Program Memorandum Carriers

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal B-00-36 **Date: AUGUST 4, 2000**

CHANGE REQUEST 1253

SUBJECT: Returned Mail - Unique Physician Identification Number (UPIN)

In June 2000, we mailed letters from the Administrator to each Medicare provider furnishing them a status on the agency's efforts to ensure accurate payment, simplify Medicare requirements and requesting their assistance in this initiative. Out of 700,000 letters mailed, we received 70,000 returns. The direct mail campaign generated mailing labels from the UPIN Registry (physicians, non-physician practitioners medical groups), National Supplier Clearinghouse (suppliers, durable medical equipment, prosthetics, orthotics supplies) and On-line Survey Certification and Reporting (institutions, hospitals, home health agencies, etc.) databases. The majority of the returns are from the UPIN file. An analysis of the returns reveals the following reasons:

- Undeliverable as addressed, forwarding order expired;
- Insufficient addresses; and
- Return to the sender, attempted address not known.

The purpose of this PM is to provide instructions on how to resolve these returns. We will review, sort, and transmit the returned mail to you. You will be required to review, correct, and update address information on your in-house provider file and the Registry, then mail the Administrator's letter to the provider's correct address according to the instructions below. Section 1005 of the Medicare Carriers Manual (MCM) Part 4 requires you to perform routine maintenance of your provider records and promptly notify the UPIN Registry of any additions, corrections, and updates.

Use the names and addresses on the returned envelopes to identify the provider addressees on your in-house provider file. Compare your in-house provider file's addresses with the Registry's addresses. Make sure each returned letter's address is active on your in house provider file. If the address is incorrect, invalid, or inaccurate, make the necessary changes on your provider file and/or the Registry (See §1005.3 MCM Part 4 for additional instructions). If no claims have been submitted within the last year, deactivate the record by sending an update to the Registry. Ensure all addresses on your in-house provider file and UPIN Registry is current.

Once you have corrected an address on your in-house provider files and the Registry, mail the letter to the provider's correct address immediately. Attached is the Administrator's letter for this purpose. In addition, send the Administrator's letters to all providers, newly enrolled, since June 1, 2000.

If you received returned mail from us, in error, which is not from your service area, forward those letters to the contractor of that service area. If you know a provider is enrolled with more than one carrier, please coordinate the missing/erroneous information with the other contractor before sending your update to the Registry.

It is important that you understand this clean-up activity is crucial to HCFA's goals and must be performed timely and accurately.

The effective date of this Program Memorandum is August 15, 2000.

The implementation date of this Program Memorandum September 15, 2000.

These instructions should be implemented within your current operating budget.

Questions regarding UPINs can be directed to Gerald Wright on 410 786-5798.

This PM may be discarded September 15, 2001.

Attachment

Dear Medicare Physician:

I am writing you to ask for your continued assistance in helping the Medicare program reduce payment errors and ensure that every dollar we spend is directed towards covered care delivered to our beneficiaries.

We have all been working hard to protect the Medicare program, and we have had good success. Four years ago, we took our first measurement of payment errors and found 14 percent of Medicare dollars were incorrectly paid. Last year, we saw that rate fall to less than 8 percent and we sustained that improvement this year -- proving that we have made real progress, but also demonstrating that we still have to go further to meet our goals.

Our partnership is essential to the delivery of quality care to our beneficiaries. We also want our beneficiaries to have confidence in all of us, and to know that we are working hard together for their sake.

Today I want to emphasize the importance of close attention to billing requirements, especially for documenting services delivered and the reason for care, as a way to ensure you receive and Medicare makes proper payments. Many of you have invested in compliance programs and other approaches to ensure proper billing, and we commend you for your diligence. We want to assure you that we want to make it easier for you to comply with our rules, and to distinguish between different kinds of errors.

To ensure that you can get information from us effectively and efficiently, I have instructed the private contractors that by law process Medicare claims to open toll free lines for your use this fall. You may use these lines to ask questions about proper billing, understand notices you may have received, or ask for information or publications. I have also instructed contractors to make educational seminars more widely available to providers. We are making more education available through the use of satellite technology and computer assisted training on the Internet. Last year, for example, we expanded an innovative $1.3 million national education program on Medicare coverage, billing procedures, and prevention efforts. Check out our website to learn more (www.hcfa.gov).

We continue to solicit suggestions from the medical community on how to eliminate unnecessary requirements while retaining important controls and safeguards. Your specific ideas are welcome. In particular, we have been working hard on simplifying documentation guidelines for evaluation and management services. We will be pilot testing new simplified guidelines this year to ensure they are not burdensome to physicians, while ensuring that they result in consistent and fair medical review. These revised guidelines are the subject of a town hall meeting that HCFA is hosting in June. This meeting will present the results

of our efforts to simplify the guidelines, reduce the burden on physicians, and foster consistent and fair medical review. We continue to look for opportunities to take advantage of new technology, such as on-line completion of certain documents or forms, that can provide us with important information while reducing technical errors and the time it takes for you to submit the data. We have also stepped up our oversight of Medicare contractors, to ensure that they are doing the right thing by us, you, and our beneficiaries.

To further our joint efforts to reduce payment errors, I asked my staff to review the data from our last audit of payment accuracy and identify common errors that, if corrected, should substantially improve our payment accuracy. We will ask Medicare claims processing contractors to focus educational and claims review resources on these areas, and we urge you to take steps internally to prevent them as well.

For physicians, we will be focusing this year on two CPT codes used to report evaluation and management services -- 99214 and 99233. These codes accounted for a significant portion of the coding errors in the last two audits. In fact, documentation for many of these services was only found to be sufficient to support services more appropriately described by CPT codes 99212 and 99231. Please make sure when you bill for an office or other outpatient visit using CPT code 99214 that you are documenting at least two of the following three key components: a detailed history, and/or a detailed examination, and/or medical decision making of moderate complexity. Using CPT code 99233 for subsequent hospital care requires documentation of at least two of these three components: a detailed interval history, and/or a detailed examination, and/or medical decision making of high complexity.

One final note: The HHS Inspector General has begun the Fiscal Year 2000 error rate study and is reviewing a sample of Medicare claims from around the country. If any of your claims are randomly selected as part of this review, we urge you to provide the appropriate documentation as quickly as possible. This will help demonstrate that the payments that you received were proper.

We know that we can continue to count on you to work with us on improving Medicare=s financial health, ensuring public confidence in our common enterprise, and improving the lives of our beneficiaries through the security of knowing we will all be there for them.

Sincerely,

Nancy-Ann Min DeParle
Administrator