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ENHANCED ENROLLMENT SCREENING OF MEDICARE PROVIDERS: EARLY IMPLEMENTATION RESULTS

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EXECUTIVE SUMMARY— ENHANCED ENROLLMENT SCREENING OF MEDICARE PROVIDERS: EARLY IMPLEMENTATION RESULTS
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WHY WE DID THIS STUDY

To bill for services they provide to beneficiaries, providers must enroll in Medicare and periodically revalidate this enrollment. Effective enrollment screening is an important tool in preventing Medicare fraud. The Centers for Medicare & Medicaid Services (CMS) has sought to enhance the enrollment screening process with new antifraud tools such as placing providers in risk categories, increasing site visits, requiring fingerprinting, implementing an Automated Provider Screening system, and denying enrollment to providers whose owners have unresolved overpayments. This study examines CMS's early implementation of new screening tools intended to prevent illegitimate providers from enrolling in Medicare.

HOW WE DID THIS STUDY

We obtained data from CMS on enrollment and revalidation applications submitted for the 1-year period before the implementation of enhanced screening procedures (i.e., March 25, 2010, through March 24, 2011) and the 1-year period after the implementation of enhanced screening procedures (i.e., March 25, 2012, through March 24, 2013). For the latter period, we reviewed detailed results of 16,022 site visits conducted by CMS's National Site Visit Contractor (NSVC). In addition, we examined CMS and its contractors' policies and procedures for enrollment, and we surveyed or interviewed CMS and contractor staff involved in the enrollment process.

WHAT WE FOUND

After CMS implemented risk screening and site visit enhancements to strengthen the provider enrollment process, we found that providers submitted fewer enrollment applications to CMS in the postimplementation period. There was also an increase in the rate of applications that CMS returned to providers and a higher rate of approvals (lower rate of denials) among CMS's enrollment determinations. Given the variation in outcome statistics, it is not possible to determine conclusively whether the enhancements prevented a greater percentage of ineligible providers from entering Medicare. However, CMS's additional efforts to revalidate all existing enrollments yielded substantial revocations and deactivations of existing providers' billing privileges. The revalidation process resulted in a much higher percentage of providers being deactivated than revoked. Additionally, we found that CMS's implementation of enhanced enrollment screening needs strengthening. Our review found gaps in contractors' verification of key information on enrollment applications that could leave Medicare vulnerable to illegitimate providers. In addition, contractors were inconsistent in applying site visit procedures and using site visit results for enrollment decisions. Finally, CMS's enrollment data system does not contain the information needed for effective oversight and evaluation of the enhancements to the enrollment screening process.

WHAT WE RECOMMEND

We recommend that CMS (1) monitor contractors to determine whether they are verifying information on enrollment and revalidation applications as required; (2) validate that contractors are appropriately considering site visit results when making enrollment decisions; (3) revise and clarify site visit forms so that they can be more easily used by inspectors to determine whether a facility is operational; (4) require the NSVC to improve quality-assurance oversight and training of site visit inspectors; and (5) ensure that CMS's enrollment data system contains the complete and accurate data needed to execute and evaluate CMS's enrollment-screening enhancements. CMS concurred with all five of our recommendations.

TABLE OF CONTENTS

Objectives 1

Background 1

Methodology 6

Findings 8

- Providers submitted fewer enrollment applications after CMS implemented risk-screening and site visit enhancements 8
- CMS's effort to revalidate all existing enrollments yielded substantial revocations and deactivations 10
- Key provider information is not verified during the enrollment or revalidation processes 11
- Contractors were inconsistent in applying site visit procedures and using site visit results for enrollment decisions 12
- CMS relies on an enrollment data system, PECOS, that does not contain all the information needed for effective oversight 15

Conclusion and Recommendations 18

- Agency Comments and Office of Inspector General Response 21

Appendixes 22

- A: General Site Visit Form 22
- B: Number of Contractors That Verify Identification Numbers Submitted by Providers on Enrollment and Revalidation Applications 23
- C: Agency Comments 25

Acknowledgments 28

OBJECTIVES

1. To examine how CMS and its contractors implemented enhanced screening procedures for enrolling and revalidating Medicare providers and suppliers.
2. To review the early results of enhanced screening procedures on the enrollment and revalidation of Medicare providers and suppliers.

BACKGROUND

Providers and suppliers must enroll in the Medicare program and periodically revalidate their enrollment to be eligible to bill Medicare. CMS has stated that "provider enrollment is the gateway to Medicare."[1] If this gateway is not adequately safeguarded, Medicare is at increased risk of enrolling providers and suppliers with intent to defraud the program. Effective enrollment screening is an important tool in preventing Medicare fraud.

Since 1997, the Office of Inspector General (OIG) has identified numerous vulnerabilities regarding provider and supplier enrollment and has made recommendations for improvement. In an effort to combat fraud, waste, and abuse resulting from vulnerabilities in the enrollment process, CMS has sought to enhance enrollment screening with a set of new tools. These tools include new antifraud authorities provided by the Patient Protection and Affordable Care Act (ACA), an Automated Provider Screening (APS) system, and the ability to deny enrollment to providers and suppliers with unresolved overpayments.[2, 3]

Enrollment and Revalidation Applications

Providers and suppliers submit paper or electronic applications to Medicare Administrative Contractors (MACs) or to the National Supplier Clearinghouse (NSC) when newly enrolling in Medicare, changing their information, and reactivating or revalidating their enrollment.[4] CMS contracts with MACs and the NSC to review these applications and determine whether providers are eligible to bill Medicare. In accordance

[1] CMS, *CMS Proposes New Safeguards and Incentives to Reduce Medicare Fraud*, April 24, 2013.

[2] P.L. No. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010).

[3] A Medicare overpayment is a payment that a provider or supplier received in excess of amounts properly payable under Medicare statutes and regulations.

[4] The NSC processes applications for suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). MACs process all other applications.

with the *Medicare Program Integrity Manual*, MACs and the NSC must, unless otherwise specified, verify and validate all information furnished by providers on CMS-855 application forms.

There are five CMS-855 enrollment application forms for the following broad categories of providers: [5]

- institutional providers (CMS-855A);
- clinics, group practices, and certain other suppliers (CMS-855B);
- physicians and nonphysician practitioners (CMS-855I);
- suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (CMS-855S); and
- ordering and referring providers (CMS-855O).

Applications submitted to newly enroll, change information, or reactivate enrollment—hereinafter, "enrollment applications"—may be:

- approved, i.e., determined to be eligible to bill Medicare or
- denied, i.e., determined to be ineligible to bill Medicare.

In other instances, MACs or the NSC may return an enrollment application to a provider if that provider furnished incomplete information during the application process. Providers can also withdraw their applications at any time during the process.

After providers' initial enrollment, CMS requires them to revalidate their enrollment after a certain number of years. DMEPOS suppliers are required to revalidate their enrollment every 3 years. All other providers are required to revalidate every 5 years. Revalidation applications may be

- approved,
- revoked, i.e., billing privileges are terminated, or
- deactivated, i.e., billing privileges are stopped but can be restored upon submission of updated information.

The Provider Enrollment, Chain, and Ownership System (PECOS) is CMS's repository for provider enrollment information.

Enhancements to the Enrollment-Screening Process

The ACA provided CMS with the authority for enhancements to the enrollment-screening process, including, placing providers into risk screening categories, expanding site visit requirements, using fingerprints

[5] In this report we use the term "providers" to encompass both providers and suppliers.

to conduct national background checks and criminal history record checks, and expanding revalidation efforts.[6]

In addition, CMS's APS system aims to automate and standardize the process by which MACs and the NSC verify application information. CMS also issued guidance to MACs and the NSC on denying enrollment to providers with unresolved overpayments.[7]

Risk screening. On March 25, 2011, CMS began assigning providers to one of three risk categories: limited, moderate, or high risk. Providers assigned to higher risk categories are subject to a more extensive review. Federal regulations outline which provider types are assigned to each risk category:

- High risk: newly enrolling home health agencies (HHAs) and newly enrolling DMEPOS suppliers;
- Moderate risk: ambulance service suppliers, community mental health centers, comprehensive outpatient rehabilitation facilities, hospice organizations, independent clinical laboratories, independent diagnostic testing facilities (IDTFs), physical therapists enrolling as individuals or group practices, portable x-ray suppliers, revalidating HHAs, and revalidating DMEPOS suppliers; and
- Limited risk: all other provider types.[8]

Providers initially designated as limited or moderate risk may be redesignated as high risk if they meet certain criteria, such as having been convicted of certain crimes within the previous 10 years.

Site visits. The ACA provided CMS with the authority to expand the provider types subject to site visits.[9] Prior to the ACA, IDTFs and DMEPOS suppliers were subject to site visits as part of the enrollment process.[10] In accordance with Federal regulations, all providers designated as moderate or high risk must undergo a site visit when newly enrolling, adding or changing a practice location, undergoing a change of ownership that results in a new tax identification number, reactivating, or revalidating enrollment.

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[6] ACA § 6401.

[7] CMS, Transmittal 479, Change Request 8039. *CMS Manual System*, Pub. No. 100-08, "Enrollment Denials When an Existing or Delinquent Overpayment Exists."

[8] 42 CFR § 424.518

[9] ACA § 6401(a), codified at 42 USC § 1395cc(j)(2)(B)(ii)(III).

[10] Prior to the ACA, certain DMEPOS suppliers did not receive site visits, including chains with 25 or more locations, physicians, hospitals, skilled nursing facilities, ambulatory surgical centers, physical therapists, occupational therapists, and managed care organizations. After the ACA, all DMEPOS suppliers are subject to site visits.

The NSC performs site visits of DMEPOS suppliers. For all other providers, CMS implemented a site visit process using a National Site Visit Contractor (NSVC). MSM Security Services, Inc. serves as the NSVC. The NSVC began performing site visits in late January 2012 and was fully operational on March 15, 2012.[11] The NSVC and the NSC use three standard forms to conduct site visits depending on the type of provider visited. The NSVC uses a specialized form for IDTFs and the NSC uses a specialized form for most DMEPOS suppliers. For all other providers and certain DMEPOS suppliers, the NSVC and the NSC use a more general site visit form.[12]

MACs and the NSC are responsible for reviewing the results of site visits prior to making final decisions regarding applications. For applications screened with the general site visit form, the site visit determines whether

- the facility is open,
- personnel are at the facility,
- customers are at the facility (if applicable to that provider or supplier type), and
- the facility appears to be operational.[13]

The general site visit form contains six closed-ended (i.e., "Yes/No") questions and a section for additional comments from site visit inspectors.[14] Four of the questions each directly corresponds with one of the four standards noted above. Appendix A contains the general site visit form. The IDTF site visit form used during our review period contained 22 closed-ended questions addressing the IDTF standards in 42 CFR § 410.33 and additional questions asking for specific information or explanations of responses. The site visit form for DMEPOS suppliers contains 44 closed-ended questions addressing the DMEPOS supplier standards in 42 CFR § 424.57. The DMEPOS supplier site visit form has additional questions asking for specific information or explanations of responses.

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[11] Prior to the ACA, MACs conducted site visits of IDTFs. After the ACA, MACs conducted site visits for non-DMEPOS providers until the NSVC was fully operational.

[12] The general site visit form is used during enrollment and revalidation of the following DMEPOS suppliers: chains with 25 or more locations; hospitals; skilled nursing facilities; professionals (excluding chiropractors); ambulatory surgical centers; physical and occupational therapists; and managed care organizations. The form also may be used for all DMEPOS suppliers to conduct site visits not associated with enrollment or revalidation, including site visits in response to complaints.

[13] CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08 (Rev. 636, 02-04-16), ch. 15, § 19.2.2.B.

[14] Two questions on the general site visit form are applicable only to DMEPOS suppliers.

Fingerprinting. The ACA also gave CMS the authority to conduct fingerprinting for national background checks and criminal history record checks.[15] According to CMS, fingerprinting would be reserved for owners of providers in the high-risk category. Although fingerprint-based background checks were included in the 2011 regulation establishing the enhanced enrollment screening procedures, CMS did not award a contract to manage this process until 2014, when it selected Accurate Biometrics, Inc. to serve as the Fingerprint-Based Background Check Contractor.

Revalidation. Prior to the ACA, CMS required DMEPOS suppliers to revalidate their enrollment every 3 years, and other providers were required to revalidate every 5 years. The ACA provided CMS with the authority to conduct "off-cycle" revalidations and revalidate the enrollment of all existing providers under the new ACA screening requirements.[16] This off-cycle revalidation effort applies to providers who were enrolled prior to March 25, 2011. CMS began the revalidation process in September 2011.

APS system. In 2011 CMS contracted with Turning Point Solutions to develop the APS system. The APS system verifies certain application information against government records and private vendor data. When information does not match or criteria are unmet—for example, if the provider's license has expired—the APS system will flag that application information for MACs and NSC to verify.

Overpayment screening. In 2008 CMS modified regulations to allow MACs and the NSC to deny enrollment applications if a physician, nonphysician practitioner, or a provider's current owner has an unresolved overpayment.[17, 18] In August 2013 CMS issued guidance to MACs and the NSC on denying enrollment applications for providers with unresolved overpayments.[19] After this guidance was issued, CMS placed the implementation of the guidance on hold. In December 2014 CMS issued a final rule, effective February 3, 2015, that clarifies when a provider can be

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[15] ACA § 6401(a), codified at 42 USC § 1395cc(j)(2)(B)(ii)(II).

[16] ACA § 6401(a), codified at 42 USC § 1395cc(j)(2).

[17] 73 Fed. Reg. 69726, 69940 (Nov. 19, 2008).

[18] 42 CFR § 424.530(a)(6).

[19] CMS, Transmittal 479, Change Request 8039, *CMS Manual System*, Pub. No. 100-08, "Enrollment Denials When an Existing or Delinquent Overpayment Exists (Aug. 1, 2013)."

denied enrollment due to unresolved Medicare debts (including overpayments).[20]

METHODOLOGY

Data Collection and Analysis

CMS data. We met with CMS staff and collected data regarding enrollment and revalidation applications received and processed by MACs and the NSC 1 year before the implementation of enhanced screening procedures (i.e., March 25, 2010, through March 24, 2011) and 1 year after the implementation of enhanced screening procedures (i.e., March 25, 2012, through March 24, 2013).[21, 22] Our analysis compared trends in application outcomes across years.

MAC and NSC procedure data. From the NSC and the 12 MAC jurisdictions that process applications, we obtained and reviewed written policies and survey responses regarding enrollment and revalidation procedures. We requested additional information from one MAC regarding its review of site visit results and associated application determinations for certain providers it enrolled or revalidated. We also interviewed staff at one MAC to learn more about their procedures for processing enrollment and revalidation applications.

NSVC procedure data. From NSVC we obtained and reviewed written policies, training materials, and interview responses regarding site visit procedures. To collect information about site visit inspectors' experiences in conducting site visits, we surveyed a simple random sample of 200 of the 866 NSVC inspectors authorized to perform site visits as of September 2013.[23] We received and reviewed completed surveys from 133 inspectors. Because of a survey response rate of 67 percent, we did not project the survey responses of the 133 inspectors to the entire population of 866 inspectors.

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[20] 79 Fed. Reg. 72499 (Dec. 5, 2014). CMS amended the regulation to allow MACs and NSC to deny enrollment applications for any unresolved debt, be it an overpayment or some other type of financial obligation to Medicare. The final rule allows for the denial of enrollment if the provider or owner has an unresolved debt or had debt when the provider's enrollment was terminated or revoked and (1) the owner left the provider that had the debt 1 year before or after the provider's termination or revocation, (2) the debt has not been fully repaid, and (3) CMS determines that the debt poses an undue risk of fraud, waste, or abuse.

[21] The time period March 25, 2010, through March 24, 2011, is hereinafter referred to as the "preimplementation period." The time period March 25, 2012, through March 24, 2013, is hereinafter referred to as the "postimplementation period."

[22] We did not collect data regarding CMS-855O enrollment applications because this type of application did not exist during the preimplementation time period.

[23] We did not include NSVC inspectors located in U.S. territories in our review.

NSVC site visit results data. We obtained from CMS detailed results of 16,022 site visits conducted by NSVC during the postimplementaiton period for applications received and processed by MACs within that period. Of these, 1,914 site visits were conducted for IDTFs and 14,108 were conducted for non-IDTF providers. Our analysis compared the results of each site visit to the enrollment decision with a date that directly followed the date of the site visit.

APS procedure data. From the APS contractor, we obtained and reviewed written policies and interview responses regarding the APS system.

Limitations

We were not able to review the procedures or address the impact of the Fingerprint-Based Background Check Contractor because it was not operational when we conducted this study. We did not validate the data that CMS provided from its data systems.

Standards

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

FINDINGS

Providers submitted fewer enrollment applications after CMS implemented risk-screening and site visit enhancements

In March 2011 CMS began assigning providers to risk-screening categories and conducting site visits for those in the moderate- and high-risk categories. Providers submitted fewer enrollment applications in the year after CMS had implemented these enhancements. During the preimplementation period, providers submitted 546,916 enrollment applications, as shown in Table 1. In the year after implementation of enhancements, providers submitted 12 percent (67,801) fewer enrollment applications. This reduction may be evidence of a "deterrent effect" resulting from the enhanced enrollment screening process.

It was not possible to determine conclusively whether the new Medicare enrollment enhancements prevented a greater percentage of ineligible providers from entering the program

CMS's approval of submitted enrollment applications decreased slightly—from 91 percent to 88 percent—after implementation of the new enhancements. At the same time, CMS's denial of enrollment applications decreased, from 2.5 percent to less than 1 percent. Table 1 provides the numbers of approved and denied enrollment applications made before and after the implementation of enhanced enrollment screening procedures.

One might expect an inverse relationship to exist between approval and denial percentages—if approval rates decrease, denial rates increase. But this is not the case when one factors in the incomplete applications that were returned to providers. The percentage of applications returned to providers because of incomplete information increased from 6 percent to 11 percent. Thus, a smaller overall percentage of submitted applications were deemed ready for enrollment determinations in the postimplementation period.

Table 1: Enrollment Results Before and After the Implementation of New Enhancements

	Preimplementation Period (March 25, 2010, through March 24, 2011)	Postimplementation Period (March 25, 2012, through March 24, 2013)
Number of Enrollment Applications Submitted	**546,916**	**479,115**
Number Approved	**500,076**	**423,355**
Percentage Approved	**91.4%**	**88.4%**
Number Denied	**13,600**	**3,411**
Percentage Denied	**2.5%**	**0.7%**
Number Returned	**32,857**	**51,819**
Percentage Returned	**6.0%**	**10.8%**
Number Withdrawn	**383**	**530**
Percentage Withdrawn	**0.1%**	**0.1%**

Source: OIG analysis of data compiled by CMS from PECOS, MACs, and the NSC, 2014.

When we considered only those applications for which enrollment determinations were made, the approval rate increased from 97 percent to 99 percent. For the applications with determinations, the percentage of denials decreased from 2.6 percent to 0.8 percent, as shown in Table 2. The latter denial rate is similar to the 0.7 denial percentage seen across all enrollment applications submitted during the postimplementation period.

Table 2: Medicare Provider Enrollment Determination Results Before and After the Implementation of New Enhancements

	Preimplmentation Period (March 25, 2010, through March 24, 2011)	Postimplementation Period (March 25, 2012, through March 24, 2013)
Number of Enrollment Applications Submitted	**546,916**	**479,115**
Number of Enrollment Applications with Determinations	**513,676**	**426,766**
Percentage of Enrollment Applications with Determinations	**93.9%**	**89.1%**
Number Approved	**500,076**	**423,355**
Percentage Approved	**97.4%**	**99.2%**
Number Denied	**13,600**	**3,411**
Percentage Denied	**2.6%**	**0.8%**

Source: OIG analysis of data compiled by CMS from PECOS, MACs, and the NSC, 2014.

Given the multiple types of variation across the two time periods—fewer applications submitted, a greater rate of applications returned, a higher rate of approvals (and lower rate of denials) among applications with determinations in the postimplementation period—it is not possible to

determine whether the new Medicare enrollment enhancements prevented a greater percentage of ineligible providers from entering Medicare.

CMS's effort to revalidate all existing enrollments yielded substantial revocations and deactivations

The ACA established a requirement for all providers to revalidate their enrollment information under the new enrollment screening enhancements. This off-cycle revalidation effort applies to all providers enrolled prior to March 25, 2011. All revalidation notices were mailed to providers by March 23, 2015.

During the revalidation process, a provider's enrollment can be approved, revoked, or deactivated. Providers who are revalidating their enrollment may have it revoked for a number of reasons, including noncompliance with Medicare standards. Providers' enrollment can be deactivated when they do not respond timely to a revalidation request.

As outlined in Table 3, the number of revocations and deactivations of submitted revalidation applications substantially increased after CMS implemented the revalidation effort using risk category and site visit enhancements. However, MACs revoked and deactivated a greater percentage of limited-risk providers than higher risk providers, even though these limited-risk providers were not subject to all of the new screening enhancements.

Table 3: Medicare Provider Revalidation Determinations Before and After Implementation of CMS's Revalidation Effort and New Enhancements

	Number of Revalidation Determinations	Number of Approvals/ Approval Rate	Number of Revocations/ Revocation Rate	Number of Deactivations/ Deactivation Rate
Preimplementation Period (March 25, 2010, through March 24, 2011)				
Total	**51,673**	**51,574** **99.8%**	**62** **0.1%**	**37** **0.1%**
NSC: Moderate- and High-Risk Providers	289	285 98.6%	0 0%	4 1.4%
MACs: Moderate- and High-Risk Providers	1,849	1,841 99.6%	4 0.2%	4 0.2%
MACs: Limited-Risk Providers	49,535	49,448 99.8%	58 0.1%	29 0.1%
Postimplementation Period (March 25, 2012, through March 24, 2013)				
Total	**177,932**	**145,234** **81.6%**	**5,414** **3.0%**	**27,284** **15.3%**
NSC: Moderate- and High-Risk Providers	15,589	15,221 97.6%	52 0.3%	316 2.0%
MACs: Moderate- and High-Risk Providers	13,775	11,509 83.5%	51 0.4%	2,215 16.1%
MACs: Limited-Risk Providers	148,568	118,504 79.8%	5,311 3.6%	24,753 16.7%

Source: OIG analysis of data compiled by CMS from PECOS, MACs, and the NSC, 2014.

Key provider information is not verified during the enrollment or revalidation processes

Providers seeking to enroll or revalidate their enrollment in Medicare must submit important application information to CMS. However, key information—i.e., identification numbers, supporting documents, and criminal convictions—is not always verified by MACs and the NSC as required by CMS policy. Even when the APS system is fully implemented, some key enrollment information will not be verified.[24] These gaps in CMS's verification of information submitted by providers on enrollment applications leave Medicare vulnerable to providers that submit false information.

CMS's contractors did not verify key enrollment information

CMS has relied on MACs and NSC to verify whether information on enrollment and revalidation applications is correct. Although the *Medicare Program Integrity Manual* directs MACs and the NSC to verify all application information, none reported doing so.[25, 26] Even when contractors did verify key information, they did not always use an outside source to do so.[27]

Identification numbers. Providers must submit—depending on the provider type—Social Security numbers, National Provider Identifiers (NPIs), Drug Enforcement Agency (DEA) numbers, Tax Identification Numbers (TINs), and/or Employer Identification Numbers (EINs) on the application forms that MACs process. None of the MACs reported verifying all the identification numbers that providers supply on their individual enrollment and revalidation applications. Nor did the NSC always verify DMEPOS suppliers' tax identification numbers or EINs with an outside source.

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[24] CMS began piloting APS system procedures with a subset of MACs in April 2013, but as of December 2015, CMS had not used the APS system to routinely screen applications.

[25] Section 15.1.3 of the *Medicare Program Integrity Manual* states: "Unless stated otherwise in this chapter or in another CMS directive, verify and validate all information collected on the enrollment application."

[26] Section 15.7.3.B of the *Medicare Program Integrity Manual* states: "Once the contractor has completed its review of the CMS-855 (e.g., approved/denied application, approved change request), it shall provide a written statement asserting that it has (1) verified all data elements on the application, and (2) reviewed all applicable names on the CMS-855 against the MED [Medicare Exclusion Database] and the System for Access Management (SAM).

[27] We define an "outside source" as any source that is external to CMS. We did not consider MACs' and the NSC's internal review of provider-submitted documents to constitute verification with an outside source. For certain types of provider information, CMS policy does not require verification with what OIG considers an outside source.

Appendix B outlines the number of contractors that verified identification numbers.

Supporting documentation. Applicants must submit certain documentation with their applications, including copies of licenses, certifications, and registrations required by States for certain health care providers; Internal Revenue Service documentation; lease agreements; educational degrees; and bank statements. Only the license, certification, and registration documentation is verified with an outside source by all MACs and the NSC.[28]

Criminal convictions. Applicants must report information regarding final adverse legal actions, such as convictions and exclusions from participation in Federal health care programs. All contractors used OIG or General Services Administration (GSA) data to verify whether applicants omitted exclusions. The majority of MACs stated that they also use OIG or GSA data—in addition to State licensure Web sites—to verify whether applicants omitted any criminal convictions. However, these outside sources are not comprehensive sources of criminal conviction information. In addition, the NSC does not verify whether applicants omitted information on criminal convictions.

APS will not verify some key application information even after the system is fully implemented

APS will not fully address enrollment vulnerabilities because some key application information will still not be verified even after the system is fully implemented. This information includes:

- TINs of individuals and organizations who have ownership/managing control of the applicant;
- TINs or EINs of other individual or organizational principals associated with the applicant, such as an applicant's billing agency or supervising physician;
- DEA numbers of applicants; and
- supporting documentation.

Contractors were inconsistent in applying site visit procedures and using site visit results for enrollment decisions

After the enhancements to the enrollment screening process were introduced, less than 2 percent of the 16,022 site visits conducted by the

[28] Three of these MACs verify against an outside source only for Part B providers.

NSVC resulted in denials or revocations of providers' enrollment. For another 2 percent of site visits, MACs approved providers for enrollment even though site visit results indicated noncompliance with each of CMS's standards.

We found some examples in which NSVC inspectors' observational comments on the site visit forms contradicted their answers to questions on the forms. In addition, there were inconsistencies in how NSVC inspectors determined whether a facility was operational. Vulnerabilities related to the implementation of site visits can compromise the effectiveness of screening providers for entry into Medicare.

MACs approved hundreds of providers to enroll in Medicare despite site visit results indicating noncompliance

MACs approved 362 of the 651 provider enrollment and revalidation applications for which NSVC inspectors reported that the provider's facility did not meet any of the enrollment standards on the site visit form.[29] If these providers had not been approved, there would have been more than twice as many denials and revocations from site visits during the postimplementation period.

For these 362 site visits, some NSVC inspectors provided additional comments, such as "facility does not exist," "building has been vacated," "suite appeared closed and abandoned," "calling the telephone number resulted in response that the line was disconnected with no forwarding number," and "facility is closed with a padlock on the door."

These comments and the inconsistencies between site visit results and enrollment determinations raise questions about whether MACs always consider site visit results when making enrollment and revalidation decisions and whether valid and accurate address information is being used for site visits. We followed up with one MAC to determine under what circumstances it would approve enrollment applications with unfavorable site visit results. Of the nine cases we sent to the MAC for review, the MAC reported that in six cases it had not reviewed the site visit results, in two cases it had not thoroughly reviewed the site visit results or should have conducted more research on the facility location, and in one case it may have provided an incorrect location for the site visit. The MAC reported that it had recognized the need to change its standard operating procedures. To ensure that providers are meeting enrollment requirements, the MAC now routes certain types of provider applications to a designated group of analysts for review.

[29] We provided CMS the site visit information for these 362 providers.

NSVC inspectors' observational comments about a facility sometimes contradicted their responses to questions on the site visit form

NSVC inspectors can enter additional observations and comments about the facility at the end of the general site visit form. We found several examples of site visit results for which NSVC inspectors' comments contradicted their responses to closed-ended ("Yes/No") questions. For example, an inspector answered "Yes" to indicate that a facility was open, yet the inspector's additional comments indicated that the facility was closed. In other cases, inspectors answered "Yes" to a question about whether customers were seen at the facility, yet the inspectors' additional comments indicated that they saw no customers. MACs approved the enrolling and revalidating providers associated with these instances. Such discrepancies raise questions about (1) potential issues with NSVC oversight of quality assurance or training of its inspectors and (2) whether MACs are reviewing inspectors' additional comments when making enrollment and revalidation decisions.[30]

NSVC inspectors were not consistent in how they determined whether a facility was operational

One of the questions on the general site visit form asks NSVC inspectors, "Does the facility appear to be operational?" This is an important criterion that site visits are meant to determine. The form clarifies:

> Operational means the provider or supplier has a qualified physical practice location, is open to the public for the purpose of providing health care related services, is prepared to submit valid Medicare claims, and is properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or items being rendered) to furnish these items or services.[31, 32]

One of the roles of an NSVC inspector is to determine whether a facility is operational. However, 50 of the 133 inspectors that responded to our survey reported that they did not receive training regarding how to determine whether a facility is operational. The difficulties surrounding the determination of a facility's operational status may be due to the definition of "operational," as stated above, which does not provide sufficient detail

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[30] According to NSVC staff, the results of all site visits are reviewed by a member of the NSVC review team before being submitted to CMS.

[31] CMS, *Site Verification Survey Form*.

[32] NSVC training materials instruct inspectors to disregard the reference to "valid Medicare claims." In addition, according to NSVC staff, CMS allows inspectors to disregard the parts of the definition referring to being prepared to submit valid Medicare claims and being properly stocked because they relate to DMEPOS facilities and not the type of facilities that NSVC inspectors visit.

for inspectors to follow when determining whether the facility is operational. For example, some surveyed inspectors reported finding it particularly challenging to determine whether ambulance companies and providers that can be located in private residences, such as HHAs, were operational because these facilities may not be continuously staffed during normal business hours.

Approximately half of responding inspectors reported that they determine whether a facility appears "operational" solely on how they answered other questions on the general site visit form. The remaining inspectors reported that they do not rely solely on how they answered other questions. When we asked inspectors how they determine whether a facility is operational, their responses varied. Methods included, but were not limited to,

- assessing the condition of the facility's building,
- calling the facility's telephone number, and
- observing other criteria such as whether or not lights were on, the facility had office furniture and supplies, the door was unlocked, and equipment was present.

CMS relies on an enrollment data system, PECOS, that does not contain all the information needed for effective oversight

CMS relies on PECOS as its centralized repository for all provider enrollment information. However, PECOS data related to oversight of enrollment screening enhancements were often incomplete and therefore could not be used to evaluate the impact of certain enhancements implemented by CMS.

PECOS lacked key data to evaluate the outcomes of the new enhancements

Data pertinent to tracking provider enrollment trends associated with the recent screening enhancements were not consistently maintained in PECOS. These data included

- denials and returns of enrollment applications;
- risk category designations (e.g., limited, moderate, or high risk) for each enrolling and revalidating provider; and
- reasons providers submitted enrollment applications.

Denials and returns. PECOS did not contain information on all denials and returns that occurred during the time periods before and after the enhancements were implemented. According to CMS staff, the records for some denials and returns reside outside of PECOS in MACs' local systems.

To provide complete counts of denials and returns, CMS requested supplementary data from MACs.

However, after receiving the data from the MACs, CMS was still unable to provide us with complete information on denials, returns, and withdrawals of enrollment applications by provider type because two MACs were unable to provide data by provider type. Because of this lack of data, we were unable to compare trends in enrollment application determinations across provider types. This prohibited us from evaluating the impact of enhanced screening on the enrollment of higher risk providers. This lack of data also limits CMS's ability to evaluate and oversee the effectiveness of its enhanced screening procedures.

Risk category designations. PECOS did not contain the risk category designations for 10 percent of enrolling and revalidating providers' applications submitted during the postimplementation period. According to CMS staff, PECOS was not updated to include risk category data at the time of the risk category enhancements. In addition, CMS staff acknowledged that MACs do not always enter risk category information into PECOS.

Reasons providers submitted enrollment applications. PECOS did not contain the reason for submission, e.g., new enrollment or change of information, for 11 percent of the nearly half-million enrollment applications (54,903 of 479,115) submitted during the postimplementation period. According to CMS staff, CMS would need to go back to the MACs to obtain submission reasons for these applications because the information resides outside of PECOS in MACs' local systems. CMS staff indicated that to obtain this data, it would have to issue a technical direction letter to the MACs and that it would be a "significant amount of work to get that information." In addition to the applications for which CMS could not provide a submission reason, there were 91,519 enrollment applications for which "other" was the reason for submission in PECOS.

The lack of complete data regarding submission reasons in PECOS is problematic because for some provider categories, the reason for the application affects the level of review. Only higher risk providers that are submitting an application for reasons of new enrollment, revalidation, addition or change of practice location, certain changes of ownership, or reactivation of enrollment are required to have a site visit. Therefore, knowing the reason a provider submitted an enrollment application is necessary to know whether the application required a site visit and whether all required site visits were performed.

CMS cannot readily use PECOS to link enrollment outcomes to site visit results

According to CMS staff, the data housed in PECOS cannot be easily used to connect the results from site visits to MACs' enrollment decisions. To determine a direct link between a site visit result and the enrollment decision associated with that specific site visit would require a labor-intensive manual review on the part of CMS and its contractors. In this respect, CMS's current enrollment data system presents challenges for overseeing implementation of the enhancements to the site visit component of the screening process.

In addition, there was a discrepancy between the number of site visits that CMS reported the NSVC as having conducted (17,024 site visits in PECOS) and the number of site visits for which CMS provided complete and valid results from NSVC (16,022 site visits obtained from the NSVC). According to CMS staff, the difference in numbers can be attributed to errors in how site visits are tracked in PECOS, possible typographical errors, or other data anomalies.

PECOS may not contain accurate enrollment data on DMEPOS suppliers for the preimplementation period

Prior to October 2010 the NSC stored DMEPOS suppliers' enrollment information in the Provider Information Management System (PIMS). In October 2010 the NSC converted this information from PIMS to PECOS. According to CMS staff, some errors may have occurred during this transfer. To provide data for the year before implementation of enhancements, CMS combined data from PECOS and PIMS and stated that the data may contain an error rate of at least 10 percent.

CONCLUSION AND RECOMMENDATIONS

OIG has performed extensive work focusing on provider enrollment and found significant vulnerabilities in this area and made recommendations for improvement. CMS has implemented new provider-screening tools that are intended to reduce vulnerabilities in the provider enrollment process and thus reduce the number of illegitimate providers enrolling in Medicare. Discouraging illegitimate providers from seeking to gain entry into Medicare may have contributed to the decline of enrollment applications after the implementation of the enhancements.

It is not possible to determine conclusively from the results of enrollment decisions whether or not the new enhancements to the Medicare enrollment process prevented a greater percentage of ineligible providers from entering the program. However, CMS's efforts to revalidate all existing enrollments yielded substantial revocations and deactivations of providers' billing privileges. As a result of its revalidation and screening efforts, CMS reported that as of May 2015 the billing privileges of more than 470,000 providers had been deactivated and those of almost 28,000 had been revoked.

However, the gaps in CMS's verification of information submitted by providers on enrollment applications leaves Medicare vulnerable to providers that submit false information. Additionally, CMS should improve the implementation of enhancements such as site visits to ensure that providers are being effectively screened for entry into Medicare.

Effective oversight of enrollment data is key to ensuring that contractors are performing their activities appropriately and that enhancements are producing intended results. At the time of our review, shortcomings in PECOS rendered CMS unable to leverage existing data to determine how the enhancements were affecting provider enrollment.

Preventing dishonest providers from enrolling in Medicare is the first step in ensuring the integrity of the program. Therefore, to strengthen the provider enrollment-screening process, we recommend that CMS:

Monitor MACs and the NSC to determine whether they are verifying information on enrollment and revalidation applications as required

According to the *Medicare Program Integrity Manual*, contractors must, unless otherwise specified, verify and validate all information collected on the enrollment application. CMS should confirm that all the information on an enrollment or revalidation application is verified as required. Verifying this information is an important safeguard to prevent unscrupulous providers from enrolling in Medicare.

Validate that MACs are appropriately considering site visit results when making enrollment decisions

Site visits are used to determine whether providers actually exist at the physical locations on file with CMS. As a means to reduce inappropriate Medicare payments, OIG has recommended and supported the use of site visits to deny enrollment to providers who do not maintain operational facilities. However, this tool is rendered ineffective if MACs approve enrollment and revalidation applications when site visits show that providers are failing to meet CMS's standards. CMS should determine why these approvals occur and address any identified problems with its contractors. CMS should also instruct MACs to review their standard operating procedures to ensure they are reviewing and appropriately using the results of site visits for enrollment decisions.

Revise and clarify site visit forms so that they can be more easily used by inspectors to determine whether a facility is operational

The general site visit form is used by inspectors to indicate whether or not a facility is operational and, in turn, by MACs to determine whether the provider meets the operational criteria for enrollment. CMS should issue more specific guidance to the NSVC as to what it means for a facility to be considered operational. This includes guidance as to what CMS expects inspectors to observe during a site visit for them to consider a facility "operational." In addition, CMS may consider whether customized site visit forms for certain provider types or more in-depth questions on the general site visit form are needed to minimize confusion and inconsistencies.

Require the NSVC to improve quality assurance oversight and training of site visit inspectors

Although the NSVC has quality assurance processes and trains its site visit inspectors, we identified instances in which inspectors reported contradictory information in their site visit results and inconsistencies in how inspectors determined whether a facility appeared operational. To ensure that NSVC inspectors provide the MACs with consistent and valid site visit assessments, CMS should require that the NSVC improve its quality assurance oversight of inspectors and provide more specific training to inspectors as to how to determine whether a site is operational.

Ensure that PECOS contains the complete and accurate data needed to execute and evaluate CMS's enrollment-screening enhancements

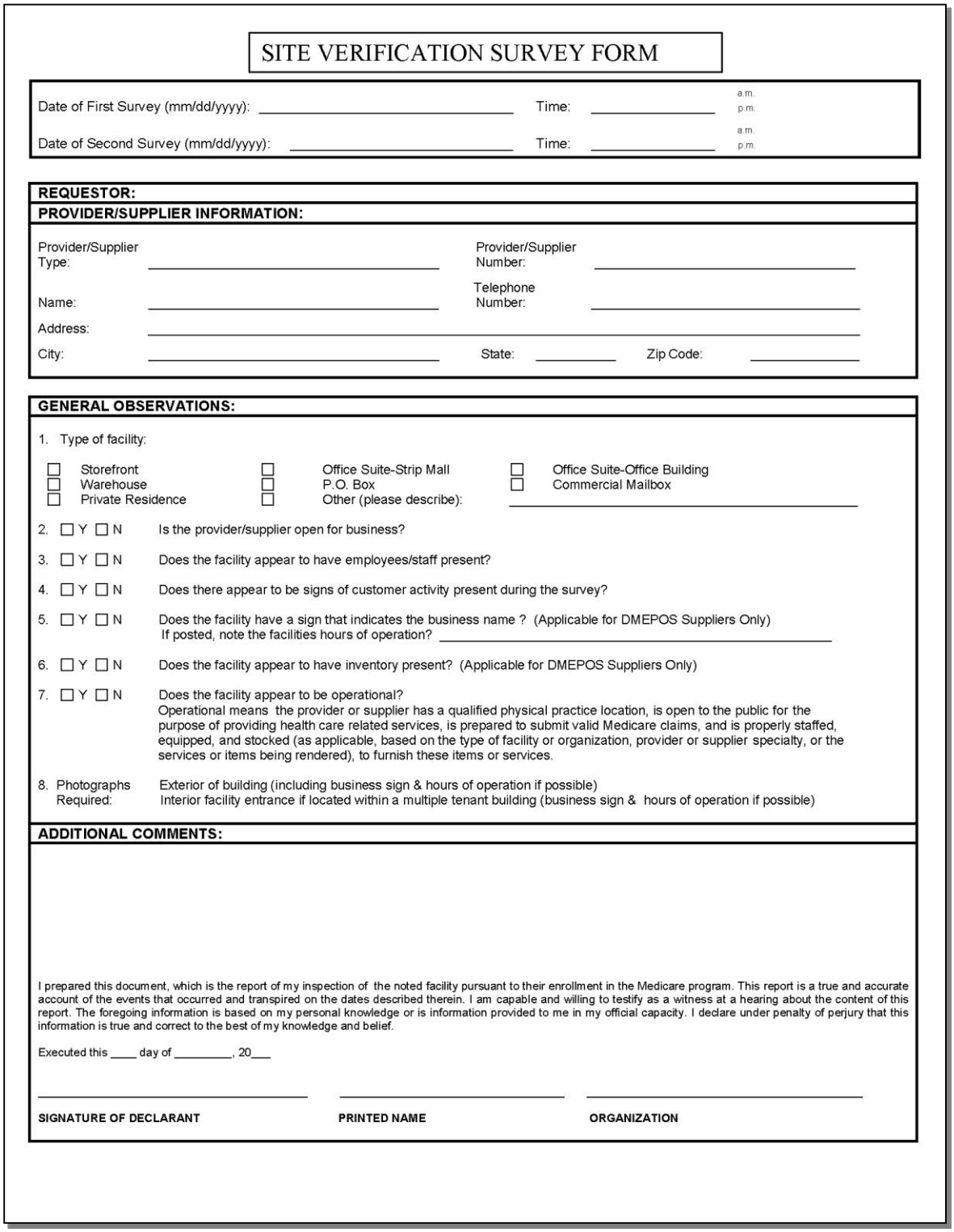
PECOS is CMS's national data repository for Medicare enrollment information about providers. The information housed in PECOS can aid CMS in tracking enrollment and revalidation trends as well as determine whether contractors are abiding by program requirements. For CMS to accomplish this, however, the data maintained in PECOS must be complete and accurate. CMS should ensure that PECOS includes fields that relate to the enhancements implemented for the provider enrollment process and that MACs and the NSC enter all required data.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with all five of our recommendations. In its comments, CMS highlighted its most recent efforts as it continues to improve upon the new enrollment enhancements. For example, CMS notes that it is expanding the use of site visits and has made improvements to the NSVC training process since the time of our review. CMS also described the ways in which it has already made progress on our recommendations. Some of this progress includes working with the MACs and NSC to ensure they are verifying all information on enrollment and revalidation applications, analyzing data provided by OIG on site visit results that were inconsistent with enrollment decisions, revising the general site visit form, and improving the accuracy and completeness of data stored in PECOS. We look forward to receiving updates from CMS on its progress toward these recommendations through the actions it described. Appendix C contains the full text of CMS's comments.

APPENDIX A

Figure A-1: General Site Visit Form



SITE VERIFICATION SURVEY FORM

Date of First Survey (mm/dd/yyyy): _____ Time: _____ a.m. p.m.

Date of Second Survey (mm/dd/yyyy): _____ Time: _____ a.m. p.m.

REQUESTOR:

PROVIDER/SUPPLIER INFORMATION:

Provider/Supplier Type: _____ Provider/Supplier Number: _____

Name: _____ Telephone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

GENERAL OBSERVATIONS:

1. Type of facility:

☐ Storefront ☐ Office Suite-Strip Mall ☐ Office Suite-Office Building
☐ Warehouse ☐ P.O. Box ☐ Commercial Mailbox
☐ Private Residence ☐ Other (please describe): _____

2. ☐ Y ☐ N Is the provider/supplier open for business?

3. ☐ Y ☐ N Does the facility appear to have employees/staff present?

4. ☐ Y ☐ N Does there appear to be signs of customer activity present during the survey?

5. ☐ Y ☐ N Does the facility have a sign that indicates the business name ? (Applicable for DMEPOS Suppliers Only)
If posted, note the facilities hours of operation? _____

6. ☐ Y ☐ N Does the facility appear to have inventory present? (Applicable for DMEPOS Suppliers Only)

7. ☐ Y ☐ N Does the facility appear to be operational?
Operational means the provider or supplier has a qualified physical practice location, is open to the public for the purpose of providing health care related services, is prepared to submit valid Medicare claims, and is properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or items being rendered), to furnish these items or services.

8. Photographs Required: Exterior of building (including business sign & hours of operation if possible)
Interior facility entrance if located within a multiple tenant building (business sign & hours of operation if possible)

ADDITIONAL COMMENTS:

I prepared this document, which is the report of my inspection of the noted facility pursuant to their enrollment in the Medicare program. This report is a true and accurate account of the events that occurred and transpired on the dates described therein. I am capable and willing to testify as a witness at a hearing about the content of this report. The foregoing information is based on my personal knowledge or is information provided to me in my official capacity. I declare under penalty of perjury that this information is true and correct to the best of my knowledge and belief.

Executed this ____ day of _____, 20___

_____ _____ _____

SIGNATURE OF DECLARANT **PRINTED NAME** **ORGANIZATION**

APPENDIX B

Table B-1 provides information on whether the 12 MACs and the NSC reported verifying the identification numbers that providers submitted on enrollment and revalidation applications. In addition, Table B-1 shows the number of contractors that verified these identification numbers using a source external to CMS. We did not consider MACs' and the NSC's internal review of provider-submitted documents to constitute verification with an outside source.

Table B-1: Number of Contractors That Verify Identification Numbers Submitted by Providers on Enrollment and Revalidation Applications

Type of Identification Number	Application Form(s)	Entity	MACs		NSC	
			Number That Verify	Number That Verify With Outside Source[1]	Verifies	Verifies With Outside Source[1]
					Yes = 1, No = 0	
Social Security Number	All CMS-855 forms	Individual with ownership/managing control	11	11	1	1
		Billing agent	7	7	0	0
	CMS-855S	Sole proprietor	N/A	N/A	1	1
	CMS-855I	All applicants	11	11	N/A	N/A
	CMS-855A	Chain home office administrator	6	6	N/A	N/A
	CMS-855B	IDTF supervising physician	11	11	N/A	N/A
		IDTF interpreting physician	11	11	N/A	N/A
		IDTF technician	11	11	N/A	N/A
National Provider Identifier	All CMS-855 forms	Each practice location, business, and/or group affiliation of all applicants	9	7	1	1
	CMS-855S	Billing agent/agency	N/A	N/A	0	0
	CMS-855I	Physician assistant's employer when establishing employment	11	11	N/A	N/A
		Physician assistant's employer when physician assistant is terminating employment	10	10	N/A	N/A
		Physician assistant when employer is terminating employment	9	9	N/A	N/A
	CMS-855A	Old owner in changes of ownership	10	9	N/A	N/A
		Acquiring provider	10	10	N/A	N/A
		Provider being acquired	9	9	N/A	N/A
		Consolidating provider	7	7	N/A	N/A
		Individual with ownership/managing control	9	9	N/A	N/A
	CMS-855B	IDTF supervising physician	11	11	N/A	N/A
		IDTF interpreting physician	11	11	N/A	N/A
	CMS-855A, CMS-855B, CMS-855S	Organization with ownership/managing control	8	8	0	0

continued on next page

Table B-1: Number of Contractors That Verify Identification Numbers Submitted by Providers on Enrollment and Revalidation Applications (Continued)

Type of Identification Number	Application Form(s)	Entity	MACs		NSC	
			Number That Verify	Number That Verify With Outside Source[1]	Verifies	Verifies With Outside Source[1]
					Yes = 1, No = 0	
National Provider Identifier (continued)	CMS-855B, CMS-855I, CMS-855S	Individual with ownership/managing control	11	11	0	0
Drug Enforcement Agency Number	CMS-855I	All applicants, if applicable	0	0	N/A	N/A
Tax Identification Number	All CMS-855 forms	Billing agent/agency	4	2	0	0
	CMS-855S	Applicant	N/A	N/A	1	0
		Prior tax identification number for business entity	N/A	N/A	0	0
		Organization with ownership/managing control	N/A	N/A	0	0
		Surety bond company	N/A	N/A	0	0
	CMS-855I	Business entity	8	0	N/A	N/A
	CMS-855A	Chain home office	5	0	N/A	N/A
		New provider in consolidations	4	0	N/A	N/A
		Nursing registry	4	2	N/A	N/A
	CMS-855A, CMS-855B	All applicants	5	0	N/A	N/A
		Organization with ownership/managing control	7	0	N/A	N/A
Employer Identification Number	CMS-855S	Sole proprietor	N/A	N/A	1	0
		Prior employer identification number of sole proprietor	N/A	N/A	0	0
	CMS-855I	Sole proprietor	8	0	N/A	N/A
		Physician assistant's employer when establishing employment	11	0	N/A	N/A
		Physician assistant's employer when physician assistant is terminating employment	10	0	N/A	N/A

Source: OIG analysis of data submitted by 12 MACs and the NSC, 2014.

[1] This is the number of contractors that verify the identification number using information from a source that is external to CMS. We did not consider MACs' and the NSC's internal review of provider-submitted documents to constitute verification with an outside source. For certain types of provider information, CMS policy does not require verification with what OIG considers an outside source.

APPENDIX C

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: FEB - 9 2016

TO: Daniel R. Levinson
Inspector General

FROM: Andrew M. Slavitt /S/
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Enhanced Enrollment Screening of Medicare Providers: Early Implementation Results" (OEI-03-13-00050)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is strongly committed to program integrity efforts in Medicare and has a number of ongoing activities to enhance and safeguard the provider enrollment and revalidation process.

In February 2011, CMS finalized regulations to implement categorical risk-based screening of newly enrolling Medicare providers and suppliers and revalidate all current Medicare providers and suppliers under new requirements established by the Affordable Care Act. Limited risk providers and suppliers undergo verification of licensure, verification of compliance with federal regulations and state requirements, and undergo various database checks. Moderate and high risk providers and suppliers undergo additional screening, including unannounced site visits. Additionally, individuals with a five percent or greater direct or indirect ownership interest in a high risk provider or supplier must consent to criminal background checks including fingerprinting. All providers and suppliers are subject to revalidation where they are required to resubmit and recertify the accuracy of their enrollment information to maintain their Medicare billing privileges. Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers revalidate every 3 years and all other providers and suppliers every 5 years.

Since these regulations were issued, more than one million providers and suppliers have been subject to the new screening requirements. Since 2011, CMS has taken actions to deactivate billing privileges for more than 543,000 providers and suppliers as a result of revalidation and other screening efforts and more than 34,000 providers and supplier enrollments have been revoked. In addition, CMS has performed nearly 250,000 site visits on Medicare providers and suppliers. CMS uses site visits to verify that a provider's or supplier's practice location meets requirements and helps prevent questionable providers and suppliers from enrolling or maintaining enrollment in the Medicare program. All Medicare providers and suppliers already enrolled prior to the new screening requirements becoming effective were sent revalidation notices by March 23, 2015.

CMS is also working to expand its use of site visits. CMS will be increasing the number of site visits that its contractor performs, initially targeting those providers and suppliers that receive

/S/

high reimbursements from Medicare and that are located in high risk geographic areas. Other providers and suppliers may also receive site visits on an ad hoc basis, as determined necessary by CMS.

Additionally, CMS has made improvements to the National Site Visit Contractor (NSVC) training processes since the OIG's review. All NSVC inspectors are required to receive CMS-approved training and testing and undergo annual retraining. In addition, reminders and updates to procedures are provided to the inspectors throughout the year through bulletins and newsletters. All site inspections are reviewed by an NSVC official before being submitted to CMS. In addition, certain site inspections undergo a second level of quality assurance by an independent official that includes interviews with the provider and the inspector. CMS may take corrective action based on the results of this process.

OIG's recommendations and CMS' responses are below.

OIG Recommendation
Monitor Medicare Administrative Contractors (MACs) and the National Supplier Clearinghouse (NSC) to determine if they are verifying information on enrollment and revalidation applications as required.

CMS Response
CMS concurs with OIG's recommendation. CMS will continue to work with MACs and the NSC to make sure they are verifying all information on enrollment and revalidation applications. CMS has worked to improve enrollment systems to reduce provider burden and improve operational efficiencies. For example, identification numbers (Social Security Numbers and National Provider Identifiers) are validated systematically in the enrollment system. We are also currently piloting a review of criminal background information for all providers and suppliers through our Automated Provider Screening system.

OIG Recommendation
Validate that MACs are appropriately considering site visit results when making enrollment decisions.

CMS Response
CMS concurs with OIG's recommendation. CMS has started analyzing the data OIG provided on site visit results that were not consistent with enrollment decisions. CMS will work with our MACs to make sure they are appropriately considering site visit results when making enrollment decisions.

OIG Recommendation
Revise and clarify site visit forms so that they can be more easily used by inspectors to determine whether a facility is operational.

CMS Response
CMS concurs with OIG's recommendation. CMS believes that some of the questions on the site visit form are not applicable, which may cause confusion when assessing whether a practice location is operational. Specifically questions 5 and 6 are specific to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) site visits. Since the National

Supplier Clearinghouse (NSC) is responsible for conducting DMEPOS site visits, these questions are being removed from the form.

OIG Recommendation

Require NSVC to improve quality assurance oversight and training of site visit inspectors.

CMS Response

CMS concurs with OIG's recommendation. OIG conducted this study based on applications submitted from March 2012 through March 2013. Since then, CMS has made significant improvements to the National Site Visit Contractor (NSVC) training processes. All NSVC inspectors are required to go through CMS approved training and testing and are retrained annually. In addition, reminders and updates to procedures are provided to the inspectors throughout the year through bulletins and newsletters.

OIG Recommendation

Ensure that the Provider Enrollment, Chain, and Ownership System (PECOS) contains the complete and accurate data needed to execute and evaluate CMS's enrollment screening enhancements.

CMS Response

CMS concurs with OIG's recommendation. CMS has significantly improved the accuracy and completeness of data stored in PECOS through data cleanups, enhanced system functionality, and system integration efforts. CMS will further enhance PECOS to include additional fields to help evaluate enrollment screening enhancements. CMS will also provide proper guidance to MACs and the NSC to make sure enrollment data is fully entered into PECOS including Denials and Submittal Reasons accurately on a continuous basis. CMS will periodically run analysis to reconcile the data with MACs.

CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.

ACKNOWLEDGMENTS

This report was prepared under the direction of Linda Ragone, Regional Inspector General for Evaluation and Inspections in the Philadelphia regional office.

Tanaz Dutia served as the team leader for this study. Other Office of Evaluation and Inspections staff from the Philadelphia regional office who conducted the study include Robert A. Vito, Joanna Bisgaier, and Nancy J. Molyneaux. Central office staff who provided support include Evan Godfrey, Althea Hosein, Joanne Legomsky, Scott Manley, and Christine Moritz.

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