not filled another prescription for the deceased beneficiary.

- **Case 9:** A mother with a criminal history and Ritalin addiction used her child as a means to doctor shop for Ritalin and other similar controlled stimulants used to treat ADHD. Although the child received overlapping prescriptions of methylphenidate and amphetamine medications during a 2-year period and was banned (along with his mother) from at least three medical practices, the Illinois Medicaid Program never placed the beneficiary on a restricted recipient program. Such a move would have restricted the child to a single primary care, pharmacy, or both thus preventing him (and his mother) from doctor shopping. Over the course of 21 months, the Illinois Medicaid Program paid for 83 prescriptions of ADHD controlled stimulants for the beneficiary, which totaled approximately 90,000 mg and cost \$6,600.
- **Case 11:** Claims indicated that a deceased physician "wrote" controlled substance prescriptions for several patients in the Houston area. Upon further analysis, we discovered that the actual prescriptions were signed by a physician assistant who once worked under the supervision of the deceased physician. The pharmacy neglected to update its records and continued filling prescriptions under the name of the deceased prescriber. The physician assistant has never been a DEA registrant. The physician assistant told us that the supervising physicians always signed prescriptions for controlled substances. After informing her that we had copies of several Medicaid prescriptions that she had signed for Vicodin and lorazepam, the physician assistant ended the interview.

Improved Fraud Controls Could Better Prevent Abuse and Unnecessary Medicaid Program Expenditures

CMS Conducts Limited Oversight of Controlled Substances in Medicaid Program

Although states are primarily responsible for the fight against Medicaid fraud and abuse, CMS is responsible for overseeing state fraud and abuse control activities. CMS has provided limited guidance to the states on how to improve their control measures to prevent fraud and abuse of controlled substances in the Medicaid program. Thus, for the five state programs we reviewed, we found different levels of fraud prevention controls. For example, the Omnibus Budget Reconciliation Act of 1990 encourages states to establish a Drug Utilization Review (DUR) Program.¹⁶ The main emphasis of the program is to promote patient safety through an increased review and awareness of prescribed drugs. States receive increased federal funding if they design and install a point-of-sale electronic prescription claims management system to interact with their Medicaid Management Information Systems (MMIS), each state's Medicaid computer system. Each state was given considerable flexibility in how to identify prescription problems, such as therapeutic duplication and overprescribing by providers,¹⁷ and how to use MMIS to prevent such problems. The level of screening, if any, states perform varies because CMS does not set minimum requirements for the types of reviews or edits that are to be conducted on controlled substances. Thus, one state requires prior approval when ADHD treatments like Ritalin and Adderall are prescribed outside age limitations, while another state had no such controlled substance requirement at the time of our review.

¹⁶ Pub L. No. 101-508, 104 Stat. 1388 (1990).

¹⁷ Therapeutic duplication is the prescribing and dispensing of the same drug or two or more drugs from the same therapeutic class when overlapping time periods of drug administration are involved and when the prescribing or dispensing is not medically indicated.

Recently, under the Deficit Reduction Act of 2005 (DRA),¹⁸ CMS is required to initiate the Medicaid Integrity Program (MIP) to combat Medicaid fraud, waste, and abuse.¹⁹ DRA requires CMS to enter into contracts with Medicaid integrity contractors (MIC) to review provider actions, audit provider claims and identify overpayments, and conduct provider education.²⁰ To date, CMS has awarded umbrella contracts to several contractors to perform the functions outlined above. According to CMS, these contractors cover 40 states, 5 territories, and the District of Columbia. CMS officials stated that CMS will award task orders to cover the rest of the country by the end of fiscal year 2009. CMS officials stated that MIC audits are currently under way in 19 states. CMS officials stated that most of the MIP reviews will focus on Medicaid providers and that the state Medicaid programs will handle beneficiary fraud. Because the Medicaid program covers a full range of health care services and the prescription costs associated with controlled substances is relatively small, the extent to which MICs focus on controlled substances is likely to be relatively minimal.

Selected States Lack a Comprehensive Fraud Prevention Framework for Controlled Substances

The selected states did not have a comprehensive fraud prevention framework to prevent fraud and abuse of controlled substances paid for by Medicaid. The establishment of effective fraud prevention controls by the selected states is critical because the very nature of a beneficiary's medical need—to quickly obtain controlled substances to alleviate pain or treat a serious medical condition—makes the Medicaid program vulnerable to those attempting to obtain money or drugs they are not entitled to receive. Instead of these drugs being used for legitimate purposes, these drugs may be used to support controlled substance addictions and sale of the drugs on the street. As shown in figure 1, a well-designed fraud prevention system (which can also be used to prevent waste and abuse) should consist of three crucial elements: (1) preventive controls, (2) detection and monitoring, and (3) investigations and prosecutions. In addition, as shown in figure 1, the organization should also use “lessons learned” from its detection and monitoring controls and

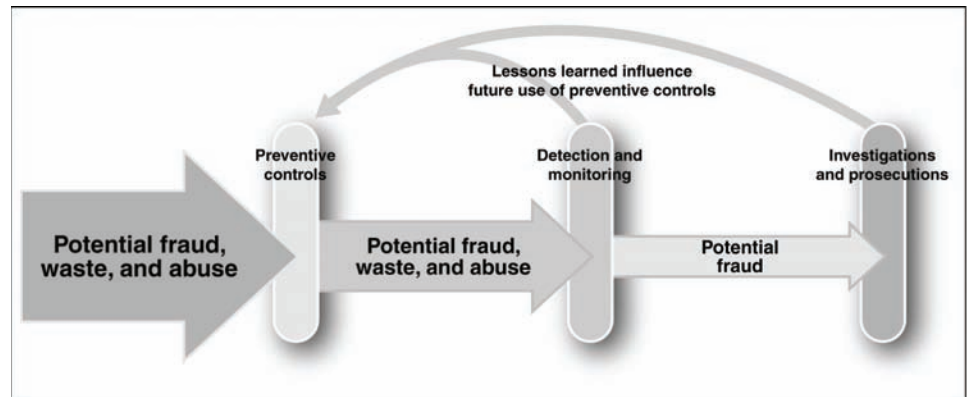
¹⁸ Pub. L. No. 109-171, 120 Stat. 4 (2005).

¹⁹ Although individual states are responsible for the integrity of their respective Medicaid programs, the MIP represents CMS's first national strategy to detect and prevent Medicaid fraud and abuse.

²⁰ In addition, CMS is required to provide effective support and assistance to states in their efforts to combat Medicaid provider fraud and abuse.

investigations and prosecutions to design more effective preventive controls.

Figure 1: Fraud Prevention Model



Source: GAO.

Preventive controls: Fraud prevention is the most efficient and effective means to minimize fraud, waste, and abuse. Thus, controls that prevent fraudulent health care providers and individuals from entering the Medicaid program or submitting claims are the most important element in an effective fraud prevention program. Effective fraud prevention controls require that where appropriate, organizations enter into data-sharing arrangements with organizations to perform validation. System edit checks (i.e., built-in electronic controls) are also crucial in identifying and rejecting fraudulent enrollment applications, fraudulent claims, or both before payments are disbursed. Some of the preventive controls and their limitations that we observed at the selected states include the following.

- **Federal debarment and exclusion:** Federal regulation requires states to ensure that no payments are made for any items or services furnished, ordered, or prescribed by an individual or entity that has been debarred from federal contracts, excluded from Medicare and Medicaid programs, or both. Officials from all five selected states said that they do not screen prescribing providers or pharmacies against the federal debarment list, also known as the EPLS. Further, officials from four states said that when a pharmacy claim is received, they do not check to see if the prescribing provider was excluded by HHS OIG from participating in the Medicaid program.

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- **DEA registration:** DEA, on behalf of the Attorney General of the United States, is the agency primarily responsible for enforcing CSA. Federal regulations require physicians and pharmacies to be registered with DEA for the controlled substance schedule(s) that they are authorized to prescribe or dispense. According to DEA officials, DEA can take administrative action against a provider who violates CSA or its implementing regulations, such as revoking DEA registration. Legal action against the provider is also a possibility. Although DEA's registrant database is available for purchase by the public through the Department of Commerce's National Technical Information Service, none of the five state Medicaid offices obtained the database at the time of our study to determine if physicians are authorized to prescribe particular controlled substances.²¹ Thus, the selected state Medicaid programs do not screen prescription claims for controlled substances to ensure that a health care provider is authorized to prescribe the particular drug(s). Further, DEA officials stated that pharmacies have corresponding responsibility to determine if a prescription is legitimate, which includes determining whether a health care provider is authorized to prescribe the particular schedule of controlled substance before filling a prescription. However, none of the pharmacy boards of the selected states said that this is a requirement they monitor. In fact, four pharmacy boards stated that the states only require that their pharmacists check to see if the DEA number on the prescription appears to be a valid DEA number, without verifying it with the DEA registration database.
 - **Duplicate enrollment:** Medicaid officials in two states said that they did not have pre-enrollment checks in place to provide assurance that duplicate applications are not approved. One state does not even require the beneficiary to furnish an SSN when applying for the Medicaid program, thus making this fraud difficult to identify. In fact, during the period covered by our work, this state had 4,296 Medicaid beneficiaries who were enrolled without SSNs. These beneficiaries were approved for about 8,300 controlled substances claims, totaling \$193,500. We did not investigate these beneficiaries for fraud or abuse.
 - **DUR:** As mentioned earlier, states perform DURs and other controls during the prescription claims process to promote patient safety, reduce costs, and prevent fraud and abuse. The DURs include prospective screening and edits for potential inappropriate drug

²¹ Officials from one state said that they now obtain copies of the DEA registration database.

therapies, such as overutilization, drug-drug interaction, or therapeutic duplication.²² In addition, selected states also require health care providers to submit prior authorization forms for certain prescriptions of drugs because those medications have public health concerns, are considered high risk for fraud and abuse, or both. Each state has developed its DUR differently, and some of the differences that we saw from the selected states include the following:

- Officials from certain states said that they use the results of prospective screening (e.g., findings of overutilization, overlapping controlled substance prescriptions, etc.) as an automatic denial of the prescription. Officials from the other states generally use the prospective screening as more of an advisory tool for pharmacies, which pharmacies can override by entering a reason code. As such, the effectiveness of the tool for preventing fraud and abuse in these states is more limited.
- The types of drugs that require prior authorization vary greatly between the selected states. In states where it is used, health care providers may be required to obtain prior authorization if a specific brand name is prescribed (e.g., OxyContin) or if a dosage exceeds a predetermined amount for a therapeutic class of controlled substances (e.g., hypnotics, narcotics).

Detection and monitoring: Even with effective preventive controls, there is risk that fraud and abuse will occur in Medicaid regarding controlled substances. States must continue their efforts to monitor the execution of the prescription program, including periodically matching their beneficiary files to third-party databases to determine continued eligibility, monitor controlled substance prescriptions to identify abuse, and make necessary corrective actions. Such actions include the following.

- **Checking death files:** After enrolling beneficiaries, Medicaid offices in the selected states generally did not periodically compare their information against death records. Specifically, two of the five selected states said that they did not obtain death records from SSA or the state vital statistics office to determine if a Medicaid beneficiary was still alive. Officials from two states said that Medicaid offices primarily rely

²² In addition, state Medicaid offices also perform retrospective analysis to identify patterns of potential waste and abuse of drugs so that pharmacies and Medicaid providers are notified of this potential problem.

on obituaries, providers, family members, or others to report the status change of the beneficiary.

- **Increasing the use of the restricted recipient program:** In the course of DURs or audits, the state Medicaid offices may identify beneficiaries who have abused, the Medicaid prescription drug program, defrauded the program, or both. In those cases, the selected states may place the beneficiaries into a restricted recipient program.²³ Under this program, the state Medicaid office restricts the beneficiaries to one health care provider, one pharmacy, or both for receiving prescriptions. This program only applies to those beneficiaries in a fee-for-service arrangement since managed care organizations are responsible for determining the quality of care treatments for their enrollees. Thus, a significant portion of the Medicaid recipients for some of the selected states are not subject to this program.
- **Fully utilizing the prescription drug monitoring program:** Beginning in fiscal year 2002, Congress appropriated funding to the Department of Justice to support prescription drug monitoring programs (PDMP). These programs help prevent and detect the diversion and abuse of pharmaceutical controlled substances, particularly at the retail level where no other automated information collection system exists. States that have implemented PDMPs have the capability to collect and analyze data on filled and paid prescriptions more efficiently than those without such programs, where the collection of prescription information can require a time-consuming manual review of pharmacy files. If used properly, PDMPs are an effective way to identify and prevent diversion of the drugs by health care providers, pharmacies, and patients. The PDMPs at the selected states have the following limitations:
 - For PDMPs to be useful, health care providers and pharmacies must use the data. Officials from the five selected states said that physician participation in the PDMP is not widespread and not required. In fact, one state did not have a Web-based PDMP; a health care provider has to put in a manual request to the agency to have a controlled substance report generated.

²³ One of the eight “doctor shoppers” in our report was placed in the restricted recipient program. The other seven doctor shoppers in our report were never placed in this program. Also, one of the two “overprescribers” was placed in the restricted recipient program.

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- Program officials at the selected states said that their systems were primarily used to respond to requests for controlled substance information on specific patients from medical practitioners. None of the selected states compared all the prescribers of controlled substances to the DEA authorization list to identify medical practitioners who are illegally prescribing drugs that they are not authorized to prescribe.²⁴
 - Although the PDMPs generally capture the name and address of the patient, the controlled substance prescribed, the date of the prescription, and the identity of the prescriber, they generally do not capture the method of payment that the patient used. Thus, the system will not differentiate between prescriptions paid in cash and those paid using health insurance.
 - One state restricts law enforcement access to the PDMP to only the state bureau of investigation. As such, local police and sheriff's departments cannot access the data, which impedes their ability to conduct prescription drug diversion investigations. According to state officials, the limitation was enacted because of privacy concerns.
 - No nationwide PDMP exists, and only 33 states had operational PDMPs as of June 2009. According to an official in one of the selected states, people would sometimes cross state borders to obtain prescription drugs in a state without a program.

Investigations and prosecutions: Another element of a fraud prevention program is the aggressive investigation and prosecution of individuals who defraud the federal government. Prosecuting perpetrators serves as a preventive measure; it sends the message that the government will not tolerate individuals stealing money. Schemes identified through investigations and prosecution also can be used to improve the fraud prevention program. The MFCU serves as the single identifiable entity within a state government that investigates and prosecutes health care providers who defraud the Medicaid program. In the course of our investigation, however, we found several factors that may limit its effectiveness.

²⁴ Officials in one state said that its PDMP generates a report on nurse practitioners who write prescriptions outside their authority for further investigation.

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- Federal regulations generally limit MFCUs from pursuing beneficiary fraud. According to MFCU officials at one selected state, this limitation impedes investigations because agents cannot use the threat of prosecution as leverage to persuade beneficiaries to cooperate in criminal probes of Medicaid providers. In addition, the MFCU officials in this selected state said that this limitation restricts the agency's ability to investigate organized crime related to controlled substances when the fraud is perpetrated by the beneficiaries.
 - Federal regulations do not permit federal funding for MFCUs to engage in routine computer screening activities that are the usual monitoring function of the Medicaid agency. According to MFCU officials in one selected state, this issue has caused a strained working relationship with the state's Medicaid OIG, on whom the MFCU relies for claims information. The MFCU official stated that based on fraud trends in other states, the state MFCU wanted the Medicaid OIG to provide claims information on providers who had similar trends in that state. The Medicaid OIG cited this prohibition on routine computer screening activities when refusing to provide these data. In addition, this MFCU official also stated that the state Medicaid office and its OIG did not promptly incorporate improvements that the MFCU suggested regarding preventing the abuse of controlled substances.

DEA Monitoring of Pharmacy and Physician Prescription Practices Related to Controlled Substances

DEA officials stated that although DEA monitors purchases of certain Schedule II and III controlled substances by pharmacies, it does not routinely receive information regarding written or dispensed controlled substance prescriptions. In states with PDMPs, a state agency collects and maintains data relating to dispensed controlled substance prescriptions. In the course of an investigation regarding the diversion or abuse of controlled substances, DEA may request information from a PDMP. In those states without PDMPs, DEA may obtain controlled substance prescription information from an individual pharmacy's records during the course of an inspection or investigation.

Conclusions

Fraud and abuse related to controlled substances paid for by Medicaid exist in the five selected states. Given that states are responsible for administering Medicaid and investigating and prosecuting any fraudulent activities, each state must set its own course to ensure the integrity of its Medicaid program, including its monitoring of the dispensing and use of controlled substances. CMS is also responsible for actively partnering with and providing guidance to the states to ensure that they succeed in minimizing fraud and abuse in the Medicaid program.

Recommendations for Executive Action

To establish an effective fraud prevention system for the Medicaid program, we recommend that the Administrator of CMS evaluate our findings and consider issuing guidance to the state programs to provide assurance that

- claims processing systems prevent the processing of claims from providers and pharmacies debarred from federal contracts (i.e., on the EPLS), excluded from the Medicare and Medicaid programs (i.e., on the LEIE), or both;
- DUR and restricted recipient program requirements adequately identify and prevent doctor shopping and other abuses of controlled substances;
- effective claims processing systems are in place to periodically identify both duplicate enrollments and deaths of Medicaid beneficiaries and to prevent the approval of claims when appropriate; and
- effective claims processing systems are in place to periodically identify deaths of Medicaid providers and prevent the approval of claims when appropriate.

Agency Comments and Our Evaluation

We provided a draft of this report to DEA and CMS for comment. DEA provided us technical comments by e-mail. CMS comments are reprinted in appendix II. CMS stated that it generally agrees with the four recommendations. CMS stated that it will continue to evaluate its programs and will work to develop methods to address the identified issues found in this report.

CMS provided us two comments regarding our recommendations. First, CMS stated that we should be more specific as to the databases that the states should access in screening for debarred providers. Second, CMS also stated that we recommend that DEA make its registrant database available to the states without a fee. Third, CMS stated that information on deceased providers and beneficiaries could be provided by a feed from SSA. CMS also provided us two technical comments to the report.

In response to CMS comment on the specificity of databases, we revised the recommendation to specify the two databases that should be used in screening claims: (1) the EPLS on federal debarments and (2) Medicare and Medicaid exclusions (i.e., the LEIE) maintained by HHS OIG. As stated in the report, both of these databases are required to be used by the states before they pay prescription claims. We did not recommend that states use the DEA registration database in the processing of Medicaid controlled substance claims, and thus we do not make any recommendations to DEA at this time. In response to CMS's comment about screening for deceased

providers and beneficiaries, we agree with CMS that SSA data can be used in determining the eligibility of Medicaid beneficiaries and providers. In developing its guidance to the states, we believe that CMS should consider SSA death records and other sources to identify deceased Medicaid providers and beneficiaries. We incorporated the technical comments made by DEA and CMS into the report as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the date of this letter. We will then send copies of this report to interested congressional committees and the Acting Administrators of CMS and DEA. The report also will be available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff members have any questions about this report, please contact me at (202) 512-6722 or kutzg@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix III.

A handwritten signature in black ink that reads "Gregory D. Kutz". The signature is written in a cursive style with a large, stylized initial "G".

Gregory D. Kutz
Managing Director
Forensic Audits and Special Investigations

Appendix I: Additional Examples of Fraud, Waste, and Abuse of Controlled Substances in Medicaid

Table 5, in the main portion of the report, provides data on 15 detailed case studies. Table 6 provides details of the remaining 10 cases we selected. As with the 15 cases discussed in the body of this report, we also found fraudulent, improper, and abusive controlled substances activities in Medicaid for these 10 cases.

Table 6: Fraudulent, Improper, and Abusive Controlled Substance Activity in Medicaid

| Case | State | Nature of activity | Type of controlled substance(s) | Case details |
|------|-------|--|---|--|
| 16 | CA | Prescribing controlled substances to Medicaid beneficiaries while on sanction list | Oxycodone, Vicodin, and Tylenol with Codeine | <ul style="list-style-type: none"> Physician has been excluded from prescribing to Medicaid beneficiaries as a result of a felony controlled substance conviction in 2003. Physician pled guilty to a felony count of writing fraudulent controlled substance prescriptions after his Drug Enforcement Administration (DEA) registration had been revoked. |
| 17 | NY | DEA noncompliance | Oxycodone, Methadone, Morphine, Focaline, Ritalin, Concerta, and Adderall | <ul style="list-style-type: none"> According to DEA, physician was only authorized to prescribe Schedule III drugs. Physician prescribed over 8,000 pills of DEA Schedule II drugs to over 20 Medicaid beneficiaries in violation of DEA regulations. |
| 18 | NY | Prescribing controlled substances to Medicaid beneficiaries while on sanction list | Ritalin, Concerta, Adderall, Focalin, Tylenol with Codeine, Ambien, Klonopin, Ativan, Valium, Sonata, Restoril, and Lunesta | <ul style="list-style-type: none"> Physician has been excluded from prescribing to Medicaid beneficiaries since 2000 as a result of a criminal conviction for submitting false Medicaid claims. Physician pled guilty to fraudulent billing/cost reporting and was sentenced to pay restitution of \$210,000. Medicaid paid \$764,000 for 9,236 controlled substances claims for 773 beneficiaries even though the physician was excluded from the Medicare and Medicaid programs during fiscal years 2006 and 2007. Pills prescribed by physician and paid for by Medicaid totaled over 350,000. |

**Appendix I: Additional Examples of Fraud,
Waste, and Abuse of Controlled Substances in
Medicaid**

| Case | State | Nature of activity | Type of controlled substance(s) | Case details |
|-------------|--------------|---------------------------|---|---|
| 19 | NC | Doctor shopping | Oxycodone | <ul style="list-style-type: none"> Beneficiary received 1,850 pills of oxycodone over 21 months. Beneficiary received prescriptions of oxycodone from 27 prescribers that were then filled by eight pharmacies. Employee at one pharmacy stated that the beneficiary was known as an abuser of controlled substances. According to one pharmacist, the beneficiary would present prescriptions from different doctors and hospital emergency rooms. On at least one occasion, the pharmacist believes a doctor instructed him to cancel a prescription after learning beneficiary had obtained a similar prescription from another physician. The state has never placed the beneficiary on a restricted recipient program because the state did not identify beneficiary as a doctor shopper. |
| 20 | IL | Doctor shopping | Adderall | <ul style="list-style-type: none"> Over the course of 2 years, beneficiary received 2,000 pills (42,290 mg) of controlled substances used to treat attention-deficit/hyperactivity disorder, equivalent to over a 5-year supply. Beneficiary received overlapping prescriptions of Adderall from 11 prescribers that were then filled by eight pharmacies. Prescribing physicians were not aware beneficiary was receiving multiple prescriptions of the same drug. Beneficiary stated that she was addicted to Adderall and did not realize she could get into trouble for obtaining prescriptions from two physicians simultaneously for the same controlled substance. The state has never placed the beneficiary on a restricted recipient program because the state did not identify beneficiary as a doctor shopper. |
| 21 | IL | DEA noncompliance | Focaline, Ritalin, Concerta, and Adderall | <ul style="list-style-type: none"> According to DEA, physician was only authorized to prescribe Schedules III through V drugs. Physician prescribed over 3,500 pills of DEA Schedule II drugs to over 20 Medicaid beneficiaries in violation of DEA regulations. |
| 22 | NY | DEA noncompliance | Focaline, Ritalin, Concerta, Morphine, and Adderall | <ul style="list-style-type: none"> According to DEA, physician was only authorized to prescribe Schedule V drugs. Physician prescribed over 3,000 pills of DEA Schedule II drugs to over 50 Medicaid beneficiaries in violation of DEA regulations. |

**Appendix I: Additional Examples of Fraud,
Waste, and Abuse of Controlled Substances in
Medicaid**

| Case | State | Nature of activity | Type of controlled substance(s) | Case details |
|-------------|--------------|---|--|---|
| 23 | NY | Doctor shopping | Ambien | <ul style="list-style-type: none"> • Beneficiary received 970 pills of Ambien over 23 months. • Beneficiary received overlapping prescriptions of Ambien from nine prescribers that were then filled by five pharmacies. • Prescribing physicians were not aware beneficiary was receiving multiple prescriptions of the same drug. • The state placed the beneficiary on a restricted recipient program from April 2007 through April 2009, which limited the beneficiary to one primary care physician and one primary pharmacy. • Medicaid paid over \$180,000 for medical services rendered in fiscal years 2006 and 2007, including controlled substances claims. |
| 24 | CA | DEA noncompliance | Oxycodone, Methadone, Dilaudid, Morphine, Fentanyl, Focalin, Kadian, Adderall, and Marinol | <ul style="list-style-type: none"> • According to DEA, physician was only authorized to prescribe Schedules III through V drugs for at least 10 years. • Physician prescribed over 14,300 pills of DEA Schedule II drugs to over 60 Medicaid beneficiaries in violation of DEA regulations. |
| 25 | IL | Dispensing controlled substances to Medicaid beneficiaries while on sanction list | OxyContin, Concerta, Adderall, Vicodin, Tylenol with Codeine, Ambien, and Xanax | <ul style="list-style-type: none"> • Pharmacy has been excluded from filling prescriptions for Medicaid beneficiaries as a result of a felony conviction for making false statements in order to receive Medicaid payments. • Pharmacy was found guilty of billing Medicaid for thousands of dollars in medical prescriptions that were never filled. • Medicaid paid \$3,315 for 81 controlled substances claims even though the pharmacy was excluded from the Medicare and Medicaid programs. Controlled substance pills dispensed by the pharmacy and paid for by Medicaid totaled 5,200. |

Source: GAO.

Appendix II: Comments from the Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

AUG 21 2009

Greg Kutz
Managing Director
Forensic Audits and Special Investigations
Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Kutz:

Enclosed are the Department's comments on the U.S. Government Accountability Office's (GAO) draft report entitled: "Medicaid: Fraud and Abuse Related to Controlled Substances Identified in Selected States" (GAO-09-957).

The Department appreciates the opportunity to review and comment on this report before its publication.

Sincerely,

A handwritten signature in cursive script that reads "Barbara Pisaro Clark".

Barbara Pisaro Clark
Acting Assistant Secretary for Legislation

Enclosure

Appendix II: Comments from the Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: AUG 21 2009

TO: Greg Kutz
Managing Director, Forensic Audits and Special Investigations
Government Accountability Office

FROM: *Charlene Frizzera*
Charlene Frizzera
Acting Administrator

SUBJECT: Government Accountability Office (GAO) Draft Report, Medicaid: Fraud and Abuse Related to Controlled Substances identified in Selected States (GAO-09-957)

Thank you for the opportunity to review and comment on the subject GAO draft report. The objective of the report was to determine--(1) whether there are indications of fraud and abuse related to controlled substances paid for by Medicaid; (2) if so, specific case examples of fraudulent, improper, and/or abusive activity; and (3) the effectiveness of internal controls that the Federal Government and selected States have in place to prevent and detect fraud and abuse related to controlled substances.

GAO Recommendations

The GAO recommended that the Centers for Medicare & Medicaid Services (CMS) evaluate the GAO findings and consider issuing guidance to the State programs to establish an effective fraud prevention system for the Medicaid Program to ensure that--

- 1) Effective claims processing systems prevent the processing of claims of all prescribing providers and dispensing pharmacies debarred from Federal contracts and/or excluded from the Medicare and Medicaid programs;
- 2) Drug utilization Review (DUR) and restricted recipient program requirements adequately identify and prevent doctor shopping and other abuses of controlled substances;
- 3) Effective claims processing system to periodically identify both duplicate enrollments and deaths of Medicaid beneficiaries and prevent the approval of claims when appropriate; and
- 4) Effective claims processing systems to periodically identify deaths of Medicaid providers and prevent the approval of claims when appropriate.

Page 2 – Greg Kutz

CMS Response to GAO Recommendations

Generally, CMS agrees with each of the four recommendations. CMS continues to evaluate its programs and will work to develop methods to address the identified issues found in this report.

The CMS has two specific comments regarding the recommendations.

1. Although we agree with the first recommendation that the claims systems should screen for debarred providers (both prescribers and pharmacies), the recommendation should be more specific citing the sources (databases) that the States should be accessing. During the exit conference call with CMS, GAO stated that it would recommend that the Drug Enforcement Agency registrant database be made available to Medicaid at no cost. It is currently available for a fee through the Department of Commerce and National Technical Information Service.
2. We agree with the third and fourth recommendations that claims processing should include screening for deceased Medicaid beneficiaries and prescribers. One way for States to obtain this information in order to facilitate the sharing of these data would be through a feed of information from the Social Security Administration to the States.

Specific Comments

The CMS has two specific comments regarding the draft report.

1. In the first paragraph of page 21, CMS suggests that that the language about CMS Medicaid Integrity Contractors (MIC) be revised. Review and audit task orders have been awarded for Audit MICs in 40 States, 5 territories, and the District of Columbia. CMS will award task orders to cover the rest of the country by the end of fiscal year 2009. In addition, MIC audits are currently underway in 19 States.
2. During the entrance conference we recommended that the term “wholesale pharmacy” (on page 12) be changed to “long term care pharmacy.” In the first instance, “wholesale” was not deleted or changed. In the second occurrence, “wholesale” was deleted, but “long term care” was not added.

The CMS appreciates the opportunity to comment on this Draft Report and we look forward to working with the GAO on this and other issues.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Greg Kutz, (202) 512-6722 or kutzg@gao.gov

Acknowledgments

In addition to the contact named above, the following individuals made major contributions to this report: Matthew Harris, Assistant Director; Matthew Valenta, Assistant Director; Erika Axelson; Paul Desaulniers; Eric Eskew; Dennis Fauber; Alberto Garza; Robert Graves; Barbara Lewis; Olivia Lopez; Steve Martin; Vicki McClure; Kevin Metcalfe; Gloria Proa; Chris Rodgers; Ramon Rodriguez; and Barry Shillito.

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