United States Senate
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS
Committee on Homeland Security and Governmental Affairs

Carl Levin, Chairman
Norm Coleman, Ranking Minority Member

MEDICARE VULNERABILITIES: PAYMENTS FOR CLAIMS TIED TO DECEASED DOCTORS

STAFF REPORT

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

UNITED STATES SENATE

RELEASED IN CONJUNCTION WITH THE
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS
JULY 9, 2008 HEARING

SENATOR CARL LEVIN
Chairman
SENATOR NORM COLEMAN
Ranking Minority Member

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

ELISE J. BEAN
Staff Director and Chief Counsel

KRISTINA KO
Office of Senator Carl Levin

GINA REINHARDT
Congressional Fellow

MARK L. GREENBLATT
Staff Director and Chief Counsel to the Minority

CLIFFORD C. STODDARD, JR.
Counsel to the Minority

DONELL RIES
Detailee

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS
STAFF REPORT
MEDICARE VULNERABILITIES:
PAYMENTS FOR CLAIMS TIED TO DECEASED DOCTORS

TABLE OF CONTENTS

# # #

MEDICARE VULNERABILITIES:
PAYMENTS FOR CLAIMS TIED TO DECEASED DOCTORS

July 9, 2008

I. INTRODUCTION

The Medicare program was created to provide health insurance for the elderly and the disabled. In 2007, Medicare paid more than $400 billion to cover more than 43 million beneficiaries.[1] Despite its noble intentions, the Medicare program has faced a pervasive and persistent problem with fraud and abuse. In its fiscal year 2005 performance and accountability report, the Department of Health and Human Services (HHS) reported that Medicare paid an estimated $12.1 billion in improper payments for claims in 2005 and an estimated $21.7 billion in 2004. Since 1990, the Government Accountability Office (GAO) has consistently designated the Medicare program as high risk for fraud, waste, and abuse, because of its size, complexity, and vulnerability to mismanagement and improper payments.[2]

Abuses particularly plague the Medicare Part B program, which pays for certain medical equipment and supplies – commonly called durable medical equipment (DME) or durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) – for eligible beneficiaries. According to the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Medicare program, abuses related to DME claims cost billions of dollars each year.[3] On March 8, 2007, the Chief Financial Officer of CMS testified before a Congressional committee that "[t]he fraudulent business practices of unscrupulous durable medical equipment, orthotics, prosthetics and supplies suppliers continue to cost the Medicare program billions of dollars."[4] In 2007, GAO reported that CMS estimated that Medicare made improper payments based on mistakes, abuse, or fraud totaling approximately $700 million for DME supplies in one year alone. According to GAO, these types of payments represented approximately 7.5 percent of total payments made for DME items.[5]

In light of reports of abuses in the Medicare program, the United States Senate Permanent Subcommittee on Investigations (the Subcommittee) initiated an investigation into fraud, waste, and abuse in Medicare, with a particular focus on DME claims. The Subcommittee's inquiry is also examining the efficacy of efforts to identify and prevent such abuses by CMS and its

---

[1] 2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds at page 2.

[2] GAO-07-310, High-Risk Series: An Update, January 2007.

[3] Testimony of CMS Chief Financial Officer Timothy B. Hill before the House Ways and Means Subcommittees on Health and Oversight, March 8, 2007. The Centers for Medicare and Medicaid Services was formerly called the Health Care Financing Administration (HCFA). The name was changed in 2001.

[4] Id.

[5] GAO 07-59, Medicare: Improvements Needed to Address Improper Payments for Medical Equipment and Supplies, January 31, 2007.

contractors. The Subcommittee's investigation has included a detailed examination of data concerning millions of DME claims submitted between 1995 and 2007. The Subcommittee has also interviewed numerous officials from CMS, Medicare contractors, the Department of Justice Fraud Section, the Department of Health and Human Services Office of the Inspector General (HHS/OIG), as well as physicians, representatives of DME suppliers, Medicare beneficiaries, and DME suppliers who have been convicted of Medicare fraud. This Report presents the findings and recommendations of the Subcommittee staff on one aspect of the problem, the payment of Medicare DME claims referencing a prescribing physician who is deceased.

II. EXECUTIVE SUMMARY

Medicare regulations require that DME claims contain certain information in order to qualify for payment.[6] For instance, claims must include valid identification numbers for the beneficiary and the DME supplier. Another essential element is the identification number for the prescribing medical provider – the Unique Physician Identification Number, commonly called the UPIN.

Over the course of its investigation into fraud, waste, and abuse in Medicare, the Subcommittee has uncovered a substantial volume of paid DME claims that contained UPINs for deceased physicians. Specifically, the Subcommittee staff estimates that, from 2000 through 2007, Medicare paid for approximately 478,500 claims that contained the UPINs of deceased doctors, and the number of claims paid could be as high as 570,000. The Subcommittee staff also estimates that the amount of money paid for these claims is well over $76.6 million, and it is possible that that number actually exceeds $92 million.[7] The Subcommittee's analysis indicates that these Medicare claims contained the UPINs of between 16,500 and 18,200 deceased physicians. Sixteen percent of the estimated 478,500 claims, amounting to 51,534 claims valued at roughly $4 million, contained UPINs of doctors who died ten or more years before the service date on the claims.[8] The Subcommittee also found that an estimated 2,000 to 2,900 deceased physicians still had active UPINs as of May 2008.[9]

Because of the high number of Medicare claims and reports of fraud, waste, and abuse in Florida, the Subcommittee also examined claims using deceased physician UPINs in that state. The Subcommittee's investigation uncovered alarming case studies that included one UPIN that was used in 484 claims, totaling more than $544,000, that were paid more than six years after the death of the prescribing physician. Similarly, the Subcommittee discovered that the UPIN

[6] Medicare Claims Processing Manual, Chapter 1, Section 80.3.1 through 80.3.2.

[7] All estimates presented here are based on a 95-percent confidence level, as discussed in greater detail in Footnote 44 below. For the number of claims submitted to Medicare with deceased physician UPINs, the 95-percent confidence interval ranges from a low of 384,730 claims to a high of 572,268 claims. For the Medicare expenditures on claims containing deceased physician UPINs, the 95-percent confidence interval ranges from a low of $60,317,099.12 to a high of $92,819,900.74.

[8] The 95-percent confidence interval for the claims tied to doctors who died at least ten years before the listed service date ranges from 26,915 to 76,154. The 95-percent confidence interval for the amount of money paid for those claims ranges from a low of $2,000,595.81 to a high of $5,793,331.90.

[9] The estimate for the number of deceased doctors with active UPINs as of May 2008 was generated by calculating the proportion of doctors within the sample that had active UPINs as of May 2008, and estimating the population proportion and confidence interval using the equation: $\pm 1.96\left(\sqrt{\frac{(p)(1-p)}{n}}\right)$.

assigned to one doctor who died in 2001 was used in more than 3,800 claims submitted between 2002 and 2007, resulting in Medicare payments of more than $354,000. In another instance, the Subcommittee found that the UPIN of a physician who died before 1999 was used on more than 1,600 claims submitted after April 2002, resulting in Medicare payments of more than $478,000.

These problems are not new. In November 2001, HHS/OIG reported that Medicare paid $91 million in 1999 for medical equipment and supply claims with invalid or inactive UPINs. HHS/OIG recommended that CMS: (1) revise its claims process to ensure that UPINs listed on medical equipment and supply claims are valid and active; and (2) emphasize to suppliers the importance of using accurate UPINs when submitting claims to Medicare. CMS agreed with HHS/OIG's recommendations and, in its written comments to the report, stated that on April 1, 2002, it would provide instructions and implement changes to its automated claims processing system to reject medical equipment and supply claims using deceased physician UPINs.[10]

After the issuance of the HHS/OIG report, CMS took several steps to reject claims containing UPINs assigned to deceased physicians. For example, CMS instructed its claims processing contractors to perform a one-time review of its UPIN registry and in-house provider files to deactivate UPINs for doctors who were deceased or did not file any claims from their practices for 12 months.[11] CMS further directed its claims processing contractors, beginning on April 1, 2002, to reject claims using invalid or inactive UPINs. CMS also announced that it would make changes to its payment systems to ensure that claims using invalid or inactive UPINs would be automatically rejected.

Despite these actions, the Subcommittee investigation found that claims with deceased physician UPINs were still not automatically rejected. To the contrary, payment data supplied by CMS showed that Medicare paid claims containing UPINs from physicians who had died more than 12 months prior to the dates of service on the claims. In fact, 63 percent of the claims identified by the Subcommittee as using deceased physician UPINs were paid with dates of service after April 1, 2002, the date after which Medicare was supposed to reject such claims.

Apparently, neither CMS, the HHS/OIG, nor the claims processing contractors performed the reviews or audits needed to ensure that the steps taken in 2002 were effective in stopping the payment of Medicare claims using deceased physician UPINs. This oversight failure resulted in tens of millions of dollars in improper payments.

A. Report Findings

Based upon its investigation, the Subcommittee staff makes the following findings of fact.

1. **Tens of Millions Paid for Medicare Claims With Deceased Physician UPINs.** From 2000 to 2007, Medicare paid an estimated $60 million to

[10] HHS/OIG, Medical Equipment and Supply Claims with Invalid or Inactive Physician Numbers, November 2001.

[11] Id. at pg. 2.

$92 million for hundreds of thousands of DME claims that contained identification numbers assigned to an estimated 16,500 to 18,200 deceased physicians.

2. **CMS Actions Taken in 2002 to Stop Deceased Physician Claims Failed.** In 2002, CMS implemented procedures to ensure that DME claims with UPINs of deceased physicians would be rejected, but those procedures were ineffective in resolving the problem, and HHS and CMS personnel failed to perform the reviews or audits needed to ensure the procedures were working. As a result, CMS has paid claims containing UPINs assigned to deceased doctors years after their death.

3. **Medicare Remains Unprotected from Deceased Physician Claims.** As of May 2008, the UPINs of an estimated 2,000 to 2,900 deceased physicians remained active, until replaced by the National Provider Identifier number (NPI). The continuing inability of CMS's payment systems to reject claims containing deceased physician identification numbers renders Medicare vulnerable on a continuing basis to millions of dollars in improper claims each year.

B. Report Recommendations

After being informed of the Subcommittee's investigative findings, CMS did not dispute them, but told the Subcommittee that CMS is currently undergoing substantial changes in the way Medicare claims are processed, including recent changes to physician and DME supplier identification numbers.[12] Specifically, over the past year, CMS has terminated the UPIN registry and replaced UPINs with a new National Provider Identifier (NPI) numbering system for all Medicare service providers.[13] Beginning in May 2008, NPIs are required to be submitted for all Medicare claims.

Based upon the Subcommittee's investigative findings and the ongoing reform of the Medicare claims review processes, the Subcommittee staff makes the following recommendations.

1. **Strengthen Procedures to Deactivate NPIs after Physician Death.** CMS should examine its procedures for identifying deceased physicians to ensure timely receipt of deceased physician data, automatic deactivation of relevant NPI numbers, and continual update of the NPI registry. CMS should develop a quality control program to ensure NPIs are deactivated within a specified period of time after receiving notice of a physician's death, such as 90 days.

2. **Initiate Regular NPI Registry and Claim Audits.** CMS should initiate periodic audits of its NPI registry to test whether NPI numbers assigned to deceased physicians have been deactivated within the specified timeframe and to test Medicare

[12] CMS's responses are produced in Appendices II and III below.

[13] 45 CFR Part 162, Federal Register, Vol. 69, No. 15, January 23, 2004, at pg. 3434.

payment records to determine whether claims containing deceased physician NPIs were rejected.

3. **Consider Additional Procedures and Audits to Strengthen NPI Registry.** CMS should consider instituting additional procedures and audits to ensure the prompt deactivation of NPIs assigned to Medicare service providers who have stopped providing services due to licensure revocation, retirement, or other reasons, including automatic deactivation of any NPI that has not been used in a Medicare claim within a specified time period, such as 12 months. Consideration should also be given to developing procedures to allow deactivated NPIs to be reinstated upon proper application.

III. BACKGROUND

A. Overview of Medicare and Durable Medical Equipment Claims

1. Medicare and DME in General

Title XVIII of the Social Security Act (SSA), entitled "Health Insurance for the Aged and Disabled," established the Medicare program in 1965.[14] Medicare was created to provide health insurance for the aged, disabled, and persons with end-stage renal disease. The program is administered by HHS through CMS.

Medicare is comprised of four parts. Part A, the Hospital Insurance Program, covers hospital services, post-hospital services, and hospice services. Part B, the Supplementary Medical Insurance Program, covers medical services including physician, laboratory, outpatient services, and DME. Part C covers managed care options for beneficiaries enrolled in Part A and Part B. Part D, created by the Medicare Prescription Drug Improvement and Modernization Act of 2003, covers outpatient prescription drug benefits as of January 1, 2006.[15] For the purposes of this report, the Subcommittee will focus on Medicare Part B.

Under Part B, the Medicare program will pay for certain DME for eligible Medicare beneficiaries under the DMEPOS benefit.[16] The term DME refers to medical equipment and supplies that are used in the patient's home (including an institution such as a nursing home in which the patient resides).[17] Medicare regulations define DME as:

> [E]quipment furnished by a supplier or a home health agency that:
>
> (1) Can withstand repeated use;
> (2) Is primarily and customarily used to serve a medical purpose;

[14] Title XVIII appears in the United States Code at 42 USC §§ 1395-1395(ccc).

[15] Prior to this date, many prescription drugs were covered under Medicare Part B.

[16] SSA Section 1833(a)(1)(I).

[17] SSA Section 1861(n).

(3) Generally is not useful to an individual in the absence of an illness or injury; and
(4) Is appropriate for use in the home.[18]

Examples of DME include wheelchairs, oxygen condensers, nebulizers, canes, hospital beds, prosthetics, diabetic equipment and supplies such as blood glucose test strips, and some prescription medications.

2. DME Claims and Suppliers

The Medicare claims process for DME typically involves three parties: (1) the Medicare beneficiary who is prescribed certain medical supplies or equipment; (2) the medical practitioner, such as a physician, nurse practitioner, or physician assistant who is treating the beneficiary and prescribing the equipment; and (3) the DME supplier, a private entity authorized by CMS to provide DME items to Medicare beneficiaries and bill Medicare directly. The process of a DME claim generally starts with the Medicare beneficiary receiving treatment from a medical practitioner. If the physician writes an order or prescription for DME, the beneficiary can take the prescription to a DME supplier of his or her choosing and the DME supplier sells or rents the prescribed item to the beneficiary.[19]

In most circumstances, the DME supplier submits a claim for payment to an entity authorized by CMS to receive, review, and process Medicare claims, such as a Durable Medical Equipment Regional Carrier (DMERC) or other Medicare carrier. DMERCs were established to standardize the coverage and payment of DME claims and were designed to be the experts in the Medicare DME claims process. Their primary role was to accept and process Medicare Part B DME claims. In doing so, DMERCs were also expected to consolidate and focus efforts to combat fraud, waste, and abuse in the DME benefit program.[20]

Physicians generally file Medicare claims that deal with treatment, office visits, and other medical procedures, while DME claims are typically submitted by suppliers. As noted above, DME suppliers are entities that are authorized by the Medicare program to sell or rent DME to eligible beneficiaries and submit claims for payment directly to Medicare. DME suppliers typically include pharmacies or companies that specialize in DME such as wheelchairs, oxygen supplies, diabetic supplies and other supplies and equipment that are provided to Medicare beneficiaries, as well as other medical patients.

---

[18] 42 CFR 414.202.

[19] For certain DME, including equipment that is expensive and prone to fraudulent activity, CMS regulations require the physician to provide a Certificate of Medical Necessity (CMN) in addition to a prescription. For instance, Medicare requires a CMN for oxygen or infusion pumps. A CMN is a form required to help document the medical necessity and other coverage criteria for selected DMEPOS. Medicare Claims Processing Manual, Chapter 20, Section 100.2.

[20] Section 911 of the Medicare Modernization Act of 2003, known as the Medicare Contracting Reform provision, required CMS to compete all currently held contracts for administration of the fee-for service Medicare program. The new contractors selected through these competitions are called Medicare Administrative Contractors (MACs). DME MACs are the new contractors for DME services.

B. Unique Physician Identification Numbers

The Omnibus Budget Reconciliation Act of 1985 required CMS to establish UPINs for all physicians who provide services to Medicare beneficiaries.[21] Under the UPIN system, each physician was assigned one unique number that never changed. CMS contracted with one company, National Heritage Insurance Company Corporation (NHIC), to manage the UPIN registry, a database containing detailed information about each physician approved to submit Medicare claims, including the practice settings of each physician assigned a UPIN.[22] The database included an Internet component, available to the public, that could be used to verify a physician's UPIN or other data such as name or practice location.[23]

In addition, since 1992, Medicare regulations have required DME suppliers to provide the UPIN of the physician who ordered the DME items on all claims submitted to Medicare for payment. The regulations state that claims without a valid UPIN must be denied.[24] In its response to Subcommittee questions, CMS summarized these regulations as follows:

> The effective date for requiring the UPIN of the ordering/referring physician for all services was January 1, 1992. As required by section 1833(q) of the Social Security Act, all claims for Medicare covered services and items that are the result of a physician's order or referral must include the ordering/referring physician's name and UPIN. This includes parenteral and enteral nutrition, immunosuppressive drug claims, diagnostic laboratory services, diagnostic radiology services, consultative services, and durable medical equipment. Claims for other ordered/referred services not included in the preceding list must also show the ordering/referring physician's name and UPIN. All physicians who order or refer Medicare beneficiaries or services must obtain a UPIN even though they may never bill Medicare directly. A physician who

---

[21] UPINs were phased out of the Medicare program on May 23, 2008, in favor of a new numbering system involving NPIs. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the development of the NPIs to be used by all entities who file claims with Medicare. As a result, no new UPINs have been issued since June 2007, and all Medicare claims are now required to have NPIs.

[22] According to the definition provided on the NHIC website, "a practice setting is defined as a specific location at which a physician, medical group, or non-physician practitioner renders service. It is physically separate from any other location in which he or she renders service." *See* http://www.upinregistry.com/faq.asp#6.

[23] The UPIN online registry was terminated on May 23, 2008. According to the CMS website at http://www.cms.hhs.gov/nationalprovidentstand:

> The NPI will be Required for all HIPAA Standard Transactions on May 23rd. This means:
>
> For all primary and secondary provider fields, only the NPI will be accepted and sent on all HIPAA electronic transactions . . . [and] paper claims . . . .

The reporting of Medicare legacy identifiers in any primary or secondary provider fields will result in the rejection of the transaction.
A similar website has been established for the NPI system, which is managed by Fox Systems, Inc. under contract with CMS.

[24] Medicare Claims Processing Manual, Chapter 1, Section 80.3.2.1.2. This same restriction also applies to NPIs.

> has not been assigned a UPIN must contact the Medicare carrier. … If durable medical equipment, prosthetics and orthotics are ordered, the name and UPIN of the ordering physician must be on Form CMS-1500 in items 17 and 17a.

C. 2001 HHS Inspector General Report

In 2001, the HHS/OIG published a report analyzing the payment of Medicare claims containing invalid or inactive UPINs.[25] The study found that, in 1999, Medicare paid $32 million for medical equipment and supply claims with invalid UPINs and an additional $59 million for claims with inactive UPINs. The HHS/OIG recommended that CMS revise the claims processing procedure to ensure: (1) that claims are paid only if they contain valid and active UPINs; and (2) that CMS emphasize to suppliers the importance of using valid UPINs when submitting claims. The HHS/OIG reported that, according to CMS, the then-existing Medicare claims processing system only verified that UPINs on claims met certain format requirements and did not reject UPINs that were invalid or inactive.

CMS reviewed the HHS/OIG report prior to its release and concurred with its recommendations. In commenting on the report, the then-CMS Administrator stated:

> Since the OIG study, CMS has developed instructions, system changes, and edits which will reject medical equipment and supply claims using a deceased physician's UPIN. The implementation date for this initiative is April 1, 2002. After this initiative is implemented, CMS will expand it to include inactive and invalid UPINs.

CMS also concurred with the HHS/OIG's recommendation to educate Medicare service providers on the importance of submitting accurate UPINs on Medicare claims. In November 2001, the HHS/OIG acknowledged CMS actions taken to resolve the problem of deceased physician claims identified in the 2001 report, but also urged CMS to perform post-payment reviews in order to detect the use of invalid or inactive UPINs on claims after the new initiative's implementation.[26]

D. CMS Efforts to Ensure Rejection of Deceased Physician Claims

Following the 2001 HHS/OIG report, CMS took a number of steps to ensure Medicare claims containing deceased physician UPINs were not paid. In the latter half of 2001, CMS told the HHS/OIG that it had developed a new claims review process that would reject claims containing UPINs of deceased physicians. CMS indicated that this new process was to be implemented on April 1, 2002.[27] CMS also stated that, in addition to resolving the deceased physician problem, it would put mechanisms in place to ensure that all claims with invalid or

---

[25] HHS/OIG, Medical Equipment and Supply Claims with Invalid or Inactive Physician Numbers, November 2001.

[26] Id.

[27] Id.

inactive UPINs were not accepted. CMS stated that it would advise its carriers to deactivate all UPINs for which there had been no claim activity from the practice setting during the previous twelve months.[28]

On November 9, 2001, CMS issued a program memorandum to the DMERCs, instructing them to conduct a one-time review of deceased physician UPINs being used on DME claims.[29] The purpose of this one-time review was to identify UPINs belonging to deceased physicians, verify the remaining UPINs being used on DME claims, and update the DMERCs' provider files and the UPIN Registry with the verified information.

To implement the program memorandum, the DMERCs and other Medicare carriers were required to reconcile a UPIN file of deceased physicians that was attached to the program memorandum against their in-house provider files. Additionally, carriers were instructed to deactivate UPINs that had no claim activity for 12 months and include this information in their update of their in-house provider files and the UPIN registry. Carriers were instructed to provide a monthly progress report of their completed work on this project to CMS beginning January 4, 2002. The goal of this one-time effort was to ensure that the Medicare claims processors would be working with an updated and validated UPIN registry by April 2002.

In addition to establishing procedures for updating the UPIN registry, the November 2001 program memorandum stated that, effective April 1, 2002, the Medicare Common Working File (CWF)[30] was required to reject DMERC claims with UPINs whose date of service came after the physician's date of death.[31] CMS told the Subcommittee that, as of April 2002, the CWF began rejecting DMEPOS claims with deceased physicians' UPINs when the date of service came after the date of death.[32] CMS also indicated that if a UPIN were missing on a claim form or an entry was not in the proper format, the contractors would reject the claim and return it as unprocessable to the provider or supplier for correction.

CMS told the Subcommittee that the file containing deceased physicians' UPINs was supposed to be updated with deceased physician data every 15 months.[33] To ensure accurate data, CMS told the Subcommittee that the UPIN registry contractor set up a system with the American Medical Association (AMA) to obtain biweekly data specifying the date of death for

---

[28] Id.

[29] HHS/CMS, Program Memorandum Carriers, Reviewing Deceased Physicians' Unique Physician Identification Numbers (UPINs) on DMERC Claims, Transmittal B-01-73, Change Request 1735, November 9, 2001.

[30] The Common Working File is the master record of all Medicare beneficiary information and claim transactions, including both Medicare Part A, Part B and DME data. The claims processing systems interface with the CWF to verify the beneficiary's entitlement to Medicare, deductible status and available benefits. The CWF also reviews claims history to check for duplicate services, inpatient or Skilled Nursing Facility (SNF) stays, and other insurance that may pay primary to Medicare, secondary to Medicare or should pay in place of Medicare. As a final step in processing, most claims are sent to the CWF for review and validation of claim data.

[31] CMS letter to the Subcommittee, June 4, 2008, answers to Questions 1 and 4, reprinted in Appendix II of this Report. CMS issued a subsequent program memorandum on April 12, 2002, that stated that for a claim to be properly adjudicated, the physician's date of death would need to be included in the information provided by the carriers. The effective and implementation date for this program memorandum was October 1, 2002. HHS/CMS, Program Memorandum Carriers, Deceased Physician UPIN Information – (Transmittal B-01-73), Transmittal B-02-024, Change Request 2042, April 12, 2002.

[32] Id., answers to Questions 1, 4, and 5.

[33] Id., answer to Question 5.

deceased physicians across the country. The UPIN registry contractor then compared the AMA data to the data in the registry, identified registered physicians who had died, and issued a monthly report identifying the deceased registry physicians to Medicare's claims processing contractors that were supposed to update their in-house physician lists.[34]

To further ensure that appropriate UPINs were being deactivated, CMS told the Subcommittee that, in September 2002, it sent a program memorandum instructing its contractors to educate and train Medicare service providers about their responsibility to ensure that accurate UPINs are used on claims.[35]

CMS told the Subcommittee that the actions described in the November 2001 and September 2002 program memoranda were, in fact, carried out.[36] Additionally, in CMS's response to the OIG report of November 2001, CMS indicated they would also implement changes to the claims process that would reject claims using invalid and inactive UPINs, other than those assigned to deceased physicians.[37] In its fiscal year 2004 semiannual report to Congress, however, the HHS/OIG stated that CMS had decided against implementing changes to its automated claims processing system and the CWF to block the payment of Medicare claims containing inactive or invalid UPINs, opting instead to rely on provider-education efforts and its two program memorandums to stop service providers from submitting claims with deceased physician UPINs.[38]

IV. MEDICARE CLAIMS PROCESS ALLOWED PAYMENTS FOR DECEASED PHYSICIAN CLAIMS

Problems in the Medicare program have been long-standing and well-documented. Oversight bodies such as HHS/OIG and GAO have reported program integrity issues in the Medicare program for many years. In HHS's fiscal year 2007 agency financial report, HHS/OIG reported integrity of Medicare payments as one of the agency's top management and performance challenges.[39] In its 2007 High-Risk Series, GAO reported that further action was needed to address program integrity weaknesses.[40] Moreover, the HHS/OIG and GAO continue to find program weaknesses, specifically in the area of DME. In HHS's fiscal year 2007 agency financial report, HHS/OIG reported that it has consistently found that the Medicare DMEPOS benefit is vulnerable to fraud and abuse. To illustrate the point that action is needed to enhance Medicare program integrity, GAO pointed out that, while Medicare's fiscal year 2006 improper payment error rate was the lowest since 1996, certain providers – such as suppliers of DME – continued to receive improper payments at a higher rate.

[34] Id., answers to Questions 2 and 5.

[35] CMS stated that the instructions were reported in program memorandum AB-02-1 and had an effective date of October 1, 2002.

[36] Id., answers to Questions 1 and 2.

[37] HHS/OIG, Medical Equipment and Supply Claims with Invalid or Inactive Physician Numbers, November 2001.

[38] HHS/OIG Semiannual Report to Congress, April 1, 2004 – September 30, 2004.

[39] Department of Health and Human Services, Fiscal Year 2007 Agency Financial Report, November 15, 2007.

[40] GAO-07-310, High-Risk Series: An Update, January 2007.

In the case of deceased physician claims, the Subcommittee's investigation has found that, despite the 2001 HHS/OIG report that found CMS paid millions of dollars for claims with invalid or inactive UPINs and the actions taken by CMS to address the problem, CMS has failed to ensure claims containing only valid UPINs are paid. Since the UPIN is one of the key pieces of data required on claims, the failure of Medicare claims processing contractors to automatically reject claims with an invalid UPIN rendered the program susceptible to tens of millions of dollars in fraud, waste, and abuse. Further, the failure of the Medicare system to routinely deactivate UPINs belonging to deceased physicians created a program vulnerability that allowed DME suppliers to be paid for improper claims. When the Subcommittee presented to CMS its own payment data showing that, from 2000 to 2007, millions of dollars had been paid on Medicare claims containing deceased physician UPINs, CMS did not challenge either the payment data or the Subcommittee's interpretation of that data.[41]

A. From 2000 to 2007, Medicare Paid Between $60 Million and $92 Million for Hundreds of Thousands of DME Claims Containing Deceased Physician UPINs

The Subcommittee obtained comprehensive data concerning more than 33,000 deceased physicians from the AMA and selected a statistically random sample of 1,500 deceased physicians for further analysis. The Subcommittee obtained the UPINs belonging to the deceased physicians in the sample and obtained DME claims data from Medicare related to those 1,500 UPINs.[42]

Of the 1,500 UPINs for deceased physicians that the Subcommittee examined, 734 (48.9 percent) had been used on claims with dates of service between January 1, 2000, and December 31, 2007. For these 734 UPINs, 21,458 claims were submitted for payment. The total amount paid for these claims was $3.4 million.[43] In addition, more than 55 percent of the total claims were for dates of service at least five years after the physicians had died. The Subcommittee also found that 1,618 claims totaling more than $234,000 contained the UPINs of physicians who had died at least 10 years before the date of service on the claim. Further, the Subcommittee noted that 110 of the 1,500 deceased physicians (roughly seven percent) had active UPINs as of May 21, 2008.

Based on the results of the random sample, the Subcommittee estimates with 95 percent certainty that, from 2000 to 2007, Medicare paid 478,500 claims containing UPINs that were assigned to deceased physicians.[44] The total amount paid for these claims is estimated to be

[41] See CMS responses reprinted in Appendices II and III; Subcommittee interview of CMS officials, June 5, 2008.

[42] See Appendix I for more information about the scope and methodology of the Subcommittee's analysis.

[43] The Subcommittee reviewed only claims that contained services dates that occurred more than twelve months after the physicians' deaths. Had the Subcommittee considered all claims with dates of service after physician deaths, including claims within twelve months of the physicians' deaths, the amount of claims paid for the random sample of 1,500 doctors would have been roughly $4.1 million rather than $3.4 million. The total number of UPINs of deceased physicians would also increase from 734 to 777, and the total number of claim would also have grown from 35,717 to 43,619.

[44] For the number of claims submitted to Medicare with deceased physician UPINs, the 95-percent confidence interval ranges from a low of 384,730 claims to a high of 572,268 claims. Estimates of 95-percent confidence intervals were generated as follows. First, a statistically random sample of 1500 doctors was drawn from the population of deceased doctors with assigned

between $60 million and $92 million.[45] These claims contained UPINs for an estimated 16,548 to 18,240 deceased physicians. In addition, based on the results of the random sample, the Subcommittee estimates that between 2,011 and 2,895 deceased physicians still had active UPINs as of May 2008.

Notably, approximately 11,582 (54 percent) of the 21,458 claims that were paid were for dates of service after the physicians had been dead at least five years, and almost 15,599 (73 percent) of the claims paid contained the UPINs of physicians who had died before January 2000. Additionally, roughly 13,474 (63 percent) of the claims were paid with dates of service after April 1, 2002, the date CMS said it would implement new procedures to ensure claims with deceased doctors' UPINs were rejected. Table 1 presents claims reviewed by the Subcommittee:

Date Physician License Status Was Changed to Deceased[46]	Dates of Service on Medicare Claims	Number of Claims	Total Amount Paid
September 22, 1993	January 2000 to March 2002	396	$81,793
January 1, 1999	January 2000 to December 2007	653	$92,033
June 15, 1996	June 2000 to July 2996	101	$148,749

Table 1: Examples of Deceased Doctor Claims from the AMA Data

B. Florida Case Studies: CMS Paid Millions of Dollars in Claims Containing Deceased Physician UPINs

The Subcommittee also examined DME claims that contained UPINs of deceased Florida physicians. In its analysis, the Subcommittee considered only those claims for dates of service after April 1, 2002, the date on which Medicare was to implement new initiatives to prevent the payment of claims containing UPINs of deceased physicians. This aspect of the Subcommittee's review found that, from April 1, 2002, through December 31, 2007, more than $2 million had

---

UPINs. The mean ( ) and standard deviation ( ) of the number of claims filed per UPIN, and of the amount of money paid out per UPIN, was computed for the sample. These means and standard deviations were used to generate a confidence interval of the sample mean number of claims filed per UPIN, and the sample mean amount of money paid out per UPIN using an alpha of .05 and the equation: . The sample means and upper and lower bounds of the sample confidence intervals were then multiplied by the population size to generate population estimates. All ranges given above are thus estimated with a 95-percent level of confidence.

[45] The 95-percent confidence interval for the Medicare expenditures on claims containing deceased physician UPINs ranges from a low of $60,317,099.12 to a high of $92,819,900.74. The mean total for this amount is estimated to be $76.6 million. As noted above, this estimate includes only claims that contained services dates that occurred more than twelve months after the physicians' deaths. Including all claims with dates of service after physician deaths, such as claims within twelve months of the physicians' deaths, the estimate for the amount paid by Medicare for deceased physician claims would likely have increased to more than $100 million.

[46] The date the license status was changed may not be the date of actual death. For example, for the physician identified in the following table whose license status was changed on January 29, 2002, the State of Florida Office of Vital Statistics confirmed this physician died on September 10, 1999.

been paid for claims with UPINs belonging to 114 deceased Florida physicians. Moreover, the data obtained by the Subcommittee indicated that more than 27 percent of the deceased Florida physicians had active UPINs as of May 2008.

In its review, the Subcommittee found as many as 484 claims totaling $544,789 filed under a single UPIN years after the physician had died. Table 2 below outlines examples of claims filed using UPINs assigned to deceased Florida physicians who died more than 12 months before the dates of service on the claims.

Date Physician License Status Was Changed to Deceased	Dates of Service on Medicare Claims	Number of Claims	Total Amount Paid
July 2, 1999	July 1, 2002 to December 31, 2007	2,062	$478,985
July 7, 1999	April 17, 2003 to November 17, 2003	67	$61,302
October 4, 2001	October 4, 2002 to December 31, 2007	3,848	$354,277
November 15, 2001	December 6, 2002 to May 8, 2005	265	$229,527
January 29, 2002	July 1, 2003 to November 14, 2006	484	$544,789
March 1, 2002	March 17, 2003 to August 30, 2006	433	$317,698

Table 2: Examples of Deceased Doctor Claims from Florida Data

The Subcommittee's investigation has also uncovered links between claims containing deceased physician UPINs and claims found to be related to fraudulent activity. A review of the details on the claims submitted using the UPINs of the 114 deceased physicians in Florida, for example, revealed an alarming number of claims submitted by companies identified by the United States Department of Justice and state regulatory agencies as having submitted fraudulent Medicare claims worth millions of dollars.

In one instance, the Florida data contained claims from Professional Gluco Services, Inc. (Professional Gluco), a DME supplier. In a press release regarding the indictments of that company's officials, the Department of Justice stated the following:

> On September 25, 2007, a Miami federal grand jury returned a five (5) count indictment against two defendants in United States v. Nelson Martin and Aurelio Benavides, No. 07-20765-Cr-Huck. The Indictment charges Nelson Martin and Aurelio Benavides, with owning and operating Professional Gluco Services, Inc. ("Professional Gluco"), a Miami durable medical company, and executing a scheme to submit tens of millions of dollars in fraudulent claims to Medicare from November 2005 to September 2006 for reimbursement for durable medical equipment (DME) and related services. The Indictment alleges that the defendants submitted approximately $14.3 million in false claims on behalf of

> Professional Gluco. The claims were allegedly fraudulent in that the equipment had not been ordered by a physician and/or had never been delivered to a Medicare patient. As a result of the submission of the fraudulent claims, Medicare paid Professional Gluco approximately $1.3 million.[47]

Professional Gluco Services, Inc. is one of the companies that had submitted DME claims to Medicare using the physician's UPIN who had died in September 1999. Professional Gluco submitted 83 claims under this physician's UPIN between December 2005 and July 2006 and was paid $93,171.

Another DME supplier identified in the Subcommittee's review was the subject of a Florida Department of Health Administrative Complaint filed on June 21, 2007. The complaint stated that, when a Department of Health investigator attempted to inspect the business on December 11, 2006, the investigator found the business closed and the phone disconnected. The business did not notify the State of Florida, as required. The Florida Department of State - Division of Corporations lists the company as being voluntarily dissolved on February 1, 2007. Yet claims from this company using the same UPIN as Professional Gluco were paid by Medicare for dates of service between July 11, 2006, and November 14, 2006, in the total amount of $167,101.

A third company was also the subject of an Administrative Complaint filed by the Florida Department of Health. A Department of Health investigator attempted to inspect the purported business on February 26, 2007, and found the business closed and the phone disconnected. This business had filed claims using the same deceased physician's UPIN that Professional Gluco used for dates of service between June 16, 2006, and August 7, 2006. The total amount paid for these claims was $143,631.

Altogether, of the Florida data reviewed by the Subcommittee, at least $348,000 paid for Medicare claims containing deceased physician UPINs went to companies known to have submitted fraudulent DME claims.

C. CMS Efforts to Reject Claims Containing Deceased Physician UPINs Failed

CMS took a number of actions to stop the payment of Medicare claims containing deceased physicians UPINs, including requiring a one-time update of the UPIN registry to eliminate deceased physician UPINs and validate the remaining UPINs; instructing its claims processing contractors to deactivate UPINs with no claims activity after one year; and requiring them to reject claims with invalid or inactive UPINs after the April 1, 2002, deadline. CMS also told the Subcommittee that it had instituted system changes to require the CWF to automatically reject claims with invalid or inactive UPINs, and instructed the UPIN registry contractor to update the registry with deceased physician data every 15 months.

The Subcommittee's analysis of CMS payment data shows, however, that those measures were not fully effective, and claims with deceased physician UPINs continued to be paid. For example, CMS had instructed its UPIN registry contractor to update the UPIN registry and review it on a regular basis to ensure deceased physician UPINs were being deactivated. The

[47] *See* http://miami.fbi.gov/dojpressrel/pressrel07/mm20070928.htm.

Subcommittee's investigation demonstrated, however, that the UPIN registry continued to list deceased physician UPINs as active up to the date the registry was taken offline in May 2008. The Subcommittee found, for instance, that approximately seven percent of the deceased physician UPIN sample from the AMA data still had active UPINs in May 2008, even though the physicians had all died prior to December 31, 2002. The Subcommittee also reviewed deceased physician data for particular states, including Alabama and Connecticut, and determined that between five and seven percent of deceased physicians in those states also had active UPINs as of May 2008. Additionally, the deceased physician data from Florida indicated that approximately 27 percent of the deceased physicians in that state still had active UPINs as of April 2008.

CMS had also instructed the DMERCs and other claims processing contractors to review and update their in-house Medicare service provider lists to eliminate deceased physicians by April 1, 2002. Yet Medicare continued to pay claims with deceased physician UPINs after the April 1, 2002, implementation date. In fact, 63 percent of the deceased physician claims discovered by the Subcommittee were paid for dates of service after April 1, 2002, and thousands of claims included UPINs assigned to physicians who had died before 1999. Therefore, while CMS instructed its contractors to provide quarterly update reports to CMS on their progress in deactivating deceased physician UPINs, these efforts do not appear to have been successful.

In 2004, HHS/OIG suggested that CMS conduct post-payment reviews to ensure that the measures taken in 2002 had successfully stopped the payment of deceased physician claims. There is no evidence, however, that either CMS or its contractors performed any reviews to test the effectiveness of the measures taken to prevent the payment of deceased physician claims. HHS/OIG also failed to conduct any audits to ensure the problem had been resolved. As a result of these oversight failures, seven years after the 2001 HHS/OIG report and CMS efforts to resolve the problem, the Subcommittee found that Medicare continued to spend millions of dollars each year on improper claims containing identification numbers for deceased physicians.

V. CONCLUSION AND RECOMMENDATIONS

The Subcommittee's investigation has determined that, between 2000 and 2007, Medicare paid between $60 million and $92 million for hundreds of thousands of DME claims that contained the UPINs of thousands of dead doctors. CMS had been notified of the problem as far back as 2001, and at that time, took steps to eliminate payments for claims containing deceased doctor UPINs. Based on the Subcommittee's examination of the claims data, however, these measures were not fully implemented, and CMS, its contractors, and the HHS/OIG failed to conduct follow-up reviews to ensure that the problem had been resolved. The Subcommittee's investigation did not attempt to identify when or how the breakdowns in implementation occurred. Whether the fault lies with the UPIN registry contractor, the claims processing contractors, CMS, or the HHS/OIG, the fact is that, seven years after the problem was first identified, the claims review process is still not working properly to reject claims containing the provider numbers of deceased physicians.

The replacement of the UPIN registry with the new NPIs presents a fresh opportunity for the Medicare program to adopt new safeguards to stop the improper payment of claims containing deceased physician identification numbers. Better measures are needed to ensure that the NPI registry incorporates deceased physician information on a timely and effective basis and

promptly deactivates appropriate NPIs. Better measures are also needed to ensure that claims containing deceased physician NPIs are automatically rejected and that payment is denied.

Unless new procedures are put into place to better identify and deactivate the NPIs of deceased service providers, NPIs – like UPINs – will be used to obtain payments for services allegedly performed long after the cited service provider has died. Without new safeguards, the Medicare program will continue to be susceptible to fraudulent claims using invalid identification numbers. CMS should take action now, while it is implementing new procedures and rules, to ensure that NPI numbers are managed effectively, are deactivated promptly after a service provider's death, and trigger the automatic rejection of any Medicare claim submitted after a specified time period following the date on which the service provider died.

The Subcommittee staff accordingly recommends the following measures to resolve the ongoing problem of Medicare's paying claims alleging services performed by deceased physicians.

1. **Strengthen Procedures to Deactivate NPIs after Physician Death.** CMS should examine its procedures for identifying deceased physicians to ensure timely receipt of deceased physician data, automatic deactivation of relevant NPI numbers, and continual update of the NPI registry. CMS should develop a quality control program to ensure NPIs are deactivated within a specified period of time after receiving notice of a physician's death, such as 90 days.

2. **Initiate Regular NPI Registry and Claim Audits.** CMS should initiate periodic audits of its NPI registry to test whether NPI numbers assigned to deceased physicians have been deactivated within the specified timeframe and to test Medicare payment records to determine whether claims containing deceased physician NPIs were rejected.

3. **Consider Additional Procedures and Audits to Strengthen NPI Registry.** CMS should consider instituting additional procedures and audits to ensure the prompt deactivation of NPIs assigned to Medicare service providers who have stopped providing services due to licensure revocation, retirement, or other reasons, including automatic deactivation of any NPI that has not been used in a Medicare claim within a specified time period, such as 12 months. Consideration should also be given to developing procedures to allow deactivated NPIs to be reinstated upon proper application.

♦ ♦ ♦

APPENDIX I: SCOPE AND METHODOLOGY

Random Sample Using American Medical Association (AMA) Data

The Subcommittee requested information from the AMA. According to AMA officials, the "Master List" contains information on medical providers in the United States from the date they enter medical school until they die. The Subcommittee received a list of physicians whose dates of death were between 1992 and 2002. From the list of more than 53,000 physicians who had died during that timeframe, the Subcommittee identified more than 33,000 who had UPINs assigned.

The Subcommittee then selected a statistically valid random sample of 1,500 physicians from the population of 33,000 deceased physicians with assigned UPINs. The 1,500 UPINs (4.5 percent) selected were forwarded to CMS to obtain data on any claims filed with those UPINs that had dates of service between January 1, 2000, and December 31, 2007.

Florida Claims Data

During a review of Medicare DME claims data provided by CMS, the Subcommittee discovered claims with dates of service between 2001 and 2006 that were paid notwithstanding UPINs linked to deceased physicians. Based on this discovery, the Subcommittee obtained additional data from the Florida Department of Health for 1,086 physicians whose license status reflected that they were deceased. Some of the physicians listed as deceased in the Florida Department of Health's database did not list dates indicating when the license statuses were changed. To conduct its examination, the Subcommittee limited its review to include only those records that indicated a date of death before January 1, 2006. The Subcommittee did not consider any record without a date in the license status change date field or with a date after January 1, 2006. The Subcommittee determined that, of the 648 physicians that met the criteria, 176 still had active UPINs as of March 25, 2008, despite the fact that the status was changed in the Florida Department of Health's database to reflect dates of death between 1999 and 2006. The 176 UPINs were submitted to CMS to obtain data for any claims paid containing these UPINs with dates of service between January 1, 2000, and December 31, 2007. The data subsequently provided by CMS was then reviewed to identify those claims that were paid more than 12 months after the physician's license status was changed to reflect they were "deceased."

The Subcommittee also considered that there may have been outstanding orders for DME items that continued after the prescribing physician's death. For example, HHS/OIG commented that wheel chairs, hospital beds, and other medical equipment can be rented for up to 15 consecutive months, and this timeframe may extend beyond the date of the physician's death. However, during the Subcommittee's review, only those claims that were filed for dates of service at least 12 months after the physicians' deaths were considered.

APPENDIX II: CMS QUESTIONS AND RESPONSES

On May 28, 2008, in light of its findings regarding claims containing UPINs assigned to deceased physicians, the Subcommittee submitted several questions to CMS. CMS provided written responses to the Subcommittee questions on June 4, 2008. The Subcommittee's questions and the responses received from CMS are reprinted below.

1. **What processes and policies was Mr. Scully [CMS Administrator] referring to in his response [to the HHS/OIG report] that were to be implemented on April 1, 2002, that would cause any claim containing a deceased doctor's UPIN to be rejected?**

   CMS Response:

CMS issued Change Request (CR) 2042, effective April 2002, that instructed the Common Working File (CWF) to reject DMEPOS claims using deceased physicians' UPINs when the date of service exceeds (i.e., is later than) the physician's date of death. This CR provided that the DME contractors must deny claims with an invalid or deceased ordering or referring physician's UPIN on claims when the date of service exceeds the physician's date of death.

2. **What other efforts as discussed in the [response] letter were taken to ensure UPINs were inactivated as indicated?**

   CMS Response:

CMS released a program memorandum AB-02-1 in September 2002 that instructed contractors to educate and train providers (via newsletters and bulletins) about their responsibility to ensure that accurate UPINs are used on claims and that surrogate UPINs should not be used if ordering physicians have permanent UPINs. The effective date was October 1, 2002.

In addition, as part of the UPIN process, National Heritage Insurance Company (NHIC) (the contractor that maintains the UPIN Registry) subcontracted with the AMA to provide a physician data file, which NHIC used to validate the data submitted by contractors. Biweekly, the AMA submitted a data extract file which contained physicians' Date of Death. Contractor records submitted to the Registry were compared to the AMA physician death extract file. If, after the comparison, a physician was identified as deceased, an exception or notification was generated. Contractors were notified to update their physician records. On a monthly basis, contractors were sent a deceased physician notification list. If physician records were not updated over a period of time, the Registry would update or flag deceased physician records.

3. Are UPINs a required element of a claim and when was that requirement implemented? Since the Subcommittee is concerned only with data after January 2000, were UPINs mandatory at that point and did they ever become optional after January 2000?

CMS Response:

The effective date for requiring the UPIN of the ordering/referring physician for all services was January 1, 1992. As required by section 1833(q) of the Social Security Act, all claims for Medicare covered services and items that are the result of a physician's order or referral must include the ordering/referring physician's name and UPIN. This includes parenteral and enteral nutrition, immunosuppressive drug claims, diagnostic laboratory services, diagnostic radiology services, consultative services, and durable medical equipment. Claims for other ordered/referred services not included in the preceding list must also show the ordering/referring physician's name and UPIN. All physicians who order or refer Medicare beneficiaries or services must obtain a UPIN even though they may never bill Medicare directly. A physician who has not been assigned a UPIN must contact the Medicare carrier. During CMS's NPI contingency period (October 1, 2006 - May 23, 2008), the use of the UPIN became optional when the National Provider Identifier (NPI) became an alternative option. As of May 23, 2008, only an NPI is permitted on the claim and the UPIN (and other legacy numbers) may not be reported on the claim.

CMS provided our contractors instructions in Publication 100-8, Chapter 14 .6.1(A) CWF Edits and Claims Processing Requirements regarding UPIN reporting on Medicare claims. The following is an excerpt from the manual.

> If any procedure codes (HCPCS) associated in your claims processing system with CWF Type of Service (TOS) codes: 3 (consultative services), 4 (diagnostic radiology), 5 (diagnostic laboratory) (field 59, position 247 of the CWF Part B record) or durable medical equipment, orthotics and prosthetics, are shown on the claim form, the name of the physician who ordered or referred the item or service must be shown in Item 17. The ordering/referring physician's assigned or surrogate UPIN is to be entered in Item 17a of Form CMS-1500. The first position of the UPIN must always be alpha, the second and third positions must be either alpha or numeric and the last 3 positions must be numeric. For electronic claims, enter the name and UPIN in Record/Field, EAO-20.0, positions 80-94 of the Electronic Media Claims format. Only the 6-digit base number of the UPIN will be required for CWF edits for referring and ordering. Do not use the 4-digit location identifier.
>
> A. The following guidelines apply to those services that are edited by CWF

- If the service is a diagnostic laboratory or radiology service, the assigned UPIN of the ordering/referring physician must be shown in item 17a on Form CMS-1500;
- If the performing physician is also the ordering physician, the physician must enter his/her name and UPIN in items 17 and 17a of Form CMS-1500, confirming that the service is not the result of a referral from another physician;
- If the ordering/referring physician is not assigned a UPIN, the biller may use OTH000 until a UPIN is assigned, or a surrogate may be used (See section 14.6.2)
- If the service is a consultative service, the name and UPIN of the referring physician or other person meeting the statutory definition of a physician must be shown on Form CMS-1500 in items 17 and 17a;
- If the service was referred by other limited licensed practitioner, the name and UPIN of the physician supervising the limited licensed practitioner must be shown on Form CMS-1500 in items 17 and 17a;
- If the service was the result of a referral from a person not meeting the statutory definition of a physician or a limited licensed practitioner (for example, a pharmacist, psychologist), the billing physician must enter his or her name and UPIN in items 17 and 17a, i.e., the physician completes Form CMS-1500 as though the service was initiated by the patient; and
- If durable medical equipment, prosthetics and orthotics are ordered, the name and UPIN of the ordering physician must be on Form CMS-1500 in items 17 and 17a.

4. Does the claims review process, automated and manual, validate UPINs that are submitted on claims?

CMS Response:

The claims processing system confirmed the existence of a UPIN and validated that number as to proper form. If a UPIN was not provided on the claim form or an entry was not in proper form, the contractors (including DME contractors) would reject the claim and return it as unprocessable to the provider or supplier for correction. As of May 23, 2008, UPINs may no longer be submitted on Medicare claims. The NPI is used in secondary identifier fields.

CMS provided our contractors instructions in Publication 100-8, Chapter 14.6.1 (B) - CWF Edits and Claims Processing Requirements regarding the review and validation of UPIN reporting. The following is an excerpt from the manual.

> Deny, return or reject assigned claims requiring, but not containing, the name and UPIN of the ordering/referring physician depending on your system's capability and the cost effectiveness of the three options. If the claim is denied, afford the claimant the opportunity to appeal. Develop unassigned claims requiring a UPIN.

> In addition, CMS released a program memorandum AB-02-1 in September 2002 that instructed contractors to educate and train providers (via newsletters and bulletins) about their responsibility to ensure that accurate UPINs are used on claims and that surrogate UPINs should not be used if ordering physicians have permanent UPINs. The effective date was October 1, 2002.

5. What happens to a UPIN once CMS or a carrier/contractor is notified of a doctor's death? Is there an automated process used to inactivate a UPIN under these circumstances?

CMS Response:

As of April 2002, CWF rejects DMEPOS claims using deceased physicians' UPINs when the date of service exceeds the physicians' dates of death. The file containing the deceased physicians' UPINs was updated every 15 months. The claims processing contractor would deny claims with an invalid or deceased ordering or referring physician's UPIN on claims with dates of service that exceed the physician's date of death.

Yes, there is an automated process to alert contractors about deceased physicians. CMS provided contractor instructions in Publication 100-8, Chapter – 14.4 - Automatic Notifications regarding how to handle deceased physician notifications. The following is an excerpt from the manual.

The Registry alerts you if a record on the MPIER requires investigation and research. Notifications are sent through the Registry telecommunication system to your output file as Record Code 7. The Notification Code is displayed in Field 37 as an alpha code. Confirm and verify your file to determine if the notifications and records you submitted are valid. Act on all automatic notifications (except code X - recision/denial) within 30 calendar days. The conditions for which the Registry sends you notification are:

> A. Deceased Physician/Health Care Practitioner-Notification Code D
> Verify information regarding the alleged death of a physician/health care practitioner with the State Licensure Board, Medical Trade Association, or other outside entity.
> If the physician/health care practitioner is deceased, generate an update record for each practice setting using Record Code 5 and

update Field 20, "Date of Death," with the appropriate dates, and Field 29, "DRIP," with a "D" for deactivate for every practice setting.

If the physician/health care practitioner is not deceased, notify the Registry via a letter or TMAIL. Identify the source of your information.

Appendix III: CMS Response to Report Findings

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Deputy Administrator
Baltimore, MD 21244-1850

JUN 24 2008

TO: Chairman Carl Levin
Ranking Member Norm Coleman
Permanent Subcommittee on Investigations
Committee on Homeland Security and Governmental Affairs
United States Senate

FROM: Herb Kuhn
Deputy Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Investigative Findings Regarding Medicare Payments to Providers Who Are Using Invalid or Inactive Physician Numbers

Thank you for the opportunity to review and comment on the Permanent Subcommittee on Investigations' findings that Medicare is continuing to pay claims to providers who are using invalid or inactive physician numbers. The Centers for Medicare & Medicaid Services (CMS) appreciates the time and resources that the Subcommittee has invested in this study and shares your concerns. CMS has already taken several steps to implement changes to its policies and procedures so this type of activity does not continue to occur.

On January 25, 2008, CMS published in the Federal Register a proposed rule titled, "Medicare Program; Establishing Additional Medicare Durable Medical Equipment, Prothetics, Orthotics, and Supplies (DMEPOS) Supplier Enrollment Safeguards"(CMS-6036-P). In this proposed rule, CMS proposed requiring DMEPOS suppliers to maintain ordering and referring documentation received from a physician or other non-physician practitioner (e.g., nurse practitioner, physician assistant, etc.) for seven years. CMS believes that this change, if adopted, will strengthen our ability to identify fraudulent billing during documentation reviews. CMS is currently reviewing public comments received on this proposed rule. In addition, we are considering whether it is necessary to propose regulations requiring that physicians and nonphysician practitioners maintain documentation when ordering or referring services for Medicare patients.

Additionally, CMS is developing a data matching agreement with the Social Security Administration (SSA) which will provide CMS with monthly updates of the SSA Date of Death file. CMS will then match this information with information contained in the National Plan and Provider Enumeration System, the system that maintains information about National Provider Identifiers (NPI), and our provider enrollment database, the Provider Enrollment, Chain and Ownership System. After confirming the individual practitioner is deceased, CMS will deactivate both the NPI and the practitioner's enrollment in the Medicare program. We expect to have the data matching agreement and this new process implemented later this year.

Finally, while our current claims processing system allows an individual or organization NPI to be used for the purposes of ordering and referring services to Medicare beneficiaries, we anticipate implementing changes in 2009 that will limit ordering and referring to individual practitioners enrolled in the Medicare program.

CMS would like to again acknowledge our appreciation to the Permanent Subcommittee on Investigations for its efforts and appreciates the opportunity to review and comment on the Subcommittee's investigative findings. We believe the initiatives we have initiated will address many – if not all – of the issues surrounding the payments for claims to those health care providers who are using either invalid or inactive physician numbers. In this regard, we look forward to any additional insights the Subcommittee can provide to further assist us in strengthening our stewardship of the Medicare Trust Funds.