Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

Accuracy of Unique Physician
Identification Number Data

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OFFICE OF INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

To determine whether the information associated with Unique Physician Identification Numbers is complete and accurate.

BACKGROUND

The Consolidated Omnibus Budget Reconciliation Act of 1985 requires physicians and other health care professionals to obtain a Unique Physician Identification Number (UPIN). This is a national number that distinguishes the individual ordering or furnishing the service or supply from the entity requesting or receiving Medicare reimbursement, such as corporations, clinics and partnerships. In 1989, the Health Care Financing Administration (HCFA) established the UPIN Registry and assigned unique numbers to Medicare physicians. In 1994, the Registry was expanded to include non-physician practitioners and group practices. The Registry also maintains data on each practice location, by Provider Identification Number (PIN). The UPIN remains active as long as there is at least one active PIN. The HCFA plans to use the Registry information as source data for the National Provider Identifier, which will replace UPINs and PINs after the year 2000.

Before the unique identifier is assigned, the individual or entity must enroll with the Medicare carrier and provide documentation of any professional and governmental license requirements. Each claim for Medicare reimbursement must list the UPIN for the service provider, the number of the referring professional, if any, and the entity's PIN for the practice location.

We obtained the most recent UPIN Registry, also known as the Medicare Physician Identification and Eligibility Record data base (October 1998). We analyzed it to determine if data was missing or contained improbable entries. In addition, we validated information for a stratified sample of providers with State license agencies, independent certification entities, and Medicare carriers to determine the error rate for the sample.

FINDINGS

HCFA Has Taken Meaningful Actions to Enhance the Accuracy of UPIN Data

The HCFA has implemented a number of significant enhancements to the provider enrollment process to improve program safeguards and increase the reliability of UPIN data. These changes include: additional controls on the assignment of provider numbers; new requirements to conduct extensive verification and authentication of license and professional qualifications of number applicants; shortened protocols to deactivate numbers that do not have recent utilization; requirements for the provider to notify the carrier of any changes in their status; and mandatory inclusion of the Social Security Number. In addition, HCFA plans to require the periodic re-validation of provider information.

As a result of HCFA actions, our analysis of the sample and the universe shows that virtually all Registry data fields are complete and contain feasible entries. We identified only 92 Social Security Numbers associated with more than one UPIN, a significant improvement when compared to the 1995 Health Economics Research study which found up to 11,600 providers with potentially multiple UPIN registrations.

The Social Security Number, an important identifier, was inaccurate for 13 percent of UPINs. We recognize, however, the Balanced Budget Act of 1997 has only recently required providers to furnish this information to receive Medicare payment.

Despite These Efforts, Problems Continue to Exist With Some Physician Registry Data

Almost one-fourth of the active UPINs have no recent Medicare claims activity

From our sample we estimate 23 percent of the active UPINs had no claims activity for the past year and 17 percent had no claims activity for the past 3 years. We also estimate 39 percent of the associated active Provider Identification Numbers for individual practice settings have no Medicare claims activity within the past year. Twenty-seven percent have no activity for the past 3 years.

Coding instructions and formats adversely affect the usefulness of information

- ▸ We estimate 88 percent of the entries for the State license number do not agree with the licensure agencies' information. Of these errors, 72 percent of the numbers differ in format and 28 percent contain leading zeros in the first 3 positions of the number. Our analysis of the universe established that over 46 percent of the numbers also contain 3 or more leading zeros. This convention can create difficulties in performing computer matching and number verification.

- ▸ We estimate inaccurate professional school codes for 8 percent of the UPINs and for 5 percent of the PINs.

- ▸ We noted additional problems with the coding for physician specialities and certifications. For the universe, the board certification code, which is optional data, contained feasible codes for only 62 percent of the records for the primary speciality and 30 percent of the records for the secondary speciality.

Some providers have numerous active PINs

Many providers (68 percent of the total UPIN universe) had 3 or less PINs and most (97.9 percent) had 10 or fewer. However, the remaining UPINs had from 11 to 57 separate billing numbers for each UPIN for a total of 9,535 PINs. This small group of providers, in reflecting a high volume of billing numbers, represent an enhanced risk for improper billing or utilization by the provider, employees, a third party, or even carrier personnel.

Some UPIN Data is Inconsistent

Several UPIN data fields for a provider's individual practice settings contain data that apply to all of their practice locations. Examples include: State license number; Professional School Code; and Primary and Secondary Speciality Codes. We found carriers are updating only some of the provider-specific practice information on the UPIN record, resulting in inconsistencies for different practice locations. Maintaining such information on each provider's practice setting greatly increases the opportunity for errors, omissions, and discrepancies.

RECOMMENDATIONS

We have found a number of UPIN and PIN issues that need attention. However, many of them can be effectively addressed when HCFA implements its process for periodic re-validation of provider information.

Deactivate UPINs and PINs for Inactive Providers and Practice Locations

The HCFA should ensure that carriers deactivate provider numbers and UPINs in accordance with its instructions when no claims have been submitted to them for the preceding 12 months. This should be an active review element of the periodic Carrier Performance Evaluation review. To reduce program vulnerabilities and minimize administrative costs, HCFA could consider implementing a shorter time frame (i.e., 2 consecutive quarters).

Improve Data Entry Instructions for Specific Data Fields

We recommend the Medicare Carriers Manual Part 4, § 1015, Exhibit 2, be revised to specify that the State license number be entered exactly as shown on State records and licenses. The instructions should specify that the number be left justified, and that characters, numbers, and spaces are acceptable. In addition, HCFA should review instructions for coding provider specialities and certifications to provide for the possibilities of "none" under provider speciality and "not applicable" under board certification. This should significantly reduce coding errors by carrier personnel for health providers who are not board certified or for professions that are not independently certified.

Establish a Priority to Review Individuals with Numerous PINs

The HCFA should require carriers to establish a priority for review of individuals with numerous (i.e., more than 10) PIN numbers. Such reviews should address the utilization of these numbers and their legitimacy.

Reconcile Identical Fields in UPIN and PIN Records Before Implementing National Provider Identifier

The HCFA should ensure that its contractors update applicable changes to all related UPIN and PIN records. In planning for the National Provider Identifier and National Provider System, HCFA could avoid inconsistent data between these records by using a

single file for practitioner-specific data, or linking identical fields in different records to flag conflicting entries.

AGENCY COMMENTS

The HCFA concurs with the report and has undertaken or is planning meaningful steps to implement the recommendations. Appendix D contains the complete text of these comments.

T A B L E   O F   C O N T E N T S

INTRODUCTION

PURPOSE

To determine whether the information associated with Unique Physician Identification Numbers is complete and accurate.

BACKGROUND

The Consolidated Omnibus Budget Reconciliation Act of 1985, §9201(g)[1] requires physicians and other health care professionals to obtain a Unique Physician Identification Number (UPIN). In 1989, the Health Care Financing Administration (HCFA) established the UPIN Registry, formerly known as the Physician Registry and assigned unique numbers to Medicare physicians. In 1994, the UPIN Registry was expanded to include non-physician practitioners and medical group practices.

The UPIN is used nationally to uniquely identify physicians, non-physician practitioners and medical group practices. These individuals or entities often furnish or bill for medical services from several locations or states which are in different carrier jurisdictions. This national number distinguishes the individual ordering, referring, or furnishing the service or supply from the entity requesting or receiving Medicare reimbursement for the service, such as corporations, clinics and partnerships.

Roles of the Carriers

Before a unique identifier is assigned, the individual or entity must complete an application for enrollment with the carrier and provide documentation of professional and governmental license requirements. The HCFA has standardized provider enrollment and update forms for all carriers, implementing the current version August 1, 1998. As part of enrollment, carriers validate that the entity or individual requesting the number meets license and other standards under Federal and State laws.[2]

Upon completion of all mandated validation requirements, carriers initiate a computer inquiry to the Registry to request issuance of the UPIN for the applicant. The carrier assigns a Provider Identification Number (PIN) for each practice setting. While a physician or other health care practitioner may have more than one PIN (i.e., the provider has more than one billing location), only one UPIN is to be issued. The Registry maintains data on each PIN under the provider's UPIN.

Once the Registry assigns a UPIN and establishes a record, the carrier is responsible for assuring that the information on both their provider file and the Registry is updated when changes, additions, or deletions are needed. The carrier performs this process electronically or by mail. In addition, when the Registry receives information which creates a question about the status of the provider, such as suspected death, sanction, or fraud, it generates an electronic investigational alert by UPIN to the carrier for their research and investigation.

The billing entity must list the service provider's UPIN, the referring professional's number (if any), and the entity's PIN on the claim to receive Medicare reimbursement. However, carriers can initially process claims submitted by a new provider without a unique number through use of a temporary generic number, only until a permanent number is issued.

As a program safeguard, carriers are instructed to deactivate the PIN if it remains inactive (no claims activity) for 12 consecutive months. Prior to October 1998, the Medicare Carriers Manual required deactivation of numbers after 3 years of no claims activity. The UPIN remains active as long as there is at least one active PIN for the provider. If there is no activity on any PIN for 12 months, the UPIN should also be deactivated. In order to reactivate a PIN or UPIN, the provider must complete a new General Enrollment form and the carrier must verify all enrollment information.

Role of the Registry Contractor

Transamerica Occidental Life Insurance Company establishes and maintains the Registry of physicians, health care practitioners, and group practices receiving Medicare Part B payments. During a 5 month implementation period from January - May 1989, the Registry processed 1.2 million records submitted by 57 Medicare carriers.[3]

The Registry contractor maintains the UPIN Registry, also known as the Medicare Physician Identification and Eligibility Record (MPIER), a data base of physician and other health provider enrollment information. When a carrier electronically requests assignment of a UPIN, the Registry staff performs its own validation to determine if the enrollment request can be added to the Registry's data file.

If the Registry's internal validation checks identify discrepancies which need further review, it generates electronic exception messages to the carrier. The carrier is to conduct the needed validations and either transmit the corrections or contact the Registry to resolve the problem. When all validation is completed and approved, the Registry transmits the UPIN to the carrier.

Provider Number Issues Previously Identified by the OIG and HCFA

The OIG completed three studies that examined problems applicable to Medicare provider numbers. These studies identified problems with

- ► the accuracy and completeness of carrier provider files.
- ► inadequate carrier controls to deactivate provider numbers for individuals who are not submitting claims or have lost the legal authority to practice.
- ► poor communications with State licensing authorities.[4]

As a result, the HCFA contracted with Health Economics Research, Inc. to evaluate the quality of the Registry data.[5] Its review identified the following problems:

- ▸ as many as 11,600 providers may potentially have more than one number;
- ▸ nearly 14 percent of the practice settings are no longer being used by the physicians;
- ▸ the data base contains missing, erroneous, or infeasible entries for several data elements (i.e., State license number, date of birth, school code and graduation year); and
- ▸ Railroad Retirement Board carriers account for a disproportionately large share of the problems identified.

Implementation Plan for the National Standard Health Care Provider Identifier

In July 1993, HCFA undertook an initiative to establish a standardized provider identifier, the National Provider Identifier (NPI), that will replace the UPINs and PINs. This identifier is to be an eight-position alpha numeric identifier. It will be used by all health entities that bill or initiate referrals for Medicare patients and ultimately will be used by all health care providers and insurers. As part of this process, HCFA is concurrently developing a National Provider System which will replace the data currently in the MPIER data file. The HCFA estimates that the National Provider Identifier will not be operational until the year 2000.

Periodic Re-Validation of Providers

The HCFA is preparing a Notice of Proposed Rule for public comment which will for the first time require Medicare carriers to periodically re-validate information for its providers. The proposed rule will require physicians and other health providers to update their information every 3 years. New providers will be validated annually for the first 3 years and then will go to a 3 year re-validation cycle. However, HCFA currently has no plans to validate all provider information prior to implementation of the National Provider Identifier data base.

METHODOLOGY

We conducted an analysis of the Medicare Physician Identification and Eligibility Record (MPIER) data base as of October 1998 to measure data integrity and its validity for the universe and a random sample of UPINs. Further, we performed data comparisons to identify providers who may have more than one UPIN. The estimates are weighted in accordance with the sample design. Percentages are reported at the 95 percent confidence interval. The confidence intervals for these percentages are detailed in Appendix A.

We also selected a random sample of 225 UPINs associated with 424 PINs from the MPIER file, stratified by the year of the last record update to permit analysis of data quality and reliability over time. The sample design is given in the table on the following page.

Strata	Year UPIN Last Updated	Sample Size	Universe Size	Universe Percent
Strata 1	1989 - 1994	75	54,284	6.6%
Strata 2	1995 - 1996	75	284,109	34.6%
Strata 3	1997 - 1998	75	482,110	58.8%
Strata Total:		**225**	**820,503**	**100.0%**

Data Integrity

The records in the MPIER file were sorted by UPIN, the date the record was created, and the date that the record was last updated. We performed frequency counts and analysis of other data fields to determine the number and percentage of data that was missing or contained improbable entries. We also performed analysis of variable entries to determine if the data appeared to be accurate and complete when compared to other information contained in the provider's identification eligibility record. Further, we determined if the missing or questionable data was predominately from only certain data elements and issuing carriers.

Data Validity

To verify the sanction status of the sampled providers, we searched both the "OIG Exclusions List" and the General Services Administration's "List of Parties Excluded from Federal Procurement and Non-Procurement Programs." We also validated education, professional license, and speciality through use of the Internet sites of State Professional Boards and professional entities such as the American Medical Association and the American Board of Medical Specialities. Where Internet information was unavailable or incomplete, we contacted the applicable State professional board. In addition, we contacted Medicare carriers to validate the sampled active UPINs and PINs, and to identify providers who had not submitted claims within the previous 12 or 36 consecutive months.

Multiple Numbers

We matched the universe of UPINs to the associated Social Security Number on the Registry to identify providers who may have more than one UPIN. We also compared the provider's name, date of birth and school information.

We conducted this inspection in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

HCFA Has Taken Meaningful Actions to Enhance the Accuracy of UPIN Data

The HCFA has implemented a number of significant enhancements to the provider enrollment process designed to improve program safeguards and increase the reliability of provider enrollment data. These changes include: additional controls on the assignment of provider numbers; new requirements to conduct extensive verification and authentication of license and professional qualifications of number applicants; shortened protocols to deactivate numbers after 12 months of claims inactivity; requirements for the provider to notify the carrier of any changes in their status which are updated by the carrier to the Registry, and mandatory inclusion of the Social Security Number. In addition, HCFA is proceeding with plans to require the periodic re-validation of provider information.

As a result of HCFA actions, our analysis of the sample and the universe shows that virtually all Registry data fields are complete and contain feasible entries (Appendices B and C). We identified only 92 Social Security Numbers associated with more than one UPIN. This is a significant improvement when compared to the 1995 Health Economics Research study of UPIN Registry data which found that up to 11,600 providers may have multiple UPIN registrations.

The Social Security Number, an important identifier, was inaccurate for 13 percent of the total UPINs. We recognize, however, the Balanced Budget Act of 1997 (Public Law 105-32) has only recently required providers to furnish this information to receive Medicare payment.

Despite These Efforts, Problems Continue to Exist With Some Physician Registry Data

Almost One-fourth of the Active UPINs Have No Recent Medicare Claims Activity

In order to deactivate a UPIN, all of the associated PINs must be inactive. To confirm this, we compared the active UPINs to their claims activity for all practice settings. From our sample we estimate 23 percent of the active UPINs had no claims activity for the past year and 17 percent had no claims activity for the past 3 years. We also found that four of the active numbers in the sample belonged to providers who were deceased prior to 1996. While the carriers had deactivated the PINs, the corresponding UPINs remained active.

A provider should have only one UPIN but can have several PINs, which are billing numbers assigned by Medicare contractors to designate separate practice locations or

accounting designations. Based on sample data, we estimate 39 percent of the associated active PINs have no Medicare claims activity within the past year. Twenty-seven percent have no activity for the past 3 years.

Active UPINs and PINs with no recent claims activity represent a vulnerability to the Medicare program as unscrupulous individuals and organizations could use these numbers to submit fraudulent claims and supporting documents. Also, maintaining these numbers creates an unnecessary administrative cost for HCFA and its Medicare contractors. Performing provider mailings, researching undeliverable mail, maintaining provider files, and paying for computer time and storage are a few of the ongoing operational expenses that can be reduced by deactivating these unused numbers.

The HCFA has notified Medicare carriers to deactivate practice settings' PINs that have not had claims activity for 1 year and to update the UPIN Registry database either electronically or by mailed notification. Previously, carriers deactivated these settings after 3 years of claims inactivity.

Coding Instructions and Formats Adversely Affect the Usefulness of Information

From our sample we estimate 88 percent of entries for the State license number do not agree with licensure agencies' information. Of these errors, 72 percent of the numbers differ in format, such as missing alpha characters, digits, dashes or spaces and 28 percent contain leading zeros in the first 3 positions which do not match the number on file with the State licensing entity. Our analysis of the universe also established that 46 percent of the numbers contain 3 or more leading zeros (Appendix C). This convention can create difficulties in performing computer matching and verification.

The HCFA instructed Medicare carriers to enter the State license number in this 12-position data field right justified and preceded with zeros.[6] These instructions can alter the appearance of the number and therefore, greatly limit the usefulness of this information for automated data matching and verification.

We estimate inaccurate professional school codes for 8 percent of the UPINs and 5 percent of the PINs. Carriers currently use specific school coding for Medical Doctors, Doctors of Osteopathy, Chiropractors, and Optometrists for U.S. educated professionals. Categorical coding is used for all others, including professionals educated abroad.[7]

We found additional problems with the sample data for physician primary board speciality and certification. The HCFA instructions for these data fields do not specify coding for those health professionals not certified by independent boards.[5] Moreover, the coding options do not provide a choice of "none" or "non-applicable". From our sample we estimate the primary provider speciality code, a required entry for the UPIN Registry, was 83 percent accurate. However, the primary speciality board certification code, which is optional, was only 28 percent accurate. Problems detected included extensive use of the "U" (unknown) code and inconsistent coding for health professionals such as chiropractors, optometrists, nurses (excluding certified registered nurse anesthetists), psychologists, and physical therapists who are not certified by independent boards.

For the universe, since we could not determine the accuracy of the primary provider speciality code, we analyzed the data to determine if it contained feasible values as defined by HCFA. We found 99.9 percent of the entries corresponded to legitimate speciality codes. However, the primary speciality board certification was coded as "unknown" for 38 percent of the practices (Appendix C).

We identified the same issues in the sample for the physician secondary board speciality and certification (optional data), but the problems were more pronounced. We estimate only 76 percent of the speciality codes and 4 percent of the secondary speciality board certification codes were accurate. Problems detected included inconsistent coding for board certification and use of all code choices, or no entry for the speciality "Carrier Wide," which is synonymous for none or not applicable. This accounted for 92 percent of the errors in the secondary speciality board certification code. For the universe, the secondary provider speciality code was blank 94 percent of the time, and the corresponding secondary speciality board certification code contained an entry of "unknown" (70 percent) or did not contain data (25 percent). Refer to Appendix C.

Some Providers Have Numerous Active PINS

In analyzing the number of active practices for each UPIN, we found that many providers (68 percent of the total UPIN universe) had 3 or less practice settings and most (97.9 percent) had 10 or fewer settings. However, the 9,535 remaining PIN numbers had up to 57 separate billing numbers or practice settings for each UPIN:

- ► 8,219 providers had 11 to 20;
- ► 820 providers had 21 to 30;
- ► 414 providers had 31 to 40;
- ► 78 providers had 41 to 50; and
- ► 4 providers had 51 to 57 practice settings.

This small group of providers, in reflecting a high volume of practice locations, represent an enhanced risk for improper billing or utilization by the provider, employees, a third party, or even carrier personnel.

Some UPIN Data is Inconsistent

Several UPIN data fields for a provider's individual practice settings contain data that apply to all of their practice locations. Examples include: State license number; Professional School Code; Primary and Secondary Speciality Codes; and Primary and Secondary Speciality Board Certification Codes. We found carriers are updating only some of the provider-specific practice information on the UPIN record, resulting in inconsistencies for different practice locations. Maintaining such information on each provider's practice setting greatly increases the opportunity for errors, omissions, and discrepancies.

RECOMMENDATIONS

Accurate enrollment and practice information for Medicare providers is vital to ensure that only qualified health care professionals furnish treatment to Medicare beneficiaries. The HCFA has stated its intent to use the data contained in the UPIN Registry as source information for the NPI data base. Therefore, it is important that the UPIN and PIN data be both accurate and specific. While HCFA has initiated important improvements in the enrollment and updating of health care providers which should greatly improve the accuracy and reliability of the data records, a number of problems continue to exist. Accordingly, we recommend that HCFA implement the following actions to improve the overall accuracy and reliability of this data.

Deactivate UPINs and PINs for Inactive Providers and Practice Locations

The HCFA should ensure that carriers deactivate PINs and UPINs in accordance with its instructions when no claims have been submitted to them for the preceding 12 months. This should be an active review element of the periodic Carrier Performance Evaluation (CPE) review. To reduce program vulnerabilities and minimize administrative costs, HCFA could consider implementing a shorter time frame (i.e., 2 consecutive quarters).

Improve Data Entry Instructions for Specific Data Fields

We recommend the Medicare Carriers Manual Part 4, § 1015, Exhibit 2, be revised to specify that the State license number be entered exactly as shown on State records or licenses. The instructions should specify that the number be left justified, and that characters, numbers, and spaces are acceptable.

In addition, HCFA should revise instructions for coding provider specialities and certifications, to provide for the possibilities of "none" under provider speciality and "not applicable" under board certification. This should significantly reduce coding errors by carrier personnel for health providers who are not board certified or for professions that are not independently certified.

Establish a Priority to Review Individuals with Numerous PINs

As part of its re-validation of providers, HCFA should require carriers to establish a priority for the review of individuals with numerous (i.e., more than 10) PIN numbers. Such reviews should address the utilization of these numbers and their legitimacy.

Reconcile Identical Fields in UPIN and PIN Records Before Implementing NPI

The HCFA should ensure that its contractors update applicable changes to all related UPIN and PIN records. In planning for the National Provider Identifier and National Provider System, HCFA could avoid inconsistent data between these records by using a single file for practitioner-specific data, or linking identical fields in different records to flag conflicting entries.

AGENCY COMMENTS

The HCFA concurs with the report and has undertaken or is planning meaningful steps to implement the recommendations. Appendix D contains the complete text of these comments.

ENDNOTES

1. Public Law (P.L. 99-272), signed into law April 7, 1986.

2. "Medicare Carriers Manual, Professional Relations," (Pub. 14-4) § 1030.5D. As part of the enrollment process, carriers must:
   - ▸ establish that the facility, entity, or individual is properly licensed, certified, and registered under State law;
   - ▸ establish evidence of qualifying course work from educational institution(s) from which the applicant received his medical, professional, or related training including Diplomas or degrees;
   - ▸ authenticate each board certification listed by the applicant;
   - ▸ establish that the facility, entity, or individual is not excluded from the Medicare and Medicaid programs;
   - ▸ verify that the applicant is not on the General Services Administration's "List of Parties Excluded from Federal Procurement and Non-procurement Programs (List of Parties)"; and,
   - ▸ determine whether the individual or entity has or previously had a Medicare Provider Identification Number (PIN).

3. Health Economics Research Inc., "Unique Physician Identification Number (UPIN) Validation Studies: Carrier Analysis," August 23, 1994, p 21.

4. Previous Office of Inspector General Reports include
   "Carrier Maintenance of Medicare Provider Numbers," OEI-06-89-00870, June 1991.
   "Carrier Assignment of Medicare Provider Numbers," OEI-06-89-00871, April 1992.
   "Carriers Still Need to Purge Unused Provider Numbers," OEI-01-94-00231,
      December 1995.

5. Health Economics Research, Inc. issued the following "Unique Physician Identification Number (UPIN) Validation Studies"
   "Carrier Edits," May 27, 1994.
   "Carrier Analysis," August 23, 1994.
   "Documentation for the UPIN Integrity and Multiple-UPIN Files," October 5, 1994.
   "Final Report," February 7, 1995.
   "Understanding Properties of the UPIN for Claims-Based Research," February 11, 1997.

6. "Medicare Carriers Manual, Professional Relations," (Pub. 14 - 4) §1015, Exhibit 2.

7. Ibid, Exhibits 3A - 3D. Specific school code listing for M.D.'s, D.O.'s, D.P.M.'s, D.C.'s and O.D.'s. The following categorical codes are used for other health professionals:
   10000 - D.D.M.'s;
   20000 - D.D.S.'s
   60000 - Nurses;
   70000 - other U.S. educated health professionals; and
   99999 - professionals educated abroad.

Estimates and Confidence Intervals

The following table summarizes the estimates at the 95 percent confidence intervals for key data presented in this report. The estimates refer to projected error rates for specified variables in the Universe of the UPIN Registry.

Data Variable	Weighted Error Percentage	95% Confidence Interval
No Claims Filed in the Last 12 Months (UPIN)	23%	+/- 6.5%
No Claims Filed in the Last 36 Months (UPIN)	17%	+/- 5.7%
No Claims Filed in the Last 12 Months (PIN)	39%	+/- 6.7%
No Claims Filed in the Last 36 Months (PIN)	27%	+/- 5.9%
State License Number (UPIN - overall)	88%	+/- 5.2%
State License Number (UPIN - format problem)[1]	72%	+/-7.1%
State License Number (UPIN - leading zero problem)[1]	28%	+/- 7.1%
Professional School Codes (UPIN)	8%	+-/ 4%
Professional School Codes (PIN)	5%	+/- 2.8%
Primary Board Speciality Code (UPIN)	17%	+/-6.1%
Primary Board Certification Code (UPIN)	72%	+/-6.9%
Secondary Board Speciality Code (UPIN)	24%	+/-6.8%
Secondary Board Certification Code (UPIN)	96%	+/-3.2%

[1] These are the proportionate percentages that contribute to the overall estimated 88 percent error rate for the State License number.

Medicare Physician Identification
and Eligibility Record
Analysis of the Universe
UPIN Header Record Data

Medicare Physician Identification and Eligibility Record Data Elements Analysis of the Universe - UPIN Header Record Data		
Field Identifier / Analytical Criteria	**Total[1]**	**Percent of Universe**
Date of Birth		
Feasible Entry - Year code is 1918 to 1973, month and day are valid.[2]	677,996	98.6%
Questionable Entry - Year code is 1901 to 1917, or 1899, month and day are valid.[2]	7,616	1.1%
Erroneous Entry - Any code other than listed above.	1,171	0.2%
Missing Entry - Year code is all 9's, 0's or blanks.	982	0.1%
Date of Death		
Alive - Date code is 0's or blanks.	686,823	99.9%
Feasible Entry - Year code is 1997 or 1998, month and day are valid.	476	0.1%
Questionable Entry - Year code is 1901 to 1996, month and day are valid.	465	0.1%
Erroneous Entry - Any code other than listed above.	1	*
School Code		
Specific School Code Entry - Contains one of the school codes listed in the Medicare Carriers Manual.[3]	501,177	72.9%
Foreign School Categorical Code - Entry is equal to code 99999.	121,294	17.6%
Chiropractic School Categorical Code - Entry is equal to code 50000.	33,066	4.8%
DDS Categorical School Code - Entry is equal to code 20000.	20,134	2.9%
DDM Categorical School Code - Entry is equal to code 10000.	4,295	0.6%
Erroneous Entry - Any code other than listed above.	3,812	0.6%
Missing Entry - Code is all blanks, all 0's or 00001.	2,964	0.4%
Retired School Code	947	0.1%
Other Health Professions Categorical Code - Entry is equal to code 70000.	68	*
Nursing School Categorical Code - Entry is equal to code 60000.	8	*

Medicare Physician Identification and Eligibility Record Data Elements Analysis of the Universe - UPIN Header Record Data		
Field Identifier / Analytical Criteria	**Total[1]**	**Percent of Universe**
Graduation Year		
Feasible Entry - Year code is 1945 to 1998.[4]	670,994	97.6%
Questionable Entry - Year code is 1935 to 1944.[4]	8,166	1.2%
Erroneous Entry - Any code other than listed above.	5,858	0.9%
Missing Entry - Year code is all 9's, 0's or blanks.	2,747	0.4%
Sanction Code		
Not Sanctioned - Code is all blanks.	686,247	99.8%
Feasible Entry - Code is A to R.[5]	1,459	0.2%
Unknown - Individual is sanctioned but type of sanction action is code "U" for unknown.	57	*
Erroneous Entry - Any code other than listed above.	2	*
Sanction Date		
Not Sanctioned - Year code is all blanks or 0's.	685,573	99.7%
Feasible Entry - Year code is 1966 to 1998, and month is valid.	2,059	0.3%
Erroneous Entry - Any code other than listed above.	133	*
Sanction Length		
Not Sanctioned - Code is all blanks or 0's.	685,616	99.7%
Feasible Entry - Code for years of sanction is between 1 to 15, 20, 25, 30, 35, 40, 45, 50, 99.	2,101	0.3%
Questionable Entry - Code for years of sanction is 16 to 19, 21 to 24, 26 to 29, 31 to 34, 36 to 39, 41 to 44, 46 to 49, 51 to 98.	48	*
Social Security Number		
Feasible Entry	594,318	86.7%
Missing Entry	1	*
Zero Entry - Code is all 0's or 9's	93,446	13.3%

Medicare Physician Identification and Eligibility Record Data Elements Analysis of the Universe UPIN Practice Setting (PIN) Data

Medicare Physician Identification and Eligibility Data Elements Analysis of the Universe - UPIN Practice Setting (PIN) Data		
Field Identifier / Flag Description	**Universe Total**[1]	**Universe Percent**
Date of Birth		
Feasible Entry - Year code is 1918 to 1973, month and day are valid.[2]	1,806,547	98.9%
Questionable Entry - Year code is 1901 to 1917, or 1899, month and day are valid.[2]	12,198	0.7%
Missing Entry - Year code is all 9's, 0's or blanks.	4,891	0.3%
Erroneous Entry - Any code other than listed above.	2,443	0.1%
Date of Death		
Alive - Date code is 0's or blanks.	1,826,062	100.0%
Feasible Entry - Year code is 1997 or 1998, month and day are valid.	11	*
Questionable Entry - Year code is 1901 to 1996, month and day are valid.	6	*
School Code		
Specific School Code Entry - Contains one of the school codes listed in the Medicare Carriers Manual.[3]	1,366,674	74.8%
Foreign School Categorical Code - Entry is equal to code 99999.	367,231	20.1%
Chiropractic School Categorical Code - Entry is equal to code 50000.	46,045	2.5%
DDS Categorical School Code - Entry is equal to code 20000.	25,011	1.4%
Erroneous Entry - Any code other than listed above.	7,555	0.4%
Missing Entry - Code is all blanks, all 0's or 00001.	6,056	0.3%
DDM Categorical School Code - Entry is equal to code 10000.	5,321	0.3%
Retired School Code	2,088	0.1%
Other Health Professions Categorical Code - Entry is equal to code 70000.	88	*
Nursing School Categorical Code - Entry is equal to code 60000.	10	*

Medicare Physician Identification and Eligibility Data Elements Analysis of the Universe - UPIN Practice Setting (PIN) Data		
Field Identifier / Flag Description	**Universe Total[1]**	**Universe Percent**
Graduation Year		
Feasible Entry - Year code is 1945 to 1998.[4]	1,798,111	98.5%
Questionable Entry - Year code is 1935 to 1944.[4]	13,352	0.7%
Missing Entry - Year code is all 9's, 0's or blanks.	8,261	0.5%
Erroneous Entry -Any code other than listed above.	6,355	0.3%
Physician Status Code (Type of Provider Listed in Carriers Manual)		
Feasible Entry - Code is 1, 2, or 3.[5]	1,825,975	100.0%
Erroneous Entry - Any code other than listed above.	104	*
Credential Code		
Feasible Entry - Code is MD, DO, CH DPM, DDS, DDM, OD, CSW, PT, CP, AA, NP, OT, CNA, PSY, PA, CNM., CNS, AU.[6]	1,825,976	100.0%
Erroneous Entry - Any code other than listed above.	103	*
State License Number		
Lead Zeros - Code for the first 3 digits of the license number are 0's.	837,736	45.9%
Number Justification - Entry is **not** right justified.	764,008	41.8%
Feasible Entry - It contains an alpha numeric entry not otherwise listed.	208,606	11.4%
Missing Entry - Code is all blanks.	12,510	0.7%
Zero Entry - Code is all 0's.	3,219	0.2%
License State Code		
Feasible Entry - Code is a standard postal state abbreviation (including U.S. properties).	1,826,073	100.0%
Erroneous Entry - Any code other than listed above.	6	*

Field Identifier / Flag Description	Universe Total[1]	Universe Percent
Medicare Physician Identification and Eligibility Data Elements		
Analysis of the Universe - UPIN Practice Setting (PIN) Data		
Primary Speciality Code		
Feasible Entry - Contains one of the valid speciality codes listed in the HCFA "Data Users Reference Guide".[7]	1,824,864	99.9%
Unknown Entry -Code is 99.	618	*
Retired Entry - Code is retired - osteopathic speciality code.	321	*
Revised Entry - Code is 49 (formerly for a miscellaneous speciality, redesignated as an Ambulatory Surgical Center).	260	*
Erroneous Entry - Any code other than listed above.	16	*
Primary Speciality Board Certification Code		
Feasible Entry - Code is "Y"or "N".	1,132,899	62.0%
Unknown Entry - Code is "U".	693,180	38.0%
Secondary Speciality Code		
Missing Entry - Code is all blanks.	1,712,541	93.8%
Feasible Entry -Contains one of the valid speciality codes listed in the HCFA "Data Users Reference Guide".[7]	113,394	6.2%
Unknown Entry - Code is 99.	88	*
Retired Entry -Code is retired - osteopathic speciality code.	49	*
Erroneous Entry - Any code other than listed above.	6	*
Revised Entry -Code is 49 (formerly for a miscellaneous speciality, redesignated as an Ambulatory Surgical Center).	1	*
Secondary Speciality Board Certification Code		
Unknown Entry - Code is "U".	1,271,103	69.6%
Missing Entry - Code is all blanks.	450,819	24.7%
Feasible Entry - Code is "Y"or "N".	104,157	5.7%
UPIN Status Code - Deactivated, Resident, Intern, Practice (DRIP)		
Feasible Entry - Code is R, I, or P (Active Practice).	1,826,039	100.0%
Erroneous Entry - Any code other than listed above.	40	*

Medicare Physician Identification and Eligibility Data Elements Analysis of the Universe - UPIN Practice Setting (PIN) Data		
Field Identifier / Flag Description	**Universe Total**[1]	**Universe Percent**
Participation Status Code		
Feasible Entry - Code is "Y" or "N".	1,826,076	100.0%
Missing Entry - Code is all blanks.	2	*
Erroneous Entry - Any code other than listed above.	1	*
Group Practice Indicator		
Feasible Entry - Code is 1 (group) or 4 (solo) practice.	1,824,555	99.9%
Erroneous Entry - Any code other than listed above.	1,521	0.1%
Missing Entry - Code is all 0's or blanks.	3	*
Sanction Code		
Not Sanctioned - Code is all blanks.	1,824,038	99.9%
Feasible Entry - Code is A to R.[8]	1,948	0.1%
Unknown - Code is U, individual is sanctioned but type of sanction action is unknown.	93	*
Sanction Date		
Not Sanctioned - Date code is all blanks.	1,824,430	99.9%
Feasible Entry - Year code is between 1966 to 1998, and month is valid.	1,531	0.1%
Erroneous Entry - Any code other than listed above.	118	*
Sanction Length		
Not Sanctioned - Code is blank or 0.	1,824,442	99.9%
Feasible Entry - Code for years of sanction is between 1 to 15, 20, 25, 30, 35, 40, 45, 50, 99.	1,608	0.1%
Questionable Entry - Code for years of sanction is between 16 to 19, 21 to 24, 26 to 29, 31 to 34, 36 to 39, 41 to 44, 46 to 49, 51 to 98.	29	*
Social Security Number		
Feasible Entry	1,319,135	72.2%
Missing Entry	1	*
Zero Entry - Code is all 0's or 9's	506,943	27.8%

Agency Comments

SEP 15 ...

DATE:

TO: June Gibbs Brown
            Inspector General

FROM: Michael M. Hash
            Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Accuracy of Unique
            Physician Identification Number Data," (OEI-07-98-00410)

Thank you for the opportunity to comment on the issues raised in the above-referenced
report. The purpose of the inspection was to determine whether the information
associated with Unique Physician Identification Numbers (UPIN) is complete and
accurate.

We agree with the report recommendations. Our detailed comments follow:

OIG Recommendation
HCFA should deactivate UPINs and PINs for Inactive Providers and Practice Locations.

HCFA Response
We concur. Carriers should periodically deactivate their provider/supplier records of
inactive providers and practice locations. Prior to October 1998, we required deactivation
of numbers after 3 years of no claims activity. In November 1998, we changed our policy
to require deactivation of PINs and UPINs after 1 year of no claims activity. The Health
Care Financing Administration (HCFA) is currently considering reducing this even more
to possibly 6 months.

We agree that the Carrier Performance Evaluation (CPE) review process should include
an evaluation of the carriers' performance in this area. We will consider this as we
develop a provider enrollment protocol for fiscal year 2000.

OIG Recommendation
HCFA should improve data entry instructions for specific data fields.

HCFA Response
We concur. In January 1998, HCFA released a program memorandum (B-98-3) which instructed contractors to correct the state license number format, school code, and other fields in order to improve the consistency and accuracy of the UPIN file in preparation for the National Provider Identifier (NPI) initiative. HCFA expects to release additional instructions in March 2000 to improve data quality of the UPIN Registry.

OIG Recommendation
HCFA should establish a priority to review individuals with numerous (more than 10) PINs.

HCFA Response
We concur. It should be noted that many providers have multiple PINs for the same location. These should be reviewed since removal of these PINs would reduce the incidence of multiple PINs substantially. Otherwise, a larger number of PINs (20) should be used to trigger a review.

HCFA is implementing several initiatives which identify individuals with numerous PINs. Those initiatives include the Reassignment, Threshold Project, Physician Enrollment Chain and Ownership System (PECOS), and validating addresses on the UPIN files. Each of these initiatives identifies providers with numerous PINs.

In September 1998, the "Threshold Project" required contractors to check all reassignments that exceed the five reassignments to confirm that they are still current and legitimate. Carriers reviewed reassignment agreements for physicians who have five or more reassignments; reconcile UPIN file with in-house provider files; contact physicians to verify active payment arrangements; reconcile files based on providers' declaration; if fraud is suspected, contact Fraud and Abuse Unit; update UPIN registry file; begin reporting requirements, and start provider education.

Provider Enrollment Chain and Ownership Systems (PECOS) will allow contractors to see all Medicare activity of a particular individual, e.g., owns five clinical labs, three ambulance companies, 15 independent diagnostic testing facilities and 2 durable medical equipment suppliers. Currently, if an individual enrolls in multiple carrier or fiscal intermediary jurisdictions, the above linkages might never be established because the information about this individual would be held in local systems only. Under PECOS, all information on such an individual will be national in scope. PECOS will help on both

pre- and post-enrollment processes by enabling the contractor to see if an individual or entity has been enrolled, or has attempted to enroll, with any other contractor. PECOS will maintain all denials, as well revocations and exclusions. Through PECOS, a medical review or fraud and abuse unit can determine if an individual is engaging in similar types of suspect activity in multiple contractor jurisdictions. Therefore, PECOS will help contractors make more informed enrollment status decisions and whether to assign or deactivate a provider number.

Earlier this year, as part of the Administrator's efforts to notify providers and suppliers of their Y2K responsibilities, contractors and the UPIN Registry have been in the process of researching, updating, correcting, and deactivating addresses (PINs) on the UPIN Registry. The results have greatly reduced the number of providers' PINs.

OIG Recommendation
HCFA should reconcile identical fields in UPIN and PIN records before implementing NPI (National Provider Identifier).

HCFA Response
We concur. The purpose of the National Provider System (NPS) is to develop a system to standardize and simplify the provider enumeration process. Ultimately, the goal is to give providers one uniform number to use for all government health care programs.

NPS will have its own standard record layout and minimum data requirement. The minimum data requirements will be consistent with information currently found in UPIN, National Supplier Clearinghouse, and On-line Survey Certification and Reporting data bases. Any information or data which is inconsistent, dubious, or conflicting will be flagged and not added to the database. NPS will contain the basic data required to identify the provider uniquely, and will be a national standard under the Health Insurance Portability and Accountability Act.

The information will be consistent with what appears on the HCFA Form 855, Medicare Provider/Supplier Enrollment Application.