Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

IMPROVEMENTS NEEDED TO ENSURE PROVIDER ENUMERATION AND MEDICARE ENROLLMENT DATA ARE ACCURATE, COMPLETE, AND CONSISTENT

Daniel R. Levinson
Inspector General

May 2013
OEI-07-09-00440

EXECUTIVE SUMMARY: IMPROVEMENTS NEEDED TO ENSURE PROVIDER ENUMERATION AND MEDICARE ENROLLMENT DATA ARE ACCURATE, COMPLETE, AND CONSISTENT
OEI-07-09-00440

WHY WE DID THIS STUDY

Health care provider information, including providers' unique National Provider Identifiers (NPIs), is maintained in the National Plan and Provider Enumeration System (NPPES). To enroll in Medicare, providers must supply their NPIs and other information to the Centers for Medicare & Medicaid Services (CMS) to be entered into the Provider Enrollment, Chain and Ownership System (PECOS). Accurate, complete, and consistent provider data in NPPES and PECOS help to ensure the integrity of all health care programs. Previous Office of Inspector General work has revealed ongoing problems with CMS's oversight of provider data, sometimes resulting in improper Medicare payments to fraudulently enrolled providers.

HOW WE DID THIS STUDY

We surveyed a random sample of individual Medicare providers to determine the accuracy of the provider information stored in NPPES and PECOS. We reviewed individual provider data in both NPPES and PECOS to determine whether these data were complete and consistent between the two databases. Additionally, we interviewed CMS staff to gather information about oversight of provider data in NPPES and PECOS.

WHAT WE FOUND

Medicare provider data in NPPES and PECOS were often inaccurate and occasionally incomplete, and were generally inconsistent between the two databases. In NPPES, provider data were inaccurate in 48 percent of records, and complete for nearly all required variables but incomplete for conditionally required variables in 9 percent of records. In PECOS, provider data were inaccurate in 58 percent of records and incomplete in almost 4 percent. Additionally, provider data were inconsistent between NPPES and PECOS for 97 percent of records. Addresses, which are essential for contacting providers and identifying trends in fraud, waste, and abuse, were the source of most inaccuracies and inconsistencies. Finally, CMS did not verify most provider information in NPPES or PECOS.

WHAT WE RECOMMEND

Inaccurate, incomplete, and inconsistent provider data coupled with insufficient oversight place the integrity of the Medicare program at risk and present vulnerabilities in all health care programs. CMS should require Medicare Administrative Contractors to implement program integrity safeguards for Medicare provider enrollment as established in the *Program Integrity Manual*. Additionally, CMS should require more verification of NPPES enumeration and PECOS enrollment data. Finally, CMS should detect and correct inaccurate and incomplete provider enumeration and enrollment data for new and established records. CMS concurred with all three of our recommendations.

TABLE OF CONTENTS

OBJECTIVES

To assess:

1. provider enumeration data (i.e., from providers' applications for National Provider Identifiers (NPIs)) and Medicare provider enrollment data maintained by the Centers for Medicare & Medicaid Services (CMS) for accuracy, completeness, and consistency; and
2. CMS oversight processes for ensuring the accuracy, completeness, and consistency of provider enumeration data and Medicare provider enrollment data.

BACKGROUND

CMS has two databases with basic provider-related data—one from which providers obtain NPIs and one through which providers enroll in Medicare. Before enrolling in Medicare, a health care provider must apply through the National Plan and Provider Enumeration System (NPPES) to obtain an NPI.[1] CMS assigns NPIs to providers via a process called enumeration, and these NPI assignments are maintained in the NPPES database. A health care provider wishing to establish and maintain Medicare billing privileges must enroll in Medicare and periodically reenroll with accurate and verifiable information via an approved CMS application process.[2] Currently, Medicare provider enrollment applications are processed through the Provider Enrollment, Chain and Ownership System (PECOS). Providers are required to submit identifying information to each application system, such as individuals' names, dates of birth (DOBs), State professional license numbers, and practice locations. CMS oversees both NPPES and PECOS and uses contractors to process and maintain provider data.

As described in the Office of Inspector General's (OIG) 2012 *Compendium of Unimplemented Recommendations*, the Department of Health and Human Services (HHS) and OIG

> rely heavily on the availability and completeness of data to ensure that … departmental programs are operating as intended and help identify instances of fraud, waste, and abuse…. When these data are

[1] 42 CFR § 424.506(b); CMS, *Medicare Program Integrity Manual* (PIM) (Internet-only manual), Pub. No. 100-08, ch. 10, § 4.2.1, and ch. 15, § 15.3. (At the time of our review, information relating to provider enrollment was found in ch. 10 of the PIM; CMS has since moved some of this information to ch. 15.)

[2] 42 CFR §§ 424.505 and 424.515.

unavailable, are incomplete, or contain inaccuracies, program oversight and monitoring activities are hindered.[3]

OIG identifies the integrity and security of health information systems and data as a Top Management Challenge for HHS.[4]

Provider Enumeration in NPPES

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Secretary of HHS to (1) establish a standard unique health care system identifier for each provider and (2) specify the purposes for which the identifier may be used.[5] The resulting identifier, the NPI, is intended for use by all individuals and entities that meet the definition of a health care provider and/or a health care organization under HIPAA.[6]

On January 23, 2004, CMS promulgated a final rule in the Federal Register adopting the NPI as the standard unique health identifier for health care providers.[7] Each health care provider satisfying HIPAA's definition of covered entities[8] was required to obtain and use an NPI for HIPAA transactions[9] no later than May 23, 2007.[10] Therefore, current health care providers must use NPIs to submit electronic bills to insurers for payment.

The NPI replaced the legacy identification numbers (e.g., the Unique Physician Identification Number (UPIN) for Medicare) that health insurers used to identify their enrolled health care providers claiming reimbursement for services.[11] Prior to the use of the NPI, a provider would have used multiple identification numbers to submit claims for

---

[3] OIG, *Compendium of Unimplemented Recommendations*, December 2012 Edition, p. 131. Accessed at http://oig.hhs.gov on January 3, 2013.

[4] OIG, *2012 Top Management & Performance Challenges*, Management Issue 9: Availability and Quality of Data for Effective Program Oversight, November 9, 2012. Accessed at http://oig.hhs.gov on January 3, 2013.

[5] HIPAA (P.L. 104-191), enacted on August 21, 1996. Title II, Subpart F, § 262(a) added a new pt. C to Title XI of the Social Security Act, "Administrative Simplification." Currently, pt. C consists of §§ 1171 and 1180.

[6] 69 Fed. Reg. 3434, 3440 (Jan. 23, 2004).

[7] Ibid. at 3434.

[8] Ibid. at 3434. A covered entity means (1) a health plan, (2) a health care clearinghouse, or (3) a health care provider that transmits health information in electronic form in connection with a transaction covered by HIPAA.

[9] The HIPAA transactions are claims and encounter information, payment and remittance advice, claims status, eligibility, enrollment and disenrollment, referrals and authorizations, and premium payment.

[10] 45 CFR § 162.404(b)(2). Small health plans were required to use the NPI in standard transactions no later than May 23, 2008.

[11] CMS, *NPI Fact Sheet*. Accessed at http://www.cms.gov on May 12, 2009.

reimbursement, with a different number for each participating health insurance plan. In contrast, the NPI is used by all health insurance plans, which enables the public and private sectors to consistently track providers nationwide.

In the final rule establishing the NPI, CMS listed several examples of permissible uses of the NPI, including the following:

- The NPI may be used as a cross-reference in files on provider fraud and abuse and other program integrity files.
- The NPI may be used to identify providers for debt collection under the Debt Collection Improvement Act of 1996.
- Health plans may use the NPI in their internal files for providers to process transactions and in communications with providers.
- Health plans may communicate the NPI to other health plans for coordination of benefits.
- The NPI may be used to identify providers in patient medical records.[12]

Providers may apply for an NPI using a Web-based or a paper application.[13] The Web-based NPI application requires the following data for individuals: first and last names; Social Security number (SSN); DOB and place of birth; gender; mailing address; practice location address and telephone number; medical specialty (e.g., cardiology); State license information; and a contact person's name, email address, and telephone number.[14] Although the individual's SSN and a contact person's email address are required on Web-based applications, they are not required for paper applications.[15] Providers must communicate any changes in required data elements to NPPES within 30 days of the change.[16] As of June 30, 2012, approximately 2.8 million health care providers (e.g., physicians)

[12] 69 Fed. Reg. 3434, 3449 (Jan. 23, 2004).

[13] Providers may also apply online via Electronic File Interchange (EFI). EFI applications are submitted by CMS-approved organizations on behalf of health care providers.

[14] CMS, *NPPES Data Dictionary*, ch. 19.1, pp. 1–3, 2010.

[15] Ibid., p. 2. A provider must submit two proofs of identity if he or she does not furnish an SSN. CMS, *National Provider Identifier (NPI) Application/Update Form* CMS-10114, 2012. Acceptable forms of identification include a valid passport, birth certificate, photocopy of U.S. driver's license, or State-issued identification.

[16] 45 CFR § 162.410(a)(4).

and 913,000 health care organizations (e.g., hospitals) had been assigned NPIs.[17]

Provider Enrollment Data Maintained in PECOS

Medicare Administrative Contractors (MACs) enroll providers in Medicare using PECOS. In 2002, CMS implemented PECOS as a national data repository for Medicare enrollment information about physicians, nonphysician practitioners, and provider and supplier organizations.[18] It is intended to contribute to CMS's information-based strategy on fraud and abuse.[19]

The purpose of PECOS is to centralize Medicare provider enrollment.[20] PECOS is used to implement standard enrollment policies and procedures throughout the Medicare program.[21] Each provider must obtain an NPI prior to applying for Medicare enrollment.[22] Required provider data for initial enrollment in PECOS generally include an individual's first and last names; NPI number; Tax Identification Number (TIN), which may be an SSN or Employer Identification Number (EIN); DOB; mailing address and practice location address(es); State license information and/or certification information (if applicable); provider type; medical specialty; medical or professional school/training institution and graduation year; adverse legal history; and payment information.[23] The provider's telephone number is recommended but not required for enrollment.[24] After providers are enrolled, they must report any changes to their information within 90 calendar days of the changes.[25]

Each MAC processes enrollment data for its jurisdiction through PECOS. Data extracts from PECOS are then used to populate the Multi-Carrier System, which MACs use to process and pay Medicare claims. Many

---

[17] CMS, *NPI Enumeration Statistics by State/Entity Type As of: 5/23/2005 through 6/30/2012*. Accessed at http://www.cms.gov on July 24, 2012.

[18] 66 Fed. Reg. 51961 (Oct. 11, 2001). Providers of durable medical equipment, prosthetics, orthotics, and supplies were not included in PECOS until 2010.

[19] Ibid.

[20] Ibid. at 51962.

[21] Ibid.

[22] 42 CFR § 242.506(b); CMS, PIM, Pub. No. 100-08, ch. 15, § 15.3 (previously found in ch. 10, § 4.21).

[23] CGI Federal, *PECOS 6.0.0 Required Fields*, Doc ID: PECOS-6.0.0-REQ-67792-v0.10, April 2009.

[24] Ibid.

[25] 42 CFR § 424.520(b).

other CMS business functions rely on PECOS data. For example, PECOS may be used to:

- capture information from the Medicare enrollment forms and record the associations between the applicant and those that have an ownership or control interest in the entity;
- make informed enrollment decisions based on a provider's history and any reported exclusions, sanctions, or felonious behavior at the provider's locations or in multiple contractor jurisdictions;
- ensure that correct payments are being made under Medicare;
- assist other Federal or State agencies and their contractors;
- assist individual or organizational research, evaluation, or epidemiological projects;
- support litigation involving CMS; and
- combat fraud, waste, and abuse in certain health care programs.[26]

As of December 2012, PECOS contained records for approximately 1.2 million individual Medicare providers and 328,488 organizational Medicare providers.[27] PECOS may not contain records for providers enrolled in Medicare prior to 2003 if no enrollment updates (e.g., changes of address) have been made. Information for these providers is maintained by individual MACs.

Provider Identification Data Common to the NPPES and PECOS Databases

Although no Federal mandate requires that information in NPPES and PECOS be consistent, the databases contain specific fields that collect the same information. Data fields that can be used to identify unique providers common to both databases include the following:

- first and last names,
- NPI number,
- SSN (conditionally required in NPPES[28]),
- Gender (not required in PECOS[29]),
- DOB,

[26] 71 Fed. Reg. 60536, 60539 (Oct. 13, 2006).

[27] OIG, analysis of PECOS data, 2013.

[28] SSN is conditionally required in NPPES. It must be included on Web-based applications, but not on paper applications.

[29] The gender variable is optional rather than required in PECOS.

- mailing address and practice location address(es) and corresponding telephone numbers (telephone numbers are not required in PECOS),
- professional license number and issuing State (conditionally required in NPPES and PECOS[30]), and
- provider specialty.

CMS Oversight of Provider Data

In 2008, an OIG official testified to Congress that CMS could be more effective and efficient if it were to prevent the enrollment of unqualified and fraudulent providers rather than attempting to recover payments or redress fraud or abuse after it occurs.[31] However, CMS has faced challenges in ensuring the integrity of Medicare provider enrollment. Many health care fraud schemes involving misuse of provider information have been "committed by criminals who masquerade as Medicare providers … who do not provide legitimate services or products."[32] Such criminals have used providers' stolen identities to bill directly for services in the providers' names or to authorize payment for beneficiary health care services.

CMS Oversight of NPPES Enumeration Data. CMS uses two contractors to conduct provider enumeration.[33] One contractor maintains NPPES and establishes electronic edits (i.e., internal system processes) to ensure that the NPI data conform to database requirements at the time a provider applies for an NPI. This contractor manages an Internet-based registry that makes NPPES data available to the public in accordance with the Freedom of Information Act.[34] The other contractor enters data from paper applications into NPPES and operates a call center for providers who have questions or problems.

CMS Oversight of PECOS Enrollment Data. CMS has developed safeguards for processing provider enrollments in PECOS to ensure that

---

[30] License/certification information is conditionally required in NPPES and PECOS for specific types of providers, as applicable by the State in which they practice. For example, several States require dietitians to be licensed, others require certification, and a few do not require licensure or certification.

[31] *Medicare Payments for Claims with Identification Numbers of Dead Doctors*, 110th Cong. 12 (2008) (testimony of Robert A. Vito, Regional Inspector General for Evaluation and Inspections).

[32] *New Tools for Curbing Waste and Fraud in Medicare and Medicaid*, 112th Cong. 3 (2011) (testimony of Daniel R. Levinson, Inspector General).

[33] See 45 CFR pt. 162.408, subpart D, detailing the provider enumeration process.

[34] 72 Fed. Reg. 30011, 30013 (May 30, 2007).

the applicants are eligible to participate in Medicare.[35] When providers enroll, change ownership, or update information, the PIM requires MACs to ensure that they are not on the OIG List of Excluded Individuals/Entities or the General Services Administration's Excluded Parties List System.[36] The PIM also requires MACs to validate all data submitted on applications[37] and lists some examples of possible verification methods.[38] For example, the PIM suggests that MACs check the Yellow Pages or conduct a site visit to verify a provider's practice location.[39]

In addition, CMS issues a variety of memorandums intended to provide supplementary program integrity guidance to MACs. These documents include joint signature memorandums (JSM) and technical direction letters (TDL). For example, one JSM directed MACs to conduct site visits for providers and suppliers that listed UPS stores as their practice locations to ensure that providers were not using those locations as Medicare practice locations.[40]

CMS has undertaken ongoing efforts to update provider information. In 2010, CMS implemented efforts to establish records in PECOS for all Medicare-enrolled providers.[41] More recently, CMS instructed all providers and suppliers enrolled prior to March 25, 2011, to revalidate their enrollment data. These revalidation applications are subject to new screening provisions set forth in section 6401 of the Patient Protection and Affordable Care Act (ACA) that require classification of providers as

---

[35] Chapter 10 of the PIM contained policies and procedures for processing enrollment applications during the time of our review. This information was recently moved to ch. 15.

[36] CMS, PIM, Pub. No. 100-08, ch. 10, § 1.3. The General Services Administration's Excluded Parties List System migrated to the System for Award Management in July 2012.

[37] CMS, PIM, Pub. No. 100-08, ch. 10, § 1.3.

[38] CMS, PIM, Pub. No. 100-08, ch. 10, § 5.2.

[39] CMS, PIM, Pub. No. 100-08, ch. 10, § 5.2.B.

[40] CMS, Transmittal 331, Change Request 6822. *Onsite Verifications for Providers/Suppliers Located at a UPS Store (CONFIDENTIAL)*, March 26, 2010. Some memorandums are issued confidentially and are not available to the public online.

[41] CMS, Transmittal 712, Change Request 6842. *Medicare Claims Processing Manual*, Pub. No. 100-20, "One-Time Mailing of Solicitation Letter To All Physicians and Non-Physician Practitioners Who Are Currently Enrolled in Medicare But Who Do Not Have An Enrollment Record In the Provider Enrollment, Chain and Ownership System (PECOS)."

limited risk, moderate risk, or high risk.[42] During the first phase of the revalidation effort, 89,000 providers and suppliers that were actively enrolled in Medicare but not enrolled in PECOS were asked to revalidate their enrollment data.[43] If providers do not revalidate their data within 60 days of a request, CMS may deactivate their billing privileges.[44]

Importance of Accuracy, Completeness, and Consistency of Provider Identification Data

The accuracy and completeness of NPPES data are important for identifying the locations of providers across all health insurance programs. Public and private insurers need reliable information to identify geographic trends in provider fraud, waste, and abuse and to efficiently locate individual providers. Public health officials also need reliable provider information to locate providers during natural disasters or other emergencies. Finally, the health care industry relies on NPPES registry data to link legacy provider identifiers with NPIs, and health care providers rely on NPPES registry data to find the NPIs of other health care providers to submit certain health care claims.[45]

The accuracy and completeness of PECOS data are important for many critical CMS business functions, including the ability to make informed provider enrollment decisions; pay claims accurately; and combat fraud, waste, and abuse in Medicare and other health care programs. For example, CMS may use an edit to automatically check provider specialties listed in PECOS to determine whether providers were eligible to order beneficiary supplies and services.

Federal requirements do not mandate that information in NPPES and PECOS be consistent. However, inconsistencies in provider data can complicate efforts to locate providers. Inconsistencies in data may also hinder joint efforts among Federal, State, local, and nongovernmental entities to fight health care fraud, waste, and abuse.

Previous OIG Work

Prior to the creation of NPPES and the implementation of PECOS, we issued many reports highlighting problems with CMS's oversight of

---

[42] Patient Protection and Affordable Care Act, P.L. 111-148 § 6401, Social Security Act, § 1866(j), 42 U.S.C. § 1395cc(j); 76 Fed. Reg. 5862 (Feb. 2, 2011). The new risk-based screening provisions and the success of the revalidation efforts are outside the scope of this report.

[43] CMS, *Revalidation of Medicare Provider Enrollment National Provider Call*, transcript, October 27, 2011. Accessed at www.cms.gov on October 2, 2012.

[44] 42 CFR § 424.515(a)(2). CMS, PIM, Pub. No. 100-08, ch. 15, § 15.29; *Sample Revalidation Letter*. Accessed at www.cms.gov on October 2, 2012.

[45] 72 Fed. Reg. 30011, 30013 (May 30, 2007).

UPINs, a type of legacy identifier for providers. Our studies reported inaccuracies and inconsistencies in UPIN data maintained by CMS.[46, 47, 48] We also reported questionable and fraudulent Medicare claims associated with the use of invalid and inactive UPINs, the use of UPINs that belonged to deceased physicians, the improper use of surrogate UPINs, and the use of legitimate UPINs that were associated with an unusually large number of claims.[49, 50, 51] In congressional testimony provided in 2008, CMS stated that conversion from the use of UPINs to NPIs had strengthened CMS's ability to combat fraud and abuse schemes that rely on invalid provider identifiers.[52] However, the Inspector General cautioned Congress in 2009 that the vulnerabilities that had affected UPINs may affect the integrity of the NPI system, then recently launched.[53]

Although CMS described PECOS as an important national tracking mechanism to identify illegal Medicare activities, we identified problems early in its implementation.[54] Our first examination of PECOS revealed that contractor staff responsible for processing Medicare applications misunderstood policy and had problems accessing the system.[55] In a 2009 study of the accuracy of Medicare provider remuneration information, OIG staff were unable to reach many sampled providers using the contact information listed in PECOS, determined that the contact information listed in NPPES often differed from that in PECOS, and found

---

[46] OIG, *Accuracy of Unique Physician Identification Number Data* (OEI-07-98-00410), October 1999.

[47] OIG, *Inaccuracies in the Unique Physician Identification Number Registry: Incorrect Addresses for Mental Health Service Providers* (OEI-03-99-00131), May 2002.

[48] OIG, *Accuracy of Unique Physician/Practitioner Identification Number Registry Data* (OEI-03-01-00380), July 2003.

[49] OIG, *Medical Equipment and Supply Claims With Invalid or Inactive Physician Numbers* (OEI-03-01-00110), November 2001.

[50] OIG, *Durable Medical Equipment Ordered With Surrogate Physician Identification Numbers* (OEI-03-01-00270), September 2002.

[51] OIG, *Invalid Prescriber Identifiers on Medicare Part D Drug Claims* (OEI-03-09-00140), June 2010.

[52] *Medicare Payments for Claims with Identification Numbers of Dead Doctors*, 110th Cong. 12 (2008) (testimony of Herb B. Kuhn, CMS Deputy Administrator).

[53] *Combating Fraud, Waste, and Abuse in Medicare and Medicaid*, 111th Cong. 5 (2009) (testimony of Daniel R. Levinson, Inspector General).

[54] 66 Fed. Reg. 51961 (Oct. 11, 2001).

[55] OIG, *Provider Enrollment, Chain and Ownership System: Early Implementation Challenges* (OEI-07-05-00100), April 2007.

that about 20 percent of sampled providers could not be reached with the contact information from either database.[56]

METHODOLOGY

Scope

This study assessed the records of individual health care providers in NPPES and PECOS but did not assess records for organization health care providers or suppliers. In January 2010, NPPES contained 2,313,183 records for individual providers, and in August 2010, PECOS contained 1,211,520,[57] with 987,266 records appearing in both databases.[58] We reviewed records for individuals listed in both NPPES and PECOS. (Our review did not include individuals who had both enrolled in Medicare prior to November 2003 and had not updated their enrollment records using PECOS by the time of our review.) Provisions for provider data integrity that went into effect after our review, such as CMS's implementation of the ACA requirement for risk-based screening of providers,[59] were excluded from our analysis. Additionally, this study did not examine the accuracy of Medicare claims coding, data processing, or payments.

Data Collection and Analysis

We obtained from CMS all records of the most recent updates of NPPES and PECOS at the time of our review. NPPES contained data from January 2010, and PECOS contained data from August 2010.[60] We analyzed the following selected variables for individual providers in both databases:

- NPI,
- SSN (conditionally required in NPPES),[61]

[56] OIG, *Reassignment of Medicare Benefits* (OEI-07-08-00180), October 2009.

[57] The number of individual records in PECOS is based on the presence of 1,211,520 unique PECOS Associate Control Identifiers categorized as "individual" (not "organizational") in PECOS.

[58] The number of records located in both NPPES and PECOS is based on a match of NPIs.

[59] 76 Fed. Reg. 5862 (Feb. 2, 2011).

[60] At the time of our review, some of the variables that we requested for analysis were not available in the PECOS Global Extract routinely used for analysis. The contractor that maintained the database required a significant amount of time to create a separate interface to provide the requested data.

[61] In NPPES, SSN must be included on Web-based applications, but not on paper applications. In PECOS, the TIN field may include an SSN or EIN for each provider. For ease of reading, we refer to this variable as SSN.

- first name,
- last name,
- gender (not required in PECOS),
- DOB,
- provider specialty/credential,[62]
- State of professional licensure and license number (conditionally required in NPPES and PECOS),
- telephone number (not required in PECOS),
- mailing address ZIP Code, and
- practice address ZIP Code.

Not all of the variables we analyzed are required in order for providers to obtain an NPI or to enroll in Medicare. The SSN variable is conditionally required in NPPES; it is required for Web-based applications but not for paper applications. Provider license information is conditionally required in both NPPES and PECOS for specific types of providers.[63] Gender and telephone number are not required variables in PECOS. We considered this when presenting information about the completeness and consistency of data in the "Findings" section of this report.

Accuracy of the Data in NPPES and PECOS. We selected a simple random sample of 170 providers from those 987,266 individual providers with records in both NPPES and PECOS. We created an online survey that listed the NPPES and PECOS data for the selected variables for each provider. The survey asked providers to verify whether the data for each variable were accurate. The data included provider variables to identify individuals (i.e., name, SSN, DOB, place of birth, and license and credential information) and address information for mailing and practice

[62] A variable called "physician specialty code" denotes 77 physician and nonphysician specialties in PECOS, while a variable called "taxonomy code" indicates 644 individual provider specialties in NPPES. An optional text field in each database called "credential" allows providers to indicate a more general provider type, such as M.D. for medical doctor. We used the required specialty type fields in each database for our analysis of completeness. We used the optional credential text field in each database for our analysis of accuracy and consistency, as the two databases had very different coding schemes for specialty type.

[63] Neither NPPES nor PECOS indicate which types of providers are required to submit license information.

location(s).[64] If the data were inaccurate, the survey asked the provider whether these data were:

- partially inaccurate (e.g., included a misspelling or transposed numbers);
- correct at one time, but no longer current; or
- never correct.[65]

Data that providers indicated were not correct for a particular variable were reported as "inaccurate" in the findings.

Appendix A provides details regarding our attempts to contact providers to participate in the survey. After 4 months, 126 of 170 providers completed the survey—a response rate of 74 percent. We produced population estimates based solely on responses from these 126 providers without adjusting for nonresponse. Therefore, all estimates based on the provider survey project to an estimated total of only 731,738 provider records rather than 987,266. Appendix B provides point estimates and 95-percent confidence intervals for all survey estimates presented in the report.

Completeness of the Data in NPPES and PECOS. We analyzed each database to determine the extent to which selected provider variables were populated. We reviewed all 2,313,183 individual records in NPPES and the 1,021,652 individual records in PECOS indicating that the enrollee was a health care practitioner.[66] NPPES contained one record per provider, listing all variables. However, PECOS is substantially more complicated; records for a given provider appear across multiple "relational tables," each with different variables and different numbers of records per table. (For more detail on how PECOS is structured, see Appendix A.) Therefore, we identified two types of incomplete records for PECOS: records that were missing from the relevant table and records that were present in the relevant table but did not contain values for a particular variable. The relational tables featuring practice location

[64] Our survey did not ask providers to verify telephone numbers or gender, which are not required variables in PECOS. The survey did ask providers to verify conditionally required variables, such as professional license information.

[65] We sought to determine the accuracy of provider data, but not to correct inaccurate information. Within the survey, we notified providers that they are responsible for updating inaccurate data, and we listed the instructions for doing so.

[66] Of the 1,211,520 individual PECOS records, 1,021,652 were associated with health care practitioners. The remaining individuals were authorized or delegated officials of provider and supplier organizations or worked on behalf of providers or suppliers. Such individuals are not providers and are not required to have an NPI; therefore, we excluded them from our analysis of the completeness of PECOS data.

information did not contain all records for individual providers; some individual provider data were stored in group enrollment records.

For this analysis, we generally excluded variables that were not required, and attempted to include variables that were conditionally required. We excluded gender and telephone number from the PECOS analysis because they are not required on the Medicare enrollment application. We included SSN in the NPPES analysis because it is required for Web-based applications. We included State license information in our analyses of both databases because it is required for certain provider specialty types. However, we found no indication NPPES of whether applications were submitted via Web or paper, and no indication in either database of which provider specialty types were required to submit license information. As such, we were unable to determine whether null values were appropriate for SSNs in NPPES or license information in either database. Therefore, the totals for "incomplete" records in the findings include only missing provider records and those records that did not contain values for a particular variable when undoubtedly required.

Consistency of the Data in NPPES and PECOS. We compared the selected data fields in each database to determine whether the data were consistent in both. This matching process used variables that were required across both databases as well as variables that were conditionally required and/or not required but were populated across both databases (e.g., text field for provider credentials, if populated in both). Where there were multiple values for variables in either database, we searched for at least one match between the two databases. For example, NPPES contained up to 15 licenses per provider and PECOS contained up to 19 licenses per provider; we looked for any match and considered the record consistent if we found one. In determining whether there was a data match, we considered only the content of data fields, not their formatting. For example, we standardized the text for the credentials variable so that capitalization, spacing, and punctuation did not influence the match (e.g., "R.N." and "r n" would match).[67] Rather than attempt to standardize street addresses in their entirety, we used only the ZIP Code portion to match addresses to reduce the detection of false mismatches. The exclusive use of ZIP Codes can underestimate the precise number of

[67] We standardized only the most common credentials, including clinical social worker (CSW, LCSW, LICSW, MSW, LMSW); doctor of chiropractic (DC); doctor of dental science (DDS); doctor of optometry (OD); doctor of osteopathy (DO); doctor of philosophy (PhD); doctor of podiatric medicine (DPM); doctor of psychiatry (PsyD); licensed dietician (LD); medical doctor (MD); nurse practitioner (NP, APN, APRN, WHNP, ARNP, FNP, CFNP); occupational therapist (OT, OTR, OTRL); physical therapist (MSPT, RPT, PT, MPT, DPT); and physician's assistant (PA, PA-C).

mismatches. Appendix A includes more information regarding the process of matching addresses between NPPES and PECOS.

We reported fields that did not contain the same information for a particular variable across both databases as "inconsistent" in the findings. It is possible that a provider could have updated the information in NPPES prior to our collection of PECOS data, resulting in a mismatch between the two databases. To estimate this effect, we reviewed the PECOS record history to determine how many records with mismatches could be explained by record updates between January and August 2010.

CMS Oversight of NPPES and PECOS. CMS uses contractors to ensure the integrity of provider data. We obtained and reviewed guidance documents that CMS provided to contractors in processing the NPPES and PECOS data. We collected and reviewed information regarding CMS's oversight of contractors; current program integrity requirements; and safeguards used to implement those requirements (e.g., electronic system edits and other methods to ensure the accuracy, completeness, and consistency of the NPPES and PECOS data). We compared documented requirements with the program integrity safeguards that contractors used to protect the integrity of provider data.

We interviewed CMS contractor staff with oversight responsibilities for NPPES and PECOS at the time of our review. One contractor managed both databases,[68] and a separate contractor processed NPI enumeration. The interviews enabled the study team to gather indepth information about contractor operations following staff responses to more general questions regarding data accuracy, completeness, and consistency. We identified interview responses that described vulnerabilities for the integrity of provider data.

To assess the program integrity safeguards in place with regard to the accuracy and completeness of the PECOS data, we conducted structured interviews with staff from 11 organizations (generally MACs)[69] that managed Medicare provider enrollment at the time of our review. These interviews focused on the oversight and maintenance of the PECOS data. We analyzed interview responses to determine whether the contractors verified provider enrollment data in accordance with the PIM and

[68] After we interviewed the contractors in 2010, CMS awarded the contract for managing the NPPES system to a different entity.

[69] At the time of our review, legacy carriers in six Part A/Part B MAC jurisdictions were still processing provider enrollment because the MAC contract awards were under protest and had not been finalized. For the purposes of this report, the contractors responsible for enrolling providers into PECOS will be referred to as MACs.

supplementary guidance. See List 1 for CMS's suggested verification methods for PECOS data.

List 1: Suggested Verification Methods for PECOS Data

Adverse Legal History
Check court records
Check records of the Internal Revenue Service (IRS)

Credentials
Check information/Web sites of State boards or credentialing organizations

Exclusion Status
Check the OIG List of Excluded Providers and Entities
Check the General Services Administration (GSA) Excluded Parties List System

Legitimacy of Business
Compare telephone number to telephone listing(s)
Contact the city or county for professional/business license, certification, and/or registration

Mailing Address
Confirm that it is not a billing agency
Call telephone number to confirm applicant is reached
Confirm that it is not a management service organization
Confirm that it is not a chain's corporate office
Confirm that it is not an applicant's representative

NPI
Require supporting documentation from NPPES

Practice Location
Compare address to Internet sources
Contact the city or county for professional/business license, certification, and/or registration
Perform a site visit

Professional License
Require supporting documentation of license from each State where provider practices

SSN
Confirm provider tax identification number with an approved IRS form

Telephone Numbers
Call the number to verify connection or ownership
Compare telephone number to Internet sources
Compare telephone number to telephone listing(s)

Request for Data Change
Compare signature for request to change a special payments address
Compare signature for request to change a provider's electronic funds transfer authorization agreement
Compare signature for request to change practice location address
Compare signature for request for reactivation or revalidation
Compare signature for requests to change mailing address

Source: OIG analysis of CMS, PIM, Pub. No. 100-08, ch. 10.

Finally, we interviewed CMS staff knowledgeable about NPPES and PECOS regarding safeguards pertaining to data verification. Staff discussed program integrity activities related to provider data in NPPES and PECOS, as well as vulnerabilities and potential improvements for each.

Limitations

Although we collected information about program integrity safeguards for provider data from CMS and contractor staff, we did not determine the extent to which each safeguard worked to prevent or correct inaccurate, incomplete, and/or inconsistent data. The sampling scheme for our provider survey did not enable us to determine the extent to which individual MACs or the application submission method (paper or electronic) influenced the accuracy, completeness, or consistency of provider data.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

In NPPES, 48 percent of records contained inaccurate data; almost all required data were complete

Most currently practicing health care providers have records in NPPES. However, the provider information in NPPES was inaccurate for almost half of providers and while 91 percent of records contained values for all variables, 9 percent of records did not. We were unable to determine if most null values were appropriate, because they were associated with conditionally required variables and NPPES did not indicate whether applicable conditions were met.

Forty-eight percent of NPPES records were inaccurate, generally because address data were inaccurate

Forty-eight percent of NPPES records for Medicare-enrolled providers were inaccurate. Table 1 summarizes the inaccuracies identified by the provider survey. Appendix B provides confidence intervals for each of the point estimates.

Table 1: Inaccurate Provider Data in NPPES

Provider Variable	NPPES Inaccurate Records (Percentage) N=731,738
Mailing address	34.1%
Practice address	33.3%
License (primary)*	4.0%
Credentials**	1.6%
Date of birth	1.6%
License (secondary)*	1.6%
First name	0.0%
Last name	0.0%
NPI	0.0%
SSN (last 4 digits)*	0.0%
Gross	*76.2%*
(Overlapping)	*(27.8%)*
Any variable	**48.4%**

Note: The survey did not ask providers to verify telephone number or gender.

* Provider license and SSN variables are conditionally required in NPPES.

** The credential text variable is not required in NPPES.

Source: OIG analysis of provider survey data, 2011.

Responses from providers indicated that address information was the most common inaccuracy. When we asked providers about the accuracy of mailing addresses and practice address information, 44 percent identified at least one inaccurate NPPES address. Within the 126 survey responses, providers identified 96 data elements (i.e., provider variables shown in Table 1) as inaccurate; 51 (53 percent) were outdated, 18 (19 percent) were partially inaccurate (e.g., contained typographical errors), and 27 (28 percent) had never been correct.

Virtually all required variables in NPPES records were complete

Although 2,098,784 provider records in NPPES contained all necessary data, we found that 214,399 provider records contained null values for one or more variables that are essential for provider identification. Specifically, four records did not contain required provider specialty data and two records did not contain the required telephone number. However, all remaining null values were associated with two conditionally required variables: license number and SSN. A license number is required only for certain provider specialties; however, NPPES does not indicate which records should include license numbers. Similarly, an SSN is required only for web-based applications, but NPPES does not indicate which records were from web-based applications. We were unable to determine the appropriateness of most null values because NPPES lacks indicators regarding which records required license number and SSN data.

In PECOS, 58 percent of records contained inaccurate data and almost 4 percent were incomplete

CMS relies on the verification of PECOS data to ensure Medicare provider integrity. However, the provider information in PECOS was often inaccurate and, at times, incomplete.

Fifty-eight percent of PECOS records were inaccurate, generally because address data were inaccurate

Fifty-eight percent of PECOS records for Medicare-enrolled providers were inaccurate. Table 2 summarizes the inaccuracies identified by the provider survey. Appendix B provides confidence intervals for each of the point estimates.

Table 2: Inaccurate Provider Data in PECOS

Provider Variable	PECOS Inaccurate Records (Percentage) N=731,738
Mailing address (primary)	46.8%
Practice address (primary)	8.7%
Mailing address (secondary)	7.9%
License (primary)*	7.1%
Credentials**	4.8%
License (secondary)*	3.2%
Last name	2.4%
Practice address (secondary)	2.4%
DOB	0.8%
First name	0.0%
NPI	0.0%
SSN (last 4 digits)	0.0%
Gross	*84.1%*
(Overlapping)	*(26.2%)*
Any variable	**57.9%**

Note: The survey did not ask providers to verify telephone number or gender.

* The provider license variable is conditionally required in PECOS.

**The credential text variable is not required in PECOS.

Source: OIG analysis of provider survey data, 2011.

Responses from providers indicated that address information was often inaccurate. When we asked providers about the accuracy of mailing addresses and practice address information, 52 percent identified at least one inaccurate PECOS address. Within the 126 survey responses, providers identified 106 data elements (i.e., provider variables shown in Table 3) as inaccurate; 60 (57 percent) were outdated, 25 (24 percent) were partially inaccurate (e.g., contained typographical errors), and 21 (20 percent) had never been correct.[70]

Almost 4 percent of PECOS records were missing required data

We found that 3.7 percent provider records in PECOS were missing values in one or more required variables that are important for provider identification. Most of the incomplete data can be attributed to the fact that records were missing from the relevant relational tables in PECOS

[70] Percentages have been rounded.

(i.e., the expected record did not exist) rather than to null values (i.e., the data fields contained no values). The information most often incomplete in PECOS was NPI (3 percent). Almost all of the records that were missing NPIs were "active" and therefore should have contained an NPI.[71] We could not determine how many records contained incomplete practice location addresses because the PECOS table that lists such information associates the practice location addresses with the entities to which providers reassigned their benefits. As a result, practice location addresses are rarely associated with individual providers. As in NPPES, license number is required only for certain provider types; however, PECOS does not indicate which records should include license numbers. Therefore, we excluded the 1.2 percent of records missing license number data from our calculation of the total percentage of incomplete records. The gender variable was incomplete for approximately 11 percent of records, and the telephone number variable was incomplete for approximately 4 percent. However, those variables are not required to be populated in PECOS and were therefore excluded from our calculation of the total percentage of incomplete records. Table 3 describes the extent to which individual provider variables were incomplete in PECOS.

[71] Providers who had enrolled through PECOS before NPIs were required would not have an NPI on record; CMS should have deactivated these providers' records if they had not submitted claims in more than a year. We found that less than 1 percent of the records that were missing NPIs (30 of 32,759) had been deactivated.

Table 3: Incomplete Provider Data in PECOS

Provider Variable	Records in Database	Missing Records	Null Data Field	Incomplete Records N=1,021,652 (Number)	Incomplete Records N=1,021,652 (Percentage)
NPI	988,893	32,759	0	32,759	3.2%
Mailing address	1,016,075	5,577	37	5,614	0.5%
Provider specialty	1,016,843	4,809	0	4,809	0.5%
SSN	1,021,427	225	0	225	0.0%
DOB	1,021,652	0	0	0	0.0%
Full name	1,021,652	0	0	0	0.0%
License number*	1,009,470	12,182	0	*	*
Gender**	1,021,652	0	111,546	**	**
Telephone number**	1,016,075	5,577	38,875	**	**
Practice address***	203,637	818,015	17	***	***
Gross				*43,407*	*4.2%*
(Overlapping)				*5,964*	*0.6%*
Any variable				**37,443**	**3.7%**

*We excluded license number from our calculation of the total because it is conditionally required and PECOS data did not indicate which provider types were required to submit licensure information.

**We excluded gender and telephone number from our calculation of the total because they are not required fields in PECOS.

***The provider identification number used to link the other variables was not used to link practice address; we excluded practice address from our calculation of the total to avoid misrepresenting the number of missing records. See Appendix A for more information.

Source: OIG analysis of NPPES and PECOS data, 2011.

Provider data were inconsistent between NPPES and PECOS for 97 percent of records

Of the 987,266 records for providers listed in both NPPES and PECOS, 961,634 contained at least 1 variable that did not match. Only 11,682 records (1.2 percent of the mismatches) could potentially be attributed to the timelag between updates of the databases.[72] Only 3 percent of records contained information that matched across all selected provider variables. More than half of the records were inconsistent between the databases for provider contact information, such as practice location address (89 percent), telephone number (59 percent), and mailing address (51 percent). Address matches are based only on ZIP Codes; this methodology may overestimate the consistency between addresses in NPPES and PECOS. For required variables, such as practice location

[72] Information updates were submitted in PECOS between January and August 2010 for 1.2 percent of the records with inconsistent data. We did not determine whether the information that was entered as updates was the inconsistent information.

address, some of the inconsistencies are attributable to missing or null values in one database or the other. For nonrequired variables, such as telephone number, inconsistencies are attributable only to populated values in both databases. Table 4 lists the extent to which variables were inconsistent between the databases.

Table 4: Inconsistent Data Between NPPES and PECOS

Provider Variable	Mismatched Data Records (Number) N=987,266	Mismatched Data Records (Percentage) N=987,266
Practice location address*	874,401	88.6%
Telephone number	582,147	59.0%
Mailing address*	500,865	50.7%
License number	415,799	42.1%
Credential	91,851	9.3%
Full name	50,921	5.2%
DOB	21,199	2.2%
Gender	12,256	1.2%
SSN	376	0%
NPI	0	0%
Gross	2,549,815	258.2%**
(Overlapping)	*(1,588,181)*	*(160.8)%*
Any variable	**961,634**	**97.4%**

Note: Values that were null in both NPPES and PECOS for each variable are considered matches for this analysis. Variables that were optional in one database or the other (telephone number, credential, and gender) or conditionally required (license) were included in this analysis only if populated in both databases.

*Matches for practice location and mailing addresses are for ZIP Codes only. See Appendix A for detailed methodology regarding the analysis of addresses.

** Figures do not sum to the total because of rounding.

Source: OIG analysis of NPPES and PECOS data, 2011.

CMS did not verify most provider information in NPPES or PECOS

CMS had processes in place to verify the accuracy of provider data in NPPES and PECOS; however, the manner in which CMS implemented these processes impeded efforts to ensure that the databases contained accurate information. Contractor staff reported that CMS required verification for only one provider variable in NPPES. CMS instructed MACs to verify only four provider data variables in PECOS (SSN, NPI, State licensure, and exclusion status) and has not issued detailed guidance for verifying all provider data.

CMS required little verification of NPPES enumeration data

The SSN was the only provider data element verified within NPPES, a possible explanation for why SSNs were the most complete and consistent variable in both databases. However, no verification occurred for any of the other provider data elements. According to NPPES contractor staff, each online applicant's SSN was verified through a CMS data-sharing agreement with the Social Security Administration. Staff stated that if a provider submitted a paper application and chose not to provide an SSN, they required two other forms of identification, one of which had to be government issued. Staff also noted that although the NPPES software standardized the street names in the system to those used by the U.S. Postal Service, the software did not verify that the provider maintained a practice at the location.

CMS staff reported concentrating its program integrity efforts solely on PECOS because NPPES is not used exclusively for Federal health care programs. However, most individual providers that are registered in NPPES also enroll in Medicare.[73] CMS staff reported that NPPES data, including NPI, first and last name, SSN, and DOB, were cross-referenced with PECOS data during the Medicare enrollment process, serving as a verification check for NPPES. CMS staff required providers to correct any inaccurate information in NPPES that resulted in inconsistencies with PECOS before they could proceed with Medicare enrollment. In response to questions about the implications of missing or inaccurate information in NPPES, CMS staff indicated that the onus is on providers to keep their NPPES data correct and up to date. However, CMS is ultimately responsible for ensuring the accuracy of the database.

[73] Although no precise measure exists, the percentage of providers who choose not to participate in Medicare may be less than 1 percent. William Buczko, "Provider Opt-Out Under Medicare Private Contracting," *Health Care Financing Review*, Winter 2004–2005, vol. 26, no. 2. OEI, *Lack of Data Regarding Physicians Opting Out of Medicare* (OEI 07-11-00340), January 26, 2012.

CMS directed MACs to suspend many of the verifications required by the PIM for Medicare provider enrollment in PECOS

To expedite the provider enrollment process, CMS sent a series of memorandums[74] to instruct MACs to verify only the following information during the initial or revalidation PECOS application process:

- the provider's SSN and NPI,
- the applicable State licensure or educational requirements for the provider, and
- the provider's status of not being excluded from participation in the program.

This supplementary guidance effectively waived the PIM requirement to verify all application information, such as telephone numbers and addresses. During this time, CMS was actively encouraging "legacy providers"—providers that had enrolled in Medicare before PECOS was put into place—to reenroll through PECOS.[75] As a result, CMS's instructions to waive the PIM requirement affected not only new enrollments but also reenrollments.

CMS guidance lacks specificity regarding mechanisms of verification for PECOS enrollment data

The PIM directs MACs to verify enrollment data using the most cost-effective method available and suggests some options.[76] The broad guidance provides flexibility in choosing how to verify enrollment application information. However, MACs' use of inconsistent mechanisms of verification can contribute to inaccurate, incomplete, and inconsistent data. Appendix C lists the safeguards that MACs reported

---

[74] CMS, *Expedited Processing of Physician and Non-Physician Practitioner Initial Enrollment Applications (CONFIDENTIAL)*, JSM/TDL-10157, February 24, 2010; extended by CMS, *Extension of Joint Signature Memorandums/Technical Direction Letters (JSM/TDLs) Which Expires December 31, 2010 – Confidential*, JSM/TDL 11087, December 17, 2010, and CMS, *Extension of Joint Signature Memorandums/Technical Direction Letters (JSM/TDL) 09184, 10175, 08191, and 0822*, TDL 12171, January 18, 2012. The JSM instruction remained in effect at the time of report publication, although we use past tense for ease of reading the report. Also for ease of reading, we refer to these collective memorandums as "supplemental guidance." The memorandums are not available online to the public because they were issued confidentially. We were unaware of the existence of these memorandums until the contractor made them available to us.

[75] CMS, Transmittal 712, Change Request 6842. *Medicare Claims Processing Manual*, Pub. No. 100-20, "One-Time Mailing of Solicitation Letter To All Physicians and Non-Physician Practitioners Who Are Currently Enrolled in Medicare But Who Do Not Have An Enrollment Record In the Provider Enrollment, Chain and Ownership System (PECOS)."

[76] CMS, PIM, Pub. No. 100-08, ch. 10, § 5.2.

using during the provider enrollment process at the time of our review and distinguishes verifications required by the PIM and reiterated in supplemental guidance from those required by the PIM but waived by supplemental guidance.

MACs generally reported performing the activities suggested by CMS to verify the variables required by the PIM and reiterated in supplemental guidance. However, 4 of the 11 MACs did not require applicants to submit documentation from NPPES to verify providers' NPIs, 2 did not require applicants to submit approved IRS forms to confirm their Tax Identification Numbers/SSNs, and 3 did not require applicants to submit documentation of professional licensure.

MACs reportedly verified some of the information required by the PIM but waived by supplemental guidance; however, their methods suggested vulnerabilities in the enrollment process. For example, all of the MACs reported verifying that when an application listed a billing agency, the provider's mailing address did not match the billing agency address. However, four MACs did not verify that the mailing address was not that of a management services organization, a chain's corporate office, or the applicant's representative, as required by the PIM. Seven MACs did not verify that practice locations were legitimate businesses, and four did not call telephone numbers to confirm that they were legitimate. Additionally, when a provider's signature on a request for change (e.g., change of contact or payment information) did not match the signature from the original enrollment application, eight MACs required a driver's license or passport to verify the signature on the request for change. However, one MAC required only an attestation on the enrolled provider's letterhead as proof of identity.[77]

Ineffective safeguards can contribute to inaccurate, incomplete, and inconsistent NPPES and PECOS data

The lack of sophisticated electronic edits may explain why almost half of inaccurate NPPES data and 43 percent[78] of inaccurate PECOS data were never accurate or only partially accurate. The staff from the electronic database contractor for NPPES and PECOS reported that a variety of external databases exist to verify the identity of new applicants, check for previously deactivated or excluded providers, and check for adverse legal

[77] CMS, PIM, Pub. 100-08, ch. 10 § 5.7(A)(1). In cases in which a provider requests to change its practice location address, the MAC compares the signature on the change request to the same person's signature on file to ensure that the signatures match. If there is a discrepancy, the MAC must request additional information, such as a photocopy of a current passport or driver's license.

[78] Total has been rounded.

actions. However, they stated that NPPES and PECOS were not technologically integrated with many of these sources. CMS staff reported that they are implementing a new automated provider-screening tool for PECOS that references certain provider information against third-party sources such as State licensing boards and identity management databases.[79]

Other oversight issues may explain why more than half of inaccurate NPPES data were outdated. Contractor staff reported that NPPES uses an algorithm to flag newly submitted applications that contain some level of provider information already in the database[80] and stated that when such applications are flagged, a contractor staff member telephones the applicant to reach a resolution. However, staff reported difficulties when trying to reach providers and reported that they do not deactivate a provider's NPI because of outdated contact information.

NPPES contractor staff also reported difficulties when they processed monthly updates from the Social Security Administration's Death Master Record File to deactivate NPIs belonging to deceased providers. NPPES staff reported sending letters to the providers' NPPES mailing addresses to confirm that providers were deceased and called providers who sent no response to the letter within 20 days. If they received no response after 30 days, staff deactivated the NPIs. However, if providers responded, stating that a mistake had occurred, their NPIs remained active. Consequently, if a fraudulent provider had stolen a deceased provider's identity and indicated to NPPES staff that a mistake had occurred, the fraudulent provider would be able to continue billing as the deceased provider.

Another explanation for errors is that, according to MAC staff, approximately 80 percent of enrollment applications were still processed on paper and transcribed into the PECOS Web interface.[81] When staff transcribe the data from paper forms into PECOS, a risk of transcription errors arises. CMS estimated that fewer than 5 percent of NPPES applications are submitted via paper; however, there is a risk of transcription errors for those records as well.

---

[79] CMS originally expected that the automated provider-screening tool would be fully implemented in mid-2012. CMS, "Information on the Centers for Medicare & Medicaid Services (CMS) Fraud Prevention: Automated Provider Screening and National Site Visit Initiatives," *MLN Matters Number SE1211*, effective July 1, 2012. As of January 2013, CMS expected to fully implement the tool by the end of 2013.

[80] A duplicate record may indicate an error or an attempt to fraudulently obtain an NPI.

[81] The responses from MACs indicated that an average of 81 percent of applications were submitted in paper form, with a range between 66 and 97 percent.

Finally, although regulations require providers to update their NPPES and PECOS data soon after changes occur,[82] CMS reportedly enforces this requirement only for PECOS through revalidation efforts generally scheduled every 5 years. CMS staff reported that they prompt providers to update NPPES data only if a mismatch occurs with the provider's NPI, first or last name, SSN, or DOB in NPPES data during provider enrollment or reenrollment in PECOS.

[82] 45 CFR § 162.410(a)(4).

CONCLUSION AND RECOMMENDATIONS

The ability to identify and locate providers is fundamental to health care program integrity. However, the results of our analyses show that NPPES and PECOS data are not reliable independently or even when combined. More than three out of four providers identified inaccurate data in NPPES or PECOS, and more than one in four providers identified inaccurate data in both NPPES and PECOS. Although verification requirements for provider information are more robust in PECOS, these data are not more accurate than analogous data in NPPES. Required variables in NPPES and PECOS were largely complete, however, the databases lacked the information necessary to determine whether missing values for conditionally required variables were appropriate. Data did not match between NPPES and PECOS for more than 9 out of 10 provider records. Addresses were the source of most inaccuracies and inconsistencies.

Because the NPI is used by private and public health insurance programs, the lack of safeguards for NPPES data complicates program integrity efforts for all health care programs. Each program must separately implement robust safeguards during the enrollment process to ensure that provider data are accurate. The suspension of provider enrollment verification activities at a time of increased application volume could have compromised the accuracy and completeness of PECOS data, increasing the vulnerability of the Medicare program to fraud and abuse. CMS's new automated provider-screening tool has the potential to improve the accuracy of PECOS data. However, it does not reduce the risk of fraudulent NPI enumeration and will not improve NPPES data accuracy.

CMS and OIG have long recognized that preventing fraudulent providers from enrolling in Federal health care programs is more efficient and effective than trying to recover fraudulent payments. To prevent and correct fraudulent enumeration and enrollment, we recommend that CMS:

Require MACs To Implement Program Integrity Safeguards for Medicare Provider Enrollment as Established in the PIM

CMS should rescind the supplemental guidance that waives verification requirements in order to expedite the processing of PECOS applications and should issue new guidance reiterating that all provider data should be verified. MACs should verify all provider data, including credentials, mailing addresses, practice locations, telephone numbers, legitimacy of businesses, and adverse legal histories. CMS should take appropriate action if the safeguards that MACs use do not meet the requirements.

Require More Verification of NPPES Enumeration and PECOS Enrollment Data

CMS should require more verification of provider data in NPPES to protect Medicare and other health care programs from fraud. In addition, CMS could consider:

- using the new PECOS automated provider-screening tool to verify provider data in NPPES, including name, DOB, place of birth, licensure, credentials, mailing address, practice location, telephone numbers, and legitimacy of business;
- monitoring NPPES applications by geographic area to detect potential fraud; and
- enabling NPPES contractor staff to immediately deactivate or suspend the NPIs of providers who are presumed to be deceased.

CMS should also build upon the enhancements to the provider-enrollment screening requirements that went into effect March 25, 2011, by strengthening program integrity safeguards for all initial enrollments, change requests, and revalidations in PECOS. For example, providers identified as limited risk are exempt from the site visits required for moderate- and high-risk providers and suppliers; CMS should determine whether a computerized solution may be used to verify that limited-risk providers' locations are legitimate.

Detect and Correct Inaccurate and Incomplete Provider Enumeration and Enrollment Data for New and Established Records

CMS should consider:

- requiring more frequent revalidation of selected variables, especially address information;
- implementing an automated system edit that will require license information for providers with applicable specialty/taxonomy codes;
- reducing or eliminating the option for providers to submit enumeration and enrollment applications via paper; and
- offering providers incentives to keep their data accurate and current.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with all three of the report recommendations.

Regarding the first recommendation, CMS concurred and stated that measures to streamline the enrollment process do not jeopardize existing program integrity safeguards. CMS reiterated that MACs must adhere to the processing guidelines established in Chapter 15 of the PIM and that supplemental guidance provided to the MACs does not waive those guidelines. The results of this study suggest that MACs may not understand that supplemental guidance does not waive program integrity safeguards established in the PIM; we encourage CMS to clarify that point with the MACs directly.

Regarding the second recommendation, CMS concurred and listed mechanisms under development to further verify NPPES and PECOS data. We encourage CMS to emphasize verification of NPPES data in addition to PECOS data.

Regarding the third recommendation, CMS concurred and plans to use a new Automated Provider Screening tool to identify changes to provider data in PECOS and identify specific providers to revalidate more frequently. CMS has also made enhancements to PECOS that may decrease inaccurate and incomplete provider information. CMS stated that ongoing revalidation efforts and provider education regarding loss of billing privileges for failure to update records will encourage providers to keep their data accurate. We note that all of these efforts are directed towards PECOS data and are therefore unlikely to correct the inaccurate and incomplete provider enumeration data stored in NPPES. Reliable NPPES data could enhance program integrity efforts not just for Medicare, but all health care programs across the Nation.

We did not make any changes to the report based on CMS's comments. For the full text of CMS's comments, see Appendix D.

APPENDIX A

Detailed Methodology

Invitations for Provider Survey. We used email addresses in the National Plan and Provider Enumeration System (NPPES) and Provider Enrollment, Chain and Ownership System (PECOS) databases to notify providers and/or their designated contact people of our survey. If provider email addresses were not valid, we called providers using the telephone number(s) listed in NPPES and PECOS in an effort to obtain valid email addresses. Next, we sent invitations to complete the online survey via email and U.S. Postal Service (USPS) mail, using the mailing address listed in PECOS. The USPS invitation letters assigned each provider a unique user name and password that were required as a security measure to complete the survey. Providers who did not complete the survey after 2 weeks were sent a second USPS mailing and reminder email. Letters were sent to the same mailing address listed in PECOS unless initial mailings were returned marked as "Return to Sender," in which case the second letter was sent to the mailing address listed in NPPES. We attempted to telephone providers who did not complete the survey and sent a final invitation letter via certified mail 10 weeks after the previous mailing. This final attempted mailing was sent to the provider mailing address listed in NPPES if it was different from the mailing address in PECOS; if it was the same, the letter was sent to the practice location address listed in NPPES.

After 4 months, 126 providers had completed the survey—a response rate of 74 percent. The remaining 44 providers declined to complete the survey, were retired from practice, or accessed the survey but did not submit any response.

Completeness of Data: PECOS. Most of the variables in our analysis were linked across relational tables in PECOS using a variable called PECOS associate control ID (PAC ID). However, the PAC ID was not present in the table featuring practice address; instead, a variable called Enrollment ID was used. Email correspondence with Centers for Medicare & Medicaid Services (CMS) staff confirmed that a practice address was displayed for individual provider records in the relevant table only if those providers had not reassigned their benefits to a group or other individual provider (which is common practice for providers working in a group or clinic setting). In many cases, the practice addresses would be under groups' enrollment identifiers rather than the individual practitioners' enrollment identifiers. Data for group practices were outside the scope of this study, so findings on the completeness of practice address are absent from this report.

PECOS contained 5 schemas with 839 relational tables and 4,701 variables and different numbers of records per table. The 10 variables we reviewed were located in 8 different tables within the schema that CMS advised us to use. See Table A-1 for information about how many records were listed for each variable in PECOS.

Table A-1: Records per Variable in PECOS Schema

Variable	Table Name	Variable Link	Total Number of Records	Number of Nonduplicate Individual Practitioner Records
Full name	PEC_INDVDL_NAME	PAC ID	1,519,571	1,021,652
Date of birth	PEC_ASCT_INDVDL	PAC ID	1,426,013	1,021,652
Gender	PEC_ASCT_INDVDL	PAC ID	1,426,013	1,021,652
Social Security number	PEC_TIN	PAC ID	1,751,742	1,021,427
Specialty Code	PEC_ENRLMT_PHYSN_SPCLTY + PEC_ENRLMT_NPHYSN_SPCLTY	PAC ID	1,260,639	1,016,843
Mailing address	PEC_MLG_ADR	PAC ID	1,762,669	1,016,075
Telephone number	PEC_MLG_ADR	PAC ID	1,762,669	1,016,075
License number	PEC_STATE_LCNS	Enrollment ID	1,221,584	1,009,470
National Provider Identifier	PEC_NPI	PAC ID	1,292,182	988,893
Practice address	PEC_ENRLMT_ADR	Enrollment ID	895,234	203,637

Source: Office of Inspector General analysis of PECOS data, 2011.

Consistency of Data: Address Match. NPPES contained one set of variables (i.e., street address, city, State, ZIP Code) for each provider mailing address and another set of variables for each provider practice location address. However, the relational tables in PECOS permitted two mailing addresses and five practice location addresses per provider.[83] If the ZIP Code from the mailing address in NPPES matched the ZIP Code for either mailing address in PECOS, we considered it a match. Similarly, if the ZIP Code from the practice address in NPPES matched the ZIP Code for any of the practice addresses in PECOS, we considered it a match.

[83] Values for practice location address did not exist for many provider records, as described in the section above regarding completeness of PECOS data.

APPENDIX B

Point Estimates and Confidence Intervals Based on Provider Survey

We calculated confidence intervals for key data points in the provider survey regarding the accuracy of provider data. The sample size, point estimates, and 95-percent confidence intervals are given for each of the following:

Table B-1: Confidence Intervals for Provider Survey Data

Data Element Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Number of providers who responded to the survey	126	731,738	666,080–797,395
Percentage of providers with inaccurate NPPES mailing address or practice location address	126	43.7%	35.2%–52.5%
Percentage of providers with inaccurate NPPES mailing address	126	34.1%	26.3%–42.9%
Percentage of providers with inaccurate NPPES practice address	126	33.3%	25.6%–42.1%
Percentage of providers with inaccurate NPPES State license (primary)	126	4.0%	1.6%–9.3%
Percentage of providers with inaccurate NPPES DOB	126	1.6%	0.4%–6.2%
Percentage of providers with inaccurate NPPES State license (secondary)	126	1.6%	0.4%–6.2%
Percentage of providers with inaccurate NPPES credentials	126	1.6%	0.4%–6.2%
Percentage of providers with inaccurate NPPES first name	126	0.0%	0.0%–2.9%
Percentage of providers with inaccurate NPPES last name	126	0.0%	0.0%–2.9%
Percentage of providers with inaccurate NPPES NPI	126	0.0%	0.0%–2.9%
Percentage of providers with inaccurate NPPES SSN (last four digits)	126	0.0%	0.0%–2.9%
Percentage of providers with inaccurate NPPES data (gross)	126	76.2%	60.6%–91.8%
Percentage of providers with inaccurate NPPES data (overlapping)	126	27.8%	19.0%–36.6%
Percentage of providers with inaccurate NPPES data (net)	126	48.4%	39.7%–57.2%
Percentage of providers with inaccurate PECOS mailing address or practice location address	126	51.6%	42.8%–60.3%
Percentage of providers with inaccurate PECOS mailing address (primary)	126	46.8%	38.2%–55.6%
Percentage of providers with inaccurate PECOS practice address (primary)	126	8.7%	4.9%–15.2%
Percentage of providers with inaccurate PECOS mailing address (secondary)	126	7.9%	4.3%–14.2%

continued on next page

Table B-1: Confidence Intervals for Provider Survey Data (Continued)

Data Element Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of providers with inaccurate PECOS practice address (secondary)	126	2.4%	0.8%–7.2%
Percentage of providers with inaccurate PECOS credentials	126	4.8%	2.1%–10.3%
Percentage of providers with inaccurate PECOS State license (primary)	126	7.1%	3.7%–13.2%
Percentage of providers with inaccurate PECOS state/license (secondary)	126	3.2%	1.2%–8.2%
Percentage of providers with inaccurate PECOS last name	126	2.4%	0.8%–7.2%
Percentage of providers with inaccurate PECOS DOB	126	0.8%	0.1%–5.5%
Percentage of providers with inaccurate PECOS first name	126	0.0%	0.0%–2.9%
Percentage of providers with inaccurate PECOS NPI	126	0.0%	0.0%–2.9%
Percentage of providers with inaccurate PECOS SSN (last four digits)	126	0.0%	0.0%–2.9%
Percentage of providers with inaccurate PECOS data (gross)	126	84.1%	68.0%–100.0%
Percentage of providers with inaccurate PECOS data (overlapping)	126	26.2%	15.5%–36.9%
Percentage of providers with inaccurate PECOS data (net)	126	57.9%	49.1%–66.3%
Percentage of providers with any inaccurate NPPES or PECOS data	126	77.0%	68.7%–83.6%
Percentage of providers with inaccurate NPPES and PECOS data	126	29.4%	22.0%–38.0%

Abbreviations used in table: NPPES = National Plan and Provider Enumeration System; DOB = date of birth; NPI = National Provider Identifier; SSN = Social Security number; PECOS = Provider Enrollment, Chain and Ownership System.

Source: Office of Inspector General analysis of provider survey data, 2011.

APPENDIX C

Table C-1: Safeguards That Medicare Administrative Contractors Report Using To Verify Provider Enrollment Data

Status	Variable for Verification	Suggested Method for Verification	MACs Routinely Performing Activity (N=11)
Required by the PIM and Supplemental Guidance	Exclusion Status	Check the OIG List of Excluded Providers & Entities database	11
		Check the GSA Excluded Parties List System	11
	SSN	Confirm provider tax identification number with an approved Internal Revenue Service form	8
	Professional License	Require supporting documentation of license from each State where provider practices	9
	NPI	Require supporting documentation from NPPES	7
Required by the PIM but Waived by Supplemental Guidance	Credentials	Check information/Web sites of State boards or credentialing organizations	11
	Mailing Address	Confirm that it is not a billing agency	11
		Call telephone number to confirm that applicant is reached	8
		Confirm that it is not a management service organization	7
		Confirm that it is not a chain's corporate office	6
		Confirm that it is not an applicant's representative	4
	Request for Data Change	Compare signatures for request to change a special payments address	11
		Compare signatures for request to change the provider's electronic funds transfer authorization agreement	10
		Compare signatures for request to change practice location address	10
		Compare signatures for request for reactivation or revalidation	9
		Compare signature for requests to change mailing address	8
	Practice Location	Compare addresses to addresses in Internet sources	10
		Contact the city or county for professional/business license, certification, or registration	2
		Perform a site visit	0

continued on next page

Table C-1: Safeguards That Medicare Administrative Contractors Report Using To Verify Provider Enrollment Data (Continued)

Status	Variable for Verification	Suggested Method for Verification	MACs Routinely Performing Activity (N=11)
Required by the PIM but Waived by Supplemental Guidance	Telephone Numbers	Call the number to verify connection or ownership	7
		Compare telephone number to Internet sources	5
		Compare telephone number to telephone listing(s)	2
	Legitimacy of Business	Check records of the Internal Revenue Service (EIN)	4
		Compare telephone number to telephone listing(s)	2
		Contact the city for professional/business license, certification, or registration	2
		Contact the county for professional/business license, certification, or registration	1
	Adverse Legal History	Check court records of conviction	2

Abbreviations used in table: MAC = Medicare Administrative Contractor, PIM = Program Integrity Manual, JSM = Joint Signature Memorandum, OIG = Office of Inspector General, GSA = General Services Administration, SSN = Social Security number, NPI = National Provider Identifier, NPPES = National Plan and Provider Enumeration System, and EIN = Employer Identification Number.

Source: Office of Inspector General analysis of MAC Survey data, 2011.

APPENDIX D

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: MAR 2 5 2013

TO: Daniel R. Levinson
Inspector General

/S/

FROM: Marilyn Tavenner
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Inaccurate, Incomplete, and Inconsistent Provider Enumeration and Medicare Enrollment Data" (OEI-07-09-00440)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the subject of the OIG draft report. The purpose of this report is to assess provider enumeration data (i.e., from providers' applications for National Provider Identifiers (NPI)) and Medicare provider enrollment data maintained by CMS for accuracy, completeness, and consistency; and to assess CMS oversight processes for ensuring the accuracy, completeness, and consistency of provider enumeration data and Medicare provider enrollment data.

The CMS is committed to preventing fraudulent providers from enrolling in federal health care programs, removing fraudulent providers from the programs, and maintaining the integrity of the systems that house provider enumerators and enrollment information. Medicare Administrative Contractors (MAC) are required by the Program Integrity Manual (PIM) to use validation techniques such as documentation reviews, licensure verification, review of exclusion and debarment databases, interaction with Social Security Administration's (SSA) databases, and site visits to verify enrollment information.

In addition, CMS has already begun working on developing mechanisms to further verify provider enumerator data and implement processes to actively deactivate NPIs when appropriate for potentially fraudulent providers.

We appreciate OIG's efforts in working with CMS to help ensure that provider enumeration and Medicare enrollment data is accurate, complete, and consistent. Our response to each of the OIG recommendations follows.

OIG Recommendation

The OIG recommends that CMS require MACs to implement program integrity safeguards for Medicare provider enrollment as established in the PIM.

CMS Response

The CMS concurs with the recommendation. MACs must adhere to the processing guidelines established in Chapter 15 of the PIM. The purpose of these instructions is to ensure that the Medicare billing privileges of physicians, non-physician practitioners, and organizational providers/suppliers are protected and that Medicare only pays qualified individuals and organizations. Supplemental guidance provided to the MACs does not waive the program integrity safeguards established in the PIM. Among the validation techniques used by MACs are documentation reviews, licensure verification, review of exclusion and debarment databases, interaction with SSA's databases, and site visits as required in the PIM.

MACs continue to review all names on the Medicare enrollment form CMS-855 against the OIG List of Excluded Parties and the System for Awards Management's debarment list to ensure that the entity/person is not excluded or barred from participating in Medicare.

For initial applications and revalidations, the contractor verifies via the state licensure websites or submission of licensure documentation by the provider that the provider is currently licensed. The contractor performs a site visit on all moderate and high risk providers and suppliers as required by CMS regulations implementing the enhanced screening provisions in the Affordable Care Act. These site visits help ensure that the provider/supplier is operational and in compliance with enrollment requirements.

In an effort to reduce burden on the provider community, CMS continues to implement measures to streamline the enrollment process and incorporate program integrity safeguards. These measures in no way jeopardize the program integrity safeguards put in place throughout the manual.

OIG Recommendation

The OIG recommends that CMS require more verification of National Plan and Provider Enumeration Systems (NPPES) enumeration and Provider Enrollment, Chain and Ownership System (PECOS) enrollment data.

CMS Response

The CMS concurs with the recommendation. CMS will continue to work on developing mechanisms to further verify NPPES and PECOS data.

For instance, CMS is currently working on a process to rapidly deactivate NPIs for practice locations that are determined to be invalid. In conjunction with other data obtained, CMS will take action to deactivate NPI records with invalid practice locations or other circumstances justifying deactivation (according to 45 CFR §162.408(c)).

In addition, CMS has already implemented a method to immediately identify providers and suppliers who are deceased by obtaining the deceased provider data on a more frequent basis from SSA (weekly basis as opposed to monthly). Upon verification of death, the NPI

enumerator immediately deactivates the NPI record in NPPES and the Medicare enrollment record in PECOS.

In addition to the program safeguards and data verification mechanisms currently in place, CMS plans to use the Automated Provider Screening (APS) system to screen and validate provider and supplier information such as licensure and exclusion data in an effort to improve and standardize the enrollment data verification by MACs. CMS plans to screen all initial enrollments, changes, and revalidations through APS for providers and suppliers of all risk levels. In addition, CMS plans to analyze the information from APS and other investigative methods to conduct ad hoc site visits using the National Site Visit Contractor to further validate information provided during the enrollment process.

OIG Recommendation

The OIG recommends that CMS detect and correct inaccurate and incomplete provider enumeration and enrollment data for new and established records.

CMS Response

The CMS concurs with this recommendation. In addition to the program safeguards and data verification mechanisms currently in place, CMS plans to address OIG's recommendation by using APS to identify any key changes to provider data and monitoring recent PECOS enhancements, which will minimize inaccurate and incomplete provider enrollment data.

The CMS plans to use APS to identify any key changes to provider data and make a determination to revalidate specific providers more frequently. The APS system will rescreen and continuously monitor all provider enrollment data depending on the risk level and on an as needed basis at CMS discretion. APS screening rules will implement the necessary checks for licensure as applicable to a specific state and specialty.

The CMS has made significant changes to the PECOS web application user interface and improved the usability of the system and implemented features like e-signature and Digital Documentation. With the implementation of these changes, providers and suppliers can enroll in Medicare through a completely digital process thus decreasing inaccurate and incomplete application submissions. As a result of these enhancements, CMS has already seen an upward trend in the number of web application submissions.

Recent PECOS system enhancements, including various page level data validations, error checks, and warnings to eliminate and detect data entry errors, will further decrease inaccurate and incomplete data. CMS has already started working on analyzing and correcting PECOS data for missing key data elements like NPI by obtaining data from other referential sources and updating PECOS. Currently, NPI information is incomplete only for less than 1 percent in PECOS compared to 3 percent as referenced in this report due to these updates.

The CMS will encourage providers and suppliers to keep their data accurate and current through the ongoing revalidation effort and by educating the provider and supplier community that failure to comply may result in loss of billing privileges.

Again, we appreciate the opportunity to comment on this draft report and look forward to working with OIG on this and other issues.

ACKNOWLEDGMENTS

This report was prepared under the direction of Brian Pattison, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office, and Brian T. Whitley, Deputy Regional Inspector General.

Julie Dusold Culbertson served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the Kansas City regional office who contributed to the report include Michael J. Brown and Jordan R. Clementi; central office staff who contributed include Kevin Farber, Scott Horning, Scott Manley, Christine Moritz, and Debra Roush.

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.