

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**COLORADO PAID OVER
800 THOUSAND MEDICAID CLAIMS
WITH MISSING OR INVALID
NATIONAL PROVIDER IDENTIFIERS
DURING 2011**

*Inquiries about this report may be addressed to the Office of Public Affairs at
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**Patrick J. Cogley
Regional Inspector General
for Audit Services**

April 2015
A-07-13-06042

Office of Inspector General

<http://oig.hhs.gov/>

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EXECUTIVE SUMMARY

Colorado lacked sufficient internal controls to prevent the reimbursement of over 800,000 Medicaid claims that had missing or invalid National Provider Identifiers during Federal fiscal year 2011. Colorado claimed approximately \$213 million in Federal reimbursement associated with these claims. These control weaknesses threaten the integrity, effectiveness, and efficiency of the Medicaid program.

WHY WE DID THIS REVIEW

The U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), exercises oversight to help ensure that States comply with Federal laws and regulations in the administration of their Medicaid programs. A previous audit of Colorado's Department of Health Care Policy and Financing (State agency) determined that the State agency's Medicaid payment system was vulnerable to claims submitted by providers that did not have National Provider Identifiers (NPIs), which are unique identifiers assigned by the Federal Government to health care providers. Medicaid claims submitted for reimbursement that do not have NPIs are thus more vulnerable to improper payments. The Patient Protection and Affordable Care Act (PPACA) and implementing regulations added new requirements for the use of NPIs in the Medicaid program.

The objective of this review was to determine whether the State agency had sufficient internal controls to ensure that Medicaid claims submitted by providers for costs claimed in Federal fiscal year (FY) 2011 included NPIs as specified in Federal requirements.

BACKGROUND

Use of National Provider Identifiers in Medicaid Program

HHS OIG has the authority to require health care providers that participate in Medicaid and other Federal health care programs to enroll under the relevant State's Medicaid plan and to provide a valid and active NPI of the provider that receives payment on all claims, including Medicaid claims (the Inspector General Act of 1978 and §§ 1866 and 1902 of the Social Security Act (the Act)).

The NPI is a unique, 10-digit, sequentially assigned national identification number whose use the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated as a means to identify health care providers, health plans, and health care clearinghouses in all administrative and financial HIPAA transactions (a term that generally refers to electronic exchanges of information involving the transfer of health-care-related data between two parties for specific purposes). An NPI is routinely assigned only to medical providers; HIPAA generally does not require non-medical providers that serve Medicaid enrollees, such as certain home care services and transportation services, to obtain an NPI. The Centers for Medicare & Medicaid Services' (CMS's) implementation of HIPAA requires all providers that send electronic health care claims to a Federal health care plan, including Medicaid, to use the providers' NPIs. For this report, we refer to claims submitted by *medical* providers for reimbursement under the Medicaid program—

and that are thus subject to HIPAA requirements—as “Medicaid claims.” Depending on the type of claim, there can be many separate data fields in which providers can enter their NPIs. For this report, we refer to these data fields as “NPI fields.”

Information on all NPIs is stored in a national database, called the National Plan and Provider Enumeration System (NPPES), which CMS maintains.

The PPACA requires providers that are eligible for an NPI and that have it to submit it on all Medicaid claims for services furnished under the relevant State’s CMS-approved State Medicaid plan (State plan). Implementing regulations (effective July 6, 2010) require that the Medicaid provider agreement between the State agency and the provider include a condition that any provider eligible for an NPI must furnish it on all Medicaid claims submitted under the State plan (42 CFR § 431.107(b)(5)).

Colorado Medicaid Program

In Colorado, the State agency administers the Medicaid program in part by developing and maintaining internal controls to detect and prevent unallowable Medicaid claims.

The State agency uses a mechanized system, the Medicaid Management Information System (MMIS), in its administration of the Medicaid program (the Act, § 1903(r)(1)(a), and chapter 11 of the CMS *State Medicaid Manual*). An MMIS is a system of software and hardware used to process Medicaid claims and manage information about Medicaid beneficiaries and services. This system may be operated by either a State agency or a fiscal agent, which is a private contractor hired by the State agency. In Colorado, the State agency contracts the operations of its MMIS to a fiscal agent.

In FY 2007, the State agency completed NPI enhancements and upgrades to its MMIS to meet the requirements of the initial transition to NPIs. The State agency received and spent approximately \$2.1 million (approximately \$1.9 million Federal share) to make these system upgrades.

To identify claims associated with the NPI requirement, we reviewed approximately 26 million claims totaling approximately \$3.6 billion (at least \$1.8 billion Federal share) that the State agency paid during FY 2011 (October 1, 2010, to September 30, 2011).

WHAT WE FOUND

The State agency lacked sufficient internal controls to ensure that Medicaid claims submitted by providers and paid by the State agency during FY 2011 correctly included NPIs as specified in Federal requirements. As a result, the State agency was unable to prevent the reimbursement of Medicaid claims that had missing or invalid NPIs.

During FY 2011, the State agency paid 803,126 Medicaid claims totaling \$425,376,886 (at least \$212,688,442 Federal share) for claims that did not appropriately identify the NPI of the providers. Specifically, the State agency paid:

- 798,411 Medicaid claims totaling \$424,396,991 (at least \$212,198,495 Federal share) that had missing NPIs in all of the NPI fields that identify medical providers and
- 4,715 Medicaid claims totaling \$979,895 (at least \$489,947 Federal share) that had invalid NPIs in at least one of the NPI fields.

Although it upgraded and enhanced its MMIS beginning in FY 2007, the State agency did not implement sufficient internal controls, in the form of system edits in its MMIS, to prevent claims with missing and invalid NPIs from being submitted for, and receiving, Federal reimbursement. In addition, the State agency did not address any of the Federal requirements regarding the use of NPIs in its State plan.

The State agency's insufficient internal controls for the use of NPIs threaten the integrity, effectiveness, and efficiency of the Medicaid program. These vulnerabilities could permit individuals or entities to participate in the Medicaid program in violation of Federal regulations and could thus subject the Medicaid program to potential fraud and abuse. Without adequate internal controls for the use of NPIs, unapproved or federally banned providers could submit fraudulent claims and receive reimbursement. Moreover, the lack of system edits to verify invalid or missing NPIs undermines the intent of the relevant statutory and regulatory language to provide a single, unique identifier for those providers that participate in Federal health care programs.

WHAT WE RECOMMEND

We recommend that the State agency strengthen its internal controls to ensure that all claims submitted to Medicaid have the required valid and populated NPI fields when applicable. Specifically, the State agency should create a system edit in its MMIS to ensure that each Medicaid claim has valid NPIs in all applicable NPI fields before that claim is processed for payment.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendation that claims submitted to Medicaid have the required valid and populated NPI fields, and it described corrective actions, in conformance to our recommendation, that it planned to implement. However, the State agency said that its current MMIS "... does not have the full functionality as required under the new [F]ederal regulations" regarding the use of NPIs but added that it "... is denying appropriately for invalid or missing NPI as designed through the current MMIS." The State agency added that the new MMIS, which will "... edit all NPI fields to comply with the [F]ederal and State regulations" and strengthen internal controls, is scheduled to be implemented in November 2016.

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INTRODUCTION

WHY WE DID THIS REVIEW

The U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), exercises oversight to help ensure that States comply with Federal laws and regulations in the administration of their Medicaid programs. A previous audit of Colorado's Department of Health Care Policy and Financing (State agency) determined that the State agency's Medicaid payment system was vulnerable to claims submitted by providers that did not have National Provider Identifiers (NPIs),¹ which are unique identifiers assigned by the Federal Government to health care providers. Medicaid claims submitted for reimbursement that do not have NPIs are thus more vulnerable to improper payments. The Patient Protection and Affordable Care Act (PPACA)² and implementing regulations added new requirements for the use of NPIs in the Medicaid program.

OBJECTIVE

Our objective was to determine whether the State agency had sufficient internal controls to ensure that Medicaid claims submitted by providers for costs claimed in Federal fiscal year (FY) 2011 included NPIs as specified in Federal requirements.

BACKGROUND

Medicaid Program

Under Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

CMS reimburses State Medicaid agencies based on the Federal medical assistance percentage (FMAP) for claimed Medicaid expenditures including Medicaid expenditures for items and services furnished, ordered, or prescribed by providers enrolled in the State's Medicaid program.³

¹ *Colorado Did Not Always Identify or Prevent Excluded Providers From Participating in the Medicaid Program* (A-07-11-06026), issued July 18, 2012.

² The Patient Protection and Affordable Care Act, P.L. No. 111-148, enacted March 23, 2010.

³ Increased FMAP rates apply during the recession adjustment period that was originally defined in section 5001 of the American Recovery and Reinvestment Act of 2009, P.L. No. 111-5 (Recovery Act), as the period beginning October 1, 2008, and ending December 31, 2010. P.L. No. 111-226 amended the Recovery Act to extend the recession adjustment period to June 30, 2011.

Use of National Provider Identifiers on Medicaid Claims

HHS OIG has the authority to require health care providers that participate in Medicaid and other Federal health care programs to enroll under the relevant State’s Medicaid plan and to provide a valid and active NPI of the provider that receives payment on all claims, including Medicaid claims (the Inspector General Act of 1978 and §§ 1866 and 1902 of the Act).

The NPI is a unique, 10-digit, sequentially assigned national identification number whose use the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated as a means to identify health care providers, health plans, and health care clearinghouses in all administrative and financial HIPAA transactions.^{4,5} Information on all NPIs is stored in a national database called the National Plan and Provider Enumeration System (NPPES). CMS maintains this database and updates its downloadable version monthly.

An NPI is routinely assigned only to medical providers; HIPAA generally does not require non-medical providers that serve Medicaid enrollees, such as those that provide certain home care services and transportation services, to obtain an NPI. CMS’s implementation of HIPAA requires all providers that send electronic health care claims to a Federal health care plan, including Medicaid, to use the providers’ NPIs.⁶ For this report, we refer to claims submitted by *medical* providers for reimbursement under the Medicaid program—and that are thus subject to HIPAA requirements—as “Medicaid claims.” Depending on the type of claim, there can be many separate data fields in which providers can enter their NPIs. For this report, we refer to these data fields as “NPI fields.”

The PPACA amended the Act and requires providers that are eligible for an NPI and that have it to submit it on all Medicaid claims for services furnished under the State plan that are made to Federal health care programs, including Medicaid. Implementing regulations (effective July 6, 2010) require that the Medicaid provider agreement between the State agency and the provider include a condition that any provider eligible for an NPI must include it on all Medicaid claims submitted under the State plan.⁷

⁴ A health care clearinghouse processes information received in a nonstandard format from one entity and converts it to a standard format, or receives a standard transaction and converts it to a nonstandard format for a receiving entity.

⁵ The Health Insurance Portability and Accountability Act of 1996, P.L. No. 104-191. The term “HIPAA transaction” generally refers to electronic exchanges of information involving the transfer of health-care-related data between two parties for specific purposes. These transactions include claims and encounter information, payment and remittance advice, claims status, eligibility information, enrollment and disenrollment information, referrals and authorizations, coordination of benefits, and premium payments.

⁶ 69 Fed. Reg. 3434, 3443, 3469 (January 23, 2004).

⁷ 42 CFR § 431.107(b)(5). In 2012, CMS also issued a Final Rule to the 2010 Interim Final Rule. 77 Fed. Reg. 25284, 25287 (Apr. 27, 2012). In that Final Rule, CMS did not revise the specific requirement of including the NPI on Medicaid claims; therefore, the effective date remains July 6, 2010. *Id.* at 25287 (“[T]he effective date for the inclusion of the NPI on all Medicaid claims for payment remains July 6, 2010”).

Colorado Medicaid Program

In Colorado, the State agency administers the Medicaid program in part by developing and maintaining internal controls to detect and prevent unallowable Medicaid claims. Among other things, the State agency is responsible for enrolling new providers and maintaining provider records for all Colorado Medicaid provider types. Billing providers file Medicaid claims with the State agency.

To receive Federal funding for the use of automated data systems in the administration of its Medicaid program, a State must have a mechanized claims processing and information retrieval system (the Act, § 1903(r)(1)(a)). As provided in chapter 11, section 11100, of the CMS *State Medicaid Manual*, this mechanized system is the Medicaid Management Information System (MMIS). An MMIS is a system of software and hardware used to process Medicaid claims and manage information about Medicaid beneficiaries and services. This system may be operated by either a State agency or a fiscal agent, which is a private contractor hired by the State agency. In Colorado, the State agency contracts the operations of its MMIS to Xerox State Healthcare, a fiscal agent.⁸ The State agency retains overall responsibility for developing and maintaining internal controls to help administer the Medicaid program.

In FY 2007, the State agency completed NPI enhancements and upgrades to its MMIS to meet the requirements of the initial transition to NPIs. The State agency received and spent approximately \$2.1 million (approximately \$1.9 million Federal share) to make these system upgrades.

For FY 2011 (October 1, 2010, to September 30, 2011), the State agency claimed Federal reimbursement for Medicaid expenditures totaling approximately \$3.6 billion (at least \$1.8 billion Federal share). The standard FMAP for Colorado's Medicaid payments ranged from 50.00 percent to 61.59 percent in FY 2011.

HOW WE CONDUCTED THIS REVIEW

We reviewed approximately 26 million claims totaling approximately \$3.6 billion (at least \$1.8 billion Federal share) that the State agency paid during FY 2011. We obtained the MMIS claim data from the State agency for FY 2011. Specifically, we reviewed 13 NPI fields to determine whether there was a populated or missing NPI and to ascertain whether the NPIs in these fields were valid. In addition, for those claims that contained an NPI, we compared the NPI against the NPPES to determine whether those claims contained valid NPIs. We counted as errors only those Medicaid claims that had missing NPIs in all of the NPI fields or that had invalid NPIs in at least one of the NPI fields.

To determine the Federal share of the expenditures, we used the lowest FMAP (50.00 percent) applicable for FY 2011.

⁸ This entity has undergone a name change since we performed our audit work. During our audit period, it was known as Affiliated Computer Services, Inc.

We conducted this performance audit 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.

Appendix A contains details of our audit scope and methodology.

FINDINGS

The State agency lacked sufficient internal controls to ensure that Medicaid claims submitted by providers and paid by the State agency during FY 2011 correctly included NPIs as specified in Federal requirements. As a result, the State agency was unable to prevent the reimbursement of Medicaid claims that had missing or invalid NPIs.

During FY 2011, the State agency paid 803,126 Medicaid claims totaling \$425,376,886 (at least \$212,688,442 Federal share) for claims that did not appropriately identify the NPI of the providers. Specifically, the State agency paid:

- 798,411 Medicaid claims totaling \$424,396,991 (at least \$212,198,495 Federal share) that had missing NPIs in all of the NPI fields that identify medical providers and
- 4,715 Medicaid claims totaling \$979,895 (at least \$489,947 Federal share) that had invalid NPIs in at least one of the NPI fields.

Although it upgraded and enhanced its MMIS beginning in FY 2007, the State agency did not implement sufficient internal controls, in the form of system edits in its MMIS, to prevent claims with missing and invalid NPIs from being submitted for, and receiving, Federal reimbursement. In addition, the State agency did not address any of the Federal requirements regarding the use of NPIs in its State plan.

The State agency's insufficient internal controls for the use of NPIs threaten the integrity, effectiveness, and efficiency of the Medicaid program. These vulnerabilities could permit individuals or entities to participate in the Medicaid program in violation of Federal regulations and could thus subject the Medicaid program to potential fraud and abuse. Without adequate internal controls for the use of NPIs, unapproved or federally banned providers could submit fraudulent claims and receive reimbursement. Moreover, the lack of system edits to verify invalid or missing NPIs undermines the intent of the relevant statutory and regulatory language to provide a single, unique identifier for those providers that participate in Federal health care programs.

STATE AGENCY ACCEPTED OVER \$425 MILLION IN MEDICAID CLAIMS THAT DID NOT APPROPRIATELY IDENTIFY THE PROVIDER

Federal Requirements

The PPACA, section 6402(a), added section 1128J to the Act (42 U.S.C. 1320a-7k). Among other things, this provision tasked HHS to develop and implement regulations that all Medicaid providers include their NPIs on all Medicaid claims for payment. Effective July 6, 2010, Federal regulations require that the Medicaid provider agreement between the State agency and the provider include a condition that any provider eligible for an NPI must furnish its NPI on all Medicaid claims for services furnished under the State plan (42 CFR § 431.107(b)(5)).

The PPACA, section 6401(b)(1), amended section 1902 of the Act (42 U.S.C. § 1396a) by adding paragraph (77) and subsection (kk).⁹ These provisions require that a State plan provide that the State comply with screening and oversight of providers, and requires the State to establish reporting requirements for providers and suppliers.

In a CMS letter to State Medicaid Directors, dated September 19, 2006, CMS issued guidance regarding the use of NPIs in electronic Medicaid transactions. This guidance included a recommendation that State Medicaid agencies develop a testing plan to ensure that their MMISs are prepared to accept and accommodate NPIs. CMS added, “Please ensure that your NPI test plan includes testing with providers so that they receive appropriate reimbursement and are *properly identified*” (emphasis added).

Medicaid Claims With Missing National Provider Identifiers

During FY 2011, the State agency paid 798,411 Medicaid claims totaling \$424,396,991 (at least \$212,198,495 Federal share) that had missing NPIs in all of the NPI fields. For example, 767,936 claims paid by the State agency for services under the “Home & Community Based Services (HCBS) Waiver” did not have any NPIs to identify the medical providers that performed the services.

Federal regulations require the use of NPIs to identify medical providers that transmit health-care-related information in connection with Medicaid claims. Using NPIs also simplifies electronic transmission of HIPAA standard transactions and provides for efficient coordination-of-benefit transactions. In addition, the NPIs could help the State agency identify irregular patterns in billed claims. When NPIs are not submitted with claims data, these protections are no longer in place.

The State agency asserted that many of these claims with missing NPIs were associated with “atypical” providers. We acknowledge that this type of claims (that is, claims that had been submitted by providers that did not provide health care services as defined under HIPAA) does not require NPIs; however, the State agency was unable to specifically identify those claims that were “atypical.” For example, the State agency provided us with a significant number of claims

⁹ Originally the PPACA added paragraph (77) and subsection (ii); however, P.L. No. 111-309, § 205(f)(1)(C), replaced subsection (ii) with subsection (kk).

associated with transportation services. Those claims that were associated with emergency transportation (i.e., ambulance services) would in fact have required NPIs. However, because those claims were commingled with claims associated with nonemergency transportation services, we could not determine which claims required NPIs and which did not.

Because the State agency paid the 798,411 Medicaid claims even though they had missing NPIs in all of the NPI fields, it could not properly identify the Medicaid providers that it was paying, and thus did not have assurance that the providers being reimbursed were approved Medicaid providers. In fact, it is possible that the State agency paid claims that had been submitted by federally banned providers that claimed reimbursement and did not use NPIs in their claims. For example, we reviewed a physician claim for \$5,580 that did not contain a single NPI in any of the 11 NPI fields that were applicable to this claim. In the absence of this identifying information, neither we nor the State agency could readily verify that the provider in question was not an unapproved or federally banned provider.

Medicaid Claims With Invalid National Provider Identifiers

During FY 2011, the State agency paid 4,715 Medicaid claims totaling \$979,895 (\$489,947 Federal share) that had invalid NPIs in at least one of the NPI fields. We considered NPIs to be invalid if there was not a matching number in the NPDES. For example, the “Billing Provider” NPI field for one of the outpatient claims we reviewed did not match any of those listed in the NPDES. Furthermore, an additional outpatient claim had only a five-digit number in the “Billing Provider” NPI field. The success of reviews and fraud investigations may be limited without valid NPIs on claims.

STATE AGENCY LACKED SUFFICIENT INTERNAL CONTROLS TO PREVENT MEDICAID CLAIMS THAT DID NOT APPROPRIATELY IDENTIFY THE PROVIDER FROM RECEIVING REIMBURSEMENT

In FY 2007, the State agency completed NPI enhancements and upgrades to its MMIS to meet the requirements of the initial transition to NPIs. The State agency received and spent approximately \$2.1 million (approximately \$1.9 million Federal share) to make these system upgrades in its MMIS. Despite making these upgrades and enhancements to its MMIS, the State agency did not put sufficient internal controls in place to ensure that NPI fields were completely and correctly populated. In addition, the State agency did not make provisions to ensure that the NPIs were valid.¹⁰

Although the State agency received and expended funding to upgrade its MMIS for the initial transition to the NPIs, it did not address any of the Federal requirements regarding the use of NPIs in its State plan. In addition, as of the end of our fieldwork, the State plan did not address the new NPI requirements mandated by the PPACA. As such, the State agency remained out of compliance with the NPI requirements under the PPACA.

¹⁰ In September 2007, CMS made the NPI data available to the States.

EFFECT ON MEDICAID

The State agency's insufficient internal controls for the use of NPIs threaten the safety, effectiveness and efficiency of the Medicaid program. These vulnerabilities could permit individuals or entities to participate in the Medicaid program in violation of Federal regulations and could thus subject the Medicaid program to potential fraud and abuse. Without adequate internal controls for the use of NPIs, unapproved or federally banned providers could submit fraudulent claims and receive reimbursement. Moreover, the lack of system edits to verify invalid or missing NPIs undermines the intent of Congress to provide a single, unique identifier for those providers that participate in Federal health care programs.

RECOMMENDATION

We recommend that the State agency strengthen its internal controls to ensure that all claims submitted to Medicaid have the required valid and populated NPI fields when applicable. Specifically, the State agency should create a system edit in its MMIS to ensure that each Medicaid claim has valid NPIs in all applicable NPI fields before that claim is processed for payment.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendation that claims submitted to Medicaid have the required valid and populated NPI fields, and it described corrective actions, in conformance to our recommendation, that it planned to implement. These corrective actions include the submission of a State plan amendment to CMS, ongoing coordination with CMS to develop and implement NPI requirements, and the publication in July 2013 of an updated Medicaid provider agreement. However, the State agency also said that its current MMIS "... does not have the full functionality as required under the new [F]ederal regulations" regarding the use of NPIs but added that it "... is denying appropriately for invalid or missing NPI as designed through the current MMIS." The State agency added that the new MMIS, which will "... edit all NPI fields to comply with the [F]ederal and State regulations" and strengthen internal controls, is scheduled to be implemented in November 2016.

The State Agency's comments appear in their entirety as Appendix B.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed approximately 26 million claims totaling approximately \$3.6 billion (at least \$1.8 billion Federal share) that the State agency paid during FY 2011. We did not review the accuracy or completeness of the MMIS data. We limited our review of the MMIS data to the inclusion and validity of NPIs according to the NPEES, and reviewed only the internal controls directly related to our objective.

We did not reconcile the MMIS data to the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report) because our objective did not require it and because we addressed the reconciliation in a previous OIG review.¹¹

We conducted our audit from October 2011 to December 2013.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- interviewed CMS officials to gain an understanding of CMS's policies and requirements regarding the use of NPIs in the Medicaid program;
- interviewed State agency officials to gain an understanding of the data and their controls for Medicaid claims relating to the NPI requirement;
- obtained MMIS data for FY 2011 from the State agency;
- modified our population by removing all offsetting adjustments¹² and all claims with a total paid amount equaling \$0 from the MMIS data;
- attempted to further modify our population by removing "atypical" claims;¹³

¹¹ *Review of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in Colorado* (A-07-11-02758), issued March 12, 2012.

¹² An adjustment is either a recovery or repayment for a previously submitted claim.

¹³ We did not remove claims submitted by providers that the State agency did not or could not identify as "atypical." Furthermore, we did not remove claims that the State agency identified as waiver claims because, according to CMS officials, a large majority of these waivers, such as *Colorado's HCBS Waiver for Children with Life Limiting Illness* and the *Supported Living Services Waiver*, in fact require that an NPI be included with each claim.

- reviewed each of the NPI fields¹⁴ to determine whether an NPI was present and whether it was valid;
- downloaded the NPPES in January 2013 and used it to determine the validity of NPIs;
- calculated the total Medicaid payments and the Federal share for claims with missing or invalid NPIs; and
- discussed our findings and provided detailed information to State agency officials on December 17, 2013, and in subsequent communications.

We conducted this performance audit 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.

¹⁴ We reviewed 13 NPI fields, including the referring, prescribing, rendering, attending, billing, supervising, and facilitating NPI fields.

APPENDIX B: STATE AGENCY COMMENTS



COLORADO
Department of Health Care
Policy & Financing

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March 10, 2015

Patrick J. Cogley, Regional Inspector General for Audit Services
Office of the Inspector General
Office of Audit Services, Region VII
601 E. 12th St., Room 0429
Kansas City, MO 64106

Dear Mr. Cogley:

Enclosed is the Department of Health Care Policy and Financing's response to the U.S. Department of Health and Human Services, Office of Inspector General (OIG), draft report A-07-13-06042, entitled *Colorado Paid Over 800 Thousand Medicaid Claims With Missing or Invalid National Provider identifiers During 2011*.

If you have any questions or concerns, please contact Delora Hughes-Wise, Audit Coordinator, at 303-866-4155 or Delora.Hughes-Wise@state.co.us.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Donna Kellow', is written over a circular stamp or watermark.

Donna Kellow
Audits and Compliance Division Director

DK:dhw

Enclosure

Cc:
Mr. Richard Allen
Associate Regional Administrator for
Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services, Region VIII

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Response to final draft and recommendation for:

Department of Health and Human Services, Office of Inspector General, draft report entitled *Colorado Paid Over 800 Thousand Medicaid Claims with Missing or Invalid National Provider Identifiers During 2011*

OIG recommendation:

We recommend that the State agency strengthen its internal controls to ensure that all claims submitted to Medicaid have the required valid and populated NPI fields when applicable. Specifically, the State agency should create a system edit in its MMIS to ensure that each Medicaid claim has valid NPIs in all applicable NPI fields before that claim is processed for payment.

Response:

The Department of Health Care Policy and Financing (Department) notes that the audit finding is related to only a technical issue and that the audit does not provide any finding that services were rendered improperly or that payments were made in error; therefore, no recovery from providers is necessary because of this audit. The Department notes that this audit was for FFY 2011 which gave the Department inadequate time to meet federal regulations cited under the audit report. As stated in the audit report, the Affordable Care Act (ACA) which included new NPI editing regulations was enacted in March 2010 and the Center for Medicare and Medicaid Services (CMS) regulation mandating the inclusion of the NPI on all Medicaid claims for payment was effective July 2010, just months before the start of the audit period of FFY 2011. However, despite these time constraints generated by the federal government, the Department does maintain internal controls related to verifying a provider's NPI when the provider applies to participate in Medicaid and editing of claims for valid NPIs, but the Department's current Medicaid Management Information System (MMIS) does not have the full functionality as required under new federal regulations as implemented through the ACA. The Department is in concurrence with the recommendation that claims submitted to Medicaid have the required valid and populated NPI fields when applicable.

To implement the requirements under the ACA Provider Screening Rule that providers submit an NPI and that the Department edit claims against NPI for billing, referring, rendering, and ordering providers, the Department has submitted a State Plan Amendment (SPA) to the CMS. That SPA has been submitted, but has not been approved by CMS and the requirements to fully implement these federal regulations are still under development and being negotiated with CMS. However, the Department did update its Medicaid provider agreement in July 2013 to include a condition that any provider eligible for an NPI must furnish it on all claims submitted under the Medicaid program in accordance with 42 C.F.R. § 431.107(b)(5).

The Department is currently editing the billing NPI field and denying appropriately for invalid or missing NPI as designed through the current MMIS. The Department is scheduled to implement

a new MMIS in November 2016 which will allow the Department to increase its current internal controls. The Department is currently in the process of designing and implementing all aspects of Medicaid claims adjudication process in the new MMIS, which also includes the additional NPI editing. When implemented, the new MMIS will edit all NPI fields to comply with the federal and state regulations, which will increase the Department's internal controls as recommended under this recommendation.