

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE PAYMENTS TO
OIG EXCLUDED PHYSICIANS**



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Inspector General

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OFFICE OF INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

To determine the extent to which OIG excluded physicians in a fee-for-service setting might be providing and billing for services rendered to Medicare beneficiaries.

BACKGROUND

Congress and the Secretary have entrusted the Office of Inspector General (OIG) with a variety of authorities under which practitioners who are unqualified, or abusive or who commit fraud may be excluded from Medicare and other Federal health care programs' participation. The intended effect of these exclusions is that no payment may be made for services that the excluded provider has rendered, ordered, or prescribed to a Medicare or Medicaid beneficiary or a receiver of services under any other Federal health care program. Needless to say, it is unlawful for any provider to submit or cause to be submitted claims to the Medicare program once they have been notified of the exclusion action.

We obtained cumulative exclusion data through 1997 from the OIG Office of Investigations (OI) of all physicians for which we could identify a Unique Physician Identification Number (UPIN). This inspection focused on physicians in the fee-for-service setting. Our population did not include a number of excluded suppliers, nurses and other healthcare providers and therefore is limited in scope. We matched this data against Health Care Financing Administration (HCFA) payment data for 1997. Related to this match, we contacted each Medicare carrier for information on the reasons and the basis for any payments made to excluded physicians. Based upon these contacts we calculated a Medicare overpayment amount.

FINDINGS

Few Payments Were Made To Excluded Physicians In Fee-For-Service Medicare

Most payments made to excluded physicians were proper. We found that most Medicare payments made to excluded physicians in the fee-for-service setting were proper. These payments were due to unassigned first claim services or services rendered as a result of an OIG waiver for medically underserved areas.

Some payments were questionable. We found 12 physicians in which claims were processed where the Unique Physician Identification Number (UPIN) belonged to an excluded physician but the Provider Identification Number (PIN), upon which payment was made, belonged to a non-excluded physician. Payments for these claims totaled \$90,654.

A small number of improper payments were made to excluded physicians. Based upon our UPIN match we found that improper payments have been made to 21 physicians, totaling \$ 35,833.

Improper Payments Were Made Mostly As The Result Of Human Error

Of the 27 carriers in existence in 1997, 13 made improper payments to OIG excluded physicians. Nine carriers made these payments due to employee processing errors of which two made improper payments, but later recovered them. Other payments were made when excluded physicians submitted new applications for new provider numbers, and only one improper payment was due to a system error.

Carrier Staff Raised Some Concerns Regarding The Timeliness, Completeness, And Reliability Of Exclusion Data

The information provided to carrier personnel implementing the exclusion was not always complete and updates were not always received by them on a monthly basis. Social Security numbers, birth dates, and UPINs were sometimes missing, making proper identification of the particular excluded physician difficult for the carrier. In one instance, this resulted in an improper payment.

CONCLUSION

Our match of exclusion data to HCFA payments did not include all OIG excluded providers, only physicians in the fee-for-service setting where all appropriate data is available. For this particular group the exclusion system seems to work well. Even there, however, it is not perfect. The problems, while not serious, need to be solved. HCFA is responsible for sending notice of exclusions to the carriers. It states that as of January 1999, it has implemented protocols for sending out exclusion data on a monthly basis in electronic format. Medicare carriers now need to ensure that their staff who are responsible for processing the exclusions receive this information timely and take appropriate action on it. Meanwhile, it is important that the OIG, HCFA, and Medicare contractors work in concert to make further improvements to the system to prevent payments to excluded physicians.

It is also worth noting that the limitations and difficulties we found in our efforts to match exclusion data with health care providers working in the medical field who do not have UPINs, or who may provide services in a managed care setting, is a cause of concern.

AGENCY COMMENTS

We solicited and received comments on our draft report from HCFA, which agreed with our findings and recommendations. HCFA also expressed a willingness to work with the OIG to further strengthen the processes of notifying Medicare contractors of excluded individuals and effecting their exclusion from Federal programs. The full text of HCFA's comments are included in Appendix B.

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INTRODUCTION

PURPOSE

To determine the extent to which OIG excluded physicians in a fee-for-service setting might be providing and billing for services rendered to Medicare beneficiaries.

BACKGROUND

Congress and the Secretary have entrusted the Office of Inspector General (OIG) with a variety of authorities under which practitioners who are unqualified, or abusive or who commit fraud may be excluded from Medicare and other Federal health care programs' participation. Examples of circumstances on which an exclusion would be predicated include conviction of a crime related to health care fraud, license revocation by a State licensure board, and finding of substandard care by a Medicare Peer Review Organization. In recent years, the OIG has implemented some 2,000 - 3,000 exclusions of varying durations. The intended effect of these exclusions is that no payment may be made for services that the excluded provider has rendered, ordered, or prescribed to a Medicare or Medicaid beneficiary or a receiver of services under any other Federal health care program. Needless to say, it is unlawful for any provider to submit or cause to be submitted claims to the Medicare program once they have been notified of the exclusion action.

Direct notification of exclusions is made to the subject, Medicaid State agencies, and State licensing boards (where appropriate). The Health Care Financing Administration (HCFA) is provided a listing of all exclusions and reinstatements. Also, interested parties are able to identify excluded providers by virtue of their broad access to OIG exclusion data which includes Internet access, queries to the National Practitioner Data Bank, Federal Register publications, and the General Services Administration-sponsored Federal debarment listing. If this information is not being used to timely identify providers that have been excluded, it can be potentially harmful to Federal programs and their beneficiaries, and could result in a diminishing of the program sanction's deterrent and remedial effects.

The HCFA contracts with insurance companies, called carriers, to process and pay claims for covered Part B services. They also perform other administrative tasks, such as reviewing claims and ensuring that any mistaken payments are identified and returned to the Medicare program. It is also the responsibility of the carriers to identify and implement exclusions imposed by the OIG and transmitted to the carrier by HCFA.

According to HCFA's instructions to Medicare carriers, a listing containing exclusion and reinstatement/withdrawal actions is distributed to the carriers on a monthly basis. The carriers are instructed to use the information contained in this listing to determine whether a provider is eligible for payment and to "ensure that sanctioned providers are not being inappropriately paid." Carriers are responsible for ensuring that no payments are made for items or services furnished, ordered, or prescribed by excluded providers after the effective date of the sanction.

As one aspect of detecting excluded physicians, Medicare issues a national Unique Physician Identification Number (UPIN) used for specific identification of each participating physician. In addition, Medicare contractors make payments for services based upon Provider Identification Numbers (PINs) issued for each practice setting. HCFA guidelines require that carriers deny payment to excluded providers and that PINs for excluded providers be taken out of an active status. Contractors edit for denial of payment through a process of "flagging" which then requires all claims for that PIN to be manually adjudicated.

Proper recording of identifying information regarding excluded persons is necessary to ensure that claims are not improperly paid. It also ensures that excluded providers do not become newly enrolled by other carriers or re-enrolled with the same carrier.

The carriers' exclusion processes have similar basic features. When a provider enrolls s/he submits an application. The carrier searches for the provider in HCFA's Publication 69, which includes excluded providers, and in other sources of exclusion information that it collects and stores. If the provider is found to be excluded the application is denied. Carriers attempt to verify previous provider numbers with the UPIN registry to determine whether providers have practiced in another State. When found, the carrier also verifies the provider's good standing in that State.

When a monthly exclusion update is received, a search for the provider is made on the carrier's system of active providers. The carrier then "flags" the system so that claims will not be automatically paid. This forces claims submitted by that provider, or by beneficiaries submitting unassigned claims for that provider, to be manually adjudicated. If the claim is unassigned and it is a first time service for that beneficiary, the claim is paid and a letter is sent to both the beneficiary and the provider notifying them of the provider's excluded status. The same is true for some emergency services furnished by excluded providers. Claims for such services or services provided in geographic areas for which the exclusion has been waived are paid with no notification.

METHODOLOGY

The original scope of this inspection included all OIG excluded persons but ultimately included only physicians who had an identifiable UPIN or Social Security number. Our

ability to determine whether each provider received payment was severely limited due to a number of factors. Managed care organizations do not submit claims for services rendered to Medicare beneficiaries. Instead they are paid an amount based on the number of beneficiaries in their program. Therefore, we were unable to determine if any OIG excluded provider rendered services to a beneficiary in a managed care setting. Also, nurses and nurses aides, which make up the majority of the excluded providers in 1997, cannot submit their own claims. We were therefore unable to determine whether any of these types of providers may have received payment for services to Medicare beneficiaries. We did attempt to identify excluded providers who received payment from an organization with a Medicare contract by requesting income information from the Social Security Administration. Our request was denied and we were therefore unable to make such a determination.

We obtained cumulative exclusion data through 1997 from the OIG Office of Investigations (OI). From this data we chose those providers excluded for all of 1997. That is, to be included in the study, a physician must have been excluded from Medicare prior to January 1, 1997 and had not applied for reinstatement through December 31, 1997. This resulted in a data file of more than 5,000 providers, the majority being individuals not required to have UPINs (i.e., nurses, nurses aides). In some instances we were unable to determine whether a provider was a physician and therefore required to have a UPIN. Also, the data records for some providers in the file were missing UPINs and, as an alternative, we used their Social Security numbers, if available, to obtain that number. The final list included 1,594 excluded physicians with UPINs or for which a Social Security number and UPIN could be identified.

We matched this list against the 1997 Physician Summary File which shows total dollars paid by Medicare for each active or inactive UPIN during the year. For each matched physician, we obtained information on each line item from the National Claims History File. Based upon the match, we contacted each Medicare carrier that made any payment to an excluded physician. Contacts included those departments whose responsibility it was to enroll physicians as well as those whose responsibility it was to deny payment. We determined the basis for the payment and the carrier's awareness of the physician's excluded status, and discussed the processes used by that carrier to prevent payment from being made. Based upon these contacts we calculated an overpayment amount.

We also conducted interviews with the appropriate staff at 27 carriers to determine the general usefulness and timeliness of exclusion data. We questioned the carriers on their source of exclusion data, as well as the timeliness, completeness, and usefulness of the exclusion data.

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

FINDINGS

Few payments were made to excluded physicians in fee-for-service Medicare

We identified a relatively small number of excluded physicians where payment had been made. These fall into the three categories of proper payments, questionable payments, and payments which were improperly made to the excluded physician. Overall we found that 59 physicians received payments for providing services to Medicare beneficiaries.

Most payments made to excluded physicians were proper

While excluded, 28 physicians were correctly paid because services were rendered for emergency services (those services provided in a location other than a hospital setting), unassigned first claim services, or services rendered as a result of a waiver being granted for medically underserved areas. Appendix A provides a detailed breakdown of these excluded physicians and the basis for payment.

Some payments were questionable

Payments for claims containing an excluded physician's UPIN were made to 3 group practices in the amount of \$4,529. These claims were paid based on the Provider Identification Number of a non-excluded physician; however, the claims also contained the UPIN of an excluded physician. In 9 cases carriers paid claims amounting to \$86,115 to non-excluded physicians who were not in group practices. In our review of these cases, we identified 8 excluded physicians whose UPIN was included on the claim forms. The ninth case involved one of these physicians who was paid by two different carriers. These carriers' systems edits were not designed to detect the UPIN, but only the Provider Identification Number. The fact that these UPINs did not trigger a review by the carriers indicates a vulnerability in the review process. We were unable to determine why the UPIN of these excluded physicians were on the claims.

A small number of improper payments were made to excluded physicians

Out of 1,594 OIG excluded physicians who have UPINs in a fee-for-service setting, we found improper payments to 21 physicians, totaling \$35,833. These payments were either paid in error or to a physician who submitted a new application and was improperly assigned a new Provider Identification Number. Also, in one instance, the physician was excluded and then died. When this occurred, the death date overrode the exclusion date in the carrier's claim payment system thereby allowing the physician's office or estate to be paid.

Improper payments were made mostly as the result of human error

Of the 27 carriers in existence in 1997, 13 made improper payments to OIG excluded physicians. Nine carriers made these payments due to employee processing errors. Two of these carriers later recovered them. Other payments were made when excluded physicians submitted new applications for new Provider Identification Numbers, and one improper payment was due to a system error. The death date overrode the exclusion date in the carrier's claim payment system thereby allowing the physician to be paid.

Carrier staff raise some concerns regarding exclusion data

Although relatively few payments were made to physicians who had been excluded, staff within the carrier who are responsible for the processing of these actions identified some problems associated with exclusion data that make it difficult to identify and deny payment to excluded providers.

Timeliness

According to HCFA's instructions to carriers, a formal listing (Publication 69) containing exclusion and reinstatement/withdrawal actions taken is distributed to the carrier on a monthly basis. The carrier is instructed to use the information contained in this listing to determine whether a provider is eligible for payment and to "ensure that sanctioned providers are not being inappropriately paid." Carriers are responsible for ensuring that no payments are made to excluded physicians for services after the effective date of the sanction.

Staff from eight other carriers indicated that although they received updates monthly, there was a lag time between the exclusion date and their notification of that exclusion. Also, staff from four of these carriers noted that timeliness of the monthly updates had improved in the months prior to our inquiry. Staff implementing exclusions from one carrier stated that they did not receive information on a monthly basis.

Completeness And Reliability

It is important that carrier staff have full information to identify the excluded person. They report that the monthly information provided is not always useful to them. Social Security numbers, birth dates, and UPINs may be missing, making proper identification difficult. In one instance, a provider married, changed her name, and re-enrolled under her new name. Because her Social Security number was not included in the exclusion data and her background was not checked, she was improperly paid for services provided

to Medicare beneficiaries. It is noted that carriers were not able to require Social Security numbers on enrollment forms prior to September 1999.

We were told by such carrier staff that they do not rely exclusively on HCFA's Publication 69 monthly update listing. They obtain exclusion information from other sources as well: the OIG's web site of excluded providers; General Services Administration's web site covering all debarred individuals; letters from the OIG (discontinued after January 1, 1998); and letters from State licensure boards. Although these sources are useful, they are not necessarily identical.

CONCLUSION

Our match of exclusion data to HCFA payments did not include all OIG excluded providers, only physicians in the fee-for-service setting where all appropriate data is available. For this particular group the exclusion system seems to work well. Even there, however, it is not perfect. The problems, while not serious, need to be solved. HCFA is responsible for sending notice of exclusions to the carriers. It states that as of January 1999, it has have implemented protocols for sending out exclusion data on a monthly basis in electronic format. Medicare carriers now need to ensure that their staff who are responsible for processing the exclusions receive this information timely and take appropriate action on it. Meanwhile, it is important that the OIG, HCFA, and Medicare contractors work in concert to make further improvements to the system to prevent payments to excluded physicians.

It is also worth noting that the limitations and difficulties we found in our efforts to match exclusion data with health care providers working in the medical field who do not have UPINs, or who may provide services in a managed care setting, is a cause of concern.

AGENCY COMMENTS

We solicited and received comments on our draft report from HCFA, which agreed with our findings and recommendations. HCFA also expressed a willingness to work with the OIG to further strengthen the processes of notifying Medicare contractors of excluded individuals and effecting their exclusion from Federal programs. The full text of HCFA's comments are included in Appendix B.

APPENDIX A

Reasons For Payments

TYPE OF PAYMENT	NUMBER OF PHYSICIANS	AMOUNT OF PAYMENT
Improper Payments:		
Death Date Overrode Exclusion Date	1	\$27.50
Claims Paid In Error	14	\$17,775.28
Physician Submitted Application For And Was Assigned A New UPIN	4	\$16,679.24
Claims Paid And Later Recovered	2	\$1,351.47
Total Improper Payments	21	\$ 35,833.49
Questionable Payments:		
Excluded UPIN Included On Non-Excluded Physician's Claim For Payment	9	\$86,115.62
Payments To A Group Practice	3	\$4,529.37
Carrier Claims No Payment Made	1	\$9.05
Total Questionable Payments	13	\$90,654.04
Proper Payments:		
Unassigned First Claim/Emergency	16	\$12,418.58
Recycled UPIN - Payments Not Received By An Excluded Physician	5	\$3,751.01
Sanction Waived For Underserved Area	5	\$124,716.26
The UPIN Does Not Belong To The Excluded Physician, Therefore No Improper Payments Were Made	6	\$70,478.28
Total Proper Payments	32	\$ 211,364.13
TOTAL PAYMENTS	59*	\$337,851.66
*Five physicians received payment from more than one carrier and payments made to two physicians fall into two separate categories.		

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: JUL 17 2000

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle *Nancy-Ann DeParle*
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicare Payments to
OIG Excluded Physicians," (OEI-07-98-00380)

Thank you for the opportunity to review the above-mentioned OIG draft report, which examines the frequency of inappropriate Medicare payments to OIG excluded physicians by Medicare Carriers. The report's overall conclusion was that the system works well, meaning that few payments were made to excluded physicians in fee-for-service Medicare. This report found less than \$36,000 was paid inappropriately to excluded individuals in Fiscal Year 1997- a very small fraction of the more than \$42 billion that Medicare paid to physicians and suppliers in that year. Of those inappropriate payments identified, most were attributed to human error.

We are pleased to know that the overwhelming majority of physicians excluded from the program are not receiving Medicare payments. We agree that it is essential for the carriers that process Medicare claims to receive complete, accurate and timely data about providers excluded from Medicare participation. We rely on the OIG to provide this data in a complete and timely manner. We are willing to work with the OIG to find ways to improve the process for getting your data to carriers more quickly.

As you know, the OIG has the authority to exclude individuals from the Medicare program. The OIG sends HCFA monthly data files (Publication 69) about exclusions involving Medicare providers. HCFA usually receives these reports during the first few days of each month. Within 24 hours of receiving the reports, HCFA forwards the OIG's data files to carriers. HCFA does not change or alter the data it receives from the OIG. This has been our standard operating procedure for more than three years. We hope that the OIG will continue to work to improve the accuracy and completeness of their data, and continue to assure that this information is reliable and timely.

As the OIG only provides its data files on exclusions to HCFA in these monthly reports, it creates the possibility for brief delays in getting that information to the carriers. In turn, that creates the potential for improper payments, such as those identified in this report.

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Though the report suggests this is a small potential vulnerability, we would be open to any practical approaches that the OIG might suggest to further strengthen this process so carriers receive the OIG's data more quickly.

In addition to the development of systems like the Medicare Exclusion Database (MED) and the Provider Enrollment Chain and Ownership System (PECOS), HCFA will publish a proposed rule outlining the requirements which providers/suppliers must meet and maintain in order to bill the Medicare Program. This final regulation will allow HCFA greater authority to deny or revoke Medicare billing privileges, require periodic re-validation of enrollment data to ensure continued compliance with program rules and regulations for all providers/suppliers, and prevent questionable providers/suppliers from re-entering the Medicare Program using different identifiers. The final regulation is due to be published in the Federal Register in 2000.

These efforts are just a part of our broader strategy for protecting Medicare today and into the future. The current administration has put a greater emphasis on program integrity efforts than any previous administration. These continued efforts have resulted in Medicare's improper payment rate declining from 14 percent four years ago to less than 8 percent last year, and HCFA is committed to achieving further reductions in the future.