

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CARRIERS STILL NEED TO PURGE
UNUSED PROVIDER NUMBERS**



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Inspector General**

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CARRIERS STILL NEED TO PURGE UNUSED PROVIDER NUMBERS

In a May 1991 report the Office of Inspector General (OIG) found that most carriers did not systematically update provider files.¹ The OIG found that carriers could reduce Medicare's vulnerability to abuse and save administrative costs by periodically deactivating provider numbers with no billing history.

At that time, the OIG recommended that the Health Care Financing Administration (HCFA) require carriers to deactivate all provider numbers without current billing history. In October 1994 HCFA instructed the carriers to deactivate a provider number if no claims were submitted over a 3-year period.² Between October 1994 and February 1995 the carriers completed deactivation of provider numbers that met this criterion.

During May and June 1995, in the course of gathering survey data for a study on encouraging physicians to use paperless claims, we obtained from the carriers listings of active physician provider numbers, with December 1994 claim volumes noted for each. As was the case in 1991, we find a substantial percentage of these physician provider numbers are unused, that is, they have no recent billing history.

From a sample of active paper-biller physician provider numbers at eight carriers, we project that 65 percent were not used for billing Medicare in December 1994.

In the table below we show the unused provider number percentages at the carriers in our sample, and the projection to all carriers. Projecting the sample results to a total of 485,787 active paper-biller physician provider numbers at all 29 carriers, we estimate that 315,762 such numbers were unused nationwide.

TABLE: UNUSED PHYSICIAN PROVIDER NUMBERS					
CARRIER	PAPER BILLERS	NUMBER IN SAMPLE	NUMBER UNUSED	PERCENT UNUSED	MARGIN OF ERROR
A	690	140	44	31	± 7.7%
B	18,307	320	212	66	± 5.2%
C	6,187	200	98	49	± 6.9%
D	14,736	300	187	62	± 5.5%
E	2,233	255	97	38	± 6.0%
F	2,791	260	178	68	± 5.7%
G	6,971	300	189	63	± 5.5%
H	39,263	300	216	72	± 5.1%
All Carriers	485,787	—	—	65	± 5.7%
Source: OIG Survey of Medicare carriers, May 1995.					

We have included a description of our two-stage sampling methodology in a note at the end of this report. It is important to note here four points concerning the data in the table.

First, the data reflect claim activity for one arbitrarily chosen calendar month, December 1994. We held discussions with carrier staffs, reviewed monthly and yearly claim volumes reported to HCFA, and noted another reviewer's conclusion that seasonal changes do not lead to significant differences in Medicare Part B claim characteristics.³ From this analysis we believe that 1 month fairly represents the incidence of unused active physician billing numbers. Vacations, illness, varied billing schedules, or other factors can account for some of the unused provider numbers in any one given, but are unlikely to account for a substantial percentage of unused numbers.

Second, we relied on the carriers' then-current (May or June 1995) provider number listings. It would have been an onerous task for the carriers to reconstruct provider number listings for December. Changes in provider populations are gradual. Initiation of new practices and termination of established practices will change the carrier listings from month to month. As these incremental changes are unlikely to lead to substantial overall change in the course of several months, we believe the December claim history substantially reflects billing number use among the May or June provider population.

Third, the data are limited to physician provider numbers. Physicians account for the vast majority of all provider numbers, and the carriers have responsibility for issuing (or deactivating) physician provider numbers. Non-physician supplier numbers, by contrast, are often issued by a central registry (durable medical equipment) or the certification process (independent laboratories). In this context we note that the OIG found 30 percent of all provider numbers were unused, at the one carrier examined in detail in 1991.

Fourth, we selected the samples for the table from physician provider numbers that are not authorized to use paperless claims (paper billers). Nationwide the 485,787 paper-biller numbers accounted for 59 percent of all active physician provider numbers, but they represented just 17 percent of physician claims in December 1994.

We have some indication that the incidence of unused provider numbers among paperless billers may be substantial, if perhaps not so high as the 65 percent found for paper billers. Among nine carriers that sent us data for both categories, paper and paperless billers, we found that unweighted averages of 66 percent of paper, 29 percent of paperless, and 57 percent of all provider numbers were unused.

We sought carrier explanations for the high percentage of active but unused physician provider numbers. The carriers stressed that this situation tends to develop because physicians neglect to notify the carriers to deactivate solo billing numbers when they close an individual office to join a group practice or managed care organization.

Except in cases of sanctions, most carriers rely on physicians to report voluntarily on changes in their billing situation, such as a move out of State. Often, the carriers report, they learn of the move only by returned mail. There is no incentive for physicians to report changes in billing arrangements, nor is there a disincentive to neglect reporting.

The extent to which carriers actively seek to purge unused numbers is unclear. According to HCFA, between October 1994 and February 1995 the carriers completed the deactivation of provider numbers for which no claims were submitted over a 3-year period. Our data reflect the carrier files after this deactivation was completed.

We do know that the carrier in our sample with the smallest percentage of active but unused numbers (the Montana carrier) has long had in place a system to identify and purge unused provider numbers every 3 years. The 1991 OIG report referenced above cited the Montana carrier for its effective practice in sending out information verification letters to providers.

The large number of active but unused numbers poses significant issues regarding integrity and efficiency.

- **MISUSING PROVIDER NUMBERS:** Billing numbers can be misused by physicians, their office staffs, or billing agents who process and submit claims. With two of more billing numbers controlled by one physician it becomes easier for duplicate billings, unbundling, fragmentation, or global service period violations to occur, by accident or by design.
- **SKEWING UTILIZATION REVIEWS:** Utilization parameters can be rendered inaccurate, or even be manipulated, by holders of multiple numbers. Postpayment screens can be more costly, or even impracticable, to apply. Quality of service reviews, which need to look at claims in the context of all other services by the billing physician, can be affected.
- **EVADING SANCTIONS:** A sanctioned physician can evade deactivation of the primary provider number. Unless all the carriers and the registries with which a sanctioned provider trades fully and accurately coordinate information, exclusion might not be effective.
- **KNOWING ACCURATE GROUP COMPOSITION:** Group membership can be concealed or reported improperly. Carriers are required to keep current information on the composition of physician group practices in order to control abusive billing, to monitor program payments, and to assess reasonableness and necessity of services claimed.

It becomes especially important to remove these risks as Medicare moves toward a unified national system for processing health care claims. Within the Medicare Transaction System (MTS), HCFA plans to maintain a national provider file that will make available to claims processing sites provider data with a unique numbering system. If carrier files continue to contain so many unused provider numbers, the transition to MTS could become unnecessarily complicated and could even be jeopardized.

Just keeping a large number of active but unused numbers in provider files can impose needless administrative expenses on Medicare and the carriers. Professional relations outreach activities are duplicated, if only through printing and mailing costs. Calculations of pricing screens and charge histories need to address unused numbers, often futilely, because they can be used at any time without notice. Even routine maintenance of provider files incurs larger than needed staffing and information resource management costs.

RECOMMENDATION. *The HCFA should require the carriers to deactivate annually all provider numbers without current billing history and to update provider records periodically.*

This recommendation follows from one made by OIG in 1991. With the approach of MTS, the recommendation appears to be even more pertinent now than at that time. Further, it relates very directly to HCFA's priority interest in addressing fraud and abuse and to the goal set forth in its strategic plan to be a leader in health care information resources management.

The carriers can proactively identify unused provider numbers whose holders intend not to use them again by contacting the physicians. One way to do this would be to send a mailer with a tear-off return postcard for the physician to indicate intent to use the provider number, or not. Failure to respond could trigger a warning notice, and timely deactivation. Social Security has found that a mailer assists in screening disabled beneficiaries who are due to have mandated periodic reviews.⁴

In the Medicare Carrier Manual, HCFA has established 3 years as an acceptable time limit for inactivity. Our finding that 65 percent of physician provider numbers were unused, after the first round of deactivation by the carriers, suggests that a lower limit would be more appropriate for timely closing of unused numbers. A 1-year limit would allow provider numbers with just one claim a year to remain active.

HCFA Comments

The HCFA agrees with our recommendation in the draft report that carriers deactivate unused provider numbers, but believes that 3 years of inactivity offers an appropriate threshold before carriers deactivate an unused number. The HCFA also agrees with our

suggestion that many inactive addresses occur when physicians neglect to notify carriers to deactivate solo billing numbers. The full text of HCFA's comments is in the Appendix.

OIG Response

While we appreciate HCFA's agreement regarding the importance of deactivating unused numbers, we must emphasize the need for carriers to act more quickly and more assertively in this area. Thus we have revised our recommendation to explicitly reflect our belief that a 1-year time period for deactivation should be established.

In 1991 HCFA accepted our previous recommendation to deactivate unused provider numbers. Instructions were issued in October 1994 and deactivation completed by the carriers in February 1995. Our data from May and June 1995 show that this deactivation, with a 3-year threshold, left many unused provider numbers active in carrier files. Therefore, we believe additional corrective action is necessary.

The HCFA believes that deactivating provider numbers more frequently than every 3 years would be labor intensive and not cost effective. We are not aware of analyses documenting just how labor intensive and cost effective a 1-year deactivation threshold would be. It would appear efficient to mail a postcard to holders of the inactive numbers, and deactivate the nonrespondents. Carriers could be allowed discretion to retain nonrespondents for whom they had independent information to show continuing activity.

METHODOLOGICAL NOTE: We defined a physician provider number as a billing number assigned to a physician (defined in Section 1861(r) of the Social Security Act) or to a group of physicians. Many physicians in a billing group can share one provider number, but a group (or a solo physician) can have more than one provider number if the carrier assigns them, for example, to identify multiple practice locations.

We defined an active physician provider number as one that had not been deactivated by the carrier by reason of death, moving out of State, sanction, or similar occurrence. An active number entered in item 33 of the Health Insurance Claim Form, HCFA-1500, can induce a carrier to process the claim and issue payment, if all the other data entered on the claim form is consistent.

We defined an unused active physician provider number as one that was not used for a claim processed by the carrier during December 1994. This was the most recent complete month at the time we began the study. We asked the carriers to count processed claims rather than submitted claims so that we could also count amounts allowed on a comparable basis, and we could use the carrier performance report (HCFA-1565) numbers as a reality check.

We selected 8 (out of 29) carriers at random in the first stage of a two-stage random sample of physician providers. We then selected 100 active physician provider numbers at each carrier. When we found the first 100 selected included a substantial percentage of unused numbers (no claims during December 1994), we inflated the selection to give approximately 100 used numbers. Thus the sample sizes in the Table.

For the margin of error in the table we used standard statistical formulas to compute confidence intervals that apply to the sample design used to select this sample.

NOTES:

1. US Department of Health and Human Services, Office of Inspector General, *Carrier Maintenance of Medicare Provider Numbers*, OEI-06-89-00870, May 1991.
2. US Department of Health and Human Services, Health Care Financing Administration, *Medicare Carriers Manual*, Part 4 Professional Relations, Section 1001.2.
3. United States General Accounting Office, *Medicare Claims: Commercial Technology Could Save Billions Lost to Billing Abuse*, Report AIMD-95-135, Washington DC, May 1995, Note 6.
4. Social Security Administration, *1994 Annual Report to the Congress*, SSA Publication 03-005, July 1994, page 11.

APPENDIX

COMMENTS ON THE DRAFT REPORT



DATE OCT 16 1995

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT Office of Inspector General Draft Report, "Carriers Still Need to Purge Unused
Provider Numbers," (OEI-01-94-00231)

We reviewed the above-referenced report on the continuing need for Medicare carriers to purge unused provider numbers from their files. Attached are our comments on the report recommendation.

Thank you for the opportunity to review and comment on this draft report.

Attachment

Comments of the Health Care Financing Administration (HCFA)
on Office of Inspector General (OIG)
Draft Report: "Carriers Still Need to Purge Unused Provider Numbers."
(OEI-01-94-00231)

OIG Recommendation

The HCFA should require the carriers to deactivate all provider numbers without current billing history and to update provider records periodically.

HCFA Response

We agree that carriers should deactivate provider numbers without current billing history and update provider records. However, OIG suggested that HCFA's 3-year threshold be reduced to 1 year, and at this time we believe that 3 years is an appropriate timeframe as most carriers must maintain 3 years of provider file history to fulfill utilization review requirements. Deactivating and reenrolling in a 1-year time period would be labor intensive and, based on current information, not cost effective. In October 1994, HCFA instructed the carriers to deactivate a provider number if no claims were submitted over a 3-year period. Between October 1994 and February 1995, the carriers completed deactivation of provider numbers that met this criterion.

Since that time, HCFA has had ongoing initiatives to maintain an updated and current Provider Enrollment File. These initiatives should control entry into the system. As we review the impact of these changes we will also review the need to change the procedures for deactivating provider/supplier numbers.

- o HCFA is currently reviewing carrier provider enrollment activity for the past 3 years to identify growth patterns and trends as well as the physician enrollment totals for 1994 - 1995 to identify and target potential areas for fraud and abuse.
- o HCFA is implementing specific criteria for "Conditions of Enrollment" which all new and current providers/suppliers must meet in order to obtain validation or reenrollment into the Medicare program.
- o HCFA requests ownership information for durable medical equipment suppliers and clinical laboratories to determine if providers are subsidiaries or successors of persons or entities previously sanctioned from the Medicare or Medicaid program.

- o HCFA also assigns unique identifiers (e.g., Unique Physician Identification Numbers, National Supplier Clearinghouse numbers) to physicians, nonphysician practitioners, medical group practices, and suppliers who provide services for which Medicare payment is made. The unique identifiers are assigned to each provider whether practicing solo, in a partnership, or in a group, and remain constant throughout their Medicare affiliation.
- o Like ownership information, these unique identifiers and information are helpful in identifying sanctioned providers that either move to another state, join a medical group practice, or are subsidiaries or successors of or controlled by persons or entities previously debarred from the Medicare or Medicaid program. A listing of excluded providers is provided to contractors on an ongoing basis to ensure that sanctioned providers are not enrolled in the Medicare program and that the provider file information is current.
- o In August 1994, due to fraudulent supplier activity, HCFA devised more stringent provider enrollment verification procedures which led to the revocation of approximately 1,000 supplier numbers, the validation of over 114,000 current supplier numbers, and over 2,500 pending supplier applications.

We also agree with OIG that many inactive addresses occur when physicians neglect to notify carriers to deactivate solo billing numbers. However, as HCFA prepares for the implementation of the Medicare Transaction System (MTS), all existing data in the Provider Enrollment File will be validated. Inactive and inappropriate provider information will be eliminated from the Provider Enrollment File. HCFA will also standardize provider enrollment forms, policies, and procedures in preparation for MTS with the forms scheduled to be implemented prior to "Day One" of MTS operation. These provider enrollment data will furnish much of the information needed for processing claims after MTS is operational.

Additionally, the National Provider System (NPS), now being developed by HCFA, will address the problems associated with multiple numbers such as duplicate payments and manipulation of utilization parameters by ensuring that only one number is assigned to a provider. When a provider requests a new number through the NPS, a national data base

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will be searched to ensure that a number has not already been assigned to that provider. The NPS will not issue a new number when a physician changes or adds practice locations. Further, the NPS will track physicians' participation in group practices. We expect the NPS to begin assigning numbers to existing Medicare providers in April 1996.