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PRESCRIBERS WITH QUESTIONABLE PATTERNS IN MEDICARE PART D

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WHY WE DID THIS STUDY

Under the Medicare Part D program, the Centers for Medicare & Medicaid Services (CMS) contracts with private insurance companies, known as sponsors, to provide prescription drug coverage to beneficiaries who choose to enroll. In recent years, prescription drug abuse has emerged as a serious and growing problem. The Centers for Disease Control and Prevention has characterized prescription drug abuse as an epidemic. With the rise in prescription drug abuse, concerns about Medicare fraud, particularly prescriber fraud, have increased.

HOW WE DID THIS STUDY

We based this study on an analysis of Prescription Drug Event records. Sponsors submit these records to CMS for each drug dispensed to beneficiaries enrolled in their plans. Each record contains information about the pharmacy, prescriber, beneficiary, and drug. We analyzed all of the records for drugs billed in 2009. We developed five measures to describe Part D prescribing patterns and to identify general-care physicians with questionable patterns.

WHAT WE FOUND

Over 1 million individual prescribers ordered drugs paid by Part D in 2009. Prescribing patterns varied widely by specialty. Over 700 general-care physicians had questionable prescribing patterns. Each of these physicians prescribed extremely high amounts for at least one of the five measures we developed. For example, many of these physicians prescribed extremely high numbers of prescriptions per beneficiary, which may indicate that these prescriptions are medically unnecessary. Moreover, more than half of the 736 general-care physicians with questionable prescribing patterns ordered extremely high percentages of Schedule II or III drugs, which have potential for addiction and abuse. Although some of this prescribing may be appropriate, such questionable patterns warrant further scrutiny.

WHAT WE RECOMMEND

These findings show the need for increased oversight of Part D. We recommend that CMS: (1) instruct the Medicare Drug Integrity Contractor to expand its analysis of prescribers, (2) provide sponsors with additional guidance on monitoring prescribing patterns, (3) provide education and training for prescribers, and (4) follow up on prescribers with questionable prescribing patterns. CMS concurred with all four recommendations.

TABLE OF CONTENTS

OBJECTIVES

1. To describe Medicare Part D prescribing patterns.
2. To determine how Part D prescribing patterns differ by prescribers' specialties.
3. To determine the extent to which general-care physicians had questionable Part D prescribing patterns in 2009.

BACKGROUND

The Medicare Part D program provides an optional prescription drug benefit to Medicare beneficiaries.[1] The Centers for Medicare & Medicaid Services (CMS) contracts with private insurance companies, known as sponsors, to provide drug coverage to beneficiaries who choose to enroll. In 2011, approximately 36 million beneficiaries were enrolled.[2]

Prescription drug abuse is a serious and growing problem. The Centers for Disease Control and Prevention (CDC) has characterized prescription drug abuse as an epidemic. In 2010, approximately 7 million people in the United States were misusing prescription drugs.[3] Moreover, overdoses of prescription painkillers—called opioids—are among the leading causes of accidental death in the United States.[4]

With the rise in prescription drug abuse, concerns about Medicare fraud, particularly prescriber fraud, have increased. A number of recent convictions have involved prescriber fraud. In one case, the owner of a pain clinic and a nurse practitioner prescribed large quantities of the painkiller oxycodone to patients without medical need, four of whom died.[5] In a similar case, a physician knowingly allowed nonmedical personnel to prescribe commonly abused painkillers, such as oxycodone,

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[1] *The Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, P.L. 108-173.

[2] The Boards of Trustees, *Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medicare Insurance Trust Funds*, p. 10. Accessed at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2012.pdf on July 6, 2012.

[3] National Institute on Drug Abuse, *Topics in Brief: Prescription Drug Abuse*, December 2011. Accessed at http://www.drugabuse.gov/publications/topics-in-brief/prescription-drug-abuse on September 18, 2012.

[4] CDC, *Unintentional Drug Poisonings in the United States*, July 2010.

[5] Federal Bureau of Investigation (FBI), *Owner of Chantilly Pain Clinic Convicted of Drug Trafficking, Fraud Charges*, August 3, 2012. Accessed at http://www.fbi.gov/washingtondc/press-releases/2012/owner-of-chantilly-pain-clinic-convicted-of-drug-trafficking-fraud-charges on September 11, 2012.

morphine, and hydrocodone, to Medicare beneficiaries by using blank, presigned prescription forms.[6] In a third case, a physician wrote medically unnecessary pain prescriptions for individuals who illegally distributed them.[7]

Despite these concerns, little information has been available about Part D prescribing patterns. Data about typical prescribing patterns and prescribers with questionable patterns are important first steps in detecting fraud, waste, and abuse.

This report is part of a larger body of work examining Part D billing.[8] Another report identified pharmacies with questionable billing in 2009.[9] A third report identified inappropriate Part D payments for Schedule II drugs billed as refills.[10] A fourth report determines whether Medicare Part D paid for drugs ordered by individuals who do not have the authority to prescribe.[11] In addition, a recent analysis of Part D claims by ProPublica found that some prescribers ordered large quantities of drugs that are potentially harmful, disorienting, or addictive.[12]

Prescription Drugs

Medicare Part D covers prescription drugs that meet certain requirements and are used for medically accepted indications.[13] CMS considers a drug to be "prescription" if the Food and Drug Administration has determined it must be labeled "Rx only," which means it cannot be dispensed without a prescription from a practitioner who is licensed to prescribe such drugs.[14]

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[6] FBI, *Palmetto Physician Pleads Guilty To Illegal Prescription Drug and Medicare Fraud Conspiracies*, March 18, 2010. Accessed at http://www.fbi.gov/tampa/press-releases/2010/ta031810.htm on July 2, 2012.

[7] U.S. Department of Justice, *Operation Oxyclean: Independence Physician Pleads Guilty To $1 Million Drug-Trafficking Conspiracy*. Accessed at http://www.justice.gov/usao/mow/news2011/baker.ple.html on July 6, 2011.

[8] All four reports are part of the Health Care Fraud Prevention and Enforcement Action Team Initiative (HEAT), which focuses on detecting health care fraud through innovative data analysis and enhanced cooperation among the Department of Justice, Office of Inspector General (OIG), and CMS.

[9] OIG, *Retail Pharmacies With Questionable Part D Billing*, OEI-02-09-00600, May 2012.

[10] OIG, *Inappropriate Medicare Part D Payments for Schedule II Drugs Billed As Refills*, OEI-02-09-00605, September 2012.

[11] OIG, *Medicare Part: Drugs Ordered by Individuals Without Prescribing Authority*, OEI-02-09-00608, June 2013.

[12] Tracy Weber, Charles Ornstein, and Jennifer LaFleur, *Medicare Drug Program Fails to Monitor Prescribers, Putting Seniors and Disabled at Risk*, ProPublica, May 11, 2013. Accessed at http://www.propublica.org/article/part-d-prescriber-checkup-mainbar on May 15, 2013.

[13] 42 U.S.C. § 1860D-2(e)(1).

[14] CMS, *Medicare Prescription Drug Benefit Manual, Chapter 6, Part D Drugs and Drug Formulary Requirements*, § 10, February 2010. Also see 21 U.S.C. § 353(b)(1).

The types of practitioners that are licensed to prescribe drugs are determined by State law.

The Drug Enforcement Administration (DEA) regulates certain drugs that have potential for abuse and dependence, called controlled substances. These drugs are divided into five schedules. Schedule II drugs have the highest potential for abuse of any prescription drugs legally available in the United States.[15] They include stimulants and narcotics commonly used to relieve pain, such as oxycodone and morphine. Schedule III drugs, such as hydrocodone with acetaminophen, also have potential for abuse. DEA requires all practitioners who handle controlled substances to register with the agency.[16]

Prescriber Fraud and Abuse

A number of fraud schemes in Part D involve prescribers.[17] Notably, prescribers sometimes operate "pill mills" or accept kickbacks. To operate a pill mill, a prescriber writes large quantities of prescriptions, usually for controlled substances that are not medically necessary and are often for people who are not their patients. A kickback is paid to a prescriber to write an unnecessary prescription that is then billed to Medicare. In other schemes, prescribers' prescription pads or provider identification numbers are stolen or sold by prescribers; these items then are used to write illegal prescriptions or to submit claims to Medicare.

Detecting and Deterring Part D Fraud and Abuse

CMS relies on sponsors to help safeguard Part D from fraud and abuse. CMS requires sponsors to have compliance plans that contain measures to detect, prevent, and correct fraud, waste, and abuse.[18] CMS recommends that sponsors use data analysis as a part of these plans.[19] Specifically, it recommends that sponsors develop indicators and establish baseline data so that they can recognize abnormalities and changes in prescribing patterns.

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[15] Schedule I drugs currently have no accepted medical use in the United States. They include drugs such as heroin.

[16] DEA registration grants prescribers Federal authority to handle certain schedules of controlled substances. See 21 CFR § 1301.11.

[17] CMS, *Prescription Drug Benefit Manual, Chapter 9, Part D Program to Control Fraud, Waste and Abuse: Use of Data Analysis for Fraud, Waste and Abuse Prevention and Detection*, § 70.1.4, April 2006. Accessed at http://www.cms.gov/PrescriptionDrugCovContra/Downloads/PDBManual_Chapter9_FWA.pdf on September 12, 2012.

[18] 42 CFR § 423.504(b)(4)(vi).

[19] CMS, *Prescription Drug Benefit Manual, Chapter 9, Compliance Program Guidelines*, § 50.6.9, July 2012. Accessed at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter9.pdf on September 12, 2012.

Sponsors are also required to have a Drug Utilization Review program to assist in preventing overutilization of prescribed medications.[20] CMS recently issued guidance recommending that sponsors use data analysis as part of their Drug Utilization Review programs to identify beneficiaries who may be overutilizing opioids. Opioids include Schedule II controlled substances, such as oxycodone, morphine, and fentanyl. CMS also recommended that sponsors communicate with prescribers to ascertain the medical necessity of these drugs.

Additionally, CMS contracts with a Medicare Drug Integrity Contractor (MEDIC) to detect and prevent fraud, waste, and abuse. Its responsibilities include identifying and investigating potential Parts C and D fraud and abuse, referring cases to OIG, and fulfilling requests for information from law enforcement.[21] The MEDIC is required to identify potential fraud and abuse through external sources, such as tips, as well as proactive methods, such as data analysis.[22]

CMS is responsible for the oversight of sponsors and the MEDIC. CMS conducts a number of different audits for sponsors, including onsite audits of their compliance plans.[23] During these audits, CMS assesses the effectiveness of sponsors' fraud and abuse programs. CMS evaluates the MEDIC's performance annually.

Related Work

A recent OIG report found that 2,637 retail pharmacies had questionable billing in 2009.[24] These pharmacies had extremely high billing for at least one of the eight measures we developed. For example, many pharmacies billed extremely high dollar amounts or numbers of prescriptions per beneficiary or per prescriber, which could mean that a pharmacy is billing for drugs that are not medically necessary or were never provided to the beneficiary. Among other things, the report recommended that CMS strengthen its monitoring of pharmacies, provide additional guidance to

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[20] CMS, *Announcement of Calendar Year (CY) 2013 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*, April 2, 2012. Accessed at http://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/2013-Call-Letter.pdf on October 4, 2012. Also see CMS, *Supplemental Guidance Related to Improving Drug Utilization Review Controls in Part D*, August 31, 2012.

[21] CMS, *MEDIC Statement of Work*, July 2009.

[22] For more information on the responsibilities of the National Benefit Integrity MEDIC, see OIG, *MEDIC Benefit Integrity Activities in Medicare Parts C and D*, OEI-03-11-00310, January 2013.

[23] For more information on CMS audits, see OIG, *Audits of Medicare Prescription Drug Plan Sponsors*, OEI-03-09-00330, December 2011.

[24] OIG, *Retail Pharmacies With Questionable Part D Billing*, OEI-02-09-00600, May 2012.

sponsors on monitoring pharmacy billing, and further strengthen its compliance plan audits. CMS concurred with these recommendations.

Another recent OIG report found that Medicare Part D inappropriately paid $25 million for Schedule II drugs billed as refills in 2009.[25] Sponsors should not have paid for any of these drugs because Federal law prohibits the refilling of Schedule II controlled substances without a new prescription.[26] Also, three-quarters of Part D sponsors paid for Schedule II drugs billed as refills, indicating that many sponsors do not have adequate controls to prevent these refills. Among other things, the report recommended that CMS issue guidance to sponsors to prevent billing of Schedule II refills and to exclude Schedule II refills when calculating payments to sponsors.

Another OIG report found that Medicare Part D paid $1.2 billion in 2007 for drugs with invalid prescriber identifiers (the identifiers had either never been assigned or had been retired).[27] The report recommended that CMS conduct periodic reviews to ensure the validity of prescriber identifiers and require Part D plans to institute procedures to identify and review records containing invalid prescriber identifiers.

An additional OIG report found barriers to the MEDIC's benefit integrity efforts.[28] These barriers included problems in the sharing of information and recovering inappropriate payments. The report also found that only a small percentage of the MEDIC's investigations and case referrals resulted from proactive data analysis. In the 1-year study period, the MEDIC initiated just 209 Part D investigations from proactive methods, such as data analysis.

METHODOLOGY

We based this study on an analysis of Prescription Drug Event (PDE) records from 2009, which we collected to undertake this body of work. Sponsors submit these records to CMS for each drug dispensed to beneficiaries enrolled in their plans. Each record contains information about the beneficiary, pharmacy, prescriber, and drug. We matched these

[25] OIG, *Inappropriate Part D Payments for Schedule II Drugs Billed as Refills*, OEI-02-09-00605, September 2012.

[26] Federal law permits partial refills under certain circumstances. It is possible some of these drugs may have been inaccurately billed as refills when they were partial fills.

[27] OIG, *Invalid Prescriber Identifiers on Medicare Part D Claims*, OEI-03-09-00140, June 2010.

[28] OIG, *MEDIC Benefit Integrity Activities in Medicare Parts C and D*, OEI-03-11-00310, January 2013.

records to data from the National Plan and Provider Enumeration System (NPPES) to obtain descriptive information about the prescribers.

Sponsors are required to certify the accuracy, completeness, and truthfulness of their PDE data.[29] Beginning in January 2012, they are also required to ensure that the prescriber identifiers on the PDE records are active and valid, meaning that they are currently assigned to a health care provider. [30]

PDE Data

We obtained all PDE records for covered Part D drugs with dates of service from January 1 to December 31, 2009. This amounted to 1,070,149,994 PDE records.

For each PDE record, we identified the identification number of the prescriber, which was generally a National Provider Identifier (NPI).[31] NPIs are assigned to many different types of health care providers. Having an NPI does not mean that an individual has the authority to prescribe drugs. For records that used other types of prescriber identification numbers, we used a crosswalk developed by OIG analysts to identify the prescriber's NPI.[32]

We matched each NPI to the NPPES to determine which PDE records were prescribed by individuals, as opposed to organizations (e.g., hospitals or group practices). We focused our review on individual prescribers because organizations may be associated with multiple prescribers. We identified 1,102,275 individual prescribers who were associated with 1,026,983,870 PDE records. These records represent 96 percent of all PDE records in 2009.

Using the National Drug Code (NDC) on the PDE record, we matched the PDE records to data from First DataBank. First DataBank contains information about each drug, such as the drug name and whether the drug

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[29] 42 CFR § 423.505(k).

[30] Sponsors must also confirm that any controlled substances are consistent with the schedule of drugs that the provider is allowed to handle. CMS, *Announcement of Calendar Year (CY) 2012 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*, April 4, 2011.

[31] PDE records allow four types of prescriber identification numbers: NPIs, DEA numbers, State license numbers, and Unique [Physician] Identification Numbers (UPIN).

[32] To develop this crosswalk, we used information from the Services Tracking, Analysis, and Reporting System (known as STARS), the DEA database, and the NPPES. We were able to identify valid NPIs for 97 percent of the PDE records. The remaining 3 percent had missing identifiers or were billed with identifiers that we could not link to a valid NPI.

is brand-name or generic.[33] It also indicates whether a drug is a controlled substance and, if so, which schedule the drug is on (Schedule II or III).[34]

Prescribing Measures

We used five measures to describe Part D prescribing patterns. We developed these measures on the basis of the results of past OIG analyses and fraud investigations of Part D billing, as well as input from CMS staff. We calculated the five measures for each individual prescriber, then calculated the national average for each measure.

The five measures are:

(1) average number of prescriptions per beneficiary,[35]

(2) total number of pharmacies associated with each prescriber,

(3) percentage of prescriptions that were for Schedule II drugs,

(4) percentage of prescriptions that were for Schedule III drugs, and

(5) percentage of prescriptions that were for brand-name drugs.

We calculated the total number of beneficiaries that each prescriber ordered drugs for by using the Health Insurance Claim Number (HICN) on the PDE record. We calculated the total number of pharmacies by using the NPI for each pharmacy or, if it was unavailable, the identification number for the pharmacy on the PDE record.[36] For the purposes of this report, we use the term "prescription" to mean one PDE record.

Analysis by Prescriber Specialty

To identify the specialty for each prescriber, we matched the NPIs to the NPPES. The NPPES contains information reported by each prescriber, such as his or her specialty, address, and professional credentials, such as

[33] First DataBank determines whether a drug is brand-name or generic based on the drug's name.

[34] A total of 0.002 percent of the PDE records had an NDC that did not match to First DataBank. We did not include these records in the analysis on Schedule II, Schedule III, or brand-name drugs.

[35] This measure represents the average number of prescriptions one prescriber ordered per beneficiary. It does not represent the average number of prescriptions that each beneficiary received because a beneficiary can receive prescriptions from multiple prescribers.

[36] To identify the number of pharmacies, we used the same method as in an earlier report. See OIG, *Retail Pharmacies With Questionable Part D Billing* (OEI-02-09-00600), May 2012.

M.D. or R.N. Providers report this information to CMS and must ensure that it is updated and accurate.[37]

We identified each prescriber's specialty based on the primary taxonomy code that he or she reported in the NPPES. The taxonomy code indicates a provider's specialty and subspecialty, if any. For example, it may indicate that a prescriber is a family-medicine physician specializing in geriatric medicine.

We then grouped the taxonomy codes for similar specialties. For example, we grouped all of the nurse practitioners together and all of the dentists together. We considered general-care physicians to be general practitioners, family practitioners, and internal medicine practitioners with no specialization or a specialization in adults or geriatrics.[38] We calculated each group's average for the five measures listed above.[39]

Identification of General-Care Physicians With Questionable Prescribing Patterns

To identify prescribers with questionable patterns, we focused our analysis on general-care physicians in nonrural areas. We focused on general-care physicians because they are the most common type of Part D prescriber and they prescribed more than half of all Part D prescriptions in 2009. We focused on physicians who were located in nonrural areas because those in very rural areas may have different prescribing patterns due to their location. For example, these physicians may order unusually high numbers of drugs per beneficiary because there are fewer physicians or specialists in their areas. We considered physicians who were not located in a Core Base Statistical Area (CBSA)—a region around an urban center that has at least 10,000 people—to be in very rural areas.[40] In total, we based this analysis on 86,818 general-care physicians and 540,581,871 PDE records.[41]

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[37] When applying for an NPI, the provider signs a certification that the information is correct and that he or she agrees to provide notification of any changes within 30 days. CMS, *National Provider Identifier (NPI) Application/Update Form,* November 2008. Accessed at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS10114.pdf on June 5, 2012.

[38] We reviewed each specialty's prescribing patterns to ensure that they were similar to the other specialties and that we could group them together.

[39] For this analysis, we included the 22 specialty groups that each had more than 3 million PDE records.

[40] U.S. Census Bureau, *Metropolitan and Micropolitan Statistical Areas.* Accessed at http://www.census.gov/population/www/metroareas/aboutmetro.html on March 3, 2011.

[41] For this analysis, we included general-care physicians who were associated with 100 or more PDE records that amounted to $100,000 or more. For the analysis of Schedule II and III drugs, we included prescribers associated with 100 or more PDE records for those drugs.

To identify the general-care physicians who were very extreme outliers compared to their peers, we took several steps. We first used a standard technique for identifying outliers, known as the Tukey method.[42] Using this method, we identified 2,248 general-care physicians who were outliers (i.e., above the 75th percentile plus 3 times the interquartile range) on one or more of the five measures we reviewed. In analyzing these physicians' prescribing patterns further, we identified the prescribers who were even more extreme outliers. These outliers corresponded to a threshold of at least the 75th percentile plus 4.5 times the interquartile range for each measure.

We considered general-care physicians who exceeded one or more of these thresholds to have questionable prescribing patterns. Some of their prescribing may have been appropriate. However, prescribing high amounts on any of these measures may indicate that a physician is prescribing drugs which are not medically necessary or that he or she has an inappropriate incentive, such as a kickback, to order certain drugs. It may also indicate that the prescriber's identification number or prescription pad has been sold or stolen. We calculated the total amount Medicare paid for drugs prescribed by these general-care physicians.[43]

We then determined the extent to which prescribers with questionable prescribing patterns had certain characteristics in common. We identified each prescriber's CBSA to determine whether they were concentrated in certain areas. We also determined which drugs were most commonly ordered by prescribers with questionable patterns.

Lastly, we determined whether the general-care physicians with questionable patterns were associated with any of the 2,637 retail pharmacies with questionable billing that we identified in an earlier report.[44] We considered a physician to be associated with a pharmacy if the pharmacy billed at least 25 percent of the cost of all the drugs that the physician prescribed in 2009.

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[42] See J.W. Tukey, *Exploratory Data Analysis*. Addison-Wesley, 1977. The Tukey method traditionally sets the threshold at the 75th percentile plus 1.5 or 3 times the interquartile range. The interquartile range is calculated by subtracting the value at the 25th percentile from the value at the 75th percentile.

[43] We used three fields on the PDE records to calculate Part D payments: the ingredient cost, dispensing fee, and sales tax. This includes the amount paid by sponsors, the Government, and by, or on behalf of, beneficiaries.

[44] OIG, *Retail Pharmacies With Questionable Part D Billing*, OEI-02-09-00600, May 2012.

Limitations

We designed this study to identify prescribers who warrant further scrutiny. None of the measures we analyzed independently confirm that a particular prescriber is engaging in fraudulent or abusive practices.

We did not independently verify the accuracy of the PDE records or the data from the NPPES. In particular, we did not verify the information about prescribers' specialties that they reported in the NPPES.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Over 1 million prescribers ordered drugs paid for by Part D in 2009

A total of 1.1 million prescribers ordered Part D drugs for Medicare beneficiaries in 2009. These prescribers included many specialties, such as general-care physicians, dentists, and nurse practitioners. [45] These individuals ordered over 1 billion prescriptions during the year. In total, Medicare paid $70.7 billion for these prescriptions.[46] On average, these 1.1 million prescribers each ordered Part D prescriptions costing $64,102.

Prescribers typically did not order drugs for a very large number of beneficiaries, nor did they order many drugs per beneficiary during the year. On average, each prescriber ordered prescriptions for 80 beneficiaries and averaged 6 prescriptions per beneficiary. Interestingly, more than half of the prescribers ordered fewer than 100 Part D prescriptions each during the year. Further, on average, prescribers ordered drugs that were dispensed at 32 pharmacies. Half the prescribers ordered drugs that were dispensed at 17 or fewer pharmacies.

Two-thirds of prescribers ordered Schedule II or III drugs. Schedule II drugs are controlled substances that have potential for abuse and may lead to severe psychological or physical addiction. They include drugs such as oxycodone and morphine. On average, 4 percent of the prescriptions from each prescriber were for Schedule II drugs. Schedule III drugs also have potential for abuse and include anabolic steroids, hydrocodone with codeine, and barbiturates. On average, 7 percent of the prescriptions from each prescriber were for Schedule III drugs.

On average, about a quarter of the prescriptions ordered by each prescriber were for brand-name drugs. Interestingly, 16 percent of prescribers did not order any brand-name drugs, while 10 percent of prescribers ordered 60 percent or more of their prescriptions as brand-name. Brand-name drugs tend to be more expensive than generic drugs. See Table 1 for more information on prescribing patterns.

[45] For the purposes of this report, general-care physicians include general practitioners, family practitioners, and internal medicine practitioners with no specialization or a specialization in adults or geriatrics.

[46] This includes the amount paid by sponsors, the Government, and by, or on behalf of, beneficiaries.

Table 1: Part D Prescribing Patterns for All Prescribers, 2009

	National Average	10th Percentile	50th Percentile	90th Percentile
Average Number of Prescriptions per Beneficiary	6	1	3	16
Number of Pharmacies Associated With Each Prescriber	32	1	17	85
Percentage of Schedule II Drugs	4%	0%	0%	10%
Percentage of Schedule III Drugs	7%	0%	1%	23%
Percentage of Brand-Name Drugs	27%	0%	25%	60%

Note: For the purposes of this report, we considered a prescription to be one PDE record.
Source: OIG analysis of Part D data, 2012.

Prescribing patterns varied widely by specialty

General-care physicians were the most common type of prescriber and ordered the majority of Part D prescriptions. General-care physicians accounted for 20 percent of all prescribers in 2009 and ordered two-thirds of all of Part D prescriptions in 2009. Dentists were the second most common type of prescriber, but were responsible for just 1 percent of Part D prescriptions overall. Nurse practitioners and physicians' assistants were also common prescribers; together they represented 11 percent of prescribers and were responsible for a little less than 6 percent of the Part D prescriptions. See Table 2 for the most common specialties. See Appendix A for a more complete list.

Table 2: Most Common Specialties of Part D Prescribers

Specialty	Percentage of All Prescribers	Percentage of All Prescriptions
General Care	20%	65%
Dentistry	14%	1%
Nurse Practitioners	7%*	3%
Physician Assistants	5%	2%
Emergency Medicine	4%	1%
Psychiatry	4%	3%
Obstetrics and Gynecology	3%	1%
Surgery	3%	<1%
Cardiology	2%	5%

*The percentages of prescribers and prescriptions for nurse practitioners and physician assistants do not sum to 11 percent and 6 percent, respectively, because of rounding.
Note: For the purposes of this report, we considered a prescription to be one PDE record.
Source: OIG analysis of Part D data, 2012.

General-care physicians ordered more prescriptions per beneficiary than other specialties. Overall, general-care physicians ordered an average of 13 Part D prescriptions per beneficiary, which is more than double the national average of 6. Other specialties averaged fewer. For example, infectious disease specialists ordered an average of 11 prescriptions per beneficiary and nephrologists ordered an average of 10. (See Table 3.) In contrast, emergency medicine specialists ordered an average of two prescriptions per beneficiary. See Appendix B for more information on prescribing patterns by specialty.

Table 3: Specialties With the Highest Average Number of Prescriptions per Beneficiary

Specialty	Average
General Care	13
Infectious Disease	11
Nephrology	10

Note: For the purposes of this report, we considered a prescription to be one PDE record.
Source: OIG analysis of Part D data, 2012.

Specialties also differed in the number of pharmacies that filled each prescriber's orders. Cardiologists, endocrinologists, and rheumatologists had the highest number of pharmacies that filled the drugs they ordered; each had an average of more than 80 pharmacies per prescriber. An average of 52 pharmacies filled the drugs ordered by each general-care physician. In contrast, dentists and nurse practitioners had fewer pharmacies that filled their prescriptions, averaging 12 and 23, respectively.

Furthermore, specialties varied in their prescribing of controlled substances. A few specialties were more likely than others to order higher percentages of Schedule II or Schedule III drugs. On average, 14 percent of the prescriptions ordered by physical medicine and rehabilitation specialists were for Schedule II drugs. Surgeons and anesthesiologists were next, with 11 percent of their prescriptions being for Schedule II drugs. (See Table 4.) General-care physicians were less likely to order Schedule II drugs. On average, 2 percent of the prescriptions ordered by general-care physicians were for Schedule II drugs. Some specialties rarely prescribed Schedule II drugs; cardiologists and endocrinologists averaged a little more than 0.3 percent each for their prescriptions.

Table 4: Specialties With the Highest Average Percentage of Schedule II Drugs

Specialty	Average
Physical Medicine and Rehabilitation	14%
Surgery	11%
Anesthesiology	11%

Note: For the purposes of this report, we considered a prescription to be one PDE record.
Source: OIG analysis of Part D data, 2012.

The specialties most likely to prescribe Schedule III drugs were surgeons, emergency medicine specialists, and dentists. On average, more than 14 percent of the prescriptions ordered by prescribers in each of these specialties were for Schedule III drugs. In contrast, 3 percent of the prescriptions ordered by general-care physicians were for Schedule III drugs. A few specialties, including cardiologists and gastroenterologists, rarely prescribed Schedule III drugs.

Lastly, some specialties were much more likely than others to order brand-name drugs. Ophthalmologists, pulmonologists, and endocrinologists commonly ordered brand-name drugs. More than half the prescriptions ordered by prescribers in these specialties were for brand-name drugs, on average. In contrast, 28 percent of the prescriptions ordered by general-care physicians were for brand-name drugs. Dentists prescribed only an average of 9 percent brand-name drugs. These differences may be due to the availability of generic equivalents for the drugs commonly used by these specialties.

Over 700 general-care physicians had questionable prescribing patterns

In total, 2,248 general-care physicians were outliers on one or more of the five measures we reviewed.[47] In analyzing these physicians' prescribing patterns further, we identified 736 who were very extreme outliers; we considered these physicians to have questionable prescribing patterns. Each of these physicians prescribed extremely high amounts for at least one of the five measures we developed. (See Table 5.) Medicare paid $352 million for the Part D drugs that these physicians ordered. While some of this prescribing may be appropriate, physicians with such questionable prescribing patterns warrant further scrutiny.

These 736 physicians were located throughout the nation. Los Angeles and New York had the greatest numbers, with 34 and 32 physicians, respectively. Philadelphia (22), Tampa (19), and Detroit (15) had the next-largest numbers.

Table 5: General-Care Physicians Who Prescribed Extremely High Amounts by Measure, 2009

	National Average for General-Care Physicians	Threshold for Extremely High Amounts for General-Care Physicians	Number of General-Care Physicians That Prescribed Extremely High Amounts
Average Number of Prescriptions per Beneficiary	13	71	108
Number of Pharmacies Associated With Each Prescriber	52	342	35
Percentage of Schedule II Drugs	2%	14%	343
Percentage of Schedule III Drugs	3%	14%	174
Percentage of Brand-Name Drugs	28%	68%	116
Total Number of General-Care Physicians			**736***

*A number of prescribers exceeded multiple thresholds. As a result, the sum of prescribers exceeding the thresholds does not equal 736.
Note: For the purposes of this report, we considered a prescription to be one PDE record.
Source: OIG analysis of Part D data, 2012.

[47] Our review included 86,818 general-care physicians. To identify general-care physicians who were outliers, we first used the Tukey method, described in footnote 42.

Examples of Questionable Prescribing Patterns

- Medicare paid a total of $9.7 million—151 times more than the average—for one California physician's prescriptions. Most of this physician's prescriptions were filled by just two independent pharmacies, both of which OIG identified as having questionable billing.

- Seventy-eight percent of the prescriptions ordered by one Florida physician were for Schedule II drugs. For one beneficiary, this physician prescribed large quantities of four Schedule II drugs— a 605-day supply of morphine sulfate, a 524-day supply of oxycodone HCl, a 460-day supply of fentanyl, and a 347-day supply of hydromophone HCl.

- Fifty-seven percent of one Tennessee physician's prescriptions were for Schedule II or III drugs. This physician prescribed an average of 8 Schedule II prescriptions for each of his 427 beneficiaries, who filled their prescriptions at 368 different pharmacies.

One hundred eight general-care physicians prescribed an extremely high number of prescriptions per beneficiary

Although some of this prescribing may be legitimate, ordering a high average number of prescriptions per beneficiary could mean that a physician is prescribing drugs that are not medically necessary.

As shown in Table 5, 108 general-care physicians prescribed an extremely high number of prescriptions per beneficiary. These physicians each ordered an average of 71 or more prescriptions per beneficiary, which was more than 5 times general-care physicians' national average of 13. Further, 24 of these physicians ordered more than 400 prescriptions for 1 or more beneficiaries. In one extreme case, an Ohio physician ordered more than 400 drugs each for 13 of his 665 beneficiaries. In total, this physician ordered 50,430 drugs that were dispensed by 100 pharmacies in 18 States. This raises questions about whether these prescriptions were legitimate. In another example, a Texas physician ordered more than 400 prescriptions each for 16 beneficiaries. He prescribed 700 or more drugs for 3 of these beneficiaries in 2009.

Thirty-five general-care physicians had prescriptions filled by an extremely high number of pharmacies

This measure raises questions about whether these prescriptions were legitimate or necessary. For example, it may indicate that the physician's identification number or prescription pad was stolen or sold and then used to write illegal prescriptions and submit false Medicare claims.

Thirty-five general-care physicians each had prescriptions filled by at least 342 pharmacies. This was over six times the national average of 52 per general-care physician. In one case, prescriptions from one general-care physician in Illinois were filled by 872 pharmacies located in 47 States and Guam. Medicare paid $783,686 for these drugs.

In another case, prescriptions from a general-care physician in New Jersey were filled by 608 pharmacies located in 41 States and Puerto Rico. Medicare paid $380,847 for these drugs.

Overall, 483 general-care physicians ordered an extremely high percentage of Schedule II or Schedule III drugs, which have potential for addiction and abuse

Schedule II and III drugs have a high risk for abuse. Although some of this prescribing may be appropriate, prescribing a high percentage of these drugs may indicate that a physician is ordering medically unnecessary drugs, which may be used inappropriately or diverted and resold. Misuse of these drugs has serious human and financial costs.

A total of 483 general-care physicians ordered an extremely high percentage of Schedule II or III drugs. Specifically, 343 general-care physicians ordered a high percentage of Schedule II drugs: at least 14 percent of the prescriptions ordered by each of these physicians were for Schedule II drugs. This was seven times the national average for general-care physicians. The most common Schedule II drugs ordered by these physicians were oxycodone HCl, morphine sulfate, and methadone HCl.

In one example, about 80 percent of the prescriptions ordered by one Ohio physician were for Schedule II drugs. Also troubling is that this physician had 106 Part D beneficiaries and 98 of them received oxycodone HCl. Another California physician ordered 115 Schedule II drugs for 1 beneficiary in 2009. Medicare paid $425,711 for these drugs, which were dispensed by 11 pharmacies. In another case, 68 percent of a Wisconsin physician's prescriptions were for Schedule II drugs. On average, he ordered about 14 Schedule II prescriptions for each of his 300 beneficiaries.

In addition, 174 general-care physicians ordered a high percentage of Schedule III drugs. Fourteen percent or more of the prescriptions ordered by each of these physicians were for Schedule III drugs. This is five times general-care physicians' national average. The most common Schedule III drugs prescribed by these physicians were hydrocodone-acetaminophen, acetaminophen-codeine, and Suboxone. Interestingly, for five prescribers 35 percent or more of the drugs each ordered were Schedule III. Four of these prescribers were located in Kentucky and the fifth was in Tennessee.

One hundred sixteen general-care physicians prescribed an extremely high percentage of brand-name drugs

While some of this prescribing may have been appropriate, ordering a high percentage of brand-name drugs may indicate that a physician has inappropriate incentives to order certain drugs because brand-name drugs are more expensive than generic.

A total of 116 general-care physicians prescribed an extremely high percentage of brand-name drugs. At least 68 percent of the prescriptions ordered by each of these physicians were for brand-name drugs, compared to general-care physicians' national average of 28 percent. In one case, a California physician ordered 82 percent of his prescriptions for brand-name drugs. Medicare paid a total of $9.7 million for his prescriptions in 2009—151 times more than the average amount. He also ordered an unusually large number of prescriptions for Lovaza, which is a prescription Omega-3-acid.

Further, 15 percent of these general-care physicians were associated with retail pharmacies with questionable billing

A total of 110 of the 736 general-care physicians were associated with one or more of the retail pharmacies we previously identified as having questionable billing.[48] In each case, the retail pharmacy billed for at least 25 percent of the total cost of the Part D drugs that the physician prescribed in 2009.

Most of the physicians were associated with one retail pharmacy with questionable billing; however, five physicians were associated with two pharmacies each. In one case, 90 percent of one physician's prescriptions were filled by two pharmacies with questionable billing. These prescriptions amounted to $3.1 million.

[48] OIG, *Retail Pharmacies With Questionable Part D Billing*, OEI-02-09-00600, May 2012.

CONCLUSION AND RECOMMENDATIONS

We found hundreds of general-care physicians nationwide with questionable prescribing patterns. While there may be legitimate reasons for some of this prescribing, all of these physicians warrant further scrutiny. We found that many prescribed extremely high proportions of Schedule II or III drugs. These drugs have high risk for abuse and may be diverted and sold for profit. Many other physicians prescribed high numbers of drugs per beneficiary or high proportions of brand-name drugs, which may indicate that the prescriptions are medically unnecessary. Further still, some prescribers had their prescriptions filled at extremely high numbers of pharmacies, again raising concern about the legitimacy of the prescriptions.

These findings show the need for increased oversight of Part D. OIG is committed to continuing its investigations and audits of Part D and to following up on prescribers, as appropriate. CMS must take steps to effectively identify and prevent prescriber related fraud, waste, and abuse in Part D.

We recommend that CMS:

Instruct the MEDIC to Expand Its Analysis of Prescribers

CMS should work with the MEDIC to ensure that it effectively and systematically monitors prescribers to identify those with questionable patterns. As this study shows, prescribing patterns vary significantly by specialty; therefore, taking specialty into account is an important step in identifying prescribers with questionable patterns. We recommend that the MEDIC expand the analysis in this report and review other specialties for questionable prescribing patterns. The MEDIC should use the measures in this report, as well as others it deems appropriate.

Provide Sponsors With Additional Guidance on Monitoring Prescribing Patterns

CMS should provide additional guidance to sponsors on how to effectively monitor prescribing patterns. CMS should emphasize the importance of using data analysis to identify prescribers with questionable patterns. Specifically, CMS should recommend that sponsors compare physicians with similar specialties when conducting such analysis.

In addition, CMS recently issued guidance to sponsors on how to improve their Drug Utilization Reviews to prevent overutilization of certain Part D drugs. This guidance suggests that sponsors use PDE data to identify and follow up on beneficiaries who are receiving extremely high dosages of opioids. CMS should provide further guidance to sponsors suggesting that they identify prescribers who are associated with a high number of these

beneficiaries and refer these prescribers to the MEDIC or law enforcement if fraud is suspected.

Provide Education and Training for Prescribers

CMS should provide education and training to prescribers. Although CMS does not have a direct contractual relationship with prescribers under Part D, it is in the best position to assess and educate prescribers about prescribing patterns. CMS should provide prescribers with reports comparing their prescribing patterns to their peers'. Similar to the Comparable Billing Reports issued for other services, such as Part B, these reports would provide prescribers with important educational information and insight about their prescribing patterns.

CMS should also conduct a communication and educational campaign for prescribers about the overutilization of prescription drugs. Specifically, the campaign should raise awareness about prescription drug abuse and to remind prescribers that Part D only covers drugs that are used for medically indicated purposes. It should also educate prescribers about what constitutes Medicare fraud and the potential consequences of committing it. These efforts will help to ensure that physicians prescribe drugs only for lawful purposes.

Follow Up on Prescribers With Questionable Prescribing Patterns

In a separate memorandum, we will refer the general-care physicians with questionable prescribing patterns to CMS for appropriate action.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on the draft report, CMS concurred with all four of the recommendations. CMS concurred with our first recommendation and stated that it will continue to work with the MEDIC to expand its analysis of prescribers and build on the analysis of prescribing patterns provided by OIG in this report. Additionally, CMS has increased its monitoring of prescribers through the Part D Recovery Audit Contractor with which CMS has contracted to identify and recover improper payments in the Part D program.

CMS concurred with our second recommendation and stated that it has a responsibility for monitoring prescribing patterns beyond the responsibility of sponsors, because it has all prescribing data for Part D and sponsors have prescribing data for only their enrollees. To help sponsors overcome limitations in the plan data, CMS will provide general guidance "red flags" to sponsors concerning aberrant and abusive prescribing patterns it detects that may not be apparent to individual sponsors. It also stated that, "as a part of its opioid overutilization policy, CMS has already provided the guidance to Part D sponsors that this recommendation suggests on the critical area of opioid prescription drug abuse." In addition, the MEDIC will conduct a presentation on drug overutilization at the next quarterly fraud work group meeting.

CMS concurred with our third recommendation and stated that it has already engaged in communication and education for prescribers about the overutilization of prescription drugs in the annual Medicare "Dear Doctor" letter (i.e., the *Announcement About Medicare Participation for Calendar Year 2013*). CMS also stated that it engaged in an additional initiative to provide training and education through the Medicare Learning Network.

CMS concurred with our fourth recommendation and stated that it is committed to following up, as necessary, to determine whether the individual physician prescribing patterns are indications of likely fraud or abuse.

We support CMS's efforts to address these issues. For the full text of CMS's comments, see Appendix C.

APPENDIX A

Specialties of Part D Prescribers

Specialty	Percentage of All Part D Prescribers	Percentage of All Part D Prescriptions
General Care	19.8%	65.5%
Dentistry	13.7%	0.6%
Nurse Practitioners	6.5%	3.4%
Physician Assistants	4.9%	2.1%
Emergency Medicine	3.7%	0.9%
Psychiatry	3.6%	3.0%
Obstetrics and Gynecology	3.4%	0.5%
Surgery	2.7%	0.4%
Cardiology	2.1%	5.2%
Anesthesiology	1.6%	0.3%
Ophthalmology	1.6%	1.3%
Neurology	1.2%	1.1%
Gastroenterology	1.1%	0.8%
Hematology and Oncology	1.0%	0.7%
Dermatology	1.0%	0.4%
Urology	0.9%	0.8%
Pulmonary	0.8%	1.0%
Nephrology	0.7%	1.3%
Physical Medicine and Rehabilitation	0.7%	0.4%
Endocrinology	0.5%	1.0%
Infectious Disease	0.5%	0.4%
Rheumatology	0.4%	0.8%
Other	27.8%	8.0%

Note: For the purposes of this report, we considered a prescription to be one Prescription Drug Event record.
Source: Office of Inspector General analysis of Part D data, 2012.

APPENDIX B

Part D Prescribing Patterns by Specialty

Specialty	Average Number of Prescriptions per Beneficiary	Average Number of Pharmacies Associated With Each Prescriber	Average Percentage of Schedule II Drugs	Average Percentage of Schedule III Drugs	Average Percentage of Brand-Name Drugs
General Care	13	52	2.0%	2.7%	28.3%
Infectious Disease	11	34	1.6%	1.9%	42.5%
Cardiology	10	85	0.3%	0.5%	29.4%
Endocrinology	10	82	0.3%	1.4%	51.4%
Nephrology	10	69	0.9%	1.5%	29.4%
Psychiatry	10	30	2.5%	1.0%	34.6%
Rheumatology	9	96	2.3%	4.4%	20.5%
Pulmonary	8	61	0.9%	1.0%	56.7%
Neurology	7	56	2.3%	1.9%	36.7%
Hematology and Oncology	6	51	8.5%	4.0%	34.2%
Physical Medicine and Rehabilitation	6	41	14.2%	10.6%	23.8%
Nurse Practitioners	6	23	3.8%	3.5%	29.6%
Anesthesiology	5	15	10.7%	7.9%	26.4%
Gastroenterology	4	66	0.7%	0.9%	39.1%
Obstetrics and Gynecology	4	23	2.5%	3.2%	43.5%
Ophthalmology	4	72	0.5%	1.3%	59.4%
Urology	4	74	1.9%	4.3%	41.7%
Physician Assistants	4	24	5.6%	8.7%	23.5%
Dermatology	3	60	0.4%	1.4%	19.7%
Surgery	3	23	10.9%	18.8%	21.7%
Emergency Medicine	2	32	7.8%	14.8%	15.8%
Dentistry	2	12	1.4%	14.2%	8.7%

Note: For the purposes of this report, we considered a prescription to be one Prescription Drug Event record.
Source: Office of Inspector General analysis of Part D data, 2012.

APPENDIX C

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: MAY - 6 2013

TO: Daniel R. Levinson
Inspector General

/S/

FROM: Marilyn Tavenner
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Prescribers with Questionable Patterns in Medicare Part D" (OEI-02-09-00603)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the above-subject OIG draft report. The purpose of this report is to describe Medicare Part D prescribing patterns, to describe the extent to which Part D prescribing patterns differ by prescribers' specialties, and to identify general-care physicians with questionable Part D prescribing patterns in 2009.

Prescription drug abuse is a serious and growing problem. CMS is committed to preventing such abuse, particularly in the area of prescriber fraud. CMS relies on sponsors to help safeguard Part D from fraud and abuse. These sponsors are required to have compliance plans in place that enable them to detect, prevent, and correct fraud, waste, and abuse. Additionally, CMS recommends that the sponsors use data analysis as part of their compliance plans. CMS also contracts with a Medicare Drug Integrity Contractor (MEDIC) as part of its continuing effort to detect and prevent fraud, waste, and abuse. This contractor's responsibilities include identifying and investigating potential Part D fraud and abuse, referring such cases to OIG, and fulfilling requests for information from law enforcement.

We appreciate OIG's efforts in working with CMS to increase oversight of the Medicare Part D program in an effort to safeguard against prescription drug abuse. CMS concurs with all of OIG's recommendations to improve oversight of Part D and to expand the use of data analysis in these oversight efforts. Our response to each of the OIG recommendations follows.

OIG Recommendation

The OIG recommends that CMS should instruct the MEDIC to expand its analysis of prescribers.

CMS Response

The CMS concurs with the recommendation. CMS continuously works with the MEDIC to monitor prescribers. The MEDIC has completed several activities and projects and continues to conduct analyses to address prescriber issues. In the data analysis projects, the MEDIC makes connections among the prescribers who prescribe the drugs, the pharmacies that dispense the drugs, and the beneficiaries who receive the drugs. An example of one analysis is the Health Care Fraud Prevention and Enforcement Action Team (HEAT) analysis that identifies outlier pharmacies, prescribers, and beneficiaries. Additionally, CMS conducts weekly Data Analysis Plan meetings with the MEDIC to discuss the status of current projects and identify additional proactive data analysis projects to pursue. CMS will continue to work with the MEDIC to expand its analysis of prescribers and build on the analysis of prescribing patterns provided by OIG in this report.

Additionally, CMS has increased its monitoring of prescribers through the Part D Recovery Audit Contractor (RAC), with which CMS has contracted to identify and recover improper payments in the Medicare Part D program. The Part D RAC recently completed an analysis of providers on the OIG's list of excluded individuals and entities (LEIE) for contract year 2007 and is currently reviewing LEIE data for contract years 2008 - 2011.

OIG Recommendation

The OIG recommends that CMS should provide sponsors with additional guidance on monitoring prescribing patterns.

CMS Response

The CMS concurs with this recommendation. The agency has a responsibility for monitoring prescribing patterns beyond the responsibility of plan sponsors, because CMS has all prescribing data for Part D and sponsors only have prescribing data for their enrollees. Thus, sponsors' analyses of prescribing patterns would be incomplete. To help sponsors overcome limitations in plan data, CMS will provide general guidance "red flags" to sponsors concerning aberrant and abusive prescribing patterns it detects that may not be apparent to individual sponsors during the last quarter of this fiscal year.

Also, as part of its opioid overutilization policy that this recommendation references, CMS has already provided the guidance to Part D sponsors that this recommendation suggests on the critical area of opioid prescription drug abuse. Most recently, in the "Supplemental Guidance Related to Improving Drug Utilization Review Controls in Part D" issued on September 6, 2012, CMS reiterated that sponsors' opioid overutilization programs are expected to include policies and procedures for referrals to the appropriate agencies if the sponsor believes a beneficiary, prescriber, or pharmacy is involved in fraudulent activity. CMS believes that it is too early in the implementation of the opioid overutilization policy in Part D to issue additional guidance. If warranted, CMS will issue additional guidance to Part D sponsors identified from our oversight of the implementation of this requirement.

In addition to the guidance described above, the MEDIC will conduct a presentation on drug overutilization at the next quarterly fraud work group meeting. CMS hosts quarterly fraud work group meetings with Parts C and D plan sponsors and their first-tier, downstream, and related entities. The presentation, at a minimum, will cover MEDIC activities addressing drug overutilization.

OIG Recommendation

The OIG recommends that CMS should provide education and training for prescribers.

CMS Response

The CMS concurs with this recommendation. CMS has already engaged in communication and education for prescribers about the overutilization of prescription drugs. In November 2012, as part of the annual Medicare "Dear Doctor" letter (e.g., the "Announcement About Medicare Participation for Calendar Year 2013") CMS:

1. Included language referencing prescription drug abuse as the nation's fastest growing drug problem and asserted that additional prescriber awareness and engagement are crucial to addressing this problem.
2. Outlined the new Part D overutilization policy and requested prescribers to engage in the case management process if contacted by a Medicare prescription drug plan about the opioid use of their patients.
3. Further described state Prescription Drug Monitoring Programs (PDMP) and encouraged prescribers to actively participate in them to reduce prescription drug abuse and diversion.
4. Summarized the final rule which requires remaining prescribers to obtain an individual National Provider Identifier (NPI) which, in conjunction with the final rule requiring Part D sponsors to only submit PDE records with prescribers' NPIs, will help fight fraud in the Part D program.

Finally, CMS engaged in an additional initiative to provide training and education through the Medicare Learning Network that provides education, information, and resources for the national Medicare fee-for-service provider community. Through this network, CMS prepared and distributed an article to encourage physicians to use their state PDMPs in December 2012.

OIG Recommendation

The OIG recommends that CMS should follow up on prescribers with questionable prescribing patterns.

CMS Response

The CMS concurs with this recommendation. CMS awaits the file from OIG that identifies the prescribers with questionable prescribing patterns and is committed to following up, as

necessary, to determine if the individual physician prescribing patterns are indications of likely fraud or abuse.

Again, we appreciate the opportunity to comment on this draft report and look forward to working with OIG on this and other issues.

ACKNOWLEDGMENTS

This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, and Nancy Harrison and Meridith Seife, Deputy Regional Inspectors General.

Miriam Anderson served as the team leader for this study. Other Office of Evaluation and Inspections staff from the New York regional office who conducted the study include Jenell Clarke and Jason Kwong. Central office staff who provided support include Eddie Baker, Jr., Kevin Farber, Meghan Kearns, Christine Moritz, and Debra Roush.

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