Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REASSIGNMENT OF MEDICARE BENEFITS

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EXECUTIVE SUMMARY

OBJECTIVES

To determine the extent to which:

1. practitioners have reassignments of benefits,
2. practitioners indicate that their reassignments of benefits should be active,
3. practitioners had Medicare expenditures through reassignments of benefits that should not have been active, and
4. the Centers for Medicare & Medicaid Services (CMS) has established safeguards with respect to reassignment of benefits.

BACKGROUND

Medicare regulations require that contractors distribute payments directly to practitioners who render services, unless those practitioners' benefits are reassigned to third parties. A reassignment of benefits is a mechanism by which Medicare practitioners allow third parties to bill and receive payment for services that they rendered.

Practitioners submit to Medicare contractors Form CMS-855I (855I) to enroll in Medicare and Form CMS-855R (855R) to reassign benefits. Contractors create records in the Provider Enrollment, Chain, and Ownership System (PECOS) reflecting information in the 855I. Contractors process 855Is and 855Rs using the safeguards established in Chapter 10 of the "Medicare Program Integrity Manual." Contractors may employ additional safeguards, as needed.

We obtained the PECOS May 2008 Individual Global Extract File (the May 2008 Extract), which contained records for all reassignments that were established between January 1, 2003, and December 31, 2007. We analyzed the Extract to determine the number of practitioners with reassignments and the number of reassignments per practitioner. Our sample included 497 practitioners with 1,723 reassignments. We also used the 2007 Part B Medicare claims data from the National Claims History file to match claims to practitioners and reassignments and interviewed CMS Central Office staff and contractors regarding procedures pertaining to reassignments and safeguards.

FINDINGS

CMS data indicate that 77 percent of practitioners have at least one reassignment. The May 2008 Extract indicated that 77 percent of practitioners had at least one reassignment.

Practitioners indicated that 37 percent of reassignments should not have been active. For 92 percent of reassignments that should not have been active, the practitioners were once employed with the third parties to which their reassignments were made, but had since terminated their employment with them. For the remaining 8 percent of reassignments, practitioners had no knowledge of the third parties to which their benefits had been reassigned or had applied for positions with the third parties but were never employed there.

Medicare paid a total of $140,488 through reassignments that should not have been active. Medicare paid $140,488, in 2007, through 16 reassignments in our sample that should not have been active.

CMS contractors reported using safeguards to ensure correct processing of reassignments, but several factors may limit their effectiveness. CMS contractor staff reported that they use safeguards for processing reassignments. Contractors also reported comparing signatures on reassignment applications to signatures on file and verifying the reassignments by telephone, mail, or site visits. However, only 48 percent of PECOS addresses resulted in responses from the practitioners, and 29 percent of practitioners indicated that they never update, did not know how to update, or relied on others to update their contact information with Medicare. Further, 48 percent of practitioners were not aware that they were entitled to access the claims billed on their behalf. System vulnerabilities also could lead to abuse of active reassignments. Finally, because the Multiple Carrier System does not populate PECOS with provider transaction access number deactivation information, reassignments in PECOS remain active.

RECOMMENDATIONS

Most practitioners enrolled in Medicare have at least one reassignment. However, practitioners indicated that 37 percent of their reassignments should not have been active. Despite the high number of reassignments that should not have been active, Medicare payments made through these reassignments were low. Safeguards are in place to ensure correct processing of reassignments, but several factors may limit their effectiveness.

Subsequent to our analyses, CMS staff informed us of new policies that might address the limitations we identified regarding providers' failure to update their contact information or terminate inactive reassignments and regarding the deactivation of provider transaction access numbers.

To reduce the number of reassignments that should not be active, we recommend that CMS:

Implement Plans To Revalidate Practitioner Enrollment Information. We encourage CMS to implement its plans to revalidate practitioners' enrollment information every 5 years.

Educate Practitioners on the Need To Provide Current Information. CMS could educate practitioners on the need to provide current correspondence information and terminate inactive reassignments.

Implement Plans To Update PECOS From Other Data Sources. We encourage CMS to follow through with plans to allow the Multiple Carrier System to populate PECOS with information on practitioners whose billing privileges have been deactivated.

Follow Up With the Practitioners for Whom Payments Were Made Through Reassignments That Should Not Have Been Active. We will forward information on these claims to CMS in a separate memorandum.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments, CMS agreed with the first and second recommendations, but it did not indicate specific agreement or disagreement with the third and fourth recommendations. However, CMS described actions it has taken or plans to take to address all four recommendations.

In response to the first recommendation, CMS indicated that it instructed Medicare carriers and Part A/B Medicare Administrative Contractors to initiate and complete more than 10,000 revalidations. In response to the second recommendation, CMS indicated it has taken significant steps to help educate the public about its reporting responsibilities including discussing reporting responsibilities and the need to update enrollment information during CMS Open Door Forums, participating in conference calls with regional offices and contractors to discuss reporting responsibilities, mailing reporting responsibility information to high-risk providers, posting reporting responsibility information on the Medicare provider enrollment Web site, and sending listserv announcements to practitioners about their reporting responsibilities.

In response to the third recommendation, CMS plans in October 2009 to update PECOS with verified deactivation information contained in the Multiple Carrier System. In response to the fourth recommendation, CMS stated that once it receives the information from OIG, it will follow up with third parties that may have been inappropriately paid. We did not make changes to the report based on CMS's comments.

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INTRODUCTION

OBJECTIVES

To determine the extent to which:

1. practitioners have reassignments of benefits,
2. practitioners indicate that their reassignments of benefits should be active,
3. practitioners had Medicare expenditures through reassignments of benefits that should not have been active, and
4. the Centers for Medicare & Medicaid Services (CMS) has established safeguards with respect to reassignment of benefits.

BACKGROUND

Medicare regulations require that contractors distribute payments directly to the practitioners who render services, unless those practitioners' benefits are reassigned to third parties.[1] A reassignment of benefits (hereinafter referred to as reassignment) is a mechanism by which Medicare practitioners allow third parties to bill and receive payment for services that they rendered. Approximately $28 billion was paid through reassignments in 2007. Many practitioners routinely reassign their Medicare benefits as part of their normal business practices. For example, anesthesiologists might reassign their benefits to several different hospitals where they render services in order for the hospitals to bill and receive payment from Medicare Part B for the services that the anesthesiologists performed. The hospitals would also bill and receive payment from Medicare Part A for the hospital portion of the service. In this example, anesthesiologists might have multiple reassignments, one for each hospital where they render services.

According to 42 CFR § 424.80, third parties that may receive reassignments include the practitioners' employers or billing agents, other Medicare-enrolled entities with which practitioners have contractual arrangements, Government agencies or entities, or other entities as established by court orders.

Processing Enrollments and Reassignments

Medicare contractors are responsible for enrolling practitioners and processing payments; each contractor is responsible for a specific geographic region. Under Medicare Contracting Reform, responsibilities of contractors are transitioning to Medicare

[1] Section 1842(b)(6) of the Social Security Act; 42 CFR § 424.73.

Administrative Contractors. There were 10 contractors at the time of our review in March 2009.

Enrollments. To enroll in Medicare, practitioners must submit Form CMS-855I (855I) to Medicare contractors serving their respective regions. Each 855I contains identifying information about the practitioner, including medical specialty, billing address, practice location, and any adverse legal actions. Using information from the 855I, contractors create records in the Provider Enrollment, Chain, and Ownership System (PECOS) for each enrolled practitioner.[2]

Reassignments. To reassign benefits, practitioners submit Form CMS-855R (855R) to Medicare contractors with which the practitioners are enrolled. The 855R contains information about both the practitioners and the third parties to which practitioners reassign benefits. The 855R requires the practitioners' or delegated officials' original signatures authorizing the reassignments.[3] To reassign benefits, practitioners must first enroll in Medicare as individuals. The third parties to which the benefits are reassigned must enroll in Medicare as institutions or groups. Additionally, both the practitioners and the third parties must enroll with the same contractor serving their region. For example, practitioners enrolled through Contractor A may not reassign their benefits to clinics enrolled through Contractor B. The contractors process the 855Rs, adhering to required safeguards, and create PECOS records reflecting the information in the 855Rs. The 855Rs are also used by both the practitioners and the third parties to terminate reassignments. The 855R requires the practitioners' or delegated officials' original signatures to terminate reassignments.

Billing through reassignments. PECOS is linked to the Multiple Carrier System, which contractors use to pay Medicare claims, to create a record for each reassignment. In the Multiple Carrier System, a Provider Transaction Access Number (PTAN) is assigned to each practitioner for each reassignment so that the third party receiving the reassignment can bill on the practitioner's behalf. In effect, there is one PTAN for each reassignment. If practitioners have multiple

[2] PECOS is the CMS system of records for enrollment and reassignments of Medicare practitioners.

[3] Delegated official means an individual who is given the authority by the practitioner to report changes and updates to the practitioner's enrollment record. The delegated official must be an individual with an ownership or control interest (as defined in Section 1124(a)(3) of the Social Security Act) or be a W-2 managing employee of the practitioner.

reassignments, they will have multiple PTANs. If no billing occurs for a period of 12 consecutive months, the PTAN is deactivated and no further billing can occur through that reassignment.

Planned CMS Improvements

After we completed data collection, CMS staff informed us of new policies that would improve existing reassignment safeguards. These improvements include periodically revalidating practitioner contact information and implementing communication from the Multiple Carrier System to PECOS.

METHODOLOGY

PECOS Individual Global Extract File

From CMS, we obtained the PECOS May 2008 Individual Global Extract File (the May 2008 Extract), which CMS staff indicated to us contained records for all reassignments that were established between January 1, 2003, and December 31, 2007, and were still active on May 1, 2008.[4] We analyzed this information to determine the number of practitioners with reassignments and the number of reassignments per practitioner. Our sampling plan assigned practitioners to one of three strata, depending on the number of reassignments in the May 2008 Extract—one or two reassignments, three or four reassignments, and five or more reassignments. We initially sampled 166 practitioners in each stratum for this study. The sampled practitioners had from 1 to 21 reassignments.

Prior to sample selection, CMS enrollment staff indicated to us that the May 2008 Extract contained only active reassignments—that is, reassignments for which no terminations have been submitted. However, we discovered discrepancies between the data contained in the May 2008 Extract and those in the PECOS database. When we asked CMS staff to explain these discrepancies, they determined that errors in the procedures that created the May 2008 Extract had caused it to contain records of terminated reassignments and inaccurate effective dates for reassignments.[5] Therefore, we initially assigned

[4] We selected the May 2008 Extract to increase the likelihood that practitioners would still be in practice at the time we attempted to contact them from September 2008 to February 2009.

[5] Further information on the errors is available in our report entitled "Inaccurate Data in the Provider Enrollment, Chain, and Ownership System Individual Global Extract File," OEI-07-08-00181.

some practitioners to the wrong stratum because of inaccuracies in the May 2008 Extract. After discovering the discrepancies and inaccurate effective dates, we examined PECOS data for every practitioner and reassignment in our sample to identify the correct number of active reassignments for each practitioner. This resulted in our sample having 194 practitioners with 1 or 2 reassignments (249 total reassignments), 152 practitioners with 3 or 4 reassignments (497 total reassignments), and 151 practitioners with 5 or more reassignments (977 total reassignments).

We excluded from our analyses all reassignments that had been terminated as of May 1, 2008, and our reported study results reflect these adjustments. One practitioner with more than five reassignments was excluded because of an open Office of Inspector General (OIG) investigation.

After we made these corrections, our sample included 497 practitioners with 1,723 reassignments. Projections were made for both practitioners and reassignments. See Appendix A for further details on the original sample and adjustments. See Appendix B for point estimates and confidence intervals.

Practitioner Data Collection

After selecting our sample, we mailed lists of the reassignments found in the May 2008 Extract to the sampled practitioners. We asked these practitioners whether each reassignment listed should have been active. Our overall response rate from practitioners was 88 percent.[6] To achieve the highest response rate possible, we used multiple information sources to identify correct addresses for practitioners. We first used the correspondence address in the May 2008 Extract. If the U.S. Postal Service was unable to deliver a letter and it was returned to us with "return to sender" or "not at this address" noted on it or we received no response, we used the following sources to locate practitioners' addresses:

- the pay-to address listed in the May 2008 Extract,

[6] The response rates were: practitioners with one to two reassignments, 158 practitioners, or 93 percent; practitioners with three to four reassignments, 145 practitioners, or 86 percent; and practitioners with five or more reassignments, 136 practitioners, or 82 percent. Responses from these 439 practitioners represent 1,482 reassignments.

- the practitioner's National Provider Identifier (NPI) mailing address, and
- the practitioner's NPI practice location address.

We used additional resources to locate practitioners for whom we were still unable to identify correct mailing addresses, which included:

- searching networking Web sites and public records, such as Google.com, LinkedIn.com, Facebook.com, State medical licensing Web sites, telephone and cell phone directories, and county tax information;
- calling the practitioners;
- examining the 2008 National Claims History file for recently paid claims to identify practitioners' most recent places of employment;
- searching LexisNexis to identify other potential addresses; and
- searching the current PECOS database to determine whether the practitioners had updated their correspondence addresses.

Once we identified the correct mailing address for each practitioner, we made at least four attempts to solicit a response by mail, with the fourth attempt being a certified letter.

We then used the 2007 Part B Medicare claims data from the National Claims History file to determine how much Medicare paid through the sampled practitioners' reassignments. We used practitioners' identifying information (NPI and provider identification number) and third parties' tax identification numbers to identify Medicare Part B claims paid through specific reassignments.

Interviews With CMS and Contractors

We interviewed CMS Central Office staff regarding procedures pertaining to reassignments and required safeguards. We conducted structured interviews with staff at all 10 contractors responsible for processing reassignments to assess the established reassignment safeguards.

Nonresponse Analysis

We received an 88-percent response rate from practitioners to the survey. Therefore, we conducted a nonresponse analysis. We found no statistical evidence of nonresponse in our key survey estimates. Appendix C provides details on the nonresponse analysis.

Limitations

We limited our analyses to 2007 Medicare Part B claims from the National Claims History File and reassignment information in the May 2008 Extract. Information regarding whether reassignments should have been active was self-reported.

Quality Standards

This study was conducted in accordance with the "Quality Standards for Inspections" approved by the Council of the Inspectors General on Integrity and Efficiency.

CMS data indicate that 77 percent of practitioners have at least one reassignment

Data in the May 2008 Extract indicate that 517,936 practitioners had at least one reassignment (see Table 1). The May 2008 Extract data also indicate that these practitioners had a total of 833,016 reassignments.

As Table 1 shows, nearly all certified registered nurse anesthetists had at least one reassignment, while physician assistants rarely had reassignments. The majority of practitioners with reassignments were physicians. Appendix D provides the percentages of practitioner specialties with reassignments. As Appendix D shows, emergency department physicians had the highest rate of reassignments for any physician specialty.

Table 1: Types of Medicare-Enrolled Practitioners With Reassignments

Practitioner Type	Total Enrolled Practitioners	Total Practitioners with Reassignments	Percent of Enrolled Practitioners with Reassignments
Certified Registered Nurse Anesthetist	24,555	23,294	94.9
Nurse Midwife	3,113	2,820	90.6
Nurse Practitioner	45,140	40,333	89.4
Physical Therapist	34,354	30,329	88.3
Occupational Therapist	6,411	5,529	86.2
Doctor of Medicine/Doctor of Osteopathy	454,975	372,636	81.9
Audiologist	3,470	2,779	80.1
Dietician	6,936	5,440	78.4
Clinical Nurse Specialist	2,474	1,683	68.0
Licensed Clinical Social Worker	34,682	20,228	58.3
Clinical Psychologist	21,353	11,384	53.3
Other	1,391	741	53.3
Physician Assistant	35,712	740	2.1
Total	**674,566**	**517,936**	**76.8**

Source: Office of Inspector General (OIG) analysis of Individual Global Extract File Enrollment and Reassignment Tables, 2009.

Practitioners indicated that 37 percent of reassignments should not have been active

Overall, 37 percent of reassignments in the May 2008 Extract should not have been active. Further, 39 percent of practitioners had at least one reassignment that should not have been active. For 92 percent of reassignments that should not have been active, the practitioners were once employed with the third parties to which their reassignments were made, but had since terminated their employment with them. For the remaining 8 percent of reassignments that should not have been active, practitioners had no knowledge of third parties to which their benefits had been reassigned or indicated that they had applied for positions with the third parties but were never employed there. As one of the practitioners in our sample stated, "Years ago, I was considering [working for the third party]. I don't recall any contract [being] signed, much less [completing or signing] any Medicare forms. I never provided any services on their behalf, either."

Thirty-five percent of practitioners who indicated they had at least one reassignment that should not have been active believed that the reassignment(s) automatically terminated when their employment did. When we asked practitioners whether they knew they could terminate reassignments, 55 percent responded that they were not aware that they could do so.[7] Point estimates with confidence intervals for selected statistics are contained in Appendix B.

Appendix E compares reassignments that should not have been active among practitioners with one or two reassignments to those with three or four reassignments and five or more reassignments.

Medicare paid a total of $140,488 through reassignments that should not have been active

Third parties collected payments from Medicare through reassignments that should not have been active for only 1 percent of practitioners.[8] From our sample, we identified 12 practitioners who had a total of 16 reassignments through which Medicare made payments (1) after the dates the

[7] After completing our survey, 12 practitioners requested us to provide them with copies of the CMS-855R or asked us how to find the CMS-855R so they could terminate their inactive reassignments.

[8] We counted payments in error only for services that were provided more than 1 month after the dates the practitioners indicated the reassignments should have been terminated.

practitioners indicated their employment with the third parties ended or (2) to third parties of which practitioners were not aware.[9] While Medicare allowed a total of $35.3 million in payments through the sampled reassignments, only $140,488 in payments were made through reassignments that should not have been active. The amount paid through each of these 16 reassignments ranged from $7 to $66,901.

In one example, a practitioner had a total of 21 reassignments. Of these, only three should have been active. For the remaining 18 reassignments, four were for third parties with which the practitioner had terminated her employment in 2004. These third parties continued to collect Medicare payments on the practitioner's behalf. Medicare payments to these third parties totaled more than $7,800 in 2007, which was 3 years after the practitioner indicated she terminated her employment with them. All four of these entities shared the same address.[10]

CMS contractors reported using safeguards to ensure correct processing of reassignments, but several factors may limit their effectiveness

CMS contractor staff reported using safeguards to ensure that both practitioners and third parties are enrolled in Medicare, the signatures on the applications are those of the practitioners or delegated officials, the signatures are original (not photocopied or stamped), and the third parties listed are eligible to receive reassigned benefits.[11]

Although they are not required to do so, 7 of 10 Medicare contractors reported using additional safeguards, such as comparing the signatures on reassignment applications to signatures on file or contacting the practitioners or the third parties to verify the reassignments by telephone, mail, or site visits. Contractors that used these additional safeguards indicated that they target these efforts to areas of high

[9] When practitioners indicated they had no knowledge of the third parties, all payments made through those reassignments were determined to be made in error regardless of date.

[10] We found that 25 separate legal entities shared this same address and suite number.

[11] The safeguards contractors reported using are those in CMS's "Medicare Program Integrity Manual," Pub. No. 100-08, ch. 10.

suspected fraud, practitioners with multiple reassignments, and/or 855Rs they find suspicious or questionable.[12]

While contractors have implemented safeguards to prevent payments made through reassignments that should not have been active, the safeguards have limited effectiveness because (1) many practitioners fail to update their contact information with CMS, (2) many practitioners fail to review claims that were billed on their behalf, and (3) PTANs are not automatically deactivated when reassignments are deactivated.

More than half of practitioners failed to update their information with CMS

Many practitioners failed to provide CMS updated contact information, which could create challenges in contacting practitioners to verify reassignments. Only 48 percent of PECOS addresses resulted in responses from the practitioners. We identified correct mailing addresses for nearly all of the remaining practitioners using sources other than the May 2008 Extract. We obtained addresses from the NPI registry for 32 percent of practitioners. We obtained addresses for 19 percent of practitioners through multiple Internet sources, such as Google.com, State licensing board Web sites, LexisNexis, and social networking sites. We were unable to locate addresses for 2 percent of practitioners.[13]

Additionally, 29 percent of practitioners indicated that they never update, did not know how to update, or relied on others to update their contact information with Medicare.[14] One practitioner explained, "I personally do not contact Medicare. I have always presumed that the credentialing and billing departments take care of this. . . ." All of the practitioners in our sample who had payments made through reassignments that should not have been active failed to either

[12] In one example demonstrating the efforts contractors undertake to prevent inappropriate reassignments, a contractor rejected a reassignment application because it lacked required information. Subsequent to the rejection, the third party provided the missing information, resubmitting the original application. However, the contractor noted that the date on the application had been erased and rewritten. The contractor spoke with the practitioner, who explained that he decided not to join the group, leading the contractor to believe that the third party submitted the reassignment application without the practitioner's knowledge. The contractor referred the group for further investigation.

[13] Percentages exceed 100 percent because of rounding.

[14] Practitioners indicated that they relied on administrative staff and credentialing or billing departments to update their information or prompt them to do so.

terminate their reassignments or update their contact information with CMS.

Nearly half of practitioners were unaware that they could review claims billed on their behalf

Practitioners, upon request to CMS, have unrestricted access to all claims billed on their behalf by the third parties to which their benefits have been reassigned.[15] Theoretically, practitioners would see potential inappropriate claims that third parties billed to Medicare when reviewing the claims billed on their behalf. However, two factors impede the effectiveness of this safeguard. First, 48 percent of practitioners reported that they were not even aware that they were entitled to access the claims billed on their behalf. Second, if practitioners are not aware that third parties are billing Medicare on their behalf, they have no reason to request access to claims that the third parties are billing.

PTAN deactivation does not currently update PECOS and terminate the reassignment

Contractors use the Multiple Carrier System to pay Medicare claims. If after 12 months a PTAN is not used, it is deactivated in the system.[16] Deactivation of the PTAN prevents further billing through a given reassignment. However, as long as third parties continue to bill on practitioners' behalf, the deactivation date is not triggered. Additionally, deactivation of a PTAN has no effect on the reassignment record in PECOS because the Multiple Carrier System did not populate PECOS with deactivation information at the time of this study.

[15] 42 CFR § 424.80(d)(2). Although the regulation requires practitioners to have unrestricted access, it does not specify how this access should be given.

[16] CMS, "Medicare Program Integrity Manual," Pub. No. 100-08, ch. 10, § 13.1.

Most practitioners enrolled in Medicare have at least one reassignment. However, practitioners indicated that 37 percent of their reassignments should not have been active. Despite the high number of reassignments that should not have been active, Medicare payments made through these reassignments were low. Safeguards are in place to ensure correct processing of reassignments, but several factors may limit their effectiveness.

Subsequent to our analyses, CMS staff informed us of new policies that might address the limitations that we identified. These include periodically revalidating practitioner contact information and implementing communication from the Multiple Carrier System to PECOS. The implementation of these new policies would address the limitations we identified regarding providers' failure to update their contact information or terminate inactive reassignments and regarding the deactivation of PTANs.

To reduce the number of reassignments that should not be active, we recommend that CMS:

Implement Plans To Revalidate Practitioner Enrollment Information. We encourage CMS to implement its plans to revalidate practitioners' enrollment information every 5 years.

Educate Practitioners on the Need To Provide Current Information. CMS could educate practitioners on the need to provide current correspondence information and terminate inactive reassignments.

Implement Plans To Update PECOS From Other Data Sources. We encourage CMS to follow through with plans to allow the Multiple Carrier System to populate PECOS with information on practitioners whose billing privileges have been deactivated.

Follow Up With the Practitioners for Whom Payments Were Made Through Reassignments That Should Not Have Been Active. We will forward information on these claims to CMS in a separate memorandum.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments, CMS agreed with the first and second recommendations, but it did not indicate specific agreement or

disagreement with the third and fourth recommendations. However, CMS described actions it has taken or plans to take to address all four recommendations.

CMS indicated that it has taken a number of steps to strengthen the reassignment process, such as implementing a systematic process to deactivate approximately 2 million infrequently used Medicare billing numbers. CMS indicated that it has also provided practitioners online access to enroll, change, or view existing enrollments.

In response to the first recommendation, CMS indicated that it instructed Medicare carriers and Part A/B Medicare Administrative Contractors, through program instructions, to initiate and complete more than 10,000 revalidations.

In response to the second recommendation, CMS indicated it has taken significant steps to help educate the public about its reporting responsibilities including discussing reporting responsibilities and the need to update enrollment information during CMS Open Door Forums, participating in conference calls with regional offices and contractors to discuss reporting responsibilities, mailing reporting responsibility information to high-risk providers, posting reporting responsibility information on the Medicare provider enrollment Web site, and sending listserv announcements to practitioners about their reporting responsibilities.

In response to the third recommendation, CMS plans in October 2009 to update PECOS with verified deactivation information contained in the Multiple Carrier System. The synchronization process will ensure PECOS maintains current information on practitioners.

In response to the fourth recommendation, CMS stated that once it receives the information from OIG, it will follow up with third parties that may have been inappropriately paid.

We did not make changes to the report based on CMS's comments. The full text of CMS's comments can be found in Appendix F.

APPENDIX ~ A

Table A-1: Original Sampling Frames

Stratum	Stratum Definition	Practitioners in Population*	Reassignments in Population*	Original Sample Design	
				Practitioners in Sample	Reassignments in Sample
1	Practitioners with one or two active reassignments	448,824	559,308	166	202
2	Practitioners with three or four active reassignments	54,345	178,208	166	543
3	Practitioners with five or more active reassignments	14,767	95,500	166	1,076
Total		**517,936**	**833,016**	**498**	**1,821**

*The population figures are based on data in the Provider Enrollment, Chain, and Ownership System May 2008 Extract. As described in the "Methodology" section, the May 2008 Extract is known to contain reassignments that should not be active. However, no other data source is available to provide more accuarate population figures.

Source: Office of Inspector General (OIG) analysis of May 2008 Individual Global Extract File Enrollment and Reassignment Tables, 2009.

Table A-2: Active Reassignments Correctly Identified

Stratum	Practitioners With One or Two Active Reassignments	Practitioners With Three or Four Active Reassignments	Practitioners With Five or More Active Reassignments	Design Sample Size	Reassignments in Sample
1	166	0	0	166	249
2	22	144	0	166	497
3	6	8	152	166	977
Adjusted Sample Size	**194**	**152**	**152**	**498**	**1,723**

Source: OIG analysis of May 2008 Individual Global Extract File Enrollment and Reassignment Tables and Provider Enrollment, Chain, and Ownership System data, 2009.

APPENDIX ~ B

Table B-1: Point Estimates and Confidence Intervals

Description	Sample Size (n)	Point Estimate	95-Percent Confidence Interval
Medicare expenditures through reassignments	497	$27,828,102,201	$21,056,195,180–$34,600,009,222
Percentage of reassignments practitioners indicated should not have been active	1,482	36.5	31.4–41.6
Percentage of practitioners with reassignments that should not have been active	439	38.8	32.5–45.5
Percentage of reassignments to third parties that should not have been active for which the practitioner worked previously	682	91.7	87.2–96.2
Percentage of reassignments to third parties that should not have been active for which the practitioner never worked	682	8.3	3.8–12.8
Percentage of practitioners believing that reassignments automatically terminated with end of employment	267	35.1	25.2–44.9
Percentage of practitioners unaware they could terminate a reassignment	439	55.2	48.2–62.0
Percentage of reassignments that should not have been active (practitioners with one or two reassignments)	233	33.1	26.2–40.1
Percentage of reassignments that should not have been active (practitioners with three or four reassignments)	428	42.1	36.2–48.0
Percentage of reassignments that should not have been active (practitioners with five or more reassignments)	821	50.0	43.6–56.5
Percentage of practitioners with reassignments that should not have been active (practitioners with one or two reassignments)	182	34.7	27.3–42.0
Percentage of practitioners with reassignments that should not have been active (practitioners with three or four reassignments)	132	70.4	62.5–78.3
Percentage of practitioners with reassignments that should not have been active (practitioners with five or more reassignments)	125	79.2	72.1–86.3
Percentage of practitioners with payments for reassignments that should not have been active	439	1.0	0.2–2.9
Percentage of Provider Enrollment, Chain, and Onwership System (PECOS) correspondence addresses that were correct	497	48.1	41.5–54.7
Percentage of practitioners with correct National Provider Identifier contact information and incorrect PECOS contact information	497	31.8	26.0–38.3
Percentage of practitioners with correct other contact information and incorrect PECOS and NPI contact information	497	18.5	14.0–24.0
Percentage of practitioners we could not locate	497	1.7	0.4–4.5
Percentage of practitioners who never updated Medicare on contact information	439	29.0	23.1–35.7
Percentage of practitioners unaware they had access to claims billed on their behalf	439	48.1	41.3–55.1

Source: Office of Inspector General analysis of survey responses and 2007 National Claims History file data, 2009.

APPENDIX ~ C

Nonresponse Analysis

We analyzed how nonresponse to our survey may have affected our survey estimates. We examined potential nonresponse bias effects on key survey questions. Our nonresponse analysis provided no statistical evidence that our survey results were biased because of nonresponse.

Our basic approach was to impute answers for nonrespondents and determine whether the survey estimate calculated with the imputed values differed significantly from the survey estimate based solely on the respondents' answers. If no statistical difference was found between the two estimates, we considered our survey estimates to be unaffected by potential nonresponse bias.

Variables available for both respondent and nonrespondent practitioners were the number of allowed claims for 2007, the amount of allowed claims for 2007, the number of active reassignments indicated in PECOS, and the number of years since graduating from their medical programs. We determined whether respondents and nonrespondents differed statistically at the 95-percent confidence level on these variables. We found only one difference for practitioners with five or more reassignments: nonresponding practitioners graduated more recently (on average 14 years ago) than responding practitioners (on average 17 years ago).

Because practitioners with five or more reassignments who graduated more recently were now underrepresented in our sample because of nonresponse, we investigated whether this might bias our survey results. To do this, we first classified respondents into two categories corresponding to 14 or 17 years since graduation. Then we randomly assigned respondents' values to missing nonrespondents' values within the same graduation year categories. Finally, we conducted statistical tests of significance at the 95-percent confidence level to determine whether the estimates based on both respondents' answers and nonrespondents' imputed values differed from the estimates based only on respondents' answers.

Based on this analysis, we found no statistical evidence that our survey results were biased because of practitioner nonresponse.

APPENDIX ~ D

Table D-1: Practitioners With Reassignments by Specialty

Comparisons should not be made between Table 1 and Table D-1. Practitioners may have multiple specialties; thus, the information will not match between the tables.

Physician Specialty	Enrolled Providers	Providers With Reassignments	Percentage of Enrolled Providers With Reassignments
Emergency Medicine	35,993	34,341	95.4
Interventional Radiology	1,493	1,399	93.7
Radiation Oncology	3,259	3,046	93.5
Critical Care	4,435	4,085	92.1
Diagnostic Radiology	29,701	27,284	91.9
Cardiac Surgery	1,803	1,654	91.7
Nuclear Medicine	1,049	954	90.9
Anesthesiology	26,913	24,385	90.6
Interventional Pain Management	3,957	3,549	89.7
Hematology/Oncology	5,780	5,162	89.3
Pediatrics	25,470	22,706	89.1
Surgery Oncology	711	632	88.9
Pathology	7,667	6,805	88.8
Cardiology	18,422	16,326	88.6
Family Practice	58,364	51,687	88.6
Nephrology	5,056	4,453	88.1
Gynecological/Oncology	796	701	88.1
Hematology	968	852	88.0
Peripheral Vascular Medicine	262	228	87.0
Medical Oncology	1,920	1,661	86.5
Orthopedic Surgery	14,846	12,817	86.3
Pulmonary Disease	6,835	5,877	86.0
Neurosurgery	3,400	2,923	86.0
Vascular Surgery	2,721	2,339	86.0
Internal Medicine	84,207	72,145	85.7
Other	1,595	1,363	85.5
Obstetrics/Gynecology	21,967	18,727	85.3
Geriatric Medicine	2,925	2,487	85.0
Thoracic Surgery	2,650	2,245	84.7
Hand Surgery	1,228	1,040	84.7
Urology	5,934	5,011	84.4

continued on next page

Table D-1: Practitioners With Reassignments by Specialty (continued)

Physician Specialty	Enrolled Providers	Providers With Reassignments	Percentage of Enrolled Providers With Reassignments
Infectious Medicine	3,666	3,092	84.3
Neurology	9,023	7,610	84.3
Gastroenterology	7,405	6,231	84.1
Colorectal Surgery	827	690	83.4
Osteopathic Manipulative Treatment	1,366	1,139	83.4
Physical Medicine and Rehabilitation	5,767	4,806	83.3
General Surgery	17,241	14,349	83.2
Ophthalmology	10,497	8,706	82.9
Endocrinology	3,586	2,928	81.7
Otolaryngology	5,461	4,455	81.6
Preventative Medicine	789	641	81.2
Allergy/Immunology	2,221	1,803	81.2
Rheumatology	2,674	2,159	80.7
Dermatology	6,174	4,940	80.0
Psychiatry	22,880	18,053	78.9
Addiction Medicine	408	305	74.8
Maxillofacial Surgery	1,029	761	74.0
Optometry	19,055	14,036	73.7
Plastics	3,505	2,443	69.7
General Practice	8,739	5,981	68.4
Podiatry	9,109	6,223	68.3
Neuropsychiatry	196	133	67.9
Oral Surgery	3,014	1,965	65.2
Chiropractic	32,276	17,263	53.5
Total	**559,235**	**469,596**	

Source: Office of Inspector General analysis of Provider Enrollment, Chain, and Ownership System data, 2009.

Reassignments That Should Not Have Been Active

Although practitioners with one or two reassignments were less likely to have reassignments that should not have been active than practitioners with more than two reassignments, they had the greatest number of reassignments that should not have been active overall. Among practitioners with three or four reassignments, the proportion of practitioners with at least one reassignment that should not have been active was 35 percentage points higher than that of practitioners with one or two reassignments. Among practitioners with five or more reassignments, the proportion of practitioners with at least one reassignment that should not have been active was 45 percentage points higher than that of those with one or two reassignments (see Table E-1). Statistical significance is shown in Table E-2.

Table E-1: Comparisons of Percentages of Reassignments That Should Not Have Been Active

Number of reassignments	Percentage of Reassignments That Should Not Have Been Active	Percentage of Practitioners With One or More Reassignments That Should Not Have Been Active
One or two reassignments	33.1	34.7
Three or four reassignments	42.1	70.4
Five or more reassignments	50.0	79.2
Total	**36.5**	**38.8**

Source: Office of Inspector General (OIG) analysis of survey responses and claims data, 2009.

Table E-2: Statistical Significance Between Strata

Number of Reassignments	Percentage of Practitioners With One or More Reassignments That Should Not Have Been Active	95-Percent Confidence Interval	P-Value
One or two reassignments	34.7	-	-
Three or four reassignments	70.4	-	-
Difference	35.7	24.9–46.5	< 0.0001
One or two reassignments	34.7	-	-
Five or more reassignments	79.2	-	-
Difference	44.5	34.3–54.8	< 0.0001

Source: OIG analysis of survey responses, 2009.

APPENDIX ~ F

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: SEP 1 2009

TO: Daniel R. Levinson
Inspector General

FROM: Charlene Frizzera /S/
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Reassignment of Medicare Benefits" (OEI-07-08-00180)

Thank you for the opportunity to review and respond to the above referenced OIG Draft Report. The Centers for Medicare & Medicaid Services (CMS) appreciates the OIG's efforts in reviewing the Medicare reassignment process.

The CMS has already taken a number of steps to strengthen the reassignment process. Specifically, after the publication of "Medicare Program: Requirements for Providers and Suppliers to Establish and Maintain Medicare Enrollment (CMS-6002-F)" in the *Federal Register* on April 21, 2006, CMS implemented a systematic process to deactivate infrequently used Medicare billing numbers (i.e., a billing number not used in more than 12 consecutive months) for physicians, non-physician practitioners, and other suppliers. Since implementing this systematic process, we have deactivated approximately 2 million billing numbers.

In addition, CMS implemented an internet-based provider enrollment system known as, the Provider Enrollment, Chain and Ownership System (PECOS), an electronic version of the Medicare enrollment application process, earlier this year. The PECOS system allows physicians, non-physician practitioners, and other providers and suppliers (except for suppliers of durable medical equipment, prosthetics, orthotics and supplies) to enroll, change, or view an existing enrollment record at any time. By allowing physicians and non-physician practitioners ready access to their Medicare enrollment record, we believe that physicians and non-physician practitioners will review and, as appropriate, update their current reassignments with the Medicare program more routinely.

OIG Recommendation

Implement plans to revalidate practitioner enrollment information.

CMS Response

We agree that revalidation efforts will ensure that only qualified practitioners and suppliers participate in the Medicare program. Moreover, the revalidation process will strengthen CMS' efforts to ensure that physicians and non-physician practitioners are taking the necessary steps to update their enrollment records to reflect their current reassignments. To this end, we instructed Medicare carriers and A/B MACs via various program instructions to initiate and complete more than 10,000 revalidations in calendar year 2009.

OIG Recommendation

Educate practitioners on the need to provide current information.

CMS Response

The CMS agrees that it is essential that physicians, non-physician practitioners, and other providers and suppliers comply with their reporting responsibilities. Moreover, to ensure payment accuracy and reduce the Medicare program's exposure to fraud and abuse, we believe that it is necessary for individual practitioners to notify their Medicare carrier or Part A/B Medicare administrative contractor about changes in their reassignments. To help educate the provider and supplier community about their reporting responsibilities, we have taken several significant steps to help educate the public about their reporting responsibilities, including:

- Discussing provider and supplier reporting responsibilities, including the need to update enrollment records to reflect current reassignments, during CMS Open Door Forums;
- Participating in conference calls with CMS' Regional Office and Medicare contractors to discuss provider and supplier responsibilities;
- Mailing reporting responsibility information to suppliers in South Florida – a high risk area of the country;
- Posting reporting responsibility information on the Medicare provider enrollment Web site, www.cms.hhs.gov/MedicareProviderSupEnroll; and
- Sending listserv announcements to physicians, non-physician practitioners, and other providers and suppliers about their reporting responsibilities.

We will continue to educate the providers and suppliers about their reporting responsibilities, including updating their Medicare enrollment record to reflect correct reassignments.

OIG Recommendation

Implement plans to update PECOS from other data sources.

CMS Response

In October, 2009, CMS plans to update PECOS with deactivation information contained in the Multiple Carrier System, the Part B claims processing system. This synchronization process will ensure that PECOS maintains current information regarding those physicians, non-physician practitioners, and other suppliers whose Medicare billing privileges, including billing privileges associated with a reassignment, have been deactivated. While this change has no impact on current claims processing operations, it will ensure that PECOS maintains accurate information on the billing status and reassignments for each provider.

Since PECOS is the Agency's system of record for Medicare provider/supplier enrollment data and it updates CMS' Part A and Part B claims processing systems, it is essential that CMS' enrollment and claims processing systems contain consistent information. Therefore, we will only transfer information into PECOS from another system when the other source of information contains verified data. For this reason, with limited exceptions, we believe that enrollment data should update the claims processing and other systems. This will ensure that CMS and its Medicare contractors have obtained and verified information submitted by a physician, non-physician practitioner, provider, or supplier before updating CMS' claims processing systems.

OIG Recommendation

Follow-up with the practitioners for whom payments were made through reassignments that should not have been active.

CMS Response

Once CMS receives the information from the OIG on those providers they believe may have been inappropriately paid, we will follow-up with the identified providers.

The CMS thanks the OIG for their efforts on this report. We look forward to continuing to work with you in the future to strengthen our Medicare enrollment process and to identify and prevent fraud, waste, and abuse in the Medicare program.

ACKNOWLEDGMENTS

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

Brian Whitley 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 Megan Buck and Michala Walker; central office staff who contributed include Kevin Farber and Kevin Manley.