

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**CMS REPORTING TO THE  
HEALTHCARE INTEGRITY AND  
PROTECTION DATA BANK**



Daniel R. Levinson  
Inspector General

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OEI-07-09-00290



## E X E C U T I V E   S U M M A R Y

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### OBJECTIVE

To determine whether the Centers for Medicare & Medicaid Services (CMS) reported all of its adverse actions to the Healthcare Integrity and Protection Data Bank (HIPDB) as required.

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### BACKGROUND

The HIPDB is a national data bank containing reports of adverse actions against health care practitioners, providers, and suppliers (hereinafter referred to as providers). The HIPDB plays an important role in preventing the employment of potentially fraudulent or abusive providers, so it is important that the information it contains be complete and accurate. The HIPDB is administered by the Health Resources and Services Administration (HRSA) through a Memorandum of Understanding with the Office of Inspector General.

The Social Security Act defines the types of adverse actions that must be reported to the HIPDB. These include licensure and certification actions, exclusions from participation in Federal and State health care programs, criminal convictions, civil judgments related to health care, and any other adjudicated actions or decisions that the Secretary of Health & Human Services establishes by regulation. CMS takes several types of adverse actions that are required to be reported to the HIPDB, including revocations and suspensions of laboratory certifications; terminations of providers from participation in Medicare; and civil monetary penalties against all types of providers, managed care plans, and prescription drug plans. Federal and State government agencies and health plans are required to report certain adverse actions to the HIPDB.

We reviewed the data contained in the HIPDB as of April 30, 2009, to determine the extent of CMS's reporting of adverse actions as of that date. We conducted structured interviews with CMS officials in each division that is responsible for oversight and/or HIPDB reporting of Medicare providers. For CMS divisions that maintained lists of imposed adverse actions, we collected documents or data to support the number of adverse actions imposed.

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## FINDING

**CMS took adverse actions against providers, but did not report all of these actions to the HIPDB as required.** CMS's reporting to the HIPDB varied by provider type; CMS officials believe that only adverse actions related to fraud and abuse should be reported to the HIPDB. However, the Social Security Act does not limit the reporting of adverse actions to cases of fraud and abuse. CMS failed to report the following adverse actions or failed to report them within the required timeframes:

- None of the 148 adverse actions imposed against laboratories in 2007 and the 30 adverse actions imposed against managed care and prescription drug plans between January 1, 2006, and July 31, 2009 (the last action was effective March 7, 2009), had been reported to the HIPDB at the time of our review.
- None of the adverse actions against durable medical equipment (DME) suppliers taken after 2008 had been reported to the HIPDB. However, as of April 30, 2009, the HIPDB contained 5,125 adverse actions against DME suppliers imposed from 1998 through 2008. According to the officials with whom we spoke, as a cost-saving measure, CMS is no longer reporting adverse actions taken against DME suppliers to the HIPDB.
- None of the 45 nursing homes terminated from participating in Medicare from 2004–2008 were reported to the HIPDB until 2009, well after the required reporting timeframe.

The Division of National Systems (DNS), the group within CMS responsible for reporting adverse actions against certified provider types, did not report any actions between 2001–2008. DNS uses an electronic system to track adverse actions against providers that are required to have a State survey or are accredited by an accrediting organization, such as hospitals and nursing homes. DNS officials indicated that they report only termination actions that are for failure to meet health and safety requirements and that have gone through the entire appeals process, after which the terminated providers will no longer participate in Medicare. However, adverse actions are required to be reported within the timeframes specified by law regardless of whether appeals are pending.

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## RECOMMENDATION

**CMS should report all adverse actions as required.** To accomplish this, CMS should educate staff and contractors about the types of adverse actions required to be reported and the timeframes for reporting.

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## AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on the report, CMS concurred with our recommendation. CMS described planned efforts to report adverse actions imposed against nursing facilities, laboratories, and DME suppliers, including working with HRSA to develop technical procedures and educating staff and contractors about HIPDB reporting. We did not make any changes to the report based on CMS's comments.



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## OBJECTIVE

To determine whether the Centers for Medicare & Medicaid Services (CMS) reported all of its adverse actions to the Healthcare Integrity and Protection Data Bank (HIPDB) as required.

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## BACKGROUND

The HIPDB is a national data bank containing reports of final adverse actions (e.g., exclusions from participation in a Federal health care program, health-care-related criminal convictions) against health care practitioners, providers, and suppliers (hereinafter referred to as providers). State and Federal agencies and health plans may query the HIPDB to assist them in preventing the employment of potentially fraudulent or abusive providers. As of April 30, 2009, the HIPDB contained information on 389,273 adverse actions.<sup>1</sup>

The HIPDB plays an important role in preventing fraud and abuse, so it is important that the information it contains be complete and accurate. Furthermore, users pay fees for each query they submit to the HIPDB with the expectation that they will receive complete and accurate information in return.

Federal and State government agencies and health plans are required to report to the HIPDB certain final adverse actions that they take against providers relating to a health care item or service. Within the Department of Health & Human Services (HHS), CMS oversees health care programs that serve the largest percentage of health care consumers—an estimated 45 million Medicare beneficiaries and 59 million Medicaid beneficiaries.<sup>2</sup> CMS may take many types of adverse actions against the providers it oversees, including revocations and suspensions of certifications, terminations of participation in Medicare, and civil monetary penalties (CMP). State agencies also report final adverse actions imposed against providers—for example, an adverse action that could be taken by a State agency is the loss of a

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<sup>1</sup> Of the 389,273 adverse actions, 328,516 were reported by State agencies, 55,385 were reported by Federal agencies, and 5,372 were reported by health plans.

<sup>2</sup> *Medicare Enrollment: National Trends 1966-2008*. Accessed at <http://www.cms.hhs.gov> on January 4, 2010. *Total Medicaid Enrollment, FY 2006*, The Henry J. Kaiser Family Foundation. Accessed at <http://www.statehealthfacts.org> on December 9, 2009.

provider's license or certification agreement for participation in its Medicaid program.<sup>3</sup>

### **Establishment of the HIPDB**

Section 221 of the Health Insurance Portability and Accountability Act of 1996 amended the Social Security Act by adding section 1128C, which required the Secretary of HHS, acting through the Office of Inspector General (OIG) and the United States Attorney General, to create a national health care fraud and abuse control program, including a national data bank containing certain adverse actions against providers. This data bank, known as the HIPDB, became operational in 1997.

The HIPDB is administered by the Health Resources and Services Administration (HRSA) through a Memorandum of Understanding with OIG. HRSA also administers the National Practitioner Data Bank (NPDB), which collects information related to the professional competence and conduct of physicians, dentists, and other health care practitioners. HRSA contracts the operations of both data banks to a private company, SRA International.

### **Purpose of the HIPDB**

The purpose of the HIPDB is to prevent health care fraud and abuse and to improve the quality of patient care within the United States.<sup>4</sup> To that end, the HIPDB should contain all adverse actions subject to reporting requirements in the implementing regulations found in 45 CFR pt. 61. The HIPDB information is intended to be used in combination with information from other sources (e.g., peer recommendations, verification of training and experience) when making determinations about employment, affiliation, certification, or licensure.

Section 1128E of the Social Security Act and the implementing regulations require the reporting of a variety of adverse actions to the HIPDB and do not limit the reporting of adverse actions to cases of fraud and abuse. The Federal Register containing the final rule implementing section 1128E states:

Congress used the term health care fraud and abuse only once in the provision's opening paragraph for purposes of naming the data

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<sup>3</sup> 45 CFR § 61.7.

<sup>4</sup> *HIPDB Guidebook*, p. A-2. Accessed at <http://www.npdb-hipdb.com> on November 30, 2009.

collection program. The term does not appear elsewhere, especially with regard to limiting the scope of reportable actions .... To limit the adverse actions collected by the data bank to only those that are based on health care fraud and abuse would create a data bank that does not fully capture the types of reports that Congress clearly intended to be collected in accordance with the statute.<sup>5</sup>

### **HIPDB Reporting Requirements**

Federal and State government agencies and health plans are required to report certain final adverse actions (hereinafter referred to as adverse actions) that they take against providers. The regulations in 45 CFR §§ 61.7–61.11 describe which adverse actions must be reported to HIPDB; however, neither the Social Security Act nor the regulations list the *specific* agencies required to report. Section E of the *HIPDB Guidebook* provides further explanation of each type of action, which includes licensure and certification actions, exclusions from participation in Federal and State health care programs, criminal convictions, civil judgments related to health care, and any other adjudicated actions or decisions that the Secretary of HHS establishes by regulation. Table 1 gives an overview of the types of adverse actions that must be reported to the HIPDB. See Appendix A for more detailed information about each type of reportable action.

Adverse actions must be reported within 30 calendar days of the date the action was taken or the date the reporting entity became aware of the action or by the close of the next monthly reporting cycle as determined by the entity, whichever is later.<sup>6</sup> If an appeal overturns a reported action, the reporting entity must submit a revised report to the HIPDB.<sup>7</sup> Information reported to the HIPDB is maintained permanently, unless it is corrected or voided from the system. A correction or void may be submitted only by the reporting entity or at the direction of the Secretary of HHS.<sup>8</sup>

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<sup>5</sup> 64 Fed. Reg. 57740 (Oct. 26, 1999).

<sup>6</sup> 45 CFR § 61.5.

<sup>7</sup> 45 CFR § 61.6(b); *HIPDB Guidebook*, pp. E-5 and E-15. Accessed at <http://www.npdb-hipdb.com> on November 30, 2009.

<sup>8</sup> *HIPDB Guidebook*, p. E-14. Accessed at <http://www.npdb-hipdb.com> on November 30, 2009.

# I N T R O D U C T I O N

*CMS reporting to the HIPDB.* As shown in Table 1, CMS takes several types of adverse actions that are required to be reported to the HIPDB, including revocations and suspensions of laboratory certifications; terminations of providers from participation in Medicare; and CMPs against all types of providers, managed care plans, and prescription drug plans. The CMS Division of National Systems (DNS) maintains the electronic system CMS uses to track adverse actions for Medicare-certified provider types (i.e., providers that are required to have a State survey or that are accredited by an accrediting organization) and reports those actions to the HIPDB. As of April 30, 2009, the HIPDB contained 5,146 adverse actions reported by CMS.

Table 1: Types of Adverse Actions Reportable to the HIPDB

Type of Action	Is This Action Taken by CMS?	Example
Licensure and Certification Actions	Yes	The denial of an application for licensure or certification because of a provider's deliberate failure to report a licensure disciplinary action taken by another licensing agency
Exclusions	No*	Exclusion of a provider because he or she has filed false claims or because his/her medical license has been suspended
Health-Care-Related Criminal Convictions	No	Conviction and fining of a mental health institution for condoning physically abusive methods of controlling patients
Health-Care-Related Civil Judgments	No	A judgment against a nursing home for neglect of and failure to adequately clean patient rooms
Other Adjudicated Actions	Yes	Termination of a Federal or State government contract for cause

\*42 CFR § 402.200 authorizes CMS exclusion authority, but CMS had not exercised this authority at the time of this review.

Source: *HIPDB Guidebook*, 2009.

### Querying the HIPDB

Federal and State government agencies and health plans are eligible to query the HIPDB. The information may be used for employment, affiliation, certification, or licensure decisions. Federal Government agencies may query the HIPDB without charge. State government agencies and health plans must pay a per-query fee of \$4.75. Providers may self-query the HIPDB for a fee of \$8.00; they are allowed to access only information about themselves.

**Related Report and Legislation**

An October 2005 OIG report on HHS agencies' reporting to the NPDB found that between June 1997 and September 2004, HHS agencies failed to report as many as 474 medical malpractice cases that should have been reported. The underreporting was caused by factors including lost or incomplete files and the lack of an identifiable HHS contact for the NPDB reporting.<sup>9</sup>

The information in the HIPDB and the NPDB overlaps, but agencies are required to report information to the HIPDB that is not required to be reported to the NPDB. On March 23, 2010, legislation was enacted that will consolidate this information within the NPDB and terminate the HIPDB.<sup>10</sup> When the legislation is implemented, agencies that currently report to the HIPDB will be required to report to the NPDB.

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**METHODOLOGY****HIPDB Data**

We obtained a copy of the data contained in the HIPDB as of April 30, 2009. We reviewed the data to determine the extent of CMS's reporting as of that date. We conducted structured interviews with HRSA staff to understand the data fields and ensure we had a complete understanding of HIPDB reporting.

**CMS Division Interviews and Adverse Action Data**

We conducted structured interviews with CMS officials in each division that is responsible for (1) oversight of providers that participate in Medicare and (2) reporting of adverse actions. In these interviews, we asked CMS officials about the provider type(s) with which they worked, the adverse actions that they were authorized to impose, whether they maintained a list of the adverse actions they imposed, and their knowledge of HIPDB reporting. Respondents offered reasons why they believed imposed adverse actions were not reportable to the HIPDB. For CMS divisions that maintained lists of imposed adverse actions, we collected documents or data to support the number of adverse actions imposed.<sup>11</sup> We verified whether the listed adverse actions had been

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<sup>9</sup> OIG, *HHS Agencies' Compliance With the National Practitioner Data Bank Malpractice Reporting Policy* (OEI-12-04-00310), October 2005.

<sup>10</sup> The Patient Protection and Affordable Care Act, P.L. 111-148 § 6403.

<sup>11</sup> Each division that supplied documents or data used a different timeframe.

# I N T R O D U C T I O N

reported to the HIPDB. Table 2 illustrates the adverse actions contained in the data and documents provided to us.

Table 2: Adverse Actions Taken by CMS Divisions That Maintained Lists of Actions

CMS Division	Timeframe of Data Provided	Number of Actions
Division of Laboratory Services	January 1–December 31, 2007	148
Program Compliance and Oversight Group	January 1, 2006–July 31, 2009*	30
Survey and Certification Group	October 1, 2004–December 31, 2008	45

\*The effective date for the latest action in these data is March 7, 2009.

Source: CMS staff divisions, 2009.

## 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 took adverse actions against providers, but did not report all of these actions to the HIPDB as required**

A variety of adverse actions that CMS takes against providers, such as certification actions and other adjudicated actions, are required to

be reported to the HIPDB. However, many CMS divisions that took adverse actions did not report all of them as required. Additionally, the division responsible for tracking and reporting adverse actions against certified providers did not report any actions between 2001–2008. Finally, some of the adverse actions CMS did report were not reported within required timeframes.

**CMS's reporting to the HIPDB varied by provider type; CMS officials were unaware that adverse actions related to program compliance should be reported**

Laboratories. Within CMS, the Division of Laboratory Services imposes terminations, certification actions, and CMPs against laboratories that do not meet Medicare requirements. These adverse actions meet the definitions of certification actions and other adjudicated actions in 45 CFR § 61.7 and must be reported to the HIPDB.

CMS imposed 148 adverse actions against laboratories in 2007, none of which had been reported to the HIPDB at the time of our review. As of April 30, 2009, the HIPDB contained only one adverse action reported by the Division of Laboratory Services; this report was submitted in 1998. CMS officials overseeing laboratories stated their belief that only adverse actions related to fraud and abuse should be reported to the HIPDB. They were unaware that adverse actions related to program compliance should also be reported.

Managed care and prescription drug plans. CMS imposes terminations and CMPs against managed care and prescription drug plans that fail to comply with Medicare requirements. These adverse actions meet the definitions of certification and other adjudicated actions in 45 CFR § 61.11 and must be reported to the HIPDB.

CMS imposed 30 adverse actions against managed care and prescription drug plans between January 1, 2006, and July 31, 2009 (the last action

was effective March 7, 2009), none of which had been reported to the HIPDB at the time of our review.<sup>12</sup> CMS officials overseeing managed care and prescription drug plans, like officials overseeing laboratories, stated that they believed only adverse actions related to fraud and abuse must be reported to the HIPDB. However, neither section 1128E of the Social Security Act nor the HIPDB regulations limit the reporting of adverse actions to cases of fraud and abuse.

*Durable medical equipment suppliers.* CMS terminates durable medical equipment (DME) suppliers that fail to comply with Medicare requirements. These adverse actions meet the definition of certification actions in 45 CFR § 61.7 and must be reported to the HIPDB.

As of April 30, 2009, the HIPDB contained 5,125 adverse actions against DME suppliers imposed from 1998 through 2008. The HIPDB contained no adverse actions against DME suppliers taken after 2008, although DME fraud is an ongoing issue in Medicare—Medicare paid more than \$30 million in fraudulent claims to DME suppliers in 2008 alone.<sup>13</sup>

According to the officials with whom we spoke, CMS is no longer reporting adverse actions taken against DME suppliers to the HIPDB. CMS officials responsible for overseeing provider enrollment explained that the 5,125 adverse actions were reported by a contractor that processes enrollment applications for DME suppliers. However, in October 2008, CMS issued a new Statement of Work discontinuing the requirement for this contractor to report enforcement actions to the HIPDB. CMS officials said this change was a cost-saving measure.

*Nursing homes.* CMS terminates or imposes CMPs against nursing homes that fail to comply with Medicare requirements. These adverse actions meet the definitions of certification and other adjudicated actions in 45 CFR § 61.11 and must be reported to the HIPDB.

The CMS Survey and Certification Group terminated 45 nursing homes from participating in Medicare from 2004 to 2008. CMS officials stated

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<sup>12</sup> The report provided to us with these data included adverse actions between January 1, 2006, and July 31, 2009. We obtained a copy of the data contained in the HIPDB as of April 30, 2009. However, the last adverse action imposed against managed care and prescription drug plans was effective March 7, 2009, within our period of review.

<sup>13</sup> *Fact Sheet: Phase Two Medicare Fraud Strike Force Los Angeles Metro Area.* HHS and Department of Justice. Accessed at <http://www.stopmedicarefraud.gov> on January 20, 2010.

that these 45 nursing home terminations were not reported to the HIPDB until the fall of 2009. They further stated that they plan to report nursing home terminations annually. However, annual reporting of nursing home terminations does not comply with the reporting requirements in 45 CFR § 61.5 as to timeframe.

Additionally, in fiscal year 2008, the CMS Office of Financial Management collected over \$37 million in CMPs, of which CMS officials estimated that 85 percent were from nursing homes. However, CMS had not reported any CMPs to the HIPDB as of April 30, 2009. CMS officials stated that CMPs against nursing homes need not be reported to the HIPDB for two reasons. First, CMS officials stated that reporting is required only for adverse actions due to fraud and abuse. Many CMPs are intended to correct lack of compliance with provider standards, not to deter fraud and abuse. However, section 1128E of the Social Security Act does not limit the reporting of adverse actions to cases of fraud and abuse. Second, CMS officials said that if providers correct the noncompliance, the CMP is rescinded and the provider never pays the penalty imposed. However, neither section 1128E of the Social Security Act nor the HIPBD regulations contain exceptions to reporting for adverse actions that may be rescinded. CMS must report all imposed adverse actions; if the actions are later rescinded, CMS must submit a revised report to the HIPDB indicating the rescission.

**CMS did not report any adverse actions against Medicare-certified provider types between 2001 and 2008**

We identified 20 reports of adverse actions against providers of various types (e.g., laboratories, clinics, medical doctors) imposed in 2000 that DNS reported to the HIPDB.<sup>14</sup> As of April 30, 2009, the HIPDB contained no further reports from DNS after 2000.

DNS uses an electronic system to track adverse actions against providers that are required to have a State survey or are accredited by an accrediting organization, such as hospitals and nursing homes. DNS officials told us that they would report only terminations for nursing homes, despite having information on other types of providers in their system. DNS reports only termination actions that are imposed for failure to meet health and safety requirements and that have gone

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<sup>14</sup> Medicare-certified providers are required to have a State survey or be accredited by an accrediting organization. Medical doctors are not certified by Medicare. We could not determine why DNS reported adverse actions against medical doctors.

## F I N D I N G

through the entire appeals process, after which the terminated providers will no longer participate in Medicare. However, adverse actions must be reported within the timeframes specified by law regardless of whether appeals are pending.

## ► R E C O M M E N D A T I O N

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CMS did not report all adverse actions to the HIPDB as required by Federal law. CMS officials stated that they believe only adverse actions related to fraud and abuse must be reported to the HIPDB.

Furthermore, the division within CMS responsible for tracking adverse actions against certified provider types did not report any actions between 2001 and 2008. However, neither section 1128E of the Social Security Act nor the HIPDB regulations limit reporting to cases of fraud and abuse, nor do they contain any exceptions to required reporting based on costs of reporting.

Section 6403 of the Patient Protection and Affordable Care Act (P.L. 111-148) transfers information from the HIPDB to the NPDB and terminates the HIPDB. Implementation is to be 1 year after enactment or when final regulations are promulgated, whichever occurs later. When implementation occurs, CMS will be required to report to the NPDB information that CMS is currently required to report to the HIPDB.

To address our finding we recommend:

### **CMS should report all adverse actions as required**

To accomplish this, CMS should educate staff and contractors about the types of adverse actions required to be reported and the timeframes for reporting.

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## **AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In its written comments on the report, CMS concurred with our recommendation. CMS described planned efforts to report adverse actions imposed against nursing facilities, laboratories, and DME suppliers, including working with HRSA to develop technical procedures and educating staff and contractors about HIPDB reporting. CMS issued instructions to the National Supplier Clearinghouse (the DME supplier enrollment contractor) to submit reports for suppliers whose Medicare billing privileges were revoked in 2009 and will establish procedures to ensure the contractor reports adverse actions monthly to the HIPDB. CMS stated that further discussion with HRSA and OIG is necessary to clarify whether some actions are reportable. We did not make any changes to the report based on CMS's comments. The full text of CMS's comments on the draft report can be found in Appendix B.

## Types of Adverse Actions Required To Be Reported to the Healthcare Integrity and Protection Data Bank

*Licensure or certification actions.* Federal and State agencies responsible for the licensing and certification of providers must report adverse licensure actions taken against practitioners, providers, and suppliers to the Healthcare Integrity and Protection Data Bank (HIPDB).<sup>15</sup> The actions must be formal or official actions; they need not be related to professional conduct or competence. Examples of reportable adverse licensure and certification actions include:

- any loss, revocation, or suspension of a license or certification agreement or contract for participation in Federal or State health care programs;
- any loss of the right to apply for or renew a license, certification agreement, or contract;
- any reprimand, censure, or probation; and
- any other negative action or finding by a Federal or State agency that is publicly available information and is rendered by a licensing or certification authority, including limitations on the scope of practice, liquidations, injunctions, exclusions, revocations, suspensions or forfeitures, and excluding administrative fines or citations and corrective action plans and other personnel actions unless they are connected to the billing, delivery, or provision of health care services and taken in conjunction with other licensure or certification actions.

*Exclusions from participation in Federal or State health care programs.* The term “exclusion” is defined as a temporary or permanent debarment of an individual or entity from participation in Federal or State health-related programs, in accordance with which items or services furnished by the person or entity will not be reimbursed by the program. Sections 1128B(9)(f) and (h) of the Social Security Act specify which Federal and State health care programs are included in this definition. Examples of reportable exclusions include a practitioner who is excluded because he or she has filed false claims or because his or her medical license has been suspended.

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<sup>15</sup> All of the examples presented in this Appendix are adapted from the *HIPDB Guidebook*, February 2000. Accessed at <http://www.npdb-hipdb.com> on November 30, 2009.

*Health-care-related criminal convictions.* Federal, State, and local prosecutors must report criminal convictions and injunctions that are related to the delivery of health care items or services and that are taken against health care practitioners, providers, and suppliers. These criminal convictions include situations in which a judgment or conviction has been entered in a Federal, State, or local court, regardless of whether an appeal is pending or whether the record has been expunged; a finding of guilt has been entered; a plea of guilty or nolo contendere has been accepted; or an arrangement in which judgment or conviction has been withheld, such as a first offender or deferred adjudication program. Examples of criminal convictions that must be reported to the HIPDB include:

- the conviction and fining of a mental health institution for condoning physically abusive methods of controlling patients,
- the conviction and fining of both a chiropractor and a medical supply company for providing kickbacks in exchange for patient referrals,
- the deferred conviction of a practitioner for accepting money for referrals to a specialist and sentencing of the practitioner for a 2-year probationary period, and
- an injunction by the Food and Drug Administration against a pharmaceutical company to stop the production of a drug found to produce harmful side effects.

Examples of criminal convictions that would not be reported to the HIPDB include:

- a civil judgment against a physician for medical malpractice resulting in an award to the plaintiff and
- a deferred conviction of a practitioner for possession and abuse of drugs and sending the practitioner to a rehabilitation facility.

*Health-care-related civil judgments.* Federal and State attorneys and health plans must report civil judgments against practitioners, providers, and suppliers related to the delivery of a health care item or service, regardless of whether the judgments are being appealed. If a government agency is party to a multclaimant suit, it is responsible for reporting the entire action. When there are multiple health plans as claimants but no government agency, the health plan that received the largest award is responsible for reporting the total action. Examples of reportable civil judgments include:

- a judgment against a clinical laboratory for fraudulent billing and misleading marketing,
- a judgment against a nursing home for neglect of and failure to adequately clean patient rooms, and
- a judgment against a plastic surgeon for misrepresenting claims as noncosmetic procedures in order to receive payment for them.

Examples of nonreportable civil judgments include:

- a judgment imposing a fine on a medical supply company for hiring discrimination,
- a judgment against a practitioner for medical malpractice, and
- a judgment against a practitioner stemming from an automobile accident not related to the delivery of health care.

*Other adjudicated actions or decisions.* Federal and State government agencies and health plans must report adjudicated actions or decisions against practitioners, providers, and suppliers. Other adjudicated actions or decisions are those which “... include the availability of a due process mechanism and [are] based on acts or omissions that affect or could affect the payment, provision, or delivery of a health care item or service.” Examples of other adjudicated actions or decisions include a personnel-related action, such as a termination and a Federal or State government contract terminated for cause.<sup>16</sup>

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<sup>16</sup> *HIPDB Guidebook*, p. E-11. Accessed at <http://www.npdb-hipdb.com> on November 30, 2009.

**AGENCY COMMENTS**



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*  
Washington, DC 20201

**DATE:** AUG 5 2010

**TO:** Daniel R. Levinson  
Inspector General -

**FROM:** Donald M. Berwick, M.D. /SI/  
Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: CMS Reporting to the  
Healthcare Integrity and Protection Data Bank (OEI-07-09-00290)

Thank you for the opportunity to review and comment on the above-referenced report from OIG. The Centers for Medicare & Medicaid Services (CMS) appreciates the input by OIG in assessing efforts to prevent the employment of potentially fraudulent or abusive healthcare providers and suppliers. The purpose of this report was to evaluate whether CMS reported all of its adverse actions to the Healthcare Integrity and Protection Data Bank (HIPDB), a national data bank containing reports of adverse actions against health care providers taken by Federal and State government agencies and health plans.

We hope to engage with the Health Resources and Services Administration (HRSA) and OIG to address the many issues relating to the HIPDB that were outside the scope of this report, as those efforts will facilitate adoption of the OIG recommendation.

**OIG Recommendation**

The CMS should report all adverse actions as required. To accomplish this, CMS should educate staff and contractors about the types of adverse actions required to be reported and the timeframes for reporting to the relevant data bank.

**CMS Response**

The CMS concurs with this recommendation.

The CMS provided the outstanding nursing home termination data from 2004 through 2008, as well as 2009 terminations, in June. In addition, we are investigating the most feasible methods to provide additional data on nursing home denial of payment for new admissions, and laboratories whose participation in the Clinical Laboratory Improvement Amendments of 1988 program has been revoked or suspended. CMS issued instructions to the National Supplier Clearinghouse (NSC) to submit 2009 revocation data to the HIPDB by September 1, 2010 when

the NSC determines (and the administrative appeals process upholds) that a supplier was not operational at the practice location found on its Medicare enrollment application or when the supplier's Medicare billing privileges were revoked due to a licensing issue. We will monitor the NSC implementation of this effort and establish procedures to ensure that the NSC continues to enter data into the HIPDB monthly.

We plan to discuss with HRSA the issue of record layouts and coding of the HIPDB with the goal of reducing the extent of manual reporting, as such manual reporting reduces the probability of accomplishing the reporting goals. We understand that CMS databases may not currently have all the mandatory data fields for full population to the HIPDB. However, we will continue to work with HRSA to see if further efficiencies, such as a flat file of data, could be accommodated in order to ensure timely and efficient transmission of the data. Once we have agreed on a strategy and definition of terms, and put the necessary infrastructure in place, we will undertake the educational effort that OIG has recommended. We also believe further discussion with both HRSA and OIG is necessary to clarify whether some compliance actions are reportable. We will initiate these discussions in the near future.



## A C K N O W L E D G M E N T S

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

Tricia Fields served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the Kansas City regional office who contributed to the report include Michael P. Barrett and Michala Walker; central office staff who contributed include Heather Barton, Anne MacArthur, and Talisha Searcy.

# *Office of Inspector General*

<http://oig.hhs.gov>

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

## *Office of Audit Services*

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

## *Office of Evaluation and Inspections*

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

## *Office of Investigations*

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

## *Office of Counsel to the Inspector General*

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