

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**COLLECTION STATUS OF  
MEDICARE OVERPAYMENTS  
IDENTIFIED BY PROGRAM  
SAFEGUARD CONTRACTORS**



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## E X E C U T I V E   S U M M A R Y

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### OBJECTIVE

To determine the collection status, as of June 2008, of Medicare overpayments that program safeguard contractors (PSC) identified and referred to claims processors for collection in 2007.

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### BACKGROUND

This report and a companion Office of Inspector General (OIG) report, entitled *Medicare Overpayments Identified by Program Safeguard Contractors*, OEI-03-08-00031, respond to a congressional request regarding the identification and collection of PSCs' overpayment referrals.

The Centers for Medicare & Medicaid Services (CMS) had 18 benefit integrity task orders with PSCs in 2007. Each task order covers a geographic jurisdiction. In this report, the term "PSC" refers to a PSC benefit integrity task order.

PSCs are required to detect and deter fraud and abuse in Medicare Part A and/or Part B in their jurisdictions. PSCs conduct investigations; refer cases to law enforcement; and take administrative actions, such as referring overpayments to claims processors for collection and return to the Medicare program.

Claims processors make a final determination on the dollar amount to "demand" from the provider, which may differ from the overpayment amount referred by the PSCs. Outcomes of law enforcement investigations or provider appeals may also change the amounts that providers must repay.

Claims processors collect overpayments by withholding the provider's future Medicare payments or by direct refund from the provider. With a few exceptions, if claims processors cannot collect the overpayment within 6 months, they must refer the overpayment to the Department of the Treasury's (Treasury) cross-servicing program for collection.

Claims processors are required to keep track of collection information on overpayments they seek to recover. However, at the time of our review, CMS did not require or provide incentives to PSCs to keep track of the amount claims processors collected on PSC overpayment referrals.

CMS is in the process of transitioning PSCs to seven Zone Program Integrity Contractors (ZPIC). Each ZPIC will be responsible for all claim types in its geographic zone. CMS is also providing incentives to

claims processors to provide collection information to ZPICs. According to CMS staff, CMS also expects ZPICs in high-fraud regions to focus on quick response to fraud and administrative actions.

For this report, we requested information from PSCs to identify each overpayment that they referred to claims processors for collection in 2007. We forwarded this information to the claims processors identified by PSCs and requested information about the collection status of each overpayment through June 2008.

The percentages in the finding add up to 101 percent rather than 100 percent because of rounding.

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## FINDING

**Overpayments that PSCs referred for collection did not result in significant recoveries to the Medicare program.** PSCs referred 4,239 overpayments totaling \$835 million to claims processors in 2007, but very little had been collected by claims processors as of June 2008. Claims processors collected 7 percent, or \$55 million. Of the \$55 million collected, 27 percent was for Part A claims; 56 percent was for Part B claims excluding durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); and 17 percent was for Part B DMEPOS claims.

Claims processors sent 53 percent, or \$446 million of \$835 million, in PSC overpayment referrals to Treasury's cross-servicing program. However, the cross-servicing program does not have a high rate of return. For each year between fiscal years 2003 and 2007, the program never collected more than 2 percent of all debt referred to it.

Claims processors reported that collection was not complete for \$40 million, or 5 percent, of the \$835 million in overpayments that PSCs referred for collection. Regarding the \$40 million, claims processors were still withholding money from the providers' future payments (\$27 million), providers were on extended repayment plans (\$4 million), the collection process had not begun as of June 2008 (\$3 million), and claims processors had not completed collection but did not explain the reason why or reported that they could not provide the information (\$6 million).

Of the \$835 million in PSC overpayment referrals, \$43 million, or 5 percent, represents overpayments for providers that stopped billing, filed for bankruptcy, are out of business, or are deceased. When

providers stop billing, it is impossible for claims processors to withhold future payments.

Claims processors reported that as of June 2008, \$139 million, or 17 percent, of PSC overpayments was on hold because of ongoing investigations (\$76 million) and provider appeals (\$63 million).

Six percent, or \$48 million, of the \$835 million in PSC overpayment referrals was no longer owed by providers as of June 2008 because of revisions claims processors made to overpayment collection amounts and appeal decisions that were favorable to providers.

For 8 percent of the overpayment dollars referred by PSCs (\$64 million of \$835 million), claims processors could not provide data. They reported that they did not receive referrals or that they could not provide any collection information for 1,060 of 4,239 overpayments. These 1,060 overpayments totaled \$58 million. Claims processors also did not provide all of the necessary information for OIG to determine the collection status for another 44 overpayments, totaling \$6 million.

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## RECOMMENDATIONS

PSCs were established to strengthen CMS's ability to detect and deter potential fraud and abuse in the Medicare program. To ensure that PSCs and ZPICs effectively safeguard the Medicare dollars at risk, it is important that CMS know the actual amount of overpayments that PSCs and ZPICs refer to claims processors and the collection status of these overpayments. Moreover, CMS needs to ensure that PSCs, ZPICs, and claims processors can identify all current and future overpayment referrals by PSCs and ZPICs.

We recommend that CMS:

**Regularly collect all necessary information to determine the overpayments PSCs and ZPICs refer to claims processors for collection, the collection status of these overpayments, and the percentage of overpayments in each category of collection status.**

**Require that PSCs, ZPICs, and claims processors have controls in their tracking systems to ensure that all overpayment referrals and data related to their collection status can be found.**

**Determine what happened to the 1,060 overpayments that PSCs referred to claims processors in 2007 for which claims processors could not provide any collection information.**

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## AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS stated that it has begun implementing its strategy to align the existing PSCs geographically with claims processors, i.e., the Medicare Administrative Contractors (MAC), and that the premise of the new strategy is to have a more concentrated effort of identifying fraud and abuse across claim types in each zone.

CMS concurred with our first recommendation and stated that to ensure that it can monitor how MACs respond to PSCs' overpayment referrals, CMS added this requirement, in October 2009, to the CMS Analysis/Reporting/Tracking System (CMS ARTS) template for monthly reporting. Additionally, in order for MACs to obtain a performance award fee, a criterion was added in fiscal year 2009 related to the tracking of overpayments received from PSCs and ZPICs.

CMS concurred with our second recommendation and, in October 2009, added a data field to CMS ARTS for monthly reporting of the collection status of the overpayment referrals. Submitting this information is now a requirement in the ZPIC Statement of Work.

CMS concurred with our third recommendation and is working with claims processors to determine what happened to the 1,060 overpayments, for which the claims processors could not provide collection information. CMS will require the claims processors to recover the potential overpayments identified by OIG consistent with the agency's policies and procedures.

Although CMS has implemented several monthly reporting requirements to improve the tracking and quality of overpayment collection information, OIG believes it is important that CMS also continually monitor and evaluate the effectiveness of its contractors' overpayment collection efforts.



# T A B L E O F C O N T E N T S

EXECUTIVE SUMMARY .....	i
INTRODUCTION .....	1
FINDING .....	9
Overpayments that PSCs referred for collection did not result in significant recoveries to the Medicare program.....	9
RECOMMENDATIONS .....	13
Agency Comments and Office of Inspector General Response ....	14
APPENDIXES .....	16
A: Benefit Integrity Task Orders in 2007 .....	16
B: Program Safeguard Contractors and the Claims Processors to Which They Referred Overpayments in 2007 .....	17
C: Agency Comments .....	18
ACKNOWLEDGMENTS .....	21

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## BACKGROUND

This report and a companion Office of Inspector General (OIG) report, entitled *Medicare Overpayments Identified by Program Safeguard Contractors*, OEI-03-08-00031, were prepared in response to a request from the Committee on Energy and Commerce's Subcommittee on Oversight and Investigations in the U.S. House of Representatives.

Although past OIG studies have looked at fraud and abuse detection and deterrence by PSCs,<sup>1</sup> this is the first work to address overpayment referrals by PSCs to claims processors for collection. The referral of overpayments to claims processors for collection is an important PSC activity because it may lead to the recovery of funds to the Medicare program. This report provides information on the collection status of PSC overpayment referrals to claims processors for collection.

### **Program Safeguard Contractors**

PSCs conduct investigations; refer cases to law enforcement; and take administrative actions, such as referring overpayments to claims processors. In their investigative work, PSCs review Medicare payments and may identify overpayments.<sup>2</sup> When they do identify overpayments, they are required to refer the overpayments to Medicare claims processors for collection.<sup>3</sup>

CMS awards benefit integrity task orders to PSCs. These task orders require PSCs to detect and deter fraud and abuse in Medicare Part A and/or Part B. Each task order covers a specific geographic jurisdiction. In 2007, CMS had 18 benefit integrity task orders with PSCs, which are

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<sup>1</sup> OIG, *Medicare's Program Safeguard Contractors: Performance Evaluation Reports*, OEI-03-04-00050, March 2006. Accessed at <http://oig.hhs.gov/oei/reports/oei-03-04-00050.pdf> on August 11, 2009. OIG, *Medicare's Program Safeguard Contractors: Activities to Detect and Deter Fraud and Abuse*, OEI-03-06-00010, July 2007. Accessed at <http://oig.hhs.gov/oei/reports/oei-03-06-00010.pdf> on August 11, 2009.

<sup>2</sup> PSCs were authorized to perform such work pursuant to the Medicare Integrity Program. Social Security Act, § 1893, 42 U.S.C. § 1395ddd.

<sup>3</sup> Centers for Medicare & Medicaid Services (CMS), *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 3, § 3.8.

listed in Appendix A. In this report, the term “PSC” refers to a PSC benefit integrity task order.

In 2007, 13 of the 18 PSCs had responsibility for both Medicare Parts A and B; 1 had Part A only; 1 had Part B only; and 3 had only Part B durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

PSCs had oversight responsibility for Medicare Part A and Part B payments totaling \$296 billion in 2007. We refer to this as PSCs’ “size of oversight responsibility.” Seventy-one percent of their oversight responsibility was for Part A and 29 percent was for Part B. Other Medicare contractors also have oversight of these payments; however, PSCs focus specifically on detecting and deterring fraud and abuse related to these payments.

### **Zone Program Integrity Contractors**

CMS is in the process of transitioning PSCs to Zone Program Integrity Contractors (ZPIC). Until the transition is complete, ZPICs and PSCs will both be responsible for Parts A and B and for referring identified overpayments to claims processors for collection.

The transition of PSCs to ZPICs is part of CMS’s consolidation of fraud-fighting work so that Parts A, B, C, and D will be under one type of contractor, the ZPIC. CMS expects to have a total of seven ZPICs. Two ZPICs became operational in February 2009, and CMS expects that by the end of 2010, all PSC work will be transitioned to ZPICs. According to CMS staff, five ZPICs that cover high-fraud regions will be expected to focus on quick response to fraud and administrative actions.<sup>4</sup>

### **Claims Processors**

Among their responsibilities, Medicare claims processors collect overpayments that are identified by PSCs and other sources. In 2007, the claims processors that received overpayment referrals from PSCs were fiscal intermediaries, carriers, or Medicare administrative contractors. These claims processors had responsibility for specific geographic jurisdictions and claim types. Fiscal intermediaries were

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<sup>4</sup> Director, Program Integrity Group, CMS, presentation slides (p. 4), “PI Contracting Overview – MEDIC vs. ZPIC,” July 29, 2009, for American Health Lawyers Association Part D Compliance Webinar.

responsible for Part A, carriers for Part B, and Medicare administrative contractors for Parts A and/or B.

Claims processors in a PSC's jurisdiction are known as the PSC's affiliated contractors. Because PSCs and claims processors do not cover identical jurisdictions and claim types, a PSC may have more than one affiliated claims processor and a claims processor may have more than one PSC in its jurisdiction. Appendix B contains a list of PSCs and the claims processors to which PSCs sent overpayment referrals in 2007.

The claims processors are also responsible for keeping track of collection information on the overpayments they seek to recover. At the time of our review, PSCs were not required to keep track of the amount claims processors collect on PSC overpayment referrals. However, as of 2009, CMS is providing ZPICs with incentives to keep track of the amounts claims processors collect on ZPIC overpayment referrals. CMS is also providing claims processors with incentives to provide collection information to ZPICs. These incentives involve reimbursement to ZPICs and claims processors under the respective contracts' performance award fee provisions.

### **Overpayment Collection Process**

**Dollar amount of overpayment.** A single overpayment that a PSC identifies and refers for collection may include numerous claims. In addition, the PSC may identify either an actual dollar amount that the provider owes or an extrapolated dollar amount based on a sample of the provider's claims.<sup>5</sup> The claims processor reviews all the overpayment referral information provided by the PSC and makes a final determination as to the dollar amount to be collected.<sup>6</sup> The dollar amount the claims processor seeks to collect from the provider based on this final determination may be the same as, more than, or less than the overpayment dollar amount that the PSC referred for collection.

**Demand letter.** Usually, after the claims processor makes a final determination of the overpayment, it sends a demand letter to the provider.<sup>7</sup> This letter typically includes the overpayment amount that the provider must repay, methods for repayment, and the provider's

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<sup>5</sup> CMS, *Medicare Program Integrity Manual*, § 3.8.1.

<sup>6</sup> CMS, *Medicare Financial Management Manual*, Pub. No. 100-06, ch. 4, §§ 10 and 80.2.

<sup>7</sup> *Ibid.*, § 90.2. A demand letter is not sent to physicians and suppliers for overpayments that are less than \$10.

appeal rights.<sup>8</sup> The letter alerts the provider that it has 120 days to appeal the overpayment determination.<sup>9</sup> However, if no payment or request for extended repayment plan is received within 30 days, the overpayment is delinquent and begins to accrue interest.<sup>10</sup>

**Investigations and appeals.** Claims processors may have to put the collection of PSC overpayment referrals on hold because of investigations. If PSCs are aware of pending investigations, they are required to notify law enforcement of the intention to collect outstanding overpayments. There may be situations in which law enforcement recommends that overpayment collection be postponed if collection of the overpayments will compromise law enforcement actions that are planned or underway. The outcome of an investigation may change the overpayment amount.

As with an investigation, the outcome of a provider appeal at any level may change or eliminate the overpayment amount. There are five levels of appeal: Redetermination, Reconsideration, Administrative Law Judge Hearing, Departmental Appeals Board Review, and Federal Court Review.<sup>11</sup> In September 2009, CMS issued a final rule to prohibit overpayment collection during appeals at the Redetermination and Reconsideration levels.<sup>12</sup>

**Collection methods.** Claims processors may collect overpayments by withholding the provider's future Medicare payments.<sup>13</sup> However, this method is possible only if the provider continues billing Medicare. Claims processors may also collect overpayments through the provider's direct repayment of the full overpayment amount or through the provider's repayment of the overpayment under an extended repayment plan.<sup>14</sup>

With a few exceptions, claims processors must refer debt that is 180 days (6 months) delinquent to the Department of the Treasury (Treasury) for collection.<sup>15</sup>

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<sup>8</sup> CMS, *Medicare Financial Management Manual*, §§ 20.2 and 90.2.

<sup>9</sup> CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 29, § 220.

<sup>10</sup> CMS, *Medicare Financial Management Manual*, §§ 10, 70.4, and 80.2.

<sup>11</sup> CMS, *Medicare Claims Processing Manual*, § 220.

<sup>12</sup> 74 Fed. Reg. 47458–47470 (Sept. 16, 2009).

<sup>13</sup> CMS, *Medicare Financial Management Manual*, § 40.1.

<sup>14</sup> *Ibid.*, § 50.

<sup>15</sup> *Ibid.*, §§ 70.4, 70.5, 70.6, and 80.2.

Overpayments sent to Treasury. According to the Debt Collection Improvement Act of 1996, all Federal agencies that have eligible debt, e.g., an overpayment, must refer it to Treasury for collection.<sup>16</sup> With a few exceptions, claims processors send overpayments to Treasury's cross-servicing program. The cross-servicing program receives referrals of nontax debt from all Federal agencies.

Even after the claims processor refers an overpayment to Treasury for collection, the overpayment remains on the claims processor's records and accrues interest.<sup>17</sup> CMS receives reports from Treasury as to whether any money has been collected.<sup>18</sup> CMS forwards these reports to the claims processor to update its records.<sup>19</sup>

If Treasury carries an overpayment on its records for 10 years, the claims processor may recommend to CMS that the overpayment be written off.<sup>20</sup> Claims processors cannot write off overpayments without CMS approval.

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## METHODOLOGY

### Scope

We reviewed all Medicare overpayments that PSCs referred to claims processors for collection in 2007. We also reviewed collection information on these referrals through June 2008. Because we collected information through June 2008, claims processors had 6 to 18 months to collect the overpayments depending on when they were referred in 2007.

### Data sources

Between May and October 2008, we collected from PSCs the identifying information about each overpayment that they referred to claims processors in 2007. Between June 2008 and January 2009, we collected from claims processors information regarding each overpayment that the PSCs told us that they referred to claims processors in 2007.

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<sup>16</sup> 31 U.S.C. § 3711(g). This section defines the timeframe for referring debt to Treasury and the types of debt that are not eligible for referral.

<sup>17</sup> CMS, *Medicare Financial Management Manual*, §§ 70.15.1 and 70.15.3.

<sup>18</sup> *Ibid.*, §§ 70.14.1 and 70.14.2.

<sup>19</sup> *Ibid.*, § 70.14.4.

<sup>20</sup> *Ibid.*, § 70.17.

**Data Collection**

Program safeguard contractors. We sent all 18 PSCs a data request that included a self-administered data collection instrument. We asked PSCs to provide the following identifying information for each overpayment that they referred to claims processors:

- PSC unique identifier for the overpayment,
- date overpayment referred,
- claims processor to which the referral was sent,
- provider identifying information,
- provider type (e.g., hospital),
- claim type (e.g., Part A),
- whether overpayment amount was actual or extrapolated,
- dollar amount of overpayment in referral,
- claims processor's tracking number for this overpayment (e.g., accounts receivable number),
- date of demand letter, and
- dollar amount of overpayment in demand letter.

We also asked PSCs for the contact information for the claims processor representatives to whom the PSCs sent overpayment referrals in 2007 or the current person handling these overpayment referrals.

All PSCs responded to the initial data request. We requested clarifying information from all PSCs at least once, and in some cases, we made repeated attempts to get clarification. After all these attempts, all PSCs except one provided the clarifications we requested. This one PSC did not provide the provider type for one overpayment referral.

Claims processors. We sent a self-administered data collection instrument to the 31 claims processor representatives at 16 claims processors identified by the PSCs. Claims processor representatives at the same claims processor were responsible for overpayment referrals based either on claim type or referring PSC. Some of the claims processors that had more than one representative identified by the PSCs chose to have only one representative respond to our data request. As a result, the number of claims processor representatives that responded to our data request was 26. We refer to these respondents as claims processors in this report.

We sent the claims processors the overpayment information that PSCs provided to identify the overpayment referrals made in 2007. For each PSC overpayment referral, we asked the claims processor to provide the following information:

- date overpayment referral received,

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

- claims processor's unique tracking number for this overpayment (e.g., accounts receivable number),
- date of demand letter,
- dollar amount in demand letter (i.e., overpayment amount sought for collection),
- changes to overpayment amount sought for collection (other than as a result of an appeal),
- whether overpayment determination was appealed,
- changes to overpayment amount sought for collection as a result of an appeal,
- overpayment principal collected and interest collected through June 2008,
- method used to collect the overpayment,
- whether collection was complete, and
- reason why collection was not complete (e.g., overpayment sent to Treasury), if applicable.

All claims processors responded to the initial data request. In cases in which claims processors did not provide all the information we requested, we requested the information or clarification at least once and, in some cases, made repeated attempts to get the information or clarification. After all attempts, some claims processors did not provide all the information we requested. For example, some claims processors did not provide information on whether the overpayments were appealed.

### **Analysis**

Overpayments provided by PSCs. PSCs provided information on 4,242 overpayments that they referred to claims processors for collection in 2007. We removed three of these overpayments from our analysis because neither the PSC nor the claims processor provided the referral dollar amounts. Therefore, we reviewed 4,239 overpayments for this report.<sup>21</sup>

After reviewing the collection information that claims processors provided, we summarized the collection status of the overpayment dollars associated with the 4,239 overpayments. We also calculated the percentage of dollars in each status by Part A, Part B excluding DMEPOS, and Part B DMEPOS.

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<sup>21</sup> Of the 4,239 overpayments, only 1 was made to a beneficiary.

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

## **Limitations**

We did not independently verify information provided by PSCs or claims processors.

## **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.

**► FINDING**

**Overpayments that PSCs referred for collection did not result in significant recoveries to the Medicare program**

PSCs referred 4,239 overpayments totaling \$835 million to claims processors during 2007, but very little had been collected as of

June 2008. Table 1 shows the collection status of these PSC overpayment referrals by claim type.

Table 1: Collection Status as of June 2008 for PSC Overpayments Referred in 2007

Status of Overpayments	Part A Dollars	Part A Percentage of Total Dollars	Part B Dollars Excluding DMEPOS	Part B Excluding DMEPOS Percentage of Total Dollars	Part B DMEPOS Dollars	Part B DMEPOS Percentage of Total Dollars	Total Dollars	Percentage of Total Dollars <sup>1</sup>
Collected	\$14,998,460	27%	\$30,623,350	56%	\$9,331,567	17%	\$54,953,377	7%
Sent to Treasury <sup>2</sup>	\$37,868,510	9%	\$128,805,119	29%	279,326,567	63%	\$446,000,196	53%
Still Being Collected or Collection Not Begun	\$6,769,940	17%	\$28,535,848	71%	\$4,768,221	12%	\$40,074,009	5%
Not Likely To Be Collected by Claims Processors	\$3,894,421	9%	\$34,695,985	81%	\$4,247,910	10%	\$42,838,316	5%
On Hold for Investigation or Appeal	\$7,569,038	5%	\$126,085,562	91%	\$5,616,949	4%	\$139,271,549	17%
No Longer Owed by Providers	\$3,940,844	8%	\$25,046,129	52%	\$19,153,664	40%	\$48,140,637	6%
Claims Processor Could Not Provide Data	\$12,932,525	20%	\$38,777,544	61%	\$12,067,788	19%	\$63,777,857	8%
<b>Total</b>	<b>\$87,973,738</b>		<b>\$412,569,537</b>		<b>\$334,512,666</b>		<b>\$835,055,941</b>	

Source: OIG analysis of responses from PSCs and claims processors.

<sup>1</sup>Percentages in this column add up to 101 percent rather than 100 percent because of rounding.

<sup>2</sup>Percentages in this row for Parts A, B, and Part B DMEPOS add up to 101 percent rather than 100 percent because of rounding.

**Seven percent of the overpayment dollars referred by PSCs was collected as of June 2008**

Claims processors collected 7 percent, or \$55 million, of the \$835 million in overpayments that PSCs referred in 2007. Of the overpayments collected, 27 percent was for Medicare Part A, 56 percent was for Part B excluding DMEPOS, and 17 percent was for Part B DMEPOS.

Part A represented 27 percent of the dollars collected on PSC overpayment referrals and 11 percent of PSCs' overpayment dollars referred for collection. Part B, excluding DMEPOS, represented 56 percent of dollars collected on PSCs' overpayment referrals and 49 percent of PSCs' overpayment dollars referred for collection. Part B DMEPOS represented 17 percent of dollars collected on PSCs's overpayment referrals and 40 percent of PSCs' dollars referred for collection.

**Fifty-three percent of the PSC overpayment dollars was sent to Treasury for collection**

As of June 2008, more than half (53 percent) of the overpayments that PSCs referred for collection in 2007 (\$446 million of \$835 million) was referred to Treasury's cross-servicing program for collection. It is unlikely that the full amount of the PSC overpayments referred to Treasury will be collected in the future. Treasury is the last avenue for collecting overpayments and other nontax debt from all Federal agencies. However, the cross-servicing program does not have a high rate of return. For each year between fiscal years 2003 and 2007, the program never collected more than 2 percent of all debt referred to it.<sup>22</sup>

Of the \$446 million in overpayments referred to Treasury, 63 percent was for Part B DMEPOS.

**For 5 percent of the overpayment dollars, collection was still underway or had not begun yet**

Claims processors reported that collection was not complete for \$40 million. Of this \$40 million, \$27 million was still being withheld from the providers' future payments. In addition, they were still collecting on \$4 million because the providers were on extended repayment plans. As long as these providers continue billing or making payments, this portion of the \$40 million is expected to be collected in full.

For \$3 million in overpayment referrals, claims processors reported that the collection process had not yet begun as of June 2008. Claims processors were either setting up the collection process or had requested more information from the PSCs about these overpayments. For the remaining \$6 million of \$40 million, claims processors reported that

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<sup>22</sup> Treasury, *Fiscal Year 2007 Report to the Congress: U.S. Government Receivables and Debt Collection Activities of Federal Agencies*, May 2008, p. 13. Accessed online at <http://fms.treas.gov/news/reports/debt07.pdf> on March 20, 2009.

collection was not complete but did not explain the reason why or reported that they could not provide the information.

Of the \$40 million still being collected, 71 percent represented Part B, excluding DMEPOS.

**Five percent of the PSC overpayment dollars will not likely be collected by claims processors**

Five percent, or \$43 million, will not likely be collected by claims processors. This amount represents providers that stopped billing (\$31 million), filed for bankruptcy (\$7 million), are out of business (\$4 million), or are deceased (less than \$1 million). Of the \$43 million not likely to be collected by claims processors, 81 percent was for Part B claims, excluding DMEPOS.

**Collection was on hold as of June 2008 pending investigations or appeals for 17 percent of PSC overpayment dollars**

Claims processors reported that \$139 million of the \$835 million referred by PSCs (17 percent) was on hold as of June 2008. Regarding the \$139 million, claims processors reported that ongoing investigations were the reason \$76 million was currently not being collected and provider appeals were the reason \$63 million was currently not being collected. Depending on the outcome of the investigations and appeals, these overpayment amounts may be increased, reduced, or eliminated.

Of the \$139 million on hold because of investigations and provider appeals, 91 percent represented Part B excluding DMEPOS.

**Six percent of the PSC overpayment dollars was no longer owed by providers**

Of the \$835 million in overpayment referrals, 6 percent, or \$48 million, will not be collected because the overpayment amounts were reduced by the claims processors. The reasons for these reductions include revisions to the overpayment collection amounts made by claims processors and changes because of appeal decisions that were favorable to the providers.

Of the \$48 million that providers no longer owe, 52 percent (\$25 million) was for Part B claims, excluding DMEPOS; 40 percent (\$19 million) was for Part B DMEPOS claims; and 8 percent (\$4 million) was for Part A claims.

## F I N D I N G

### **Claims processors could not provide data for more than a quarter of the PSC overpayment referrals, which represent \$64 million, or 8 percent, of the PSC overpayment dollars**

For 8 percent of the overpayment dollars referred by PSCs—\$64 million of \$835 million—claims processors could not provide data. Claims processors could not provide information for 1,060 overpayments, or 1 in 4 overpayments PSCs referred (1,060 of 4,239). These 1,060 overpayments represented \$58 million of the \$64 million. Claims processors reported that they did not receive these referrals from the PSCs or that they could not provide any collection information about them. Claims processors did not provide all of the necessary information for OIG to determine the collection status for another 44 overpayments, totaling \$6 million.

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This OIG report presents the collection status of overpayments, as of June 2008, that Medicare's PSCs identified and referred to claims processors for collection in 2007. A companion OIG report, entitled *Medicare Overpayments Identified by Program Safeguard Contractors*, OEI-03-08-00031, presents the number, dollar amount, and claim type of overpayments PSCs identified and referred to claims processors for collection in 2007.

PSCs were established to strengthen CMS's ability to detect and deter fraud and abuse in the Medicare program. PSCs conduct investigations; refer cases to law enforcement; and take administrative actions, such as referring overpayments to claims processors for collection and return to the Medicare program. As CMS transitions PSCs to ZPICs, CMS expects ZPICs that cover high-fraud regions to focus on quick response to fraud and administrative activities.

Because of the emphasis on administrative actions and the Medicare dollars at risk, it is important that CMS know the actual amount of Part A and Part B overpayments that PSCs and ZPICs refer to claims processors and the collection status of these overpayments. We found that overpayments that PSCs referred to claims processors for collection did not result in significant recoveries to the Medicare program. Of \$835 million in overpayments that PSCs referred in 2007, only 7 percent was collected by June 2008.

CMS has the responsibility to ensure that PSCs and ZPICs perform effectively. To help it do so, it needs to have complete and accurate information about PSCs' overpayment referrals to claims processors and the collection status of these overpayments. Moreover, CMS needs to ensure that PSCs, ZPICs, and claims processors can identify all current and future overpayment referrals by PSCs and ZPICs.

We recommend that CMS:

**Regularly collect all necessary information to determine the overpayments PSCs and ZPICs refer to claims processors for collection, the collection status of these overpayments, and the percentage of overpayments in each category of collection status**

For example, for each overpayment referral, collect the overpayment amount referred, changes to overpayment amount and reason for the changes, method used to collect the overpayment, amount collected to

## R E C O M M E N D A T I O N S

date, the collection status, and reasons why collection is not complete. This information would help CMS determine whether PSCs and ZPICs are performing effectively.

### **Require that PSCs, ZPICs, and claims processors have controls in their tracking systems to ensure that all overpayment referrals and data related to their collection status can be found**

We found that PSCs and claims processors had different information about PSC overpayment referrals for 2007. PSCs reported that they referred 4,239 overpayments to claims processors, but claims processors reported that they did not receive or could not provide information for 1,060 of these 4,239 PSC overpayments referrals. We also found that claims processors could not always provide collection status information, such as whether an overpayment was appealed.

### **Determine what happened to the 1,060 overpayments that PSCs referred to claims processors in 2007 for which claims processors could not provide any collection information**

These 1,060 overpayments totaled \$58 million and represented 25 percent of the PSC overpayment referrals sent to claims processors in 2007. It is important that the overpayments PSCs refer to claims processors be reviewed and collected. We will provide CMS with the identifying information that PSCs sent us for these 1,060 overpayments.

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

CMS stated that it has begun implementing its strategy to align the existing PSCs geographically with claims processors, i.e., the Medicare Administrative Contractors (MAC), and that the premise of the new strategy is to have a more concentrated effort of identifying fraud and abuse across claim types in each zone. CMS stated it is concerned about the low level of collection and the missing information related to overpayments. CMS also stated that since the date of OIG's review, CMS has established procedures to strengthen the monitoring and oversight of overpayment collection and ensure better contractor communication. CMS added that the ZPIC Statement of Work (SOW) includes internal controls to ensure coordination of the overpayment activities.

CMS concurred with our first recommendation and stated that to ensure that it can monitor how MACs respond to PSCs' overpayment referrals, CMS added this requirement, in October 2009, to the CMS

## R E C O M M E N D A T I O N S

Analysis/Reporting/Tracking System (CMS ARTS) template for monthly reporting. Additionally, in order for a MAC to obtain an award fee, a criterion was added in fiscal year 2009 related to the tracking of overpayments identified by PSCs and ZPICs.

CMS concurred with our second recommendation and, in October 2009, added a data field to CMS ARTS for monthly reporting of the collection status of the overpayment referrals. Submitting this information is now a requirement in the ZPIC SOW.

CMS concurred with our third recommendation and is working with claims processors to determine what happened to the 1,060 overpayments that the PSCs referred to the claims processors in 2007, for which the claims processors could not provide collection information. CMS will require the claims processors to recover the potential overpayments identified by OIG consistent with the agency's policies and procedures.

Although CMS has implemented several monthly reporting requirements to improve the tracking and quality of overpayment collection information, OIG believes it is important that CMS also continually monitor and evaluate the effectiveness of its contractors' overpayment collection efforts.

The full text of CMS's comments is provided in Appendix C.



## A P P E N D I X ~ A

Table A-1: Benefit Integrity Task Orders in 2007

<b>Company</b>	<b>Number of Benefit Integrity Task Orders</b>
AdvanceMed	3
Cahaba Safeguard Administrators, LLC	2
Computer Sciences Corporation	1
IntegriGuard, LLC	1
SafeGuard Services, LLC	6
TriCenturion	3
TrustSolutions, LLC	2
<b>Total</b>	<b>18</b>

Source: Centers for Medicare & Medicaid Services, Office of Financial Management, Program Integrity Group.

➤ A P P E N D I X ~ B

Table B-1: Program Safeguard Contractors and the Claims Processors to Which They Referred Overpayments in 2007

Program Safeguard Contractor Task Order	Claims Processor
AdvanceMed	National Government Services, Inc.
	Palmetto GBA, LLC
AdvanceMed	CIGNA Government Services, LLC
	Riverbend Government Benefits Administrator
AdvanceMed	Pinnacle Business Solutions, Inc.
	TriSpan Health Services
Cahaba Safeguard Administrators, LLC	Palmetto GBA, LLC
Cahaba Safeguard Administrators, LLC	Cahaba Government Benefit Administrators, LLC (Part A)
	Cahaba Government Benefit Administrators, LLC (Part B)
Computer Sciences Corporation	CIGNA Government Services, LLC
	Noridian Administrative Services, LLC (Part A)
	Noridian Administrative Services, LLC (Part B)
IntegriGuard, LLC	Wisconsin Physicians Service Insurance Corp.
SafeGuard Services, LLC	First Coast Service Options, Inc.
	National Government Services, Inc.
	NHIC, Corp.
	Pinnacle Business Solutions, Inc.
SafeGuard Services, LLC	NHIC, Corp.
SafeGuard Services, LLC	Group Health Incorporated
	HealthNow New York, Inc.
	National Government Services, Inc.
	Riverbend Government Benefits Administrator
SafeGuard Services, LLC	Highmark Medicare Services, Inc. (Part A)
	Highmark Medicare Services, Inc. (Part B)
SafeGuard Services, LLC	First Coast Service Options, Inc.
	Triple-S Salud, Inc.
SafeGuard Services, LLC	Noridian Administrative Services, LLC
TriCenturion	Trailblazer Health Enterprises, LLC
TriCenturion	Palmetto GBA, LLC
TriCenturion	National Government Services, Inc.
	NHIC, Corp.
TrustSolutions, LLC	National Government Services, Inc.
	Wisconsin Physicians Service Insurance Corp.
TrustSolutions, LLC	CIGNA Government Services, LLC

Source: Office of Inspector General review of responses from program safeguard contractors.

**Agency Comments**



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*  
Washington, DC 20201

**DATE:** FEB 02 2010

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

**FROM:** Charlene Frizzera */SI/*  
Acting Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: "Collection Status of Medicare Overpayments Identified by Program Safeguard Contractors" (OEI-03-08-00030)

Thank you for the opportunity to review and comment on the above referenced Office of Inspector General (OIG) Draft Report.

The OIG conducted this audit to determine the collection status, as of June 2008, of Medicare overpayments that the Program Safeguard Contractors (PSCs) identified and referred to claims processing contractors for collection in 2007. The Centers for Medicare & Medicaid Services (CMS) has begun implementing its strategy to align the existing PSCs geographically with the Medicare Administrative Contractors (MACs). The premise of the new strategy is to have a more concentrated effort of identifying fraud and abuse across claim types in each zone. Under this new strategy, CMS will divide the nation into seven zones, each of which contains one or more entire MAC jurisdictions. Each zone will have a Zone Program Integrity Contractor (ZPIC) that performs benefit integrity functions. With this approach, CMS has brought together responsibility for all Medicare program integrity efforts for Parts A, B, home health and hospice, and Durable Medical Equipment (DME). The agency is now in the process of transitioning PSCs to ZPICs. Currently, we have two ZPICs fully operational.

The PSCs are required to detect and deter fraud and abuse in their jurisdictions, a role the ZPICs will assume as they become operational. The PSCs conduct investigations, refer cases to law enforcement, and take administrative actions, such as referring overpayments to claims processing contractors for collection. The claims processing contractor makes the final determination of the dollar amount to demand from a provider, and this amount may differ from the overpayment amount referred by the PSC.

The OIG found that during 2007, PSCs referred 4,239 overpayments totaling \$835 million to claims processing contractors. As of June 2008, claims processing contractors collected only 7 percent, or \$55 million. For 8 percent of the overpayment dollars referred by the PSCs (\$64 million of \$835 million), claims processing contractors could not provide any data on these referrals. The contractors reported that they did not receive or could not provide any collection information for 1,060 of 4,239 overpayments.

Page 2 – Daniel R. Levinson

CMS is concerned about the low level of collection and the missing information related to these overpayments. Since the date of the OIG review, CMS has established procedures to strengthen the monitoring and oversight of overpayment collection and ensure better contractor communication. The ZPIC Statement of Work (SOW) includes internal controls to ensure coordination of the overpayment activities. CMS considers the PSCs/ZPICs valuable partners in its efforts to fight fraud, waste, and abuse in the Medicare program.

**OIG Recommendation**

The CMS should regularly collect all necessary information to determine the overpayments PSCs and ZPICs refer to claims processors for collection, the collection status of these overpayments, and the percentage of overpayments in each category of collection status.

**CMS Response**

We concur. In order to ensure that CMS can monitor how the MACs respond to the PSCs overpayment request, in October 2009 CMS added this requirement to the CMS Analysis/Reporting/Tracking System (ARTS) template for monthly reporting. Additionally, in order for the MACs to obtain an award fee, a criteria was added in fiscal year 2009 related to the tracking of overpayments received from the PSCs/ZPICs. The MACs are now required to provide a monthly report to the PSCs/ZPICs listing all demand letters issued and overpayment dollars recouped, as a result of PSCs/ZPICs initiated activities. The report should contain, at a minimum, the following fields: provider name, provider number, date of the demand letter, and amount paid by the provider.

**OIG Recommendation**

The CMS should require that PSCs, ZPICs, and claims processors have controls in their tracking systems to ensure that all overpayment referrals and data related to their collection status can be found.

**CMS Response**

We concur. The PSCs/ZPICs send a letter to the Provider/Supplier informing them of an overpayment and indicate that the Affiliated Contractors (AC) MAC will be sending a demand letter in the near future. In the past, it was not a requirement for the AC/MAC to report back to the PSCs/ZPICs on any collections of the overpayment requests and they are not copied on the demand letters. In October 2009, CMS added this data field to the CMS ARTS template for monthly reporting and the above information will be tracked in these reports. Submitting this information is now a requirement in the ZPIC SOW, which was first implemented on September 30, 2008, and is continuing to be implemented as we transition from PSCs to ZPICs.

**OIG Recommendation**

CMS should determine what happened to the 1,060 overpayments that PSCs referred to claims processors in 2007 for which claims processors could not provide any collection information.

Page 3 - Daniel R. Levinson

**CMS Response**

We concur. CMS is working with the Medicare claims processing contractors to determine what happened to the 1,060 overpayments that the PSCs referred to the claims processing contractors in 2007, for which the claims processing contractors could not provide any collection information. CMS will require the Medicare claims processing contractors recover the potential overpayments identified by the OIG consistent with the Agency's policies and procedures. In addition, we will conduct a comparative analysis of overpayments referred to contractors in 2008 and 2009. We will direct contractors to resolve any outstanding collections for those periods and monitor their progress.

We thank the OIG for conducting this audit and find their input to be very valuable.



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

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

Isabelle Buonocore served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the Philadelphia regional office who contributed to the report include Consuelia McCourt and Cynthia R. Hansford; other central office staff who contributed include Scott Manley.

# *Office of Inspector General*

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