Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CARRIER MAINTENANCE OF MEDICARE PROVIDER NUMBERS

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EXECUTIVE SUMMARY

PURPOSE

This report describes maintenance efforts by Medicare carriers to 1) ensure the accuracy of provider information and 2) identify and restrict payments to providers who have lost the legal authority to practice.

BACKGROUND

Medicare carriers assign provider numbers to qualified providers of Part B services who furnish services or supplies to Medicare beneficiaries. The numbers are used for processing both assigned and nonassigned claims. Additionally, the numbers are used in establishing Medicare pricing and utilization profiles. If the provider of services does not have a provider number, payment may not be made for services. To obtain a provider number from a carrier, providers need to complete the carrier's application form and meet criteria specified by Medicare regulations.

METHODOLOGY

This inspection consisted of three phases in addition to a review of relevant Health Care Financing Administration (HCFA) policies and Medicare laws and discussions with HCFA staff. First, we contacted 38 carriers to discuss maintenance issues. Carriers completed mailout questionnaires followed by telephone or onsite interviews. Second, we mailed questionnaires to professional licensing authorities in each State which are responsible for licensing physicians (121 respondents). Finally, we conducted computer matches between carriers and licensing authorities at four carriers to determine how well carriers deactivate numbers belonging to providers not legally authorized to practice. The selection of the four carriers for computer matching was purposive. We selected four carriers in States with large physician populations and whose professional licensing authority for physicians agreed to produce a computer file of providers who were no longer legally authorized to practice their profession.

FINDINGS

HCFA's direction to carriers is inadequate.

- We believe inadequate direction by HCFA has resulted in weaknesses in carrier controls to maintain the integrity of Medicare carrier provider numbers. We believe this constitutes a material internal control weakness within the meaning of the Federal Managers' Financial Integrity Act and should be reported to the Secretary along with plans for corrective action.

Weaknesses exist in carrier controls to maintain Medicare provider numbers.

- Most carriers do not systematically update provider files.
- Communications between carriers and professional licensing authorities are weak.
- Many carriers do not have adequate controls to identify and deactivate provider numbers belonging to providers who have lost the legal authority to practice.
- Many providers who have lost the legal authority to practice still have active provider numbers which they may use and, in some cases, are using to bill Medicare services.
- Inaccurate or missing information in some carrier files may hamper effective use of State licensing authority information.

Improvements through various administrative actions or programs are possible.

- Carriers can reduce the number of active provider numbers, reduce Medicare's vulnerability to abuse, and save administrative costs by periodically deactivating provider numbers with no billing history.
- Computer matching with licensing authorities could help many carriers identify providers not legally authorized to practice.
- Carrier efforts under HCFA's physician identification and registration program (UPIN) have improved the accuracy of provider number records of physicians.

RECOMMENDATIONS

The HCFA should require carriers to:

- update provider records periodically.
- deactivate all provider numbers without current billing history.
- establish adequate controls to ensure providers not legally authorized to practice are identified and their provider numbers deactivated. As a part of these controls, carriers should:
  - negotiate with State licensing authorities to obtain license and registration information at a minimum cost to the Medicare program.

- assess the feasibility of computer matches with State licensing authorities and perform such matches routinely, if practical.

- maintain the license or certification number of providers in its provider file.

- develop computer data entry edits for license numbers to ensure uniformity and consistency with the licensing authority's method of recording license numbers.

The HCFA should:

➤ evaluate carrier provider number controls established above as a part of its regular carrier Contractor Performance Evaluation Program.

➤ negotiate with State licensing authorities, which carriers report to be uncooperative, to obtain license and registration information at a minimum cost to the Medicare program.

HCFA COMMENTS AND OIG RESPONSE

The HCFA acknowledges the need to improve its instructions to Medicare carriers regarding the maintenance of provider numbers. However, HCFA does not concur with all OIG recommendations. Additionally, HCFA does not believe our findings constitute a material internal control weakness.

The OIG continues to believe a material internal control weakness exists and each recommendation should be implemented. Identified weaknesses in carrier maintenance efforts and HCFA's direction meet several of the criteria upon which a material weakness designation is determined. In accordance with the Federal Managers' Financial Integrity Act, the HCFA should report this as a material internal control weakness through the Secretary to the President and Congress. A detailed discussion of the material weakness designation can be found in Appendix B. (See Appendix B also for a more complete discussion of HCFA's comments and the OIG's response. Appendix C includes the full text of HCFA's comments.)

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INTRODUCTION

PURPOSE

This report describes maintenance efforts by Medicare carriers to 1) ensure the accuracy of provider information and 2) identify and restrict payments to providers who have lost the legal authority to practice.

Specific objectives were to:

1) describe how carriers maintain the accuracy of provider information,

2) determine whether Part B providers who lose legal authority to practice are identified by carriers, and

3) determine the feasibility of routine computer matches between State licensing authorities and carriers to identify providers having no legal authority to practice.

An upcoming report entitled "Carrier Assignment of Medicare Provider Numbers," prepared in conjunction with this inspection, describes and assesses how carriers assign provider numbers.

BACKGROUND

Medicare is a Federal program authorized by title XVIII of the Social Security Act (42 U.S.C. 1395). The program pays for much of the health care costs for eligible persons age 65 or older and certain individuals under 65 who are disabled or have chronic kidney disease. The Health Care Financing Administration (HCFA) administers the program through a network of contractors which process claims, make payments, and provide various other services to beneficiaries and providers.

Medicare consists of two types of insurance, Part A and Part B. Part A covers services furnished primarily by hospitals, home health agencies, and skilled nursing facilities. Medicare Part B typically covers physicians' care and various other medical services and supplies. Contractors under Part A are referred to as *intermediaries*; those under Part B are called *carriers*.

Under Part B, claims are assigned or nonassigned. If a claim is assigned, the provider submits it to the contractor for payment and agrees to accept the contractor's determination of the allowed charge. The beneficiary remains responsible for any coinsurance, which is the percentage of the allowed charge for covered medical expenses a beneficiary pays, and the deductible, which is the covered medical expenses a beneficiary must pay before Medicare pays. If the claim is nonassigned, the provider is required to submit the claim to the contractor, which pays the beneficiary. The beneficiary then pays the provider and is responsible for the coinsurance

amount, any unmet deductible, noncovered charges, and any difference between the provider's actual charge (up to the maximum allowable actual charge) and the Medicare-allowed charge.

Carrier Provider Numbers

Under most situations, carriers require providers of Medicare services to submit information sufficient for the carrier to assign the provider a unique carrier identification number (hereafter referred to as a provider number). Carriers assign provider numbers to qualified providers of Medicare Part B reimbursable services or supplies. (See Figure 1.)

FIGURE 1
Provider Types

Physicians

Doctors of Medicine	Doctors of Osteopathy	Dentists
Chiropractors	Optometrists	Podiatrists

Suppliers and Nonphysician Practitioners

Physician Assistants	Certified Nurse Anesthetists	Nurse Midwives
Clinical Psychologists	Nurse Practitioners	Physical Therapists
Occupational Therapists	Speech Therapists	Audiologists
Clinical Social Workers	Durable Medical Equipment	Clinical Labs
Ambulatory Surgery Centers	Rehabilitation Centers	Ambulance
Diagnostic Testing Centers	Independent Physiological Labs	

Provider numbers are used for processing both assigned and nonassigned claims. The number is also used in establishing Medicare pricing and utilization profiles. If the provider of services does not have a provider number, payment may not be made for services. To obtain a provider number from a carrier, providers need to complete the carrier's application form and meet criteria specified by Medicare regulations.

Through the provider number application process and maintenance practices, carriers must ensure providers meet qualifications specified by Medicare. Federal laws and regulations governing the Medicare program acknowledge the States' primary role in regulating many providers. For example, the Medicare law requires covered physician services be rendered by licensed physicians who are "legally authorized to practice" (Social Security Act, Section 1861) by the State in which the services are rendered.

Although qualifications for other Medicare provider types (Figure 1) may include State licensure or certification, some providers are required to meet additional education, work experience, staff, or equipment needs in order to participate in the Medicare program (e.g., ambulance companies). Additionally, some providers require HCFA approval. However, this is not to say every provider type must meet specified criteria. Some providers, such as durable medical equipment (DME) suppliers, generally do not have to meet any criteria except to possess a Social Security number or an employer identification number.

A provider may legitimately have more than one provider number. Some carriers give a physician who practices in both a group and a solo practice a number for each. If a provider has a practice in more than one reasonable charge locality, carriers may assign the provider different numbers or modifiers to an existing number. Also, providers receive different numbers or modifiers if practicing under different specialties.

Groups or clinics composed of multiple physicians require special processing. Most carriers assign groups or clinics a provider number. Additionally, the carrier must be able to identify each physician in the practice. Carriers accomplish this by assigning a number or modifier to each physician regardless of any other number(s) the physician may have. In the group practice setting, the physician should list this number on the HCFA 1500 claim form to show who performed the service.

Federal Interest in Provider Qualifications

The Federal government continues to show an interest in ensuring providers have adequate qualifications. The Consolidated Omnibus Budget Reconciliation Act of 1985 mandated a registry of physicians and the use of a unique practitioner identifier number (UPIN) to prevent duplicate payments for hospital-based physicians and interns under the Medicare program and to more accurately track federally sanctioned practitioners. This registry is monitored by HCFA.

Another database, the National Practitioner Data Bank, has been funded and recently began operation to monitor State licensed health practitioners. This data bank maintains records of all adverse actions (e.g., license revocation, malpractice) taken against medical providers and entities after the opening of the databank. The databank was authorized by the Health Care Quality Improvement Act of 1986 (P.L. 99-660, title IV) and the Medicare and Medicaid Patient and Program Protection Act of 1987 (P.L. 100-93, section 5). This databank is monitored by the Public Health Service (PHS).

These two databases provide the Federal government with added tools to monitor providers. However, the responsibility for ensuring Medicare providers meet licensing and other requirements specified by State and Federal law rests ultimately with carriers.

State Licensure and Certification

Licensing and certifying providers are primarily State functions. Individuals or entities must meet State criteria to obtain and maintain a license or certification. The States are responsible for regulating the practice of those they have licensed or certified. They are also responsible for ensuring all providers meet standards of professional competence and personal integrity considered necessary to protect the public.

The State license or certificate demonstrates the provider satisfies the State's established standards in such areas as education, experience, and ethics. Once licensed or certified, the provider must then comply with the State's prescribed standards for the practice of the profession and any other specified criteria for maintaining a license or certification. Failure to meet these requirements may result in the State suspending or restricting the license or certificate to provide

services. When a provider loses the legal authority to practice, no services of the provider are covered by Medicare.

Prior OIG Study

An audit (A-04-87-02011) of physicians by the Office of Inspector General in 1987 found management controls at the Florida carrier were inadequate to prevent continued participation by and reimbursement to physicians who had lost their authority to practice as a result of State actions. Because of this inadequacy, the Medicare carrier and State agency allowed charges in excess of $15.8 million to 463 physicians who continued to practice after losing legal authority to practice. Further, an additional 789 physicians maintained Medicare and/or Medicaid provider numbers under which they could have potentially billed the programs after losing legal authority to practice.

METHODOLOGY

This inspection consisted of three phases in addition to a review of relevant HCFA policies and Medicare laws, discussions with HCFA staff, and review of the above audit findings.

Reviewing Carrier Maintenance Procedures

We visited three carriers and mailed surveys, with telephone followup, to 35 other carriers. (See Appendix A for a complete list of carrier respondents and State jurisdictions.) Questions addressed provider number maintenance procedures carriers follow and were directed to the department which is responsible for assigning numbers to Medicare providers.

Surveying State Licensing Authorities

Many (121) State authorities responsible for licensing one or more types of medical providers who can receive reimbursement under Medicare Part B responded to our survey. The number of licensing authority respondents ranged from a high of 28.States for dentists to a low of 15 States for psychologists. (See Figure 2.)

FIGURE 2

State Licensing Authority Respondents

Type of Licensing Authority	*Number of States Responding*
Dentists	28
Doctors of Osteopathy	25
Optometrists	25
Doctors of Medicine	24
Chiropractors	21
Podiatrists	18
Physician Assistants	18
Psychologists	15

Note: Some of the State licensing authorities monitored licensing of several or all of the types of providers listed (e.g., a single agency in Nebraska monitors all providers listed, while in Texas separate boards represent each provider type, with the exception of the Texas Medical Board which monitors medical and osteopathic physicians and physician assistants).

Computer Matching

We conducted computer matches between licensing authorities and carriers responsible for three State jurisdictions (New York, Pennsylvania, and Texas). The carriers involved were Empire Blue Cross and Blue Shield, Blue Shield of Western New York, Pennsylvania Blue Shield, and Texas Blue Cross and Blue Shield. These carriers were selected because of 1) the high number of providers within the State and 2) the capacity and willingness to provide us with a computer file of all licensees who have lost the legal authority to practice in the State. The computer matches were conducted to determine the number of active provider numbers in carrier files belonging to providers not legally authorized to practice according to the applicable State licensing authority.

In order to limit the scope of this study, we limited our review of providers to physicians and several nonphysician practitioners. Entities such as labs, diagnostic testing centers, ambulatory surgery centers, etc. were not reviewed.

Each carrier provided a copy of its provider file on computer tape. The file contained all provider numbers in its computer system which are approved to bill Medicare. Each State licensing authority provided a computer file listing all providers who have lost the legal authority to practice in their State. Figure 3 indicates the types of licensed providers supplied on the computer tape by the specified State licensing authority.

FIGURE 3

Types of Medical Providers on Licensing Tape

	Texas	*Pennsylvania*	*New York*
Doctors of Medicine	■	■	■
Doctors of Osteopathy	■	■	■
Dentists		■	■
Podiatrists		■	■
Chiropractors		■	■
Optometrists		■	■
Psychologists		■	■
Audiologists		■	■
Physical Therapists		■	■
Occupational Therapists		■	■

The State licensing authority determined loss of legal authority. The following are typical actions resulting in loss of legal authority to practice:

Disciplinary Actions

- Revocation or suspension of license or certificate
- Negotiated surrender of license

Other Actions

- Failure to renew the license or certificate
- Retirement or death
- Failure to complete continuing education

After the license is issued, States require licensees to maintain a current registration to be legally authorized to practice. This generally involves payment of a registration fee at intervals determined by the State. Additionally, it might involve presenting evidence of completing State approved continuing education. Failure to maintain a current registration may lead, in some States, to canceling the license (e.g., Texas Medical Board). In other States, the license is simply recorded as inactive (e.g., Florida and New York). Several State laws provide penalties for practicing without a valid license and registration. For example, North Carolina's law governing the practice of medicine states:

> *"any person [who] shall practice medicine or surgery without being duly licensed and registered . . . shall not be allowed to maintain any action to collect any fee for such*

services. The person so practicing without license shall be guilty of a misdemeanor, and upon conviction thereof shall be fined not less than fifty dollars ($50.00) nor more than one hundred dollars ($100.00), or imprisoned at the discretion of the court for each and every offense." (Section 90-18, North Carolina Medical Practice Act)

"Historically, management has not recognized the importance of maintaining accurate and up-to-date information on providers in our corporate file."

- A Carrier Provider Number Dept. Manager

HCFA'S DIRECTION TO CARRIERS IS INADEQUATE.

Although Medicare regulations specify qualifications a provider must meet before being reimbursed by Medicare, HCFA has issued no directives concerning a carrier's responsibility to ensure whether a provider is still qualified at some later date after an initial provider number is issued. Additionally, little guidance has been given concerning how and at what frequency carriers should determine the accuracy of provider-supplied information (e.g., practice location).

In the absence of such requirements, the extent of updating, if done, varies from one carrier to the next. For example, Nationwide Insurance of Ohio updates physician assistant records every year, certified nurse anesthetists and nurse midwives every 2 years, and ambulance companies every 3 years. On the other hand, Empire Blue Cross and Blue Shield updates DME suppliers annually.

We believe inadequate direction by HCFA has resulted in weaknesses in carrier controls to maintain the integrity of Medicare carrier provider numbers. We believe this constitutes a material internal control weakness within the meaning of the Federal Managers' Financial Integrity Act and should be reported to the Secretary along with plans for corrective action.

WEAKNESSES EXIST IN CARRIER CONTROLS TO MAINTAIN MEDICARE PROVIDER NUMBERS.

Although virtually all carriers report the provider number assignment process is "very important" to the integrity of the Medicare program, we found little carrier effort to ensure the information maintained on providers is accurate and up-to-date.

➢ ***Most carriers do not systematically update provider files.***

Many carriers (21) report little effort to update provider files except in response to changes submitted by the provider, to returned mail, or as part of group membership validation. Most of the remaining carriers (17) which do report periodically seeking update information generally do so only on an as required basis and only in response to a perceived problem or need.

Typically, carriers reported the following reasons for not routinely updating or recertifying providers after a number has been issued:

- lack of staffing,
- lack of funding,
- no perceived need for file review, or
- no HCFA requirement to do so.

An Effective Practice

One practice involves routinely sending out information verification letters to providers. As an example, Montana Blue Shield sends out an information gathering letter each year to all providers except durable medical equipment suppliers and hospital based physicians. Providers are required to fill out the form and return it. Providers not responding are called by carrier staff. The answers given on the questionnaires are verified against data already on file for discrepancies.

Physician Group/Clinic Membership Updating

One of the few provider types for which carriers do conduct some type of routine updating involves physician groups and clinics. In connection with the physician identification and registration program (UPIN), HCFA requires carriers to maintain accurate group membership information. Specifically, carriers are required to 1) inform groups of their obligation to report any group member additions or deletions and 2) perform an annual survey of groups to detect any changes not reported by the group during the year.

Carriers typically notify groups to report membership changes, both at the time numbers are given out and periodically in carrier newsletters. Still, carriers report such changes are not always reported. Six of 38 carriers surveyed report members joining a group or clinic are only sometimes reported, while 19 report members leaving are only sometimes reported.

➤ ***Communications between carriers and professional licensing authorities are weak.***

Lack of Reporting

Many of the licensing authorities we contacted do not routinely share information with carriers when a provider loses the legal authority to practice. However, medical and osteopathic licensing authorities routinely report more often than any other. (See Figure 4.)

Lack of reporting is especially notable with regard to nondisciplinary actions. Of the authorities who reported routinely sharing information with the Medicare carrier, less than 24 percent (12 of 51) report nondisciplinary actions as well.

FIGURE 4

Many Licensing Authorities Do Not Share Information With Carriers

Licensing Authority	*States Surveyed*	*Do Not Share*	*Share*
Doctors of Medicine	23	26%	74%
Doctors of Osteopathy	24	29%	71%
Podiatrists	17	65%	35%
Optometrists	14	74%	26%
Chiropractors	19	74%	26%
Dentists	25	76%	24%
Psychologists	14	86%	14%

Some possible reasons why licensing authorities do not routinely report actions to Medicare carriers include a lack of staff or resources, not being aware Medicare needs the information, and privacy considerations. However, according to the Federation of State Medical Boards,[1] only four medical boards (Connecticut, New Hampshire, South Dakota, and Wyoming) do not consider formal board actions or agreements a matter of public record.

Organizational Differences

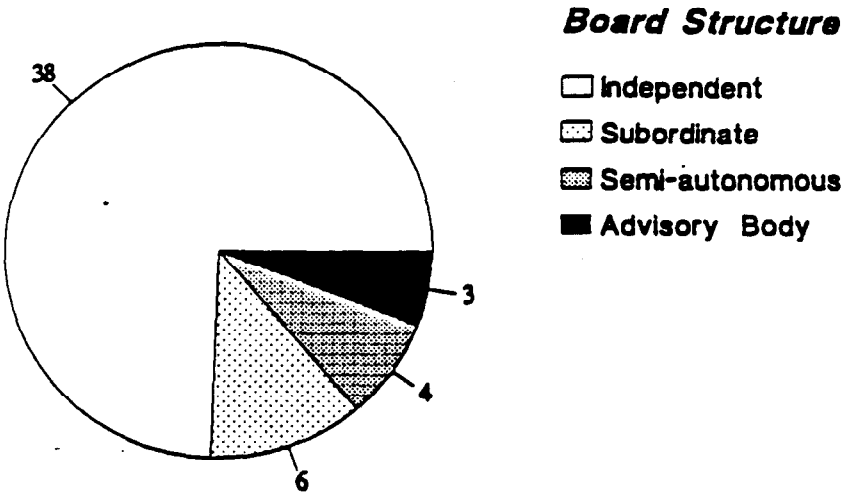
Each State is different in the way it has set up authorities responsible for licensing medical professionals. At one extreme, we found States where one agency maintains information on actions taken by several boards (hereafter referred to as an umbrella agency). In some cases, boards act only as advisory bodies to the umbrella agency. At the other extreme, we found States where individual boards are completely independent from other boards, and no central authority monitors board actions affecting a licensee's authority to practice.

The Federation of Medical Boards classifies State medical boards into four broad categories which describe board structure and operation (see Figure 5):

- ***Independent*** — The board exercises all licensing and disciplinary powers, though some clerical services may be provided by an umbrella agency.
- ***Semi-autonomous*** — The board exercises most key powers; an umbrella agency provides most clerical and administrative services and makes some decisions.
- ***Subordinate*** — The board exercises few key powers; an umbrella agency provides services and makes most decisions.
- ***Advisory*** — The board acts in a purely advisory role to the umbrella agency.

FIGURE 5

Most State Medical Boards are Independent



Source: Federation of State Medical Boards' 1989-90 Exchange

As illustrated in Figure 5, most medical physician licensing boards are independent. However, at least 15 of the 38 independent boards rely on other State agencies for most administrative functions (e.g., maintaining computer systems, collecting renewal fees, etc.). This means at least 54 percent of all States and the District of Columbia are monitored by umbrella agencies.

These umbrella agencies can greatly assist a carrier in obtaining complete licensing information. Although the boards often must be consulted for specific details about disciplinary actions, the umbrella agency maintains adequate information in its computer system to provide information on the legal status of a licensed professional. Carriers need only contact the umbrella agency to coordinate any exchange of information.

On the other hand, autonomous boards lacking an umbrella agency require the carrier to contact each individual board for information. Since autonomous boards are generally small and burdened with many aspects of licensing (e.g., administering examinations and collecting license renewal fees), they are less likely to have the resources (e.g., staff and degree of automation) to respond to carrier requests for information. In such situations, it may be more feasible to contact providers directly to submit proof of current licensure or certification.

Automated Record Keeping

Responses from completed surveys by 121 licensing authorities indicate State licensing authorities have the capacity to generate listings of providers who are actively registered in a profession. Nearly 90 percent of respondents report licensee information is maintained in a computer system. Only one licensing authority for medical physicians, West Virginia, reported no computer. (However, they indicated a micro computer would be purchased by the end of the year.) Boards with a small licensee population (e.g., psychologists) were least likely to keep records in an automated system.

Many State licensing authorities keep records in a mainframe or mini computer. However, licensing authorities which do not share resources with other State licensing authorities (e.g., small autonomous boards) typically keep information in a personal computer. Of the 73 licensing authorities which provided information on the type of computer system used, 71 percent use a mainframe or mini computer; others use personal computers.

Whether computerized or not, each licensing authority has the ability to provide listings of providers who have the authority to practice. Such listings take the form of periodic publications or computer listings generated at the time of the request. Virtually all authorities we contacted produce such listings at no or minimal cost ($10 to $100). We contacted a few of the licensing authorities reporting higher costs ($200 or more) to discuss whether the cost could be lowered for a Federal Medicare contractor since its use would be to monitor providers the board reports to be not legally authorized to practice. As an example, Colorado's quote of $320 for a complete listing would be lowered at least by half to the cost other State entities are paying.

➢ ***Many carriers do not have adequate controls to identify and deactivate provider numbers belonging to providers who have lost the legal authority to practice.***

Many carriers do not have arrangements with licensing authorities to receive notice of all actions (disciplinary or other) affecting the legal authorization of providers to practice. Failure to receive this information and take appropriate action leaves the carrier vulnerable to making payments for services which are noncovered by Medicare.

Disciplinary Actions

While many carriers report they have established communication with licensing authorities to receive disciplinary actions, some have not. (See Figure 6.) Generally, licensing authorities report disciplinary actions in the form of a board order. The order states the type of action taken and its duration. For most carriers who report receiving actions, the board order is sent to the medical review or program integrity department where a decision is made on whether the provider's number should be deactivated or flagged for postpay or prepay review.

FIGURE 6

Not All Carriers Receive Notices of Disciplinary Actions

Types of Providers	*Number and Percent of Carriers Receiving Notice*	
Doctors of Medicine	30	79%
Doctors of Osteopathy	28	74%
Chiropractors	20	53%
Optometrists	19	50%
Podiatrists	19	50%
Dentists	19	50%
Psychologists	19	50%
Physical Therapists	18	47%
Occupational Therapists	17	45%
Ambulance Companies	15	39%
Certified Nurse Midwives and Anesthetists	13	34%

Source: Survey of 38 Carriers

Other Actions

Although loss of authority to practice for nondisciplinary reasons (nonpayment of renewal fees, death, retirement, voluntary surrender of license, etc.) cause a provider's services to be noncovered by Medicare, many carriers do not identify such providers. (See Figure 7.)

FIGURE 7

Even Fewer Carriers Receive Notices of Nondisciplinary Actions

Types of Providers	*Number and Percent of Carriers Receiving Notice*	
Doctors of Medicine	25	66%
Doctors of Osteopathy	23	61%
Chiropractors	14	37%
Optometrists	13	34%
Podiatrists	14	37%
Dentists	13	34%
Psychologists	14	37%
Physical Therapists	13	34%
Occupational Therapists	12	32%
Ambulance Companies	11	29%
Certified Nurse Midwives and Anesthetists	11	29%

Source: Survey of 38 Carriers

Our review at four carriers revealed vulnerabilities in this area. Although each carrier reported receiving nondisciplinary actions from licensing authorities, we found many active provider numbers belonging to providers not legally authorized to practice for other than disciplinary

reasons. None of the carriers had asked for or received complete listings of providers adequate to identify all providers not legally authorized to practice.

As with our computer match States, carriers who report receiving notice of nondisciplinary actions may not use the information or may receive incomplete or untimely information. This is evidenced by many carriers reporting they deactivate very few, if any, providers who lose State legal authority to practice for other than disciplinary actions.

An Effective Practice

A formal agreement with licensing authorities prescribing exactly what actions will be communicated to the carrier, at what times, and to whom the information will be sent is a good practice. Such an agreement adds confidence that all actions affecting a licensee's legal authority to practice will be communicated in a timely manner.

➤ ***Many providers who have lost the legal authority to practice still have active provider numbers which they may use and, in some cases, are using to bill Medicare services.***

Through our computer matches, we identified 4,770 active carrier provider numbers belonging to providers who had lost the legal authority to practice. (See Figure 8.)

FIGURE 8
Many Providers Not Legally Authorized to Practice Have Active Numbers

Carriers	Match Results - Provider Numbers Belonging to Providers Not Authorized						
	Total Numbers	Percent of All Numbers Subject to Match	Percent Caused by Disciplinary Action	Match #'s Sampled for Allowed Charges While Not Authorized		Sampled Provider Numbers With Allowed Charges	
				Count	Percent	Count	Allowed
Empire Blue Shield	1,426	5.2%	2.5%	160	11.2%	21	$132,567
Blue Shield of Western New York	217	2.5%	2.0%	104	47.9%	19	$81,160
Pennsylvania Blue Shield	1,590	3.8%	1.1%	121	7.6%	9	$78,416
Texas Blue Shield	1,537	3.4%	1.8%	464	30.2%	39	$12,311
Total	**4,770**			**849**		**88**	**$304,454**

Approximately 10 percent (88 of 849) of sampled provider numbers had allowed charges[2] while the provider was not legally authorized to practice. This percentage varied slightly at each carrier. For example, at the 95 percent confidence level as few as 8.1 percent or as many as 18.1 percent of the 1,426 provider numbers identified at Empire Blue Shield had allowed charges. When a 95 percent confidence level was computed for Blue Shield of Western New York, the estimated percentage of provider numbers with allowed charges was within the interval of 12.6-24.0 percent.

We found over $300,000 in allowed charges to the provider numbers sampled at the four carriers. These allowed charges ranged from $18.30 for one service by one provider to over $100,000 for 3,018 services by another. Because of this extreme variability and the small number of provider numbers with allowed charges while the provider was not legally authorized to practice, any resulting projections will be very imprecise. This does not mean any projections of the allowed charges to the unsampled population would be inaccurate. However, it does mean with the sample data we do not have sufficient power to provide a precise estimate of the allowed charges to providers not legally authorized to practice.

Still, these results reinforce past OIG findings. The review of Florida physicians between 1980 and 1985 showed carrier allowed charges in excess of $15 million for services rendered by 439 providers after they had lost legal authority to practice.

- ***Inaccurate or missing information in some carrier files may hamper effective use of State licensing authority information.***

Especially in the case of computer matches, certain carrier records must be maintained accurately. Two fields are especially important - provider name and license number. These are the only two fields we are certain both licensing authorities and carriers collect.

Missing Carrier License Numbers

While few carriers do not record provider license numbers, a considerable number of carriers have only recently begun to enter the license number in a computer file. As a consequence, in many older provider records set up previously, the license number fields are empty. Records were missing license numbers in each of the carriers where we conducted computer matches. Figure 9 illustrates the degree of missing license numbers at Empire Blue Shield and Blue Shield of Western New York.

As indicated in Figure 9, the percentage of license numbers differed markedly depending on the type of provider. For example, physicians had the highest rate of license numbers while practitioners such as physical therapists had the lowest. This may be an indication of the impact of HCFA's UPIN project. The license number has been termed a critical element to be collected by carriers when setting up a physician number. However, HCFA does not require the license number in order to issue a UPIN.

FIGURE 9

Missing License Numbers

Empire Blue Shield

	Numbers Reviewed	Percent Missing Number
Doctors of Medicine and Osteopathy	32,448	29%
Chiropractors	2,337	14%
Optometrists	774	17%
Podiatrists	1,712	18%
Psychologists	2,641	93%
Audiologists	141	97%
Physical Therapists	377	99%
Dentists	226	3%
Total	**40,656**	**33%**

Blue Shield of Western New York

	Numbers Reviewed	Percent Missing Number
Doctors of Medicine and Osteopathy	12,152	38%
Chiropractors	577	77%
Optometrists	501	42%
Podiatrists	354	37%
Psychologists	246	44%
Audiologists	49	20%
Physical Therapists	210	53%
Dentists	262	63%
Total	**14,351**	**40%**

Source: Review of Carrier Provider Files

Inaccurate Carrier License Numbers

Even if the license number is entered, carriers may not be ensuring the accuracy of the number or may not be entering the number in a form which will correspond to the licensing authority's number. To illustrate, we encountered error and inconsistency in the way our sample carriers had entered license numbers. Transposing digits in the number was the most frequently encountered error. To a lesser extent, some license numbers were incomplete, had too many digits, or included inappropriate prefixes.

Provider Name Irregularities

Review of carrier files in which we conducted computer matches revealed carriers enter the name as given by the provider on the application. For example, one provider might be listed as Robert Stanley Smith, Jr. on the licensing authority's file, while the carrier might have entered

the name as Bob Smith or R. Smith on the carrier's file. This creates an unwarranted potential for confusion. Carriers could easily ask providers for complete legal names and verify the name spelling with that of the licensing authority when the provider's qualifications are verified (i.e., license number is checked).

IMPROVEMENTS THROUGH VARIOUS ADMINISTRATIVE ACTIONS OR PROGRAMS ARE POSSIBLE.

Many types of carrier activity can improve the accuracy and reliability of information maintained in provider records. Often, such activities can be accomplished at little cost to the Medicare program through largely automated rather than manual verification procedures. The following are a few examples of specific maintenance activities. Also, we include a short discussion of the actual beneficial effects to physician provider records obtained by carriers during UPIN associated activity.

- ***Carriers can reduce the number of active provider numbers, reduce Medicare's vulnerability to abuse, and save administrative costs by periodically deactivating provider numbers with no billing history.***

One simple and cost effective method for updating provider files, followed by nearly two-thirds of carriers surveyed, is to deactivate the numbers which belong to providers without recent billing. The effects of removing inactive providers could be significant.

At one carrier not routinely deactivating provider numbers with no billing history, nearly 30 percent of "active" provider numbers belonged to inactive providers. (See Figure 10.) (Inactive providers were defined as provider records with no Medicare billing for the past 27 months.) Letters were sent to providers to determine if they still wished to participate in the Medicare program. Almost 78 percent of these providers failed to respond or requested termination of their number. Ultimately, 15,215 or 76.6 percent of provider numbers with no billing history were canceled because of this project. Not only does this reduction in provider numbers increase the manageability of the carrier's provider file, it translates to an administrative cost savings to the Medicare program. Such activities as yearly profile calculations, file maintenance activity, and routine mailings will not be required.

FIGURE 10

Many Provider Numbers With No Billing Could be Canceled

Texas Blue Cross and Blue Shield's Experience

Type of Provider	Active Provider Numbers	Numbers With No Billing		Cancelled Provider Numbers		
		Numbers	Percent of Active Numbers	Numbers	Percent of No Billing	Percent of all Numbers
Doctor of Medicine	42,932	11,842	27.6%	9,819	82.9%	22.9%
Drug and Medical Supply	6,348	2,013	31.7%	1,752	87.0%	27.6%
Dentist	6,123	3,250	53.1%	2,274	70.0%	37.1%
Doctor of Osteopathy	2,646	672	25.4%	567	84.4%	21.4%
Certified Nurse Anesthetist	1,960	617	31.5%	300	48.6%	15.3%
Chiropractor	1,750	203	11.6%	130	64.0%	7.4%
Psychologist	1,236	688	55.7%	312	45.3%	25.2%
Podiatrist	624	75	12.0%	60	80.0%	9.6%
Occupational Therapist	7	1	14.3%	1	100.0%	14.3%
Total	**63,626**	**19,361**	**30.4%**	**15,215**	**76.6%**	**23.9%**

➤ ***Computer matching with licensing authorities could help many carriers identify providers not legally authorized to practice.***

Our experience with computer matching to identify providers not legally authorized to practice has proven such activity is an effective tool to maintain the integrity of provider records and reduce Medicare's vulnerability to fraud and abuse. Additionally, such files can have other uses. Not only could the file be used to conduct computer matching, lists of authorized providers could be produced for departments responsible for assigning provider numbers. In fact, carriers could incorporate the licensing authority's file into a carrier computer program screen such that all carrier departments would not have to manually look up licensing information on providers, but could query the computer instead.

All of the licensing authorities which indicated having a computer system also reported they could generate a computer file of all licensed providers. Of these, over 50 percent also have the capacity to generate listings only of providers who have lost the legal authority to practice. Apparently, some licensing authorities keep only records of actively registered providers. Any licensee failing to renew a license is purged from its system.

Medical physician licensing authorities reported charges for such files ranged from no charge to a government agency to several cents per record. Some of the estimated costs were as follows:

Medical Physician Licensing	*Cost of File*
Rhode Island	$50
Nevada	$50
Oklahoma	$75-150
Idaho	$100
Texas	$100
Alabama	$150
Ohio	$150
Nebraska	$175
North Carolina	$250
Florida	$260
Connecticut	$65 per profession plus $25 for a tape
Vermont	$5 processing fee plus five cents per record
North Dakota	$0.05 per physician record
Missouri	No charge to Federal government agency
New York	No charge to Federal government agency
California	No charge to Federal government agency

Costs for smaller boards such as chiropractic or optometry were generally between $25 and $50. It should also be noted State licensing authorities may lower processing costs, if they realize the purpose of Medicare's request for the information and that the carrier is a Medicare contractor. As an example, Ohio sells a computer tape of licensed physicians for $1,500 to private entities. However, certain State and Federal agencies (including Medicare) can receive the tape for as little as $150.

An Effective Practice

Carriers for 3 States (Florida, Missouri and Texas) reported obtaining a computer file from a licensing board in order to identify providers not legally authorized to practice. Each carrier reports use of such a computer file to be an inexpensive, yet effective, method to detect providers not legally authorized to practice.

In 1989, Florida reported the deactivation of approximately 300 physician provider numbers for failure to renew their license. In 1990, Texas deactivated nearly 1,500 provider numbers for physicians not legally authorized to practice.

How costly are computer matches?

The effectiveness and cost of computer matching depends upon several factors. Some of these factors are:

- the carrier's computer capabilities,
- carrier programming costs,
- licensing authority ability to produce a useable file at a reasonable cost,
- adequate identifiers for matching (license number, name, birth date, etc.), and
- sufficient integrity of the carrier's and licensing authority's provider file (e.g., if matched on the license number, all carrier records must have license numbers).

practical example of the cost of computer matching, Florida Blue Cross and Blue Shield ıated its match cost for start-up and yearly follow-up:

$1,120	Initial development for first match
$ 260	Computer tape purchase cost from State licensing authority
$ 200	Administrative costs to run match (e.g., computer CPU time, letter generation to providers without a valid license, staff time to receive and file provider responses)
$ 250	Maintenance (activity associated with updating match programs)
$1,830	**Total Cost for Initial Match**
$ 710	**Cost for Subsequent Matches (the $1,120 initial development is no longer required)**

➤ ***Carrier efforts under HCFA's physician identification and registration program (UPIN) have improved the accuracy of provider number records of physicians.***

Seventy percent of carriers responding to our survey stated that, in the course of fulfilling requirements for HCFA's physician identification and registration program (UPIN), it substantially cleaned up physician records. In total, 18 carriers reported the identification of

approximately 11,500 physicians whose numbers needed to be canceled or deactivated. Some other carriers responded on a percentage basis; from 10 to 20 percent of physicians in its system had their numbers deactivated or canceled. The primary reasons for deactivation were death, retirement, or no longer practicing in the State.

Material Weakness

Inadequate HCFA oversight and direction of the provider number process is a basic systemic weakness that compromises the integrity of the trust fund and could result in significant losses. In accordance with the Federal Managers' Financial Integrity Act, the HCFA should report this as a material internal control weakness through the Secretary to the President and Congress. A detailed discussion of the material weakness designation can be found in Appendix B.

RECOMMENDATIONS

The HCFA should require carriers to:

- update provider records periodically.

- deactivate all provider numbers without current billing history.

- establish adequate controls to ensure providers not legally authorized to practice are identified and their provider numbers deactivated. As a part of these controls, carriers should:

  - negotiate with State licensing authorities to obtain license and registration information at a minimum cost to the Medicare program.

  - assess the feasibility of computer matches with State licensing authorities and perform such matches routinely, if practical.

  - maintain the license or certification number of providers in its provider file.

  - develop computer data entry edits for license numbers to ensure uniformity and consistency with the licensing authority's method of recording license numbers.

The HCFA should:

- evaluate carrier provider number controls established above as a part of its regular carrier Contractor Performance Evaluation Program.

- negotiate with State licensing authorities, which carriers report to be uncooperative, to obtain license and registration information at a minimum cost to the Medicare program.

HCFA COMMENTS AND OIG RESPONSE

The HCFA acknowledges the need for improvement in its instructions given to Medicare carriers regarding the maintenance of provider numbers, but does not believe our findings constitute a material internal control weakness. The HCFA maintains that UPIN requirements "firmly established both a means and a HCFA commitment to maintaining accurate provider number information."

The HCFA concurs with our recommendations to periodically update provider records and conditionally concurs with our recommendation to deactivate numbers with no recent billing activity. The HCFA does not concur with recommendations requiring carriers to implement controls which are adequate to ensure providers not legally authorized to practice are identified and their provider numbers deactivated. The HCFA cites the OIG's sanction role and several impediments precluding the implementation of computer matching. Additionally, HCFA does not believe a CPEP standard is warranted to ensure and evaluate carrier maintenance activity.

The HCFA incorrectly argues the responsibility for ensuring providers losing legal authority to practice are identified rests with the OIG. The OIG's sanction role is limited and does not take away the responsibility of carriers to ensure payments are not made to unqualified providers. The Physician Registry does not ensure maintenance of the accuracy of provider number information as indicated by HCFA, except for detecting sanctioned physicians. Finally, carrier efforts to maintain the integrity of provider numbers warrants evaluation during HCFA's annual carrier survey process.

The OIG continues to believe a material internal control weakness exists. The HCFA's lack of direction has resulted in vulnerabilities which meet several of the criteria upon which a material weakness designation is determined.

See Appendix B for a summary of HCFA's comments to the draft report and a complete discussion of the OIG's response. Also, this discussion includes factors considered in determining a material weakness[3] designation exists (Appendix B, pages 4-5). Appendix C includes the full text of HCFA's comments.

ENDNOTES

1. According to information in the Federation's 1989-90 Exchange, Section 3: Physician Licensing Boards and Physician Discipline.

2. Allowed charges represent those amounts determined by the carrier based on the lower of the usual, customary, or prevailing charges for the service.

3. Material weakness criteria are specified in OMB Circular A-123.

APPENDIX A

CARRIER RESPONDENTS and STATE JURISDICTIONS

Respondents (count=38)	Jurisdiction
Blue Cross and Blue Shield of Alabama	Alabama
Aetna Life and Casualty	Arizona, Nevada
Arkansas Blue Cross and Blue Shield, Inc.	Arkansas, Louisiana
Blue Shield of California	California
Transamerica Occidental Life Insurance	California
Travelers Insurance	Connecticut
Blue Cross and Blue Shield of Florida, Inc.	Florida
Aetna Life and Casualty	Georgia
Aetna Life and Casualty	Hawaii
Equicor	Idaho
Health Care Service Corporation	Illinois
Associated Insurance	Indiana
Blue Shield of Iowa	Iowa
Blue Cross and Blue Shield of Kentucky	Kentucky
Blue Cross and Blue Shield of Maryland	Maryland
Blue Cross and Blue Shield of Michigan	Michigan
General American Life	Missouri
Blue Cross and Blue Shield of Kansas City	Missouri, Kansas (Johnson and Wyandotte Counties)
Travelers Insurance	Minnesota
Travelers Insurance	Mississippi
Blue Cross and Blue Shield of Montana, Inc.	Montana
Blue Shield of Western New York	New York
Empire Blue Cross and Blue Shield	New York
Group Health Incorporated	New York
Equicor	North Carolina
Blue Cross and Blue Shield of North Dakota	North Dakota, South Dakota, Wyoming
Nationwide Mutual	Ohio, West Virginia
Aetna Life and Casualty	Oklahoma, New Mexico
Aetna Life and Casualty	Oregon, Alaska
Pennsylvania Blue Shield	Pennsylvania, Maryland (Prince Georges & Montgomery Counties), Delaware, District of Columbia, New Jersey
Blue Cross and Clue Shield of Rhode Island	Rhode Island
Blue Cross and Blue Shield of South Carolina	South Carolina
Blue Cross and Blue Shield of Texas, Inc.	Texas
Equicor	Tennessee
Blue Cross and Blue Shield of Utah	Utah
Travelers Insurance	Virginia
Washington Physicians Service	Washington
Wisconsin Physicians Service	Wisconsin

APPENDIX B

SUMMARY OF HCFA'S COMMENTS TO SPECIFIC RECOMMENDATIONS AND OIG'S RESPONSE

RECOMMENDATION 1: ***HCFA should require carriers to update provider records periodically.***

HCFA Comments

The HCFA concurs with this recommendation.

OIG Response

The OIG is pleased HCFA acknowledges carrier responsibility to ensure the accuracy of provider records through periodic updating.

ECOMMENDATION 2: ***HCFA should require carriers to deactivate all provider numbers without current billing history.***

CFA Comments

e HCFA concurs with this recommendation and further proposes implementing carrier ıctivation as an annual activity to be implemented by carriers when funds become available.

IG Response

The OIG does not believe deactivating inactive provider numbers should be delayed. This ctivity is important to maintaining the integrity of carrier provider files and may also result in n administrative cost savings to the carrier. Additionally, requiring carriers to perform this ctivity *will* only affect about a third of the carriers. As referred to in the report, the other arriers already perform this function.

RECOMMENDATION 3: ***HCFA should require carriers to establish adequate controls to ensure providers not legally authorized to practice are identified and their provider numbers deactivated.***

HCFA Comments

The HCFA does not concur with this recommendation. The HCFA believes problems exist which limit or prohibit implementation of computer matching. Primarily, HCFA believes the benefit to the integrity of the Medicare program is too small to justify the cost. However, HCFA

will encourage those carriers which can establish data exchanges with State licensing authorities without charge and with minimal administrative costs to conduct computer matches. Finally, HCFA believes UPIN establishes "both a means and a HCFA commitment to maintaining accurate provider number information."

OIG Response

Medicare law does not allow carriers to make payment to providers not legally authorized to practice in the State where services are rendered. Consequently, HCFA cannot permit carriers to ignore a State's legal authorization requirements.

We acknowledge the existing differences among States concerning State licensing authorities' ability to provide computerized registration information. Also, we understand carrier differences which may impact on the cost and effectiveness of implementing this recommendation. However, we do not suggest that computer matching with licensing agencies is the only means available to carriers. We suggest only that carriers study the feasibility of conducting computer matching. Manual procedures can be effectively and efficiently used when computer matching is infeasible or not cost effective.

Procedures must be tailored to fit the carrier and State. Some carriers will encounter less success or more cost in meeting this requirement. However, this does not justify not requiring carriers to implement procedures to deactivate all providers not legally authorized according to State law. If excessive or unsurmountable problems exist in achieving the integrity of provider records, HCFA should seek legislative relief.

The HCFA argues our report does not indicate they can expect a significant return on its investment. Specifically, HCFA believes determining legal authorization is not cost effective. Because carriers have not yet studied the feasibility of conducting such matches, we question HCFA's estimate that costs to implement computer matching may exceed one million dollars.

While an exact cost estimate of Medicare overpayments is not determinable, we believe our report shows a significant vulnerability which warrants carrier action.

We agree UPIN activity has improved the accuracy of physicians records and can be used to effectively detect sanctioned physicians. However, improvements to physician records were due primarily to carrier review and contact with licensing boards and/or physicians to develop for missing data or nonassignment of a UPIN. The UPIN database has little real impact on maintaining the accuracy of provider records beyond detecting sanctioned physicians. Carrier action is required to identify those providers losing legal authorization to practice who are not subject to sanction under Medicare law or are nonphysicians excluded from UPIN.

RECOMMENDATION 4: ***HCFA should evaluate provider number controls established above as a part of its regular carrier Contractor Performance Evaluation Program (CPEP).***

HCFA Comments

The HCFA does not concur with the establishment of a CPEP standard(s) for provider number maintenance. HCFA refers to deactivation of inactive provider numbers as a "small area" of claims processing. The HCFA argues that existing CPEP standards used to measure adherence to HCFA's policies will evaluate compliance with our recommendation to deactivate provider numbers with no billing activity.

OIG Response

Carrier maintenance is not a relatively small area as implied by HCFA; rather, it warrants serious HCFA review. Establishing a specific standard(s) for provider number maintenance would be critical to ensure carriers implement controls recommended in this report.

CPEP contains 10 functional criteria which contain a total of 79 standards plus two test standards. Four of these standards alone involve the Physician Registry (UPIN). Certainly, carrier maintenance warrants adequate review as well.

The OIG does not agree carrier deactivation of inactive provider numbers would be adequately evaluated by any existing CPEP standard. Adequate evaluation under existing standards could only be accomplished by altering HCFA's method of evaluating a standard to include specifically assessing carrier deactivation policies.

RECOMMENDATION 5: ***HCFA should negotiate with State licensing authorities, which carriers report to be uncooperative, to obtain license and registration information at a minimum cost to the Medicare program.***

HCFA Comments

The HCFA does not concur with our recommendation to negotiate with State licensing authorities to obtain license and registration information at a minimum cost to the Medicare program.

OIG Response

The OIG continues to believe intervening on behalf of carriers could be critical. The OIG does not fully understand the reasons for HCFA's nonconcurrence with this recommendation.

The HCFA believes carriers should update provider records periodically and acknowledges verifying provider status with licensing authorities "has merit." Further, HCFA proposes to

encourage carriers to establish data exchanges with licensing authorities. However, HCFA is unwilling to negotiate with State licensing authorities on behalf of carriers wishing to obtain licensing information (computer or hardcopy).

Additionally, if carriers are required by HCFA to deactivate providers losing legal authority, HCFA's intervention to assist carriers in negotiating with licensing agencies could be critical.

MATERIAL WEAKNESS DESIGNATION:

The OIG believes inadequate direction by HCFA has resulted in weaknesses in carrier controls to maintain the integrity of Medicare carrier provider numbers. The OIG believes this constitutes a material internal control weakness within the meaning of the Federal Managers' Financial Integrity Act and should be reported to the Secretary along with plans for corrective action.

HCFA Comments

The HCFA does not believe a material internal control weakness exists in HCFA's direction to carriers or in provider number controls. The HCFA believes the material weakness designation "does not meet the Office of Management and Budget's or the Department's definition of a material weakness." However, HCFA does agree problems exist with timely carrier identification and restriction of payments to providers losing legal authority to practice. Yet, HCFA believes the solution to the problem is more involvement by OIG's sanction staff, rather than more carrier effort.

OIG Response

The OIG continues to believe a material internal control weakness exists. The material weakness designation is based on inadequate HCFA direction and carrier efforts to maintain the integrity of Medicare provider numbers.

The HCFA incorrectly argues that OIG, through its sanction role, is responsible for ensuring providers losing the legal authority to practice are identified. *The responsibility for the integrity of Medicare provider numbers rests with carriers.*

The OIG sanction process applies only to those providers committing actions sanctionable under Section 1128 of the Social Security Act. Yet, several State actions can cause a provider to lose State legal authority to practice without necessarily justifying program exclusion. Additionally, the sanction process can be lengthy.

Carriers are responsible for understanding State-imposed practice requirements, maintaining adequate communication with licensing agencies, and administering provider files; consequently, carriers can most effectively and efficiently establish procedures to identify restricted providers.

Material Weakness Criteria

The Office of Management and Budget (OMB) has specified many criteria upon which a material weakness decision should be based. Findings meeting any single criterion constitute noncompliance with the Integrity Act and thus, should be classified as a material weakness. The following examples illustrate how our findings meet several criteria substantiating a material weakness designation:

- *Does the weakness violate statutory or regulatory requirements?*

  As a result of inadequate controls, carriers fail to identify and deactivate all provider numbers belonging to providers no longer legally authorized to provide services in the carrier's jurisdiction. This violates Medicare law which does not allow payment to providers not in compliance with local, State, or Federal requirements.

- *Does the weakness significantly impact on the safeguards against waste, loss, unauthorized use of funds, property, or other resources?*

  While we were unable to determine a precise financial vulnerability, the potential for abuse is high. In Florida, from 1980 to 1985, the carrier allowed charges of over 15 million dollars for physicians not legally authorized to practice. Carriers do not have controls in place to identify loss of legal authorization except for those providers excluded from program participation (sanctioned).

- *Is the weakness of high political sensitivity such that it would result in embarrassment to the Department?*

  Beneficiaries trust the Medicare program to ensure providers are in compliance with Federal, State, and local requirements. The HCFA, through carriers, is responsible for assuring this trust is not betrayed. However, report findings raise concerns that carrier maintenance activity does not adequately scrutinize providers once provider numbers have been issued to ensure the provider is still qualified and that payment variables are correctly determined. Substantial Medicare payments to providers not legally authorized to practice would, indeed, be politically sensitive and embarrassing to the Department.

- *Is the weakness a crosscutting weakness which indicates major systemic problems?*

  Inadequate provider number maintenance is a major systemic problem within Medicare. Errors in the provider number affect:

  - *the ability to detect fraud and abuse,*
  - *coverage and pricing of Medicare services, and*
  - *investigations of particular individuals or business.*

While this inspection involved only Medicare carriers, the OIG believes vulnerabilities identified in this report may exist in other programs which assign provider numbers to providers (e.g., Medicaid).

APPENDIX C

HEALTH CARE FINANCING ADMINISTRATION COMMENTS

Memorandu

Date FEB 28 1991

From Gail R. Wilensky, Ph.D.
Administrator

Subject OIG Draft Report - "Carrier Maintenance of Medicare Provider Numbers," OEI-06-89-00870

To The Inspector General
Office of the Secretary

We have reviewed the subject draft report which concerns Medicare carriers' efforts to ensure the accuracy of provider numbers and to identify and restrict payments to providers who have lost their legal authority to practice.

The report found that some Medicare carriers are not periodically updating provider records. OIG recommends that HCFA improve the maintenance of provider numbers by requiring carriers to periodically update provider records, and suggests specific requirements for these updates.

HCFA acknowledges the need for improvement in the instructions given to Medicare carriers regarding the maintenance of provider numbers. However, we believe that this situation clearly does not constitute a material internal control weakness. Our specific comments on the report's recommendations are attached for your consideration.

Thank you for the opportunity to review and comment on this draft report. Please advise us whether you agree with our position on the report's recommendations at your earliest convenience.

Attachment

Comments of the Health Care Financing Administration (HCFA) on the OIG Draft Report - "Carrier Maintenance of Medicare Provider Numbers," OEI-06-89-00870

Recommendation 1

HCFA should require carriers to update provider records periodically.

Response

HCFA concurs with this recommendation.

Recommendation 2

HCFA should require carriers to deactivate all provider numbers without current billing history.

Response

HCFA concurs with this recommendation. We propose that this be an annual activity. The national start-up cost has been estimated to be approximately $200,000 and the annual cost for all carriers to conduct the purge would be approximately $26,000. This requirement will be incorporated into the Medicare Carriers Manual. When the funds necessary to start this project are available, HCFA will instruct the carriers to implement this recommendation.

Recommendation 3

HCFA should require carriers to establish adequate controls to assure that providers not legally authorized to practice are identified and their provider numbers deactivated. As part of these controls, carriers should:

- negotiate with State licensing authorities to obtain license and registration information at a minimum cost to the Medicare program.

- assess the feasibility of computer matches with State licensing authorities and perform such matches routinely, if practical.

- maintain the license or certification number of providers in their provider file.

- develop computer data entry edits for license numbers to assure uniformity and consistency with the licensing authority's method of recording license numbers.

Recommendation 5

HCFA should negotiate with State licensing authorities, that carriers report to be uncooperative, to obtain license and registration information at a minimum cost to the Medicare program.

Response to Recommendation 3 and 5

HCFA does not concur with these recommendations. While the recommendation that carriers should use State licensing authorities when verifying the licensing status of providers has merit, we anticipate problems that will preclude its implementation. Some States have privacy laws which prohibit or limit the release of license and registration information. Some States do not have automated files, which eliminates the possibility of a computer match. Also, there is no legislative authority for requiring States to cooperate with a computer match. Any one of these problems could severely restrict carriers' success in accessing the information maintained by State authorities.

Our primary concern with the computer match proposal, however, is the return for the cost of such an operation. We project costs of over $1 million nationally to implement such a data exchange at all carrier sites and over $250,000 annually for ongoing activities. The data included in the OIG's report does not indicate that we can expect a significant return on our investment. Because of the severe budget restrictions under which we operate, we do not believe that this data match will be cost effective. However, if carriers can establish data exchanges with State licensing authorities without charge and with minimal administrative costs, we will certainly encourage them.

We believe that the Unique Physician Identification Number (UPIN) requirements firmly established both a means and a HCFA commitment to maintaining accurate provider number information. The physicians covered by the UPIN requirements (medical doctors, doctors of osteopathy, dentists, optometrists, chiropractors and podiatrists) make up the majority of the Medicare providers subject to license requirements. In the future, the UPIN may include additional limited license practitioners, such as clinical psychologists, clinical social workers and certified registered nurse anesthetists.

The UPIN process requires the following from carriers when a UPIN is established:

- o verification of State licensure to practice,
- o verification that a physician is not sanctioned, and
- o information about prior out-of-State practice, if any.

After establishing a record on the UPIN Registry, which serves as a national clearinghouse, carriers receive physician-specific sanction information from the Registry on a quarterly basis. This data is taken from OIG's report on Medicare fraud and abuse and other sanctions. Carriers use this data to ensure that sanctioned physicians do not have active status in the provider files.

In addition to the UPIN system, HCFA's Health Standards and Quality Bureau (HSQB) maintains a certification process which requires State licensure for Medicare participation by certain other providers and suppliers. Included in HSQB's certification process are physical therapists, occupational therapists, independent laboratories, ambulatory surgical centers and cardiac rehabilitation centers.

Recommendation 4

HCFA should evaluate provider number controls established above as a part of its regular carrier Contractor Performance Evaluation Program (CPEP).

Response

HCFA does not concur with this recommendation. With the issuance of the carrier manual revision proposed in response to the second recommendation, the existing CPEP standard used to measure carrier adherence to HCFA's policies will evaluate compliance with this new requirement. Establishing a specific standard for provider number control would create problems associated with the measurement of a relatively small area of carrier claims processing responsibility.

Allegation of the Existence of a Material Weakness

HCFA does not agree that a material internal control weakness exists in HCFA's direction to carriers, or in the provider number carrier controls. This situation clearly does not meet the Office of Management and Budget's or the Department's definition of a material weakness.

HCFA believes that OIG did not consider the integral part that sanctions under Section 1128(b)(4) of the Social Security Act (the Act) play in maintaining the integrity of provider numbers.

Traditionally, HCFA's sanction staff collected information from Medical Licensing Boards and imposed sanctions prohibiting those providers who had lost their legal authority to practice from participating in the Medicare and Medicaid programs under Section 1128(b)(4) of the Act. Medicare carriers were informed of the Licensing Board adverse actions during the development of the sanction case, and when the sanction itself was imposed. HCFA relied on the sanctions process to ensure that all Medicare carriers were informed of Medical Licensing Board adverse actions. However, a number of years ago, HCFA's Program Integrity function was transferred permanently to OIG, along with the staff and budget for that function. Sanctioning of Medicare providers then became the responsibility of OIG. We believe that a continuation of this effort is essential in maintaining the integrity of provider numbers.

OIG's rationale for determining that a material internal control weakness exists, appears to be based on OIG's findings that HCFA's carriers are unable to timely identify and restrict payments to providers who have lost their legal authority to practice because of adverse actions by Medical Licensing Boards. HCFA agrees this problem exists and believes that the solution to the problem will require more involvement by OIG's sanction staff.