Michael F. Mangano /s/
Principal Deputy Inspector General

OIG Final Report: "Inaccuracies in the Unique Physician Identification Number Registry: Incorrect Addresses for Mental Health Service Providers," OEI-03-99-00131

Thomas Scully
Administrator
Centers for Medicare & Medicaid Services

SUMMARY

The purpose of this memorandum is to present the Centers for Medicare & Medicaid Services (CMS) with information regarding the inaccuracy of provider data contained in the Unique Physician/Practitioner Identification Number (UPIN) Registry. We identified inaccurate addresses in the UPIN Registry for 28 percent of the providers in our sample during the course of an inspection assessing the appropriateness of Medicare Part B payments for outpatient mental health services. Even the Medicare carriers did not have correct addresses for all of these providers. We estimate that Medicare paid about $35 million (± $17 million) in 1998 for outpatient mental health services billed by providers with inaccurate mailing addresses.

We recommend that CMS take steps to validate and update UPIN Registry data.

BACKGROUND

Unique Provider Identification Number Registry. The Consolidated Omnibus Budget Reconciliation Act of 1985 required CMS to establish a unique identifier for all physicians who provide services to Medicare beneficiaries. Since that time, CMS has assigned Unique Physician Identification Numbers (UPINs) to physicians who bill or perform services for Medicare payment, and established a database of physician enrollment information known as the UPIN Registry. In 1994, the Registry was expanded to include non-physician practitioners and group practices. The CMS contracts with a single carrier to maintain the Registry of providers who bill Medicare Part B.

To obtain a UPIN, each health care practitioner or group practice must submit an application for enrollment in the Medicare program to the appropriate carrier. Currently, CMS has standardized provider enrollment and update forms for all carriers. As part of the enrollment process, practitioners must provide carriers with information such as full name; State in which the applicant is licensed or practicing; license, registration, or certification number; tax identification number; and mailing address for Medicare-related correspondence. Providers often furnish or bill for services from several locations in different carrier jurisdictions. Therefore, applicants must also provide an address for each practice setting where services are rendered, as well as a "pay to" address for each practice setting.

Carriers validate the information contained in the enrollment application and assign a Provider Identification Number (PIN) for each of the applicant's practice settings. The carrier then submits this information to the UPIN Registry. Additional data entry checks are performed by the Registry contractor and a UPIN is assigned to the practitioner. While practitioners may have more than one PIN (indicating more than one practice setting), they have only one UPIN. The Registry maintains data on each PIN under a provider's UPIN.

Once the Registry assigns a UPIN, the carrier is responsible for maintaining provider enrollment data and promptly notifying the UPIN Registry of changes, additions, or deletions reported by providers. According to the Medicare Carriers' Manual, provider information in the Registry must be identical to provider information in carrier files, including all mailing, practice setting, and "pay to" addresses. Also, carriers must deactivate practice settings that have no Medicare claims activity for 12 consecutive months.

Implementation Plan for the National Provider Identifier. For purposes of administrative simplification, the Health Insurance Portability and Accountability Act of 1996 mandated the adoption of a "standard, unique health identifier for each individual, employer, health plan, and health care provider for use in the health care system."[1] These identifiers, known as National Provider Identifiers (NPIs), will be issued by the National Provider System. According to CMS, Medicare provider enrollment information contained in the UPIN Registry "will be loaded into the National Provider System and NPIs will be assigned automatically to Medicare providers."[2] The NPIs would then replace UPINs in the Medicare program.

Unique Provider Number Issues Previously Identified by the OIG. Over the past 10 years, the Office of Inspector General (OIG) has issued several reports identifying problems with the completeness and accuracy of provider enrollment information in carriers' files and the UPIN Registry. Between 1991 and 1992, the OIG found that some carriers did not require physicians to provide billing addresses on applications for enrollment. The OIG also found that many carriers were not updating provider files systematically, but were updating files only in response to returned mail or changes submitted by the provider. A 1999 OIG report estimated that 39 percent of Provider Identification Numbers were still listed as active in the UPIN Registry despite the fact that those practice settings had no claims activity for 12 consecutive months. In addition, data collection experiences during two 1999 OIG inspections on provider readiness for the year 2000 raised questions about the accuracy of address data contained in the UPIN Registry. In the first study, 14 percent of physician surveys were returned as undeliverable, while 17 percent of physician surveys were returned due to inaccurate addresses during the second study. A listing of these report titles and numbers is presented in Attachment 1.

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[1] Health Insurance Portability and Accountability Act of 1996, sec. 262, 1173(b) (1996).

[2] Centers for Medicare & Medicaid Services, formerly known as the Health Care Financing Administration, "National Provider Identifier Frequently Asked Questions," 24 February 1999, <http://www.hcfa.gov/stats/npi/faq3-99.htm> (13 March 2001).

METHODOLOGY

We selected a sample of 1998 claims as part of a recent inspection to assess the appropriateness of Medicare Part B payments for mental health services provided in practitioners' offices, community mental health centers, beneficiaries' homes, and custodial care facilities. We collected mental health records from Medicare providers in support of sample services and forwarded these records to an independent contractor for medical review.

Sample Selection. The stratified random sample of 650 claims was selected from a 1 percent file of paid 1998 Part B claims for nine mental health service codes provided in four outpatient places of service. This 1 percent file was created from CMS' 1998 National Claims History file, which was 98 percent complete at the time of sample selection. After eliminating 8 claims for providers under review by the Office of Investigations, our working sample consisted of 642 claims representing 571 individual providers.

Sample Claims and UPIN Registry. We accessed a CMS data file extracted from the UPIN Registry to obtain a full name and mailing address for each provider who billed for sample mental health services. A provider may have more than one practice setting. Therefore, in order to identify the most current address for each provider, we sorted Registry data and selected the most recently changed or added practice setting for each UPIN. We then matched sample claims to these practice settings using the UPIN and PIN. We obtained mailing addresses for 561 of the 571 providers in the study sample using the UPIN Registry database. We contacted Medicare carriers to obtain mailing addresses for the remaining 10 providers, as we were unable to match sample claims to address data in the UPIN Registry.

Documentation Request. Using these addresses, we mailed written requests for beneficiaries' medical records to the 571 providers of sample mental health services. Documentation requests were sent via Federal Express, except those for providers with post office box addresses. When mailings were returned to us as undeliverable, we took steps to find alternative provider addresses. For the first 23 returned mailings, we accessed Internet sites including the *American Medical Association's Physician Select* and *WebMD* to locate alternative provider addresses. However, when the volume of returns continued to grow, we contacted individual carriers to obtain alternative addresses for an additional 136 providers. We collected medical records from Medicare providers from February 2000 to June 2000.

FINDINGS

Addresses listed in the UPIN Registry database were inaccurate for 28 percent of providers

Documentation requests mailed to 159 of 561 providers for whom we obtained mailing addresses from the UPIN Registry were returned as undeliverable due to inaccurate addresses. Examples of inaccurate addresses included street addresses without company names or suite numbers, and cases where providers had moved from or were unknown to persons at the mailing

address. Inaccurate provider addresses were not limited to a small number of Medicare carriers. In fact, claims for providers with inaccurate addresses were billed to and paid by 37 of 62 separate carrier numbers. Four of these carriers accounted for 36 percent of the 159 providers with inaccurate addresses.

Carriers did not always have accurate addresses for these providers

We contacted Medicare carriers to obtain alternative addresses for 136 providers whose initial mailings were returned as undeliverable. For 23 providers, carriers were not able to provide alternative addresses because they had the same inaccurate addresses on file that we used for mailing our initial documentation requests. Carriers were able to furnish alternative addresses for 113 providers. We sent documentation requests to all new provider addresses. However, mailings to 18 of the 113 alternative provider addresses supplied by Medicare carriers were returned as undeliverable.

During our data collection period, we never received medical records for 50 services in the mental health study sample due to inaccurate addresses for 41 providers. Based on this data, we estimate that Medicare paid about $35 million (± $17 million) in 1998 for outpatient mental health services billed by providers with inaccurate mailing addresses.

RECOMMENDATION

Along with previous OIG reports that identified problems with the completeness and accuracy of provider data contained in carriers' files and the UPIN Registry, this memorandum provides additional evidence that Medicare practitioner enrollment information contained in the UPIN Registry is not entirely accurate. Therefore, we recommend that CMS take steps to validate and update UPIN Registry data.

AGENCY COMMENTS

The CMS concurred with our recommendation and stated that, since the OIG review was conducted, it has taken steps to validate and update UPIN Registry data. The CMS noted that it has worked with the Medicare contractors and an additional contractor to improve the accuracy of data in the UPIN Registry, and has reduced their returned-mail rate to 5 percent. The CMS listed a number of factors that it believes may account for the "high volume of mail returns" in our study. The CMS also noted that it has not yet determined whether provider data already housed in the UPIN Registry will be loaded into the new National Provider System, or whether all providers will be required to apply for a National Provider Identifier. The full text of CMS' comments is presented in Attachment 2.

OIG RESPONSE

We support CMS' current and future efforts to improve the accuracy and validity of provider data contained in the UPIN Registry. These efforts are important whether or not CMS decides to use UPIN Registry data to populate the National Provider System when it is implemented. We also believe that the methods we used to select provider addresses and conduct our data collection mailing were sound, and provided a firm basis for our finding that UPIN Registry addresses for 28 percent of sample providers were inaccurate.

The CMS suggested that the provider addresses we selected from the UPIN Registry for our mailing may have been inactive addresses. In February 2000, we selected addresses for sample providers from a UPIN Registry file that contained only *active* practice setting addresses. This source file was current as of January 2000. We recently reviewed UPIN Registry files containing both active and inactive practice setting addresses current as of May 2001. Only 3 percent (5 of 159) of the provider addresses we found to be inaccurate are currently listed as inactive practice setting addresses that appear to have been deactivated just prior to our data collection period. In addition, our review indicates that almost 70 percent (110 of 159) of the provider addresses we found to be inaccurate in the spring of 2000 are still listed as active practice setting addresses in the UPIN Registry.

The CMS believes that another reason for the high volume of mail returns in our study may be that, unlike the post office, Federal Express does not forward mail. We believe that our use of an express mail service provided a more reliable gauge of the validity of provider addresses than the use of standard mail service. If our letters had been forwarded to sample providers by the post office, we would never have known that the addresses we selected from the UPIN Registry were inaccurate.

The CMS also questioned our use of business addresses and group practice addresses to contact providers rather than billing addresses, suggesting that this may also have contributed to the high rate of mail returns. The UPIN Registry file from which we selected provider addresses contains practice location addresses for solo practitioners and members of group practices, but does not contain providers' billing addresses. Providers see patients at these practice location addresses, and we believe that these should be addresses where providers can be contacted.

The CMS also suggested that we may have incorrectly matched provider identification numbers to UPIN Registry address data due to the "computer software used in the study." In the methodology section of this report, we describe the process by which we identified and matched provider addresses from the UPIN Registry to standard provider identification numbers on sample claims. We believe there were no incorrect matches due to computer software error.

Attachments

Attachment 1

OIG Reports Cited in Memorandum

Carrier Assignment of Medicare Provider Numbers, OEI-06-89-00871

Carrier Maintenance of Medicare Provider Numbers, OEI-06-89-00870

Accuracy of Unique Physician Identification Number Data, OEI-07-98-00410

Y2K Readiness of Medicare Providers, OEI-03-98-00250

Y2K Readiness of Medicare Fee for Service Providers as of July 1999, OEI-03-98-00253

Centers for Medicare & Medicaid Services' Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: JUL 24 2001

TO: Michael F. Mangano
Acting Inspector General

SUBJECT: Office of Inspector General (OIG) Draft Report: *Inaccuracies in the Unique Physician Identification Number (UPIN) Registry: Incorrect Addressees for Mental Health Services Providers* (OEI-03-99-00131)

FROM: Ruben J. King-Shaw, Jr.
Deputy Administrator/Chief Operating Officer
Centers for Medicare & Medicaid Services

Thank you for the opportunity to review and comment on the above-referenced draft report regarding the inaccuracy of provider data contained in the Centers for Medicare & Medicaid Services' (CMS) UPIN Registry.

The CMS concurs with the OIG's recommendation and has taken the necessary steps to validate and update the UPIN Registry data used by Medicare to ensure an effective transition with the implementation of the new provider identifier system.

Since the OIG's study, we have used the UPIN mailing list four times. With the help of our Medicare contractors, we were able to vastly improve the overall accuracy of the file. Last year, we hired an additional contractor, Health Market Science, to assist the Medicare contractors in "cleaning up" the UPIN addresses. As a result, our current UPIN returned-mail rate has been reduced from 17 percent to 5 percent.

The CMS believes the reasons for the reported high volume of mail returns in the OIG's study may include the following:

- the addresses selected were deactivated as a result of providers non-billing of services within 1 year, or due to voluntary request by the provider. (Deactivated UPINs are maintained in the database until providers are terminated from the Medicare program. UPINs are reactivated when the provider resubmits an application and a claim for payment. The CMS automatically deactivates UPINs of nonbilling providers to safeguard against theft and improper use of UPINs);

- unlike the post office, Federal Express does not forward mail;
- the addresses were compiled incorrectly (e.g., provider names and/or provider identification numbers were incorrectly matched to addresses due to the OIG's computer software used in the study);
- business addresses (often undeliverable for mail) were used instead of the billing addresses; and
- the addresses selected were the medical groups' addresses, not the individual providers' addresses.

At the present time, CMS plans to examine whether it is more cost effective to load the UPIN data into the National Provider System or to require each provider to apply for its own National Provider Identifier. The latter approach has the advantage of acquiring up-to-date information that the provider must certify is accurate.