DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

NOV 01 2010

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SUBJECT: Memorandum Report: *The Use of Payment Suspensions To Prevent Inappropriate Medicare Payments*, OEI-01-09-00180

This memorandum report presents the findings of our recent work that (1) describes Medicare payment suspensions implemented by the Centers for Medicare & Medicaid Services (CMS) in 2007 and 2008 and (2) assesses CMS's process for approving and implementing Medicare payment suspensions.

CMS may suspend payments to a Medicare provider or supplier (hereinafter referred to as a provider) under any of three circumstances: (1) fraud or willful misrepresentation, (2) when an overpayment exists but the amount has not been determined, or (3) when payments made or to be made may be incorrect.[1] CMS may suspend payments based on requests from its contractors or from law enforcement.

We analyzed 253 suspensions that CMS imposed in 2007 and 2008. Part B providers composed 85 percent of those suspensions. Overpayments to providers in those years totaled at least $206 million. CMS extended more than half of payment suspensions, generally because its contractors needed more time to calculate overpayments or the Office of Inspector General (OIG) was considering an administrative action against a provider, such as a civil monetary penalty or permissive exclusion.

The great majority of providers that CMS suspended in 2007 and 2008 exhibited characteristics that suggest fraud. CMS recommends that providers suspended due to fraud receive no advance notice; in all but three of the suspensions, no such advance notice was given. Seventy-four percent of suspended providers showed questionable billing patterns. Sixty-three percent of suspensions were supported by information from beneficiaries or from other providers; this information included evidence that the suspended providers had billed for services that were never received or were medically

[1] 42 CFR § 405.371(a)(1).

unnecessary and had used other providers' billing numbers to seek payment for items or services that had not been authorized. Twenty-four percent of suspended providers billed Medicare before their suspensions despite having vacant physical locations.

We also found that CMS provides some inconsistent guidance on payment suspensions, particularly in specifying the types of information that its contractors should submit with a request for a suspension, as well as in describing to contractors and law enforcement the circumstances in which an extension is permitted.

We conclude that payment suspensions were used in 2007 and 2008 almost exclusively as a tool to fight fraud. Since the time when we collected data for this evaluation, the Patient Protection and Affordable Care Act (hereinafter referred to as the Affordable Care Act) was signed into law. The Affordable Care Act states that a provider's payments may be suspended based on a credible allegation of fraud, unless there is good cause not to suspend such payments. It also states that CMS must consult with OIG in determining whether a credible allegation of fraud exists.[2] On September 23, 2010, CMS issued proposed regulations for these provisions.[3] The information provided in this report may be useful to CMS when it finalizes these regulations. In the guidance that CMS develops for the new provisions for payment suspensions, CMS could also address the inconsistencies that this report identifies.

BACKGROUND

Improper Medicare Payments and Payment Suspensions

CMS may suspend payments to any Medicare provider when it possesses reliable information that the provider was overpaid for previously submitted claims. CMS imposes suspensions under any of three circumstances: (1) fraud or willful misrepresentation, (2) when an overpayment exists but the amount has not been determined, and (3) when payments made or to be made may be incorrect.[4]

Payment suspensions are a strong tool for CMS to use to protect the Medicare program from improper payments. In 2008, CMS highlighted payment suspensions as a means of fighting fraud, waste, and abuse by home health providers in Miami-Dade County, Florida.[5]

CMS may suspend payments based on requests from its contractors or from law enforcement. CMS contractors that typically request payment suspensions include Program Safeguard Contractors and Zone Program Integrity Contractors, both of which

[2] P.L. 111-148, §§ 6402(h)(1) and (2).
[3] 75 Fed. Reg. 58204, 58239 (Sept. 23, 2010).
[4] 42 CFR § 405.371(a)(1); CMS, *Program Integrity Manual* (PIM), § 3.9.1.
[5] CMS, *CMS Strengthens Efforts to Fight Medicare Waste, Fraud and Abuse*. Accessed at http://www.cms.gov/apps/media/press_releases.asp on May 3, 2010.

conduct data analysis and identify potential Medicare fraud on CMS's behalf.[6] Law enforcement entities, including OIG and the Department of Justice (DOJ), request payment suspensions from CMS through these contractors.[7] In addition, the Office of General Counsel in the Department of Health & Human Services (HHS) reviews requests for payment suspensions prior to their approval.

The Process for Payment Suspensions

Two documents outline procedures for payment suspensions. For contractors, Section 3.9 of the PIM details those procedures. For law enforcement, the *Joint Guidance on CMS Administrative Actions and the Impact on Health Care Fraud Cases* (hereinafter referred to as the *Joint Guidance*) provides information regarding payment suspensions and law enforcement investigations. Authored by CMS, OIG, and DOJ and released in July 2009, the *Joint Guidance* describes the types of administrative sanctions that CMS may impose, including payment suspensions, and their effect on ongoing investigations and litigation.

Requesting a payment suspension. The process for requesting a payment suspension is the same whether a contractor initiates it based on the contractor's own analysis or at CMS's request, or at the behest of law enforcement.[8] The contractor provides CMS with a draft notification letter (hereinafter referred to as a suspension notice) and a summary of the reliable information. The suspension notice must include the reason for the suspension, which "must be specific enough to justify the action being taken and allow the provider an opportunity to identify the problem."[9] In addition to that requirement, the notice must also include 10 other elements:

- that the suspension will be imposed,
- the extent of the suspension (all claims, certain types of claims, 100 percent suspension, or partial suspension),
- that the suspension is not appealable,
- that CMS has approved the suspension,
- when the suspension will begin,
- the items and services affected,
- how long the suspension is expected to be in effect,
- the reason for suspending payment,

[6] In 2008, CMS established Zone Program Integrity Contractors, which will consolidate benefit integrity work for Medicare Parts A and B. Seven of them will replace the Program Safeguard Contractors. As of October 2010, three are operational.

[7] CMS, PIM, § 3.9.1.1.C.

[8] A memorandum of understanding between OIG and CMS allows OIG to request a payment suspension based on a declaration signed by an OIG Special Agent. This declaration includes a description of the fraud and the evidence supporting the request for a payment suspension. The memorandum of understanding was established in January 2009 and amended in June 2010.

[9] CMS, PIM, § 3.9.1.1.C.

- that the provider has the opportunity to submit a rebuttal statement within 15 days of the suspension notice, and
- where to mail the rebuttal. [10]

Payment suspension approval and provider notification. CMS decides whether to suspend a provider's payments based on reliable information that it receives from the contractor. After CMS approves a suspension, it determines whether the provider should be notified before or after the date of the suspension. If CMS suspends a provider because of suspected fraud, willful misrepresentation, or harm to the Medicare Trust Funds, CMS directs the contractor to send the notice to the provider on or after the effective date of the suspension, but no later than 15 days after this date.[11] For suspensions imposed for other reasons, CMS instructs the contractor to send the suspension notice at least 15 calendar days before the suspension takes effect.[12]

Opportunity for rebuttal. Payment suspensions may not be appealed to an administrative law judge within HHS. However, a suspended provider may submit a rebuttal to explain why CMS should remove the suspension. A provider must submit a rebuttal letter within 15 days of the date of the suspension notice, but the contractor can shorten or extend this period for cause.[13] CMS directs its contractors to respond within 15 days of receiving a rebuttal letter with CMS's decision for continuing or removing the suspension. The process for responding to rebuttal letters is similar to that for requesting suspensions; the contractor drafts a response to the rebuttal and forwards it—along with the provider's rebuttal letter—to CMS for approval.

Calculating overpayments during a suspension. After suspending payments to a provider, the contractor calculates the overpayment, which "consists of all claims in a specific time period determined to have been paid incorrectly."[14] The contractor selects a statistically valid random sample of claims, requests medical records for these claims from the suspended provider, and reviews the records to determine the amount of the overpayment.[15] If the contractor does not receive records from the provider, then the contractor determines that 100 percent of the claims were paid in error.

During the suspension, the provider may continue to submit claims. Amounts from valid claims submitted by the provider during this period are held in suspense. Those funds must first be applied to reduce the amount of the overpayment and then to reduce any

[10] CMS, PIM, § 3.9.2.2.2.
[11] 42 CFR § 405.372(a)(3); CMS, PIM, § 3.9.2.2.
[12] CMS, PIM, § 3.9.2.2.1.
[13] 42 CFR § 405.374(b).
[14] CMS, PIM, § 3.9.2.3.1.
[15] CMS, PIM, § 3.6.

other debt owed to CMS or HHS. Any remaining funds held in suspense are then released to the provider. [16]

Extension of payment suspensions. Payment suspensions generally last 180 days. However, based on written requests from contractors or law enforcement, CMS may extend payment suspensions under certain circumstances (see Table 1).

Table 1: CMS's Provisions for Extending Payment Suspensions

Entity Requesting an Extension	Time Limit for the Extension	Circumstance Under Which CMS May Grant the Entity an Extension Based on a Written Request
Contractor, OIG, or DOJ	180 days	The entity is unable to complete its examination of the information or investigation (including calculation of the overpayment).
DOJ	180 days	An additional 180-day extension may be granted based on an ongoing investigation and the anticipated filing of criminal and/or civil actions.
OIG	No limit	The time limits for extensions do not apply if the provider has been referred to, and is being considered by, OIG for administrative action (such as permissive exclusion or civil monetary penalty).

Source: 42 CFR § 405.372(d); CMS, PIM, § 3.9.2.4.

Removal of payment suspensions. After the contractor calculates the overpayment, it issues a letter to the provider that includes the overpayment amount. The contractor then refers the overpayment to the Medicare claims processor. The claims processor issues a letter (called a demand letter) to the provider demanding refund of the overpayment and maintains the responsibility for collecting the overpayment.[17] Once the claims processor has issued the demand letter and the suspended payments have been applied to the overpayment and/or released to the provider, the suspension is removed.[18]

The Affordable Care Act and Payment Suspensions

Signed into law on March 23, 2010, the Affordable Care Act established the following provisions for payment suspensions:

- CMS may suspend payments to a provider pending an investigation of a credible allegation of fraud against the provider, unless CMS determines there is good cause not to suspend such payments;
- CMS shall consult with OIG in determining whether there is a credible allegation of fraud against a provider of services or supplier; and
- CMS shall promulgate regulations to implement the provisions listed above.[19] (CMS issued the proposed regulations on September 23, 2010.[20])

[16] 42 CFR § 405.372(e).
[17] CMS, PIM, § 3.8.
[18] *Joint Guidance*, p. 5.
[19] P.L. 111-148 § 6402(h).
[20] 75 Fed. Reg. 58204, 58239.

METHODOLOGY

Scope
This evaluation examined payment suspensions for fee-for-service Medicare providers that CMS imposed in 2007 and 2008 in the 50 States, the District of Columbia, and Puerto Rico (hereinafter referred to as States). It also examined CMS's processes for payment suspensions. This evaluation did not examine CMS's decisions on individual payment suspensions or the appropriateness of payment suspensions.

Data Sources and Analysis
Our evaluation relied on four data sources: documents for payment suspensions that CMS approved in 2007 and 2008, interviews with CMS officials, site visits at three purposively selected contractors, and a review of CMS regulations and guidance.

To examine the payment suspensions that CMS implemented, we reviewed contractor-provided documents pertaining to 253 payment suspensions imposed in these 2 years.[21] We identified the types and sources of reliable information that supported payment suspensions to determine the circumstances in which CMS approved suspensions.

To examine CMS's processes for approving and implementing payment suspensions, we used data from our review of payment suspension documents and a review of all relevant regulations and guidance for payment suspensions. We also relied on information from interviews with CMS officials and site visits at three contractors; in these interviews and site visits, we collected information about processes and procedures for implementing payment suspensions.

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

RESULTS

Payment Suspensions in 2007 and 2008 Were Concentrated in Medicare Part B, and Most Were Located in Four States
Part B providers composed 85 percent of suspensions in 2007 and 2008. We divided the Part B providers into two categories: those that supply durable medical equipment, prosthetics, and other supplies (DMEPOS); and other providers, such as physicians and

[21] According to CMS's Fraud Investigations Database, the agency imposed 260 suspensions in this 2-year period. However, contactors were unable to provide us with the files on 7 of these suspensions, leaving us with 253 suspensions that had information we could use.

home health agencies. We examined these two groups separately because of concerns that OIG has raised about fraud among DMEPOS suppliers.[22] (See Table 2.)

Table 2: Number of Payment Suspensions by Year and Provider Type

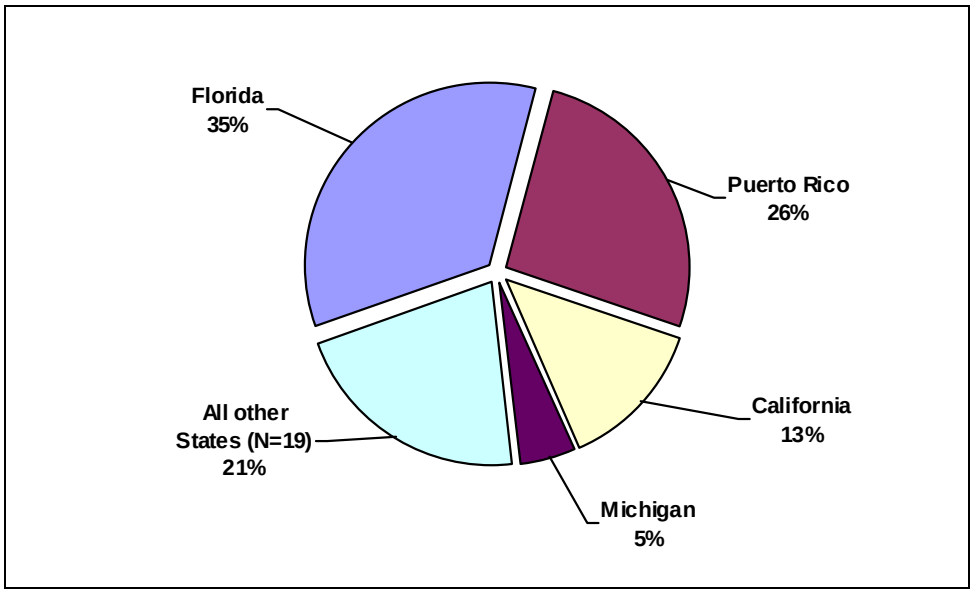
Provider Type	2007	2008*	Total
Part A	10 (6%)	28 (32%)	38 (15%)
Part B—DMEPOS	23 (14%)	41 (47%)	64 (25%)
Part B—non-DMEPOS	132 (80%)	19 (22%)	151 (60%)
Total	**165**	**88**	**253**

Source: OIG analysis of payment suspension documents, 2010.

* Percentages do not total 100 percent because of rounding.

Seventy-nine percent of providers that CMS suspended in 2007 and 2008 were located in four States; more than half were located in Medicare Fraud Strike Force areas. CMS suspended payments to providers located in 23 States, with most of the suspended providers located in Florida, Puerto Rico, California, and Michigan (see Figure 1; also see Appendix A for the number of payment suspensions by State).

Figure 1: Percentage of Providers Suspended in 2007 and 2008 by State



Source: OIG analysis of payment suspension documents, 2010.

[22] See OIG, *South Florida Suppliers' Compliance With Medicare Standards: Results From Unannounced Visits*, OEI-03-07-00150, March 2007; and OIG, *Los Angeles County Suppliers' Compliance With Medicare Standards: Results From Unannounced Visits*, OEI-09-07-00550, February 2008.

Furthermore, 53 percent (135 of 253) of providers with payment suspensions were located in the seven U.S. Attorney's Office districts in which a Medicare Fraud Strike Force currently operates.[23] The Medicare Fraud Strike Force, a joint initiative between HHS and DOJ that began in March 2007, targets "chronic fraud as well as emerging or migrating schemes perpetrated by criminals operating as health care providers or suppliers."[24]

Overpayments totaled at least $206 million. As of August 2009, CMS had removed 182 (72 percent) of the payment suspensions that it approved in 2007 and 2008. The median overpayment amount that contractors calculated for the removed suspensions was $1,288,136 (see Table 3), with overpayments ranging from $23,344 to $6,071,470. For 23 of the 182 suspensions that CMS removed, the contractor determined that there was no overpayment to calculate or recoup.

After the contractor calculates the overpayment, Medicare claims processors are responsible for collecting it. However, recent OIG work found that claims processors collected only 7 percent of overpayments that contractors referred to them for collection in 2007.[25]

Table 3: Overpayments Calculated During Payment Suspensions by Provider Type*

Provider Type	N	Median	Minimum	Maximum	Total
Part A	21	$1,645,026	$166,200	$4,596,538	$43,223,576
Part B – DMEPOS	57	$1,237,153	$23,344	$5,881,115	$72,779,627
Part B – non-DMEPOS	65	$1,072,338	$35,204	$6,071,470	$89,918,810
Overall	**143**	**$1,228,136**	**$23,344**	**$6,071,470**	**$205,922,014**

Source: OIG analysis of payment suspension documents, 2010.

* We base this analysis on the documents we received for 143 of the 182 removed suspensions. As of August 2009, 71 suspensions had not been removed, so the amount of any overpayment had not yet been determined. For 23 suspensions, contractors calculated that no overpayment had been made; for 16 suspensions, contractors did not provide information on the amount of overpayment.

[23] As of July 2010, the Medicare Strike Force is in operation in the following U.S. Attorney's Office districts: Southern District of Florida (Miami), Central District of California (Los Angeles), Eastern District of Michigan (Detroit), Southern District of Texas (Houston), Middle District of Louisiana (Baton Rouge), Eastern District of New York (Brooklyn), and Middle District of Florida (Tampa). "Medicare Fraud Strike Force Expands Operations into Brooklyn, N.Y.; Tampa, Fla.; and Baton Rouge, La." Accessed from http://www.stopmedicarefraud.gov/heatsuccess/taskforces.html on July 29, 2010.

[24] DOJ, "Fact Sheet: Medicare Fraud Strike Forces." Accessed from http://www.stopmedicarefraud.gov/heatsuccess/general_fact_sheet.pdf on July 29, 2010.

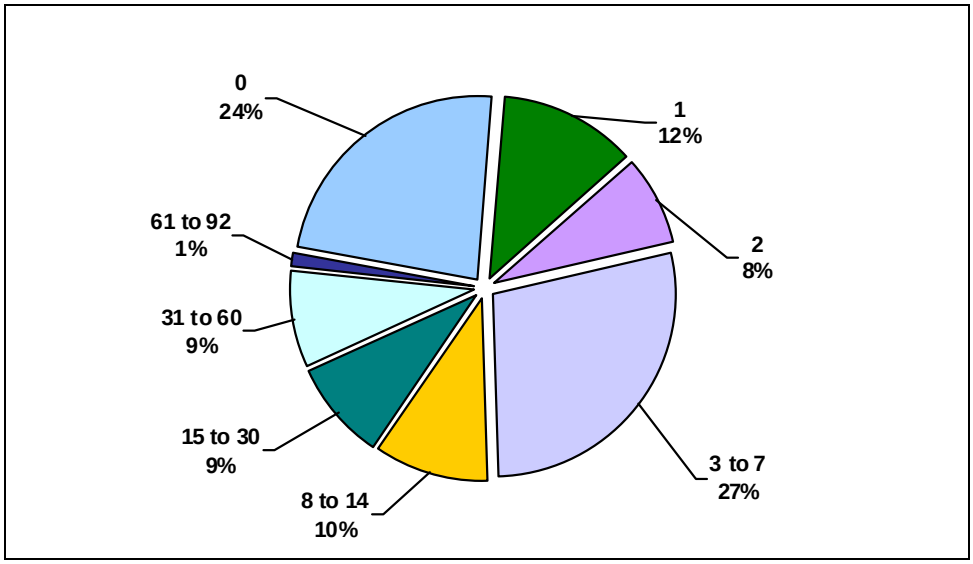
[25] See OIG, *Collection Status of Medicare Overpayments Identified by Program Safeguard Contractors*, OEI-03-08-00030, May 2010; and OIG, *Medicare Overpayments Identified by Program Safeguard Contractors*, OEI-03-08-00031, May 2010.

Implementation of Suspensions Followed the Process Described in the Program Integrity Manual

Suspension notices generally contained the required elements. Ninety-six percent (240) of the 250 suspension notices that we received included all required elements that the PIM specifies.[26] The suspension notice—which informs a provider that its payments have been suspended and provides information about the suspension process—must include (among other things) the suspension's start date, its expected duration, and information on the rebuttal process. Of the 10 notices that lacked required elements, 6 omitted information explaining that the provider has the opportunity to submit a rebuttal statement within 15 days of notification, and 4 omitted the date that the suspension began.

Although the PIM contains no requirements for timeframes, CMS approved payment suspensions in a median of 4 calendar days. CMS approved about one-quarter of suspensions (46 out of 191) on the same day that contractors requested them (see Figure 2 for approval timeframes). According to CMS officials with whom we spoke, they review each request for a payment suspension to assess the extent to which Medicare funds are at risk, as well as whether a payment suspension is the appropriate administrative tool to use.

Figure 2: Number of Calendar Days Between the Date of Contractors' Requests for Payment Suspensions and Date of CMS's Approval*



Source: OIG analysis of payment suspension documents, 2010.

* This analysis is based on 191 payment suspensions that were initiated by contractors/law enforcement. We excluded the remaining 62 payment suspensions because these were initiated by CMS.

[26] Contractors did not provide suspension notices for 3 of the 253 suspended providers.

Few providers submitted rebuttals. Of the 253 suspended providers, 41 (16 percent) submitted rebuttals to CMS. Because payment suspensions cannot be appealed, the rebuttal serves as a provider's only opportunity to submit information on why CMS should remove the suspension. Of the 41 providers that submitted rebuttals, CMS removed suspensions for 3.

CMS extended more than half of payment suspensions. The suspensions that CMS had removed lasted a median of 267 days. For Part A providers, the median length was 179 days; for Part B providers, it was 341 days. CMS extends suspensions based on requests from contractors and law enforcement. CMS approved extensions for 145 of the 253 payment suspensions (57 percent). Two-thirds of the extensions (96 out of 145) were one-time extensions of 180 days. CMS also approved a second 180-day extension for three suspensions.

In most cases, contractors requested that CMS extend suspensions so that they could complete their calculations of the overpayments made to the providers. Contractor staff told us that because of several factors, they might need additional time to calculate overpayments. These factors include the amount of time that the provider takes to submit medical records and the complexity of the medical record reviews that contractors conduct.

CMS extended 46 of 145 (32 percent) suspensions for indefinite time periods. CMS may extend a suspension indefinitely based on a request from OIG when OIG is considering an administrative action against a provider, such as a civil monetary penalty or permissive exclusion.[27]

The Great Majority of Providers That CMS Suspended in 2007 and 2008 Exhibited Characteristics That Suggest Fraud

Although the circumstances for each suspension are unique, the timing of suspension notices and the reliable information that supported the suspensions demonstrate that CMS suspended most providers because of suspected fraud.

All but three suspended providers received no advance notice, indicating suspected fraud or willful misrepresentation. If CMS suspends a provider because of suspected fraud, willful misrepresentation, or harm to the Medicare Trust Funds, CMS instructs its contractors to send the notice on or after the effective date of the suspension, but no later than 15 days after this date. For suspensions imposed for other reasons, CMS instructs its contractors to give providers at least 15 calendar days of prior notice.[28]

[27] 42 CFR 405.372(d)(3); CMS, PIM, § 3.9.2.4.
[28] CMS, PIM, § 3.9.2.2.1.

Contractors sent 99 percent of notices (243 of 246) to providers on or after the day the suspension took effect.[29] Contractors sent notices to the remaining three suspended providers just 1 day prior to the date the suspension took effect.

Seventy-four percent of suspended providers had questionable billing patterns. For 187 out of 253 suspended providers, contractors included analysis of claims data that showed unusual billing patterns.

The contractors' analyses showed billing patterns common in instances of suspected fraud, including aberrantly high amounts of services provided within a short timeframe and spikes in billing as a result of multiple claims submitted for the same beneficiary. The contractors' analyses also showed that some of the suspended providers billed Medicare using stolen identities. In these instances, suspended providers billed for services using beneficiary identification numbers that were known to have been compromised. Other suspended providers aberrantly billed for medical equipment, submitting claims that listed neurosurgeons, pediatricians, and pathologists as the ordering physicians. Those specialties do not typically order such equipment.

Sixty-three percent of suspensions were supported by information from beneficiaries or from other providers that raised questions. For 159 out of 253 suspensions, complaints or attestations from beneficiaries and/or from other providers contributed reliable information needed to implement a suspension. They filed their complaints either with contractors or with law enforcement. The attestations from beneficiaries and providers resulted from interviews conducted by law enforcement or contractors, as well as from signed statements collected by these entities. In some instances, the information provided through complaints and attestations led a contractor to initiate payment suspensions.

Beneficiary complaints and attestations indicated that the suspended providers billed them for services that they never received or that were medically unnecessary. For example, some complaints concerned out-of-State providers that had billed the beneficiaries for services that they never received. The beneficiaries had neither heard of the providers nor been to the States in which the providers were located. Beneficiaries also attested that medical equipment suppliers billed them for equipment that they never received. These beneficiaries indicated that they did not know the supplier or referring physician listed on the claim. In addition, beneficiaries told contractors or law enforcement that they received home health services even though they were not homebound, as Medicare requires.

Likewise, complaints or attestations from providers indicated that their billing numbers had been used by suspended providers to bill for items or services that they had not authorized. For example, providers attested that they had never ordered medical

[29] Contractors provided us with 250 suspension notices, of which 4 notices lacked an effective date, leaving a denominator of 246 notices.

equipment from the providers that aberrantly billed, nor had they ever treated the patients for whom the equipment was ordered. These physicians include anesthesiologists and neurologists who also indicated that they do not order medical equipment for their patients. Other physicians made complaints upon discovering that the suspended providers used their identities to establish new billing numbers in their names.

Fifty-five percent of suspended providers failed to submit medical records. Of the 182 providers in 2007 and 2008 for which suspensions had been removed, 100 providers failed to submit medical records to the contractor for calculating the overpayment. According to contractor staff with whom we spoke, failing to submit medical records during the course of a suspension demonstrates that the provider may have never existed or may have moved without notifying CMS. Such notification is a requirement to continue participating in the Medicare program.

Twenty-four percent of suspended providers billed Medicare before their suspensions despite vacant physical locations. For 61 of the 253 suspensions we analyzed, contractors, law enforcement, and/or CMS staff found that the provider's office did not appear to be in business prior to the suspension. They uncovered vacant offices and locked doors during posted business hours, as well as eviction notices posted on a provider's office door. In one instance, they went to the provider's address and found a storage facility, rather than a medical office. In addition, the site visits included interviews with landlords and tenants in neighboring businesses who attested that they had not observed any business activity at the provider's location.

CMS Provides Some Inconsistent Guidance on Payment Suspensions

Two CMS-approved documents that provide guidance on the process remain incomplete or inconsistent with requirements for payment suspensions. These documents include the PIM, which provides guidance to contractors; and the *Joint Guidance*, which provides information to law enforcement about CMS's administrative actions and their effect on health care fraud cases.

The Program Integrity Manual fails to reflect CMS's current guidance to contractors for payment suspensions. In 2009, CMS revised the PIM's section on payment suspensions, calling for contractors requesting suspension to submit "other supportive information" along with the suspension notice at the time of the suspension request.[30] However, the revised PIM does not specify the type of supportive information needed. CMS officials told us that when they suspend a provider, the information that they review includes whether the provider's billing number was revoked, the amount of pending Medicare payments, and whether the provider's claims are being reviewed prior to payment.[31] If the contractor omits this information from the suspension request, it can result in a delay in CMS's approval of the suspension.

[30] Ibid., § 3.9.2.2.2.

[31] This is known as a prepayment review. See CMS, PIM, § 3.4.

Furthermore, the model suspension notice contained in the PIM has not been updated since November 2000.[32] Most notably, the model notice describes an outdated suspension approval process. Since October 2006, the authority to approve payment suspensions has rested with the CMS central office, but the model notice describes the previous process, under which CMS regional offices approved suspensions.[33] Although the text in the 2009 update to the PIM refers to the current arrangement, the notice itself—to which contractors presumably refer when preparing their requests—continues to reflect the former regional arrangement.[34]

The model notice also lacks the current legal language that CMS requires all suspension notices to contain. That language includes the disposition of a provider's payments after the removal of the suspension.[35] Because the model notice omits this required information, contractor staff with whom we spoke told us that they rely on their own templates or refer to the most recent CMS-approved suspension notice to ensure that new suspension notices include the appropriate information. CMS's lack of a standardized model suspension notice that includes all required information could potentially cause delays in the suspension process.

CMS officials acknowledged that the PIM includes out-of-date guidance and told us that they were working with a contractor to thoroughly revise it. CMS officials told us that they had conducted in-person training at each contractor's location in the past year to review the suspension process with contractor staff.

CMS's guidance on extending payment suspensions is contradictory. In certain situations, CMS may extend payment suspensions indefinitely. According to Medicare regulations, the suspension time limits do not apply when OIG is considering administrative action, such as a civil monetary penalty or permissive exclusion.[36] Of the 253 suspensions we examined, CMS approved indefinite extensions for 46 (18 percent).

However, the PIM and the Joint Guidance—CMS's guidance documents for its contractors and for law enforcement, respectively—differ from one another in describing when a payment suspension may be extended. The PIM states that CMS may grant an additional 180-day extension at the written request of DOJ, but the *Joint Guidance* states that CMS cannot grant DOJ an additional extension. In addition, the PIM states that the

[32] CMS, PIM, Exhibit 16—Model Suspension of Payment Letters, Rev. 3, November 22, 2000.
[33] CMS memorandum, "Re-Designation of the Payment Suspension Authority and Process," September 6, 2006.
[34] CMS, PIM, ch. 3, Transmittal 282, January 8, 2009.
[35] "In discussing the effect of payment suspension, we require the following language regarding the payment suspension in all notices: 'When the payment suspension has been removed, any money withheld as a result of this action shall first be applied to reduce or eliminate the determined overpayment and then to reduce any obligation to CMS or HHS. (See 42 CFR 405.372(e).).'" CMS presentation for Strike Force law enforcement, "Medicare Payment Suspensions: Myths and Facts," October 28, 2009.
[36] 42 CFR § 405.372 (d)(3).

time limits for payment suspension do not apply if OIG is considering administrative sanctions. In contrast, the *Joint Guidance* indicates that "the payment suspension regulation does not explicitly establish a limit on the number of extensions, but it does not permit indefinite suspensions."[37]

CONCLUSION

In 2007 and 2008, CMS used payment suspensions almost exclusively as a tool to fight fraud. Since the time when we collected data for this evaluation, the Affordable Care Act was signed into law. This Act states that payments may be suspended to a provider pending an investigation of a credible allegation of fraud, unless there is good cause not to suspend such payments. It also states that CMS must consult with OIG in determining whether a credible allegation of fraud exists.[38] On September 23, 2010, CMS issued proposed regulations for these provisions.[39] The information provided in this report may be useful to CMS when it finalizes these regulations. In the guidance that CMS develops for the new provisions for payment suspensions, CMS could also address the inconsistencies that this report identifies.

This report is being issued directly in final form because it contains no recommendations. If you have comments or questions about this report, please provide them within 60 days. Please refer to report number OEI-01-09-00180 in all correspondence.

[37] CMS, PIM, § 3.9.2.4; *Joint Guidance*, p. 4.
[38] P.L. 111-148 §§ 6402(h)(1) and (2).
[39] 75 Fed. Reg. 58204, 58239 (September 23, 2010).

APPENDIX A

Number of Payment Suspensions by State in 2007 and 2008

State	Number of Providers Suspended in 2007 and 2008	Percentage of Providers Suspended in 2007 and 2008*
Arizona	8	3.2%
Arkansas	1	0.4%
California	33	13.0%
Florida	88	34.8%
Idaho	2	0.8%
Illinois	3	1.2%
Louisiana	5	2.0%
Massachusetts	3	1.2%
Michigan	12	4.7%
Mississippi	1	0.4%
Missouri	2	0.8%
Nebraska	1	0.4%
Nevada	1	0.4%
New Hampshire	1	0.4%
New York	1	0.4%
Ohio	4	1.6%
Oklahoma	1	0.4%
Oregon	3	1.2%
Puerto Rico	66	26.1%
Tennessee	5	2.0%
Texas	5	2.0%
Washington	5	2.0%
Wisconsin	2	0.8%
Total	**253**	**100%**

Source: Office of Inspector General analysis of payment suspension documents, 2010.

* Percentages do not total 100 percent because of rounding.