Memorandum

Date NOV 12 1996

From for June Gibbs Brown
Inspector General

Subject Medicare Payments to Excluded and Unlicensed Health Care Providers (A-14-96-00202)

To

Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached are two copies of our final report which provides you with the results of our review of Medicare payments to excluded and unlicensed health care providers. The objective of this review was to determine if excluded or unlicensed health care providers have been inappropriately reimbursed by the Medicare program. Our review was limited to individuals and entities with a Maryland address at the time of exclusion and individuals whose license was suspended or revoked by the Maryland Board of Physician Quality Assurance.

In order to test if systems were in place to prevent payment to excluded and unlicensed providers, we selected individuals and entities to include various types of health providers and suppliers and for whom sufficient identifying information was available. We found that the Medicare program continues to reimburse individuals who have either been excluded by the Office of Inspector General from participation in the program or continue to practice in Maryland even though their Maryland license was suspended or revoked. Specifically, from our selected individuals in Maryland, we found 22 percent of the excluded individuals (6 out of 27) and 15 percent (6 out of 40) of the unlicensed individuals billed and received Medicare reimbursements for services provided during the time of their exclusion or while unlicensed.

We also found that individuals who have had their Maryland license suspended or revoked have relocated to other States and can continue to treat Medicare beneficiaries in the States they relocated to; current data bases which contain exclusion and adverse licensure actions are incomplete and inaccessible; and a single consolidated source is needed which contains information on all adverse actions taken against health care providers.

Although nationally the percentage of aberrant health care providers (those excluded or with a suspended/revoked license) is small, they can endanger the lives of beneficiaries and should not be allowed to further abuse our health care system. We recommend that the Health Care Financing Administration (HCFA):

- Ensure that Medicare contractors have established adequate controls to preclude payments to excluded and unlicensed health care providers; expand our data match nationally to identify payments made to excluded providers; and recover the payments identified in our review and subsequent data matches from the excluded and unlicensed providers.

- Confirm that its contractors get licensing data from the appropriate State agencies and that Medicare payments are terminated to unlicensed individuals.

- Institute edits in its present and future payment systems to prevent payment to excluded and unlicensed providers.

- Take into consideration our findings as it continues development of the National Provider System and continue to support legislative proposals to create a comprehensive data base that would capture negative actions on all health care providers and would be accessible by all interested parties.

- Work with the Public Health Service to implement section 1921 of the Social Security Act which would require States to provide information to the Secretary regarding specified adverse licensing actions taken by the State entity responsible for the licensing of health care providers. It will be necessary to coordinate this with the implementation of the new adverse action data base created by Public Law 104-191.

In response to our draft report, HCFA concurred with all of the above recommendations. The HCFA's response has been included in its entirety as the attachment to this report.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104. Copies of this report are being sent to other interested Department officials.

To facilitate identification, please refer to Common Identification Number A-14-96-00202 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE PAYMENTS TO EXCLUDED AND UNLICENSED HEALTH CARE PROVIDERS

JUNE GIBBS BROWN
Inspector General

NOVEMBER 1996
A-14-96-00202

Memorandum

Date NOV 12 1996

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Inspector General

Subject Medicare Payments to Excluded and Unlicensed Health Care Providers
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Administrator
Health Care Financing Administration

This final report provides you with the results of our review of Medicare payments to excluded and unlicensed health care providers. The objective of our review was to determine if the Medicare program inappropriately reimbursed individuals or entities who were excluded from the program or whose license was suspended or revoked by a State licensing board. Our review was limited to individuals and entities with a Maryland address at the time of exclusion and individuals whose license was suspended or revoked by the Maryland Board of Physician Quality Assurance.

We found:

- the Medicare program has reimbursed 22 percent (6 out of 27) of the excluded individuals for whom we were able to locate a unique physician/practitioner identification number (UPIN) during their period of exclusion;

- the Medicare program has reimbursed 15 percent (6 out of 40) of the individuals who had known UPINs with practice locations in the State of Maryland for services provided while they were unlicensed in the State of Maryland;

- individuals who have had their Maryland license suspended or revoked have relocated to other States and can continue to treat Medicare beneficiaries in the States they relocated to;

- current data bases which contain exclusion and adverse licensure actions are incomplete and inaccessible; and

- a single consolidated source is needed which contains information on all adverse actions taken against health care providers.

Although nationally the percentage of aberrant health care providers (those excluded or with a suspended/revoked license) is small, they can endanger the lives of beneficiaries and should not be allowed to further abuse our health care system. We recommend that the Health Care Financing Administration (HCFA):

- Ensure that Medicare contractors have established adequate controls to preclude payments to excluded and unlicensed health care providers; expand our data match nationally to identify payments made to excluded providers; and recover the payments identified in our review and subsequent data matches from the excluded and unlicensed providers.

- Confirm that its contractors get licensing data from the appropriate State agencies and that Medicare payments are terminated to unlicensed individuals.

- Institute edits in its present and future payment systems to prevent payment to excluded and unlicensed providers.

- Take into consideration our findings as it continues development of the National Provider System (NPS) and continue to support legislative proposals to create a comprehensive data base that would capture negative actions on all health care providers and would be accessible by all interested parties.

- Work with the Public Health Service (PHS) to implement section 1921 of the Social Security Act which would require States to provide information to the Secretary regarding specified actions (such as revocation or suspension of a license) taken by the State entity responsible for the licensing of health care providers. The Secretary is authorized to provide this information to Federal agencies administering health care programs, State licensing authorities, State Medicaid agencies, State Medicaid Fraud Control Units, law enforcement agencies, and other specified entities. It will be necessary to coordinate this with the implementation of the new adverse action data base created by Public Law 104-191.

In response to our draft report, HCFA concurred with all of the above recommendations. The HCFA's response has been included in its entirety as the attachment to this report.

BACKGROUND

- ***Exclusions imposed by the Office of Inspector General***

The Department of Health and Human Services' Office of Inspector General (OIG) imposes exclusions on individuals and entities under sections 1128 and 1156 of the Social Security Act. These exclusion actions are taken by OIG's Office of Enforcement and Compliance (OEC) and Office of Litigation Coordination (OLC).[1] When an exclusion is imposed, Medicare payments are prohibited for any items or services (other than an emergency item or service not provided in a hospital emergency room) furnished, ordered, or prescribed by an excluded party. Payment is prohibited to any business or facility (e.g., hospital) that submits bills for payments of items or services provided by an excluded party. Exclusion actions taken by the OIG have governmentwide effect--that is, the excluded party is barred from participating in all Federal procurement as well as nonprocurement programs. Reinstatement is not automatic. The excluded party must apply for reinstatement and reinstatement must be authorized by the OIG.

When an exclusion is imposed, the OIG sends individual notification letters with the subject's identifying information (Social Security number (SSN), date of birth, UPIN, program provider number, license number, etc.) to all the State agencies, Medicare contractors, appropriate licensing boards, and any known employer in the State where the subject practices medicine. Copies of the exclusion notice are sent to the subject's attorney, the Office of Personnel Management, PHS, Department of Justice, U.S. Attorney, and any peer review organization that may be deemed appropriate.

On a monthly basis, reports of all exclusions being implemented are released to all payer agencies in the United States. Specific notice is provided to HCFA for its use in notifying all Medicare and Medicaid agencies of the exclusion action. The exclusion is also published in the Federal Register and in the Federal debarment listing. The Federal debarment listing is maintained by the General Services Administration and lists all individuals and entities who have been excluded from Federal procurement and nonprocurement programs. A cumulative report of all exclusions in effect is published twice a year and is available on the Internet. Cumulative reports are routinely sent by the OIG to recipients of the monthly reports and, on a request-specific basis, to other interested parties. The excluded parties are only removed from the cumulative list if and when they are reinstated--they are shown on the list regardless of whether eligible for reinstatement or not.

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[1]Formerly the Office of Civil Fraud and Administrative Adjudications

- ***State Licensure***

To participate in the Medicare program, a provider must hold a valid State license. Licensing health care professionals is a State responsibility and when a State licensing board revokes or suspends a provider's license, he or she can no longer legally provide services in that State. When a provider loses the legal authority to practice in a State, services rendered in that State are not covered by Medicare. The HCFA, through its carriers and intermediaries, is responsible for determining that providers are licensed before paying claims for services rendered. In addition, it is possible for providers who hold licenses in more than one State, to have one license suspended or revoked by a State licensing board, and then relocate and continue to treat Medicare patients in another State. The OIG has authority to exclude providers nationally from participation in the Medicare program based on the fact that their license was suspended or revoked by a State or surrendered while a formal disciplinary proceeding was pending for reasons relating to professional competence, professional performance, or financial integrity.

SCOPE

The objective of this review was to determine if excluded or unlicensed Maryland health care providers have been inappropriately reimbursed by the Medicare program. To accomplish this, we reviewed applicable laws and legislative history, regulations, various Medicare manuals, and prior reports relating to this subject issued by the Senate Governmental Affairs Subcommittee on Oversight, the General Accounting Office, and the OIG. We interviewed personnel in OEC, OLC and the OIG Office of Evaluation and Inspections, HCFA, PHS, three Medicare carriers, Maryland's Board of Physician Quality Assurance, and the Federation of State Medical Boards.

We obtained a June 1994 listing from OEC of individuals and entities excluded by OIG from the Medicare program. On that list of 6,486 excluded parties, there were 116 individuals and entities with Maryland addresses with known identifying information who were excluded prior to June 1993. We selected exclusion dates prior to June 1993 because at the time 1993 was the latest year for which complete data was available. In order to test if systems were in place to prevent payment to excluded providers, we selected 48 individuals and entities to include various types of health providers and suppliers such as physicians, pharmacists, dentists, podiatrists, nursing home and home health agency staffs, social workers, nurses and nurses aides, psychologists, and durable medical equipment corporation and laboratory owners. We included individuals and entities who were eligible for reinstatement to the Medicare program but have not applied for reinstatement,

and others who were not eligible to apply for reinstatement. During the course of our review we obtained updated exclusion listings from OEC to ensure the exclusion status of the selected individuals/entities did not change.

We also met with the Maryland Board of Physician Quality Assurance to discuss its criteria and procedures for negative licensure actions, such as license suspension, license revocation, or acceptance of a surrendered license in lieu of formal proceedings. We obtained a listing of all its negative license actions in effect as of November 1994. From that listing, we were able to locate sufficient identifying information on 47 individuals who had their Maryland license either revoked, suspended, or surrendered. During the course of our review we verified with the Board that the license status of our selected individuals/entities did not change.

We asked HCFA's National Registry (the Registry) contractor who is responsible for maintaining the UPIN file to ascertain the UPINs of our selected individuals/entities.

For each of the UPINs identified by the Registry, we requested that HCFA identify all bills submitted to Medicare associated with those UPINs for services provided during the period of exclusion or while license was revoked. The HCFA obtained this information for us through its National Claims History Nearline File. For all paid bills identified by HCFA, we contacted the applicable Medicare carriers and requested that they verify from their records if the bills were paid. We requested verification of payments made by Blue Cross/Blue Shield of Maryland (through Blue Shield of Texas who replaced Blue Cross/Blue Shield of Maryland as the Maryland carrier after the close of our audit period), Blue Shield of Pennsylvania, and MetraHealth for claims involving Railroad Board beneficiaries. The carriers verified the payments identified by HCFA were made except as noted in the appendices. Two of the carriers identified bills paid to three individuals which were not identified in the data provided by HCFA.

We also obtained queries from files maintained by the Social Security Administration (SSA) to verify and obtain identifying information, such as SSN and date of birth, on our selected individuals. We did this to provide sufficient identifying information to the UPIN contractor to ensure it was able to identify the UPIN for the right person. In addition, we requested and received a copy of the "Questionable Doctors in Maryland" report compiled in September 1993 by The Public Citizen group to obtain further identifying and licensing information on our selected individuals.

Our audit was conducted in accordance with generally accepted government auditing standards. Our work was done at HCFA headquarters in Baltimore, Maryland and completed in April 1996.

FINDINGS

We found that the Medicare program continues to reimburse individuals who have either been excluded by the OIG from participation in the program or continue to practice in Maryland even though their Maryland license was suspended or revoked. Specifically, from our selected individuals in Maryland, we found 22 percent (6 out of 27) of the excluded individuals and 15 percent (6 out of 40) of the unlicensed individuals billed and received Medicare reimbursements during the time of their exclusion or while unlicensed.

We also found that individuals who have had their Maryland license suspended or revoked have relocated to other States and can continue to treat Medicare beneficiaries in the States they relocated to; current data bases which contain exclusion and adverse licensure actions are incomplete and inaccessible; and a single consolidated source is needed which contains information on all adverse actions taken against health care providers. The following presents the details relating specifically to each finding.

- ***Payments to individuals excluded by OIG***

We selected 48 individuals and entities from OIG's exclusion list for our review. Included in our review were 14 individuals from the State of Maryland's list of negative licensure actions who were also excluded by OIG. The Registry was able to identify 27 UPINs for the 48 OIG-excluded individuals/entities.

- The Medicare program reimbursed 6 of the 27 (22 percent) OIG-excluded individuals for which the Registry was able to locate a UPIN.

- These six physicians billed Medicare for charges totaling $10,071 and were reimbursed by the three Medicare carriers a total of $2,931 for services provided during their exclusion period.

Although some of the improper Medicare payments to these providers are relatively small, the fact that *any* payment was made to these individuals indicates that better controls are needed to prevent improper payments. Without improved controls, unsuspecting beneficiaries are vulnerable to the dangers of unfit and unscrupulous health care providers. The details of the inappropriate reimbursements are shown in Appendix A. We referred this information to OEC.

- ***Payments to individuals whose Maryland license was revoked, suspended, or surrendered***

From the list of negative licensure actions prepared by the Maryland Board of Physician Quality Assurance we selected 47 individuals whose Maryland license was revoked, suspended, or surrendered. Included in our selection were 10 individuals who also were excluded by OIG. We are including these individuals in this section also because their OIG exclusion date differed from their licensure action data. The Registry was able to locate UPINs for 40 of the 47 selected individuals.

- The Medicare program reimbursed six physicians in our review (15 percent of the individuals for which the Registry was able to locate a UPIN) *with practice locations in the State of Maryland* while they were unlicensed in the State of Maryland. (Two of these physicians had also billed Medicare after they were excluded by the OIG and are included in the above section.)

- These six physicians billed Medicare showing Maryland practice locations for charges totaling $2,383 and have been reimbursed by the three Medicare carriers a total of $805 while unlicensed in the State of Maryland.

The fact that these physicians were reimbursed for services provided in a State in which they do not hold a valid license, indicates a strong need for improved controls. The Medicare beneficiaries were liable for the copayments for services rendered by unlicensed physicians. Furthermore, it is doubtful that the beneficiaries were aware that they were being treated by an unlicensed physician. The details of the inappropriate reimbursements are shown in Appendix A. We referred this information to OEC and the Maryland Board of Physician Quality Assurance.

- ***Payments to individuals who had their license revoked, suspended, or surrendered and relocated to another State***

If an individual's medical license is revoked, suspended, or surrendered by a State, that individual can relocate to another State where he/she holds a valid license. Unless subject to an OIG action to exclude these individuals from participating in the Medicare program nationwide, these individuals can continue to treat beneficiaries in the State where they relocate.

- Three individuals in our review who had their license revoked, suspended, or surrendered by the State of Maryland for reasons of professional performance have billed Medicare for services rendered in

other States. Two physicians have not been excluded by the OIG and the third was paid for services in another State after he surrendered his Maryland license for reasons of professional performance and before he was excluded by OIG.

- Records supplied by HCFA show these three physicians have been reimbursed over $178,500 by Medicare with practice locations other than Maryland.

- Zip code information on HCFA's records for one of these three physicians indicated a practice location in Washington, D.C. However, HCFA's Medicare Enrollment Database shows that 78 percent of the beneficiaries who received services resided in Maryland. Claims this physician submitted on behalf of Railroad beneficiaries showed a Maryland practice location.

Although it is technically not improper for physicians who had their license revoked or suspended in one State to move to another State and set up practice, it points to a need for increased coordination and sharing of information. For example, one physician in our review who, according to HCFA's records, has been reimbursed almost $172,000 by Medicare for services rendered in Virginia after he surrendered his Maryland license also had negative licensure actions taken by the States of New York and Ohio. According to the Public Citizen group, the disciplinary actions were taken for failure to conform to minimum standards of care, failure to complete and maintain accurate medical records, and failure to record the medical rationale for prescribing controlled substances. Although he cannot practice in Maryland, New York, and Ohio, he is actively treating Medicare patients in Virginia. In all probability, his current patients have no idea that these disciplinary actions have been taken against him. The details of these reimbursements are shown in Appendix B. As explained below, we believe there needs to be a centralized data base which would enable licensing and reimbursing entities to be aware of and take reciprocal actions to sanction providers who abuse or defraud health programs.

- ***Data bases are incomplete and inaccessible, making enforcement difficult***

Existing and planned data bases contain only limited information on certain types of disciplinary actions involving health care providers. Currently there are two data bases which capture disciplinary actions--the Federation of State Medical Boards Data Bank and the National Practitioner Data Bank. However, OIG, as well as HCFA and its carriers and intermediaries, have automatic access to neither. Section 1921 of the Social Security Act requiring States to report certain licensure actions to the Secretary has not been implemented.

An adverse action data bank was recently established by the Health Insurance Portability and Accountability Act of 1996 which will contain information on final adverse actions taken against health care providers. Currently, HCFA is in the process of creating NPS to identify and enumerate providers of health care services.

The data bank maintained by the Federation of State Medical Boards contains formal adverse actions since 1960 dealing mainly with licensure. It only has information on these adverse actions for medical doctors, doctors of osteopathy, and physicians' assistants. Federal agencies and State licensing boards report their exclusions to the data bank on a voluntary basis. Access to the data bank is through contract with the Federation on a fee-per-search basis and a release form from the individual who is the subject of the search is required. Most of the Federation's contracts are with insurance agencies, credentialing entities, hospitals, and HMOs. Medicaid State agencies and HCFA do not have contracts with the Federation.

The National Practitioner Data Bank was created by the Health Care Quality Improvement Act of 1986 (Title IV of Public Law 99-660) and is maintained by PHS. It contains information on malpractice payments, clinical privilege actions, and licensure actions taken by States since September 1990 against physicians and other licensed health care providers. Currently, HCFA is negotiating with PHS to have OIG-exclusion information added to the data bank. Hospitals, health maintenance organizations (HMO), other health care entities, and State licensing boards can access the data bank for a fee if they meet certain criteria. The OIG, HCFA, Medicare contractors, and Medicaid agencies are not among the parties specifically authorized to query the data bank.

The Medicare and Medicaid Patient and Program Protection Act of 1987 (Section 5 of Public Law 100-93, codified as section 1921 of the Social Security Act), requires States to provide information to the Secretary regarding specified actions (such as revocation or suspension of a license) taken by the State entity responsible for the licensing of health care providers. Section 1921 requires the reporting of certain actions that also must be reported to the National Practitioner Data Bank and requires that the Secretary provide for the coordination in the implementation of section 1921 and the reporting requirements under the National Practitioner Data Bank. Under section 1921, the Secretary is authorized to provide this information to Federal agencies administering health care programs, State licensing authorities, State Medicaid agencies, State Medicaid Fraud Control Units, law enforcement agencies, and other specified entities. Review of the legislative history of Public Law 100-93

reveals that the Congress had concerns that beneficiaries are protected from unfit providers. The legislative history states that this provision:

> "...requires medical providers, states and federal agencies to exchange information on the medical, legal and financial conduct of medical providers. The purpose of this information exchange is to protect beneficiaries from providers with criminal, patient abuse, fraud and other convictions."

The authority to implement section 1921 has been delegated to PHS; however, this provision has never been implemented. At this time, there is no centralized source for information regarding State licensure actions that is routinely available to the OIG, HCFA, Medicare contractors, and Medicaid agencies.

In August 1996, the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) was enacted. This legislation amends the PHS Act to require the Secretary to establish a national health care fraud and abuse data collection program, and to establish and maintain a data base for reporting final adverse actions against health care providers, suppliers, and practitioners. The legislation specifically states that the new data bank must be coordinated with, and not duplicate, the existing National Practitioner Data Bank. The information in the data base will be available to Federal and State government agencies and health plans as provided by the Secretary in regulations.

The purpose of the NPS is to create a vehicle for identifying and enumerating all providers of health care services at the national level. The HCFA is working with various Federal agencies, State agencies, and other organizations to design this system. Funding for the system will be provided through usage agreements among the system's participants. The system's responsibilities are limited to enumeration, and responsibility to determine the provider's qualifications for program enrollment, credentialing, and claims submission rests with the participating programs. It will be up to each subscribing organization to decide whether to mandate usage of the system for its providers. Subscribing organizations will be responsible for providing the system with changes in licensure status and exclusion information. It will be the providers' responsibility to ensure the system data is up-to-date (i.e., changes in address or group practice affiliation), but there is no penalty for nonreporting.

- ***There is a need for more complete information to protect beneficiaries from incompetent and abusive providers***

In addition to problems of accessibility to current data bases, the current data bases are incomplete. For example, the data bases do not capture disciplinary actions taken against health care providers who do not require a State license to practice, such as home health aides, social workers, and durable medical equipment suppliers.

We found this lack of information makes the activity of excluded and unlicensed providers very hard to track for enforcement purposes. It is often very difficult to obtain needed information and the needed information is not always available.

For example, our approach to identifying Medicare payments to excluded and unlicensed providers in this review was limited because:

(1) we depended on the Registry to identify UPINs and we had no assurances that all UPINs were found,

(2) some of the individuals in our review would not have been assigned UPINs, such as a social worker or home health agency worker, so our approach would not identify any Medicare work they may be doing,

(3) work performed in an HMO setting where bills are not submitted by the individual providers would not have been identified,

(4) HCFA's search only identified Part B submitted claims, and

(5) bills submitted under another UPIN would not have been identified.

It was also very difficult and time consuming to find basic information, such as date of birth and SSN. For example, 3 of our 46 OIG-excluded individuals (there was a total of 48 in our review, however 2 were corporations) had incorrect SSNs shown on OIG's list and even though we did a search of SSA's enumeration file, we were unable to locate a correct SSN. A fourth individual also had an incorrect SSN on OIG's list, but a search of SSA's enumeration file located the correct number. As for the 23 selected individuals who had their Maryland license revoked, suspended, or surrendered, but who OIG did not exclude, it was very difficult to obtain information. The Maryland Board could not provide us with date of birth or SSN because of privacy considerations. Without a date of birth, SSA's enumeration file cannot be searched to locate an SSN. We also noted that several of the physicians in our review had a different SSN on HCFA's records than was shown on OIG's

records or the SSN we obtained by searching SSA's enumeration file. Supporting data from HCFA also showed that physicians other than those selected for our review have also used multiple SSNs when submitting Medicare claims. According to SSA's records, a few of the individuals in our review also have multiple names.

We believe there needs to be a centralized data base for the mandatory reporting of final adverse actions taken against all health care providers which would permit Federal, State, and private payers to help enforce existing adverse actions as well as to become aware of and take reciprocal actions to sanction providers who abuse or defraud health programs.

RECOMMENDATIONS

Although nationally the percentage of aberrant health care providers (those excluded or with a revoked/suspended license) is small, they can endanger the lives of beneficiaries and should not be allowed to further abuse our health care system.

We believe there are several steps HCFA can take to help prevent excluded and unlicensed health care providers from being inappropriately reimbursed by the Medicare program.

We recommend that HCFA:

- Ensure that Medicare contractors have established adequate controls to preclude payments to excluded and unlicensed health care providers. Although instructions in the Medicare Carrier Manual and Medicare Intermediary Manual clearly state that Medicare contractors are responsible for ensuring payments are not made to excluded and unlicensed providers, our findings indicate increased vigilance in this area is needed. We also recommend that HCFA instruct the carriers to recover the payments identified in our review from the excluded and unlicensed providers.

- Confirm that its contractors get licensing data from the appropriate State agencies and that Medicare payments are terminated to unlicensed individuals.

- Periodically identify from its systems Medicare bills paid under the UPINs of *all* excluded providers, similar to the data run for us during our review. Identified payments should be referred to the appropriate carrier for verification and recovery. Although a match is periodically done between

the information on the Registry's files and the OIG exclusion listing to identify active UPINs, payments continue to be made by carriers to excluded providers.

- Consider the feasibility of instituting an edit in the Medicare Transaction System to prevent payment under the UPIN or NPS identifier of excluded and unlicensed providers.

- Take into consideration our findings as it continues development of the NPS. The HCFA should verify the integrity and accuracy of the data in the current UPIN file before it is loaded to NPS. We also encourage HCFA to proceed with planned NPS enhancements, such as verification of licensure information.

- Work with PHS to implement section 1921 of the Social Security Act which would require States to provide information to the Secretary regarding specified actions (such as revocation or suspension of a license) taken by the State entity responsible for the licensing of health care providers. The Secretary is authorized to provide this information to Federal agencies administering health care programs, State licensing authorities, State Medicaid agencies, State Medicaid Fraud Control Units, law enforcement agencies, and other specified entities. It will be necessary to coordinate this with the implementation of the new adverse action data base created by Public Law 104-191.

- Continue to support legislative proposals to create a comprehensive data base that would capture negative actions on all health care providers and would be accessible by all interested parties.

Other Issues

- ***Medicaid payments to excluded and unlicensed providers***

We used similar approaches to the ones described above to identify Medicaid payments made by the Maryland Medicaid agency to excluded and unlicensed providers. We identified and verified with the Maryland Medicaid agency $6,750 in Medicaid payments that were made to excluded/unlicensed providers. However, other issues concerning Medicaid provider numbers arose during our review and we are continuing our work with the Maryland Medicaid agency in this area before we draw conclusions and make any appropriate recommendations. We encourage HCFA to include the Medicaid agencies in any communication and any above-mentioned data base access dealing with excluded and unlicensed providers.

APPENDIX A

MEDICARE PAYMENTS TO EXCLUDED AND UNLICENSED PROVIDERS

	OIG EXCLUSION DATE	*PAYMENTS DURING EXCLUSION PERIOD*	*MARYLAND LICENSE ACTION*	*PAYMENTS WHILE UNLICENSED (MARYLAND PRACTICE LOCATION)*
Provider A	*08/24/92 03/31/94 reinstate*	*$2,376.52*		
Provider B	*08/30/89 & 07/10/92*	*$195.19*	*11/18/92 revoke 01/13/94 reinstate*	*$90.23*
Provider C	*11/04/88 03/14/94 reinstate*	*$132.02*	*11/27/89 revoke 09/24/91 reinstate*	
Provider D	*05/18/89*	*$97.43*	*10/02/89 suspend 08/24/93 reinstate*	
Provider E	*04/12/91 & 06/17/92*	*$96.06*	*11/02/90 suspend 09/23/92 revoke*	*$96.06*
Provider F	*05/12/92*	*$34.63*	*12/05/91 surrender*	
Provider G			*12/12/90 surrender*	*$287.87**
Provider H			*11/18/92 revoke 07/27/94 reinstate*	*$177.34*
Provider I			*12/15/93 revoke*	*$123.52*
Provider J	*11/01/91*		*12/12/90 suspend 11/18/92 revoke*	*$29.92***
TOTAL		***$2,931.85***		***$804.94***

** Two carriers were unable to locate paid claims on their systems for this physician, but data from HCFA showed payments were made by the carriers for services rendered in inpatient and outpatient hospital settings.*

*** Carrier was unable to verify because record had been purged.*

MEDICARE PAYMENTS TO INDIVIDUALS WHOSE MARYLAND LICENSE WAS RESCINDED AND WHO RELOCATED TO ANOTHER STATE (NO OIG EXCLUSION)

	MARYLAND LICENSE ACTION	*PAID BY MEDICARE WHILE MARYLAND LICENSE WAS RESCINDED*	*MEDICARE PRACTICE LOCATION*
PROVIDER K	*12/28/90 surrender (improper professional practice)*	*$171,969.18***	*VA*
*PROVIDER H**	*11/18/92 revoke 07/27/94 reinstate (loss of hospital privileges for violations of standards of care)*	*$5,679.35*	*DC* ***(but per the Medicare Enrollment Database most beneficiaries reside in Maryland)***
*PROVIDER F**	*12/05/91 surrender (substandard care, incompetence, negligence)*	*$915.79** Prior to OIG exclusion*	*DC*

** Also received payment while excluded or unlicensed in Maryland with Maryland practice location--see Appendix A*

*** We did not verify these payments with the carriers because of the large number of bills shown as paid on HCFA's records and because these payments are not considered incorrect.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: OCT - 2 1996

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General Draft Report: "Medicare Payments to Excluded and Unlicensed Health Care Providers," (A-14-96-00202)

We reviewed the subject draft report which examined whether excluded or unlicensed health care providers in Maryland have been inappropriately reimbursed by the Medicare program.

Our detailed comments are attached for your consideration.

Thank you for the opportunity to review and comment on this report. Please contact us if you would like to discuss our comments further.

Attachment

Health Care Financing Administration (HCFA) Comments on Office of Inspector General (OIG) Draft Report : "Medicare Payments to Excluded and Unlicensed Health Care Providers," (A-14-96-00202)

OIG Recommendation

Ensure that Medicare contractors have established adequate controls to preclude payments to excluded and unlicensed health care providers. We also recommend that HCFA instruct the carriers to recover the payments identified in our review from the excluded and unlicensed providers.

HCFA Response

We concur. HCFA is actively working with Medicare contractors to ensure that they have established adequate controls. We have instructed all carriers to include edits in the claims processing system to prevent payments to sanctioned providers. In addition, the listing of exclusion and reinstatement/withdrawal actions taken by OIG is distributed on a monthly basis to Medicare contractors with instructions to ensure that sanctioned providers are not being inappropriately paid. HCFA also sends out additional reminders to the Medicare contractors emphasizing the need to use the complete sanction report in order to identify providers outside their service area.

HCFA will, upon receipt of the identifying information from the OIG regarding the excluded providers and the payments identified in their study, pursue recovery with the appropriate contractors.

OIG Recommendation

HCFA should confirm that its contractors get licensing data from the appropriate state agencies and that Medicare payments are terminated to unlicensed individuals.

HCFA Response

We concur in principle. Contractors work with state agencies to obtain licensing information to the extent possible. However, licensing of health care professionals is a state responsibility and most states have at best a very rudimentary system for maintaining and sharing licensure information with their sister states. They are even less able to make the information available for use by Federal agencies. In addition, state laws require specific information, which, because it is not standard across states, complicates collection and sharing of information between the Federal and state levels.

OIG Recommendation

HCFA should periodically identify from its systems Medicare bills paid under the unique physician/provider identification numbers (UPINs) of *all* excluded providers, similar to the data run for us during our review. Identified payments should be referred to the appropriate carrier for verification and recovery.

HCFA Response

We concur. HCFA, OIG, and the UPIN Physician Registry at Transamerica Occidental periodically conduct an automated matching of the Medicare/Medicaid Sanction - Reinstatement Report and the carrier physician records at the Registry. The purpose of this match is to identify physicians who are excluded from the Medicare program because of their sanctioned status.

Briefly, the Registry attempted to match physician names on the OIG cumulative list. In some instances, carriers have already updated the Registry records to acknowledge the sanction; however many records do not contain the sanction information, suggesting that the physician may still be in active payment status.

Contractors are instructed to research and correct as necessary each practice setting for each physician. Contractors are also instructed to determine whether the match made at the Registry is correct, verify whether their in-house provider file records for each practice setting reflect the sanction information, correct the Registry records for each practice setting, and submit an updated record with the OIG sanction data for each record that has a UPIN. The instructions are found in Medicare Carrier Manual (MCM), Part 4, section 1005.3.

Contractors are also required to determine whether the physician is still active and has submitted claims to Medicare for services provided since the effective date of the sanction. Contractors must follow instructions in section 14033 of the MCM to deny payment for any claims not yet processed and follow instructions in section 14034 of the MCM to research and report to the Office of Investigations Field Office (OIFO) any overpayments to excluded persons.

The Registry releases records which have not been corrected to contractors as automatic notifications (Record Code 7) through its telecommunications system. Additional automatic notifications are released as the Registry receives new sanctions from the OIG or the carrier submits new add records to the Registry.

OIG Recommendation

HCFA should consider the feasibility of instituting an edit in the Medicare Transaction System (MTS) to prevent payment under the UPIN or National Provider System (NPS) identifier of excluded and unlicensed providers.

HCFA Response

We Concur. The MTS will edit all claims against the provider database of information and will not process a claim for reimbursement to a sanctioned provider.

OIG Recommendation

HCFA should take into consideration our findings as it continues development of the NPS. HCFA should verify the integrity and accuracy of the data in the current UPIN file before it is loaded to NPS.

HCFA Response

We concur. NPS will use procedures which use address standardization software and Social Security Administration verification to ensure the integrity of information submitted by each provider. During the initial load, any provider record that fails edits, data verification, or matches a provider already established on NPS will be placed in a pending file for further development. In addition, an interface with the OIG Sanction File will provide timely sanction information.

OIG Recommendation

HCFA should work with Public Health Service (PHS) to implement section 1921 of the Social Security Act which would require states to provide information to the Secretary regarding specified actions (such as revocation or suspension of a license) taken by the state entity responsible for the licensing of health care providers.

HCFA Response

We concur. A single data source for excluded providers is the best approach to ensure that we can identify providers that have adverse action taken against them. PHS maintains the National Practitioner Data Bank which contains much of the exclusion and licensure actions taken by the states and we are working with PHS. However, PHS has not exercised its authority to implement section 1921 of the Social Security Act which

would make this information available to all Federal and state agencies.

OIG Recommendation

HCFA should seek legislation which would allow a data match with the NPS. In the interim, HCFA should encourage its contractors (including HMOs) to use available files (e.g. the Internet) to electronically match exclusion data to Medicare files. (See note below.)

HCFA Response

We do not concur. Recently passed legislation (Kennedy/Kassebaum) requires development implementation of an Adverse Action Database no later than January 1, 1997. The database must provide for the reporting and disclosure of certain final adverse actions against health care providers, suppliers, or practitioners and therefore, satisfies the intent of the OIG recommendation.

OIG Recommendation

HCFA should continue to support legislative proposals to create a comprehensive data base that would capture negative actions on all health care providers and would be accessible by all interested parties.

HCFA Response

We concur. We will continue to work to strengthen our ability to combat fraud.

AUDITOR'S NOTE:

In our draft report we recommended that HCFA seek legislation to allow for a data match with the National Practitioner Data Bank. Subsequent to the issuance of our draft report, major fraud and abuse legislation was passed as part of Public Law 104-191 "Health Insurance Portability and Accountability Act of 1996. " This legislation effectively addressed the recommendation as contained in our draft report. We have consequently not included it as part of our final report recommendations.