

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE'S CURRENTLY  
NOT COLLECTIBLE  
OVERPAYMENTS**



**Daniel R. Levinson**  
Inspector General

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# **EXECUTIVE SUMMARY: MEDICARE'S CURRENTLY NOT COLLECTIBLE OVERPAYMENTS**

## **OEI-03-11-00670**

### **WHY WE DID THIS STUDY**

The Centers for Medicare & Medicaid Services (CMS) identifies billions of dollars in Medicare overpayments to health care providers each year. In fiscal year (FY) 2010, overpayments totaled \$9.6 billion. However, not all overpayments are recovered. Overpayments for which the provider has not made a repayment for at least 6 months after the due date on the Medicare demand letter are classified as “currently not collectible” (CNC) and are not reported on CMS’s annual financial statements. These overpayments are not reported on the financial statements because they are not likely to be recovered. This report provides information about CNC overpayments.

### **HOW WE DID THIS STUDY**

We requested details from CMS about CNC overpayments in FY 2010 and summary financial data for FYs 2007 to 2010. CMS provided most of the data from its Healthcare Integrated General Ledger Accounting System (HIGLAS). We also surveyed CMS and all its claims processing contractors to identify (1) hindrances to debt collection and (2) strategies to reduce the number and dollar amount of overpayments that become CNC.

### **WHAT WE FOUND**

CMS reported \$543 million in new CNC overpayments across all contractors in FY 2010. However, CMS provided detailed information on \$69 million in CNC overpayments for only seven contractors. Citing contractor transitions, CMS did not provide detailed data for the remaining 32 contractors. For 54 percent of CNC overpayments associated with the seven contractors, the provider type was missing in HIGLAS. For the seven contractors, 97 percent of FY 2010 CNC overpayments were not recovered. According to contractors, inaccurate provider contact information delays or prevents some overpayment demand letters from reaching providers. In addition, CMS and contractors reported that expanding the types of provider identifiers used to recover payments could improve debt collection efforts.

### **WHAT WE RECOMMEND**

CMS should: (1) ensure that the HIGLAS variable for provider type is populated for all overpayments, (2) ensure that demand letters are mailed to the contacts and addresses identified by the provider, and (3) use tax identification numbers and provider transaction access numbers in addition to national provider numbers for the collection of overpayments. CMS partially concurred with our first recommendation, did not concur with our second recommendation, and concurred with our third recommendation.

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## OBJECTIVES

1. To describe details of Medicare Part A and Part B overpayments identified in fiscal year (FY) 2010 and classified currently not collectible (CNC) as of December 31, 2011.
2. To identify the annual dollar amount of new CNC overpayments from FY 2007 to FY 2010.
3. To identify issues that hinder efforts to reduce the number and dollar amount of overpayments that become CNC.
4. To identify strategies for reducing the number and dollar amount of overpayments that become CNC.

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## BACKGROUND

In FY 2010, the Centers for Medicare & Medicaid Services (CMS) identified \$9.6 billion in Medicare overpayments.<sup>1</sup> Overpayments are improper payments to providers that need to be returned to the Medicare program, e.g., payment for a noncovered service. An overpayment becomes a debt owed to the Federal Government when CMS makes a determination of overpayment.<sup>2</sup> It is recognized as an account receivable in Medicare's financial system once a demand letter is issued.<sup>3</sup>

CNC is a financial accounting classification for any accounts receivable for which the provider<sup>4</sup> has not made a repayment for at least 6 months after the due date on the first Medicare letter requesting repayment.<sup>5</sup> CNC debt continues to be referred for collection but is not reported on CMS's financial statements because collection is unlikely.<sup>6</sup>

This is the first OIG study on all Medicare Parts A and B CNC overpayments.

### **Contractor Responsibility**

CMS contracts with private companies known as carriers, fiscal intermediaries, and Medicare Administrative Contractors (MAC) to fulfill Medicare administrative functions such as processing claims, making

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<sup>1</sup> CMS response to January 27, 2012, Office of Inspector General (OIG) data request.

<sup>2</sup> CMS, *Medicare Financial Management Manual*, Pub. No. 100-06 (*Manual*), ch. 3, § 10.

<sup>3</sup> *Ibid.*, ch. 5, § 400.21.

<sup>4</sup> In this report, provider refers to any type of Medicare provider or supplier (e.g., hospital, physician, durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) supplier) unless otherwise indicated.

<sup>5</sup> *Manual*, ch. 5, § 400.20.

<sup>6</sup> CMS, *CMS Financial Report Fiscal Year 2011*, p. 59.

payments, recovering overpayments, and reporting on all financial activities. These contractors process over a billion Medicare claims each year.

### **Contractor Identifiers**

Some administrative contractors are responsible for more than one type of claim activity, e.g., Parts A and B. CMS uses contractor identifiers to identify the contractor and type of claim activity in a particular geographic area. In this report, we use the term “contractor” to refer to these contractor identifiers. There were 39 contractors in FY 2010.

### **Overpayment Recovery Activities**

The *Manual* contains requirements for contractors regarding overpayment recovery activities. Once overpayments are identified, contractors are required to take timely and aggressive efforts to collect the debts.<sup>7</sup> CMS has stated that “although the term ‘aggressive’ may not be defined specifically in the *Manual*, CMS considers the collection processes outlined in the *Manual* to be aggressive.”<sup>8</sup>

Contractor overpayment recovery activities required by CMS include:<sup>9</sup>

- creating and managing the accounts receivables for the overpayments,
- mailing demand letters to providers for repayment,
- making phone calls to providers that have not responded to demand letters,
- implementing offsetting of providers’ future payments to recover overpayments,
- establishing and managing providers’ extended repayment plans,
- mailing notices to providers of intention to refer the overpayment to the Department of the Treasury (Treasury) for collection, and
- referring eligible overpayments to Treasury for collection.

Contractors send demand letters to providers with overpayments. Typically, the first demand letter states that the provider was overpaid, and that if the overpayment is not repaid in full within 30 days, the debt will become delinquent on day 31 and interest will begin to accrue. The letter

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<sup>7</sup> 45 CFR § 30.10(a); *Manual*, ch. 3, § 10.

<sup>8</sup> CMS response to OIG survey, March 2012.

<sup>9</sup> *Manual*, ch. 3, 4, and 5.

also explains methods the provider can use to repay the debt and the provider's right to appeal the overpayment determination.<sup>10</sup>

When a provider has not responded by day 45 to a Part A demand letter or by day 60 to a Part B demand letter, the contractor must telephone the provider to seek recovery of the overpayment.<sup>11</sup>

Although providers are responsible for updating their addresses with CMS, if letters are returned as undeliverable, the contractor must attempt to locate the provider through various means, including checking with State and local medical societies.<sup>12</sup>

Contractors send a final demand letter, known as the "Intent to Refer Letter," if the provider has not responded to earlier contacts before the debt becomes 90 days delinquent. It informs the provider that the overpayment will be referred to Treasury for collection if the provider does not repay within 60 days or request an extended repayment plan.

Recovering Overpayments. Contractors must begin recovering overpayments by offsetting payments unless the provider sends a check for the full amount of the overpayment or requests an extended repayment plan within a certain timeframe.<sup>13</sup> Contractors collect the majority of overpayments through offsetting. Offsetting is the process whereby funds are deducted from a future payment to repay a current debt. Contractors use the provider number to identify the provider payments that are to be offset.

In 2012, CMS issued instructions to contractors to implement provider requests for immediate offset.<sup>14</sup> Immediate offset prevents interest from accruing on the overpayment if the debt is recovered in full before day 31. A request for immediate offset is considered a voluntary repayment by the provider.

In 2012, CMS also issued instructions to contractors to collect overpayments owed by suppliers of DMEPOS that maintain surety bonds.<sup>15</sup> DMEPOS suppliers must maintain a surety bond of at least \$50,000 to enroll and remain enrolled in the Medicare program.

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<sup>10</sup> Upon receiving a demand letter, if a provider submits a timely request for a first- or second-level appeal of the overpayment determination, contractors must cease (or not begin) recoupment until these appeals reach their conclusion. This policy is referred to as "Limitation on Recoupment (935)" in the *Manual*, ch. 3, § 200.

<sup>11</sup> *Manual*, ch. 4, §§ 10 and 80.2.

<sup>12</sup> *Ibid.*

<sup>13</sup> *Ibid.*

<sup>14</sup> CMS, Change Request 7688, January 27, 2012, revised February 9, 2012.

<sup>15</sup> CMS, Change Request 7167, January 20, 2012; Change Request 7744, April 20, 2012.

Overpayments up to the full value of the bond can be collected from the surety bond company.

In addition, contractors can refer outstanding overpayments to Treasury for “cross servicing,” i.e., for collection through one of Treasury’s programs.<sup>16</sup> An example is the Treasury Offset Program, which may offset eligible Federal and State payments to recover the Medicare overpayment. Treasury uses a provider’s tax identification number to identify the payments to be offset.

Contractors have the option of referring overpayments to Treasury before the debt is 180 days delinquent.<sup>17</sup> However, if the overpayment is more than 180 days delinquent, contractors must refer it to Treasury. Debts are not eligible for referral to Treasury if they are less than \$25, in bankruptcy status, in appeal status, under investigation by a law enforcement agency and the investigating agency has instructed the contractor not to attempt collections, or the debtor is deceased.<sup>18</sup>

Once a debt is referred to Treasury, the contractor ceases active collection efforts but maintains the accounts receivable in its accounting system for potential offset. The contractor also ensures that any collections by Treasury are posted to the account and entered into CMS’s Debt Collection System.

### **CNC Classification**

According to the *Manual*, the CNC classification of an overpayment does not stop collection efforts and has no bearing on whether the overpayment is eligible for referral to Treasury or whether future Medicare payments to the provider can be offset. CMS classifies overpayments as CNC because they are not likely to be collected. Overpayments classified as CNC are not reported on CMS financial statements.<sup>19</sup>

An overpayment is eligible for CNC classification when it is in the amount of \$25 or more and is at least 180 days delinquent, without any collection activity within the last 180 days.

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<sup>16</sup> In a May 2010 report, *Collection Status of Medicare Overpayments Identified by Program Safeguard Contractors*, OEI-03-08-00030, OIG reported that Treasury’s cross-servicing program does not have a high rate of return. For each year between FYs 2003 and 2007, the program never collected more than 2 percent of all debt referred to it.

<sup>17</sup> *Manual*, ch. 4, § 70.5.

<sup>18</sup> *Ibid.*, § 70.6.

<sup>19</sup> CMS, *CMS Financial Report Fiscal Year 2011*, p. 59.

A debt can be classified CNC regardless of referral to Treasury, bankruptcy, appeals, fraud and abuse investigation, or litigation, or whether the debtor is deceased.<sup>20</sup>

The *Manual* instructs contractors to seek approval from the CMS regional office before classifying an overpayment as CNC.<sup>21</sup> However, according to CMS staff, overpayments are classified CNC through an automated process in the Healthcare Integrated General Ledger Accounting System (HIGLAS) when they reach a certain age. CMS reviews the debts after CNC classification and will notify contractors if it disapproves of the classification.

### **HIGLAS**

CMS began implementing HIGLAS in 2005 to meet provisions of the Federal Financial Management Improvement Act of 1996. Since 2005, CMS has been transitioning its Medicare Part A and Part B contractors into HIGLAS on a staggered basis. As of FY 2010, 17 of 39 contractors had yet to be fully transitioned to HIGLAS.

CMS expects HIGLAS to enhance CMS's "oversight of claims administration contractor financial operations ... [and] provide high quality, timely data for decision making and performance measurement."<sup>22</sup>

### **CMS Evaluation of Contractors' Recovery Activities**

CMS reported that it monitors contractor timeliness on the following recovery activities: issuing demand letters, posting updates to debts, notifying providers of intention to refer debt to Treasury, and referring eligible debts to Treasury.

CMS has stated that it reviews contractor performance through onsite visits, desk reviews, and analyses of financial reports. It uses review protocols and performance standards to monitor contractor performance. It also reviews contractors' monthly status reports with details related to overpayment recovery.

### **Previous OIG Work**

In a 2008 early alert memorandum, OIG described associations between selected DMEPOS suppliers that had CNC debts exceeding \$50,000 and other closely associated businesses that received Medicare payments.<sup>23</sup>

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<sup>20</sup> *Manual*, ch. 5, § 400.20. If the debt is less than \$25 but otherwise eligible for CNC classification, contractors are required to recommend that CMS terminate collection activity.

<sup>21</sup> *Ibid.*

<sup>22</sup> CMS, *Financial Report Fiscal Year 2011*, p. 20.

<sup>23</sup> OIG, *Early Alert Memorandum: Payments to Medicare Suppliers and Home Health Agencies Associated With "Currently Not Collectible" Overpayments*, OEI-06-07-00080, November 2008.

The results of the study indicated that individuals associated with CNC overpayments could inappropriately receive Medicare payments by omitting owner/manager information on their enrollment applications and working through other DMEPOS suppliers and home health agencies. OIG stated that although, taken alone, the finding that certain suppliers with CNC debt were associated with other suppliers receiving payments did not establish improper activity, CMS may determine that such affiliations justify enhanced oversight.

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## METHODOLOGY

### **Data Collection and Analysis**

*Financial Data From CMS.* In January 2012, we requested that CMS provide detailed financial data about overpayments demanded in FY 2010 and classified as CNC as of December 31, 2011. We received detailed data for 7 of 39 contractors. Details included the contractor's identifier number, date the accounts receivable was created, name of the provider, provider type, claim type, amount of the overpayment when it became CNC, amount recovered on milestone dates before and after the overpayment became CNC, and amount owed on the overpayment as of December 31, 2011. CMS extracted the data from HIGLAS.

We also collected summary financial data for FYs 2007 to 2010 on overpayments, CNC overpayments, and cumulative CNC overpayments. CMS extracted the data from HIGLAS for contractors using HIGLAS, and from its Contractor Administrative Budget and Financial System (CAFM) for contractors not using HIGLAS.

We sent our original request for both detailed and summary financial data to CMS in January 2012. As of April 2012, we had not received the detailed data, and the summary information we received did not properly address our request. Therefore, we met with CMS to discuss these issues and subsequently revised our request for both the detailed and summary data. We received detailed data for seven contractors and summary data for all contractors in June 2012. We continued to request and receive clarifications regarding the data until September 2012.

We reviewed the detailed financial data for FY 2010 to identify the number and dollar amount of CNC overpayments by contractor for the seven contractors. We also identified the types of providers with CNC overpayments and the amount of money recovered on CNC overpayments as of December 31, 2011, for these contractors.

We reviewed the summary financial data for FYs 2007 to 2010 to determine the level of CNC debt each year and how it trended over this period.

CMS Survey. We surveyed CMS’s Division of Medicare Debt Management, Financial Services Group in March 2012 to identify its strategies, policies, and procedures for recovering overpayments and reducing CNC debt. We also used the survey to determine CMS’s perspective on the barriers that prevent overpayment collection and changes needed to overcome the barriers.

Contractor Survey. We surveyed all CMS contractors in March 2012 to identify their strategies and procedures for collecting overpayments before they become CNC, issues they encounter that make it difficult to collect overpayments before they become CNC, and changes they believe are needed.

We obtained from CMS a list of contractors’ corporate executives. We sent the executives instructions to complete one survey each for their Parts A and B MAC, durable medical equipment (DME) MAC, carrier, and fiscal intermediary lines of business. In total, they completed 23 surveys. In our analysis, we counted each survey as one contractor, and we report the frequency of contractor responses to survey questions from the 23 surveys. Table 1 shows the number of each type of contractor that completed the survey.

**Table 1: Contractors Completing OIG Survey**

Type of Contractor	Number of Surveys
Parts A and B MAC	11
DME MAC	4
Carrier	4
Fiscal Intermediary	4
<b>Total</b>	<b>23</b>

Source: OIG survey, March 2012.

### **Limitations**

We did not independently verify financial data that CMS provided, nor did we independently verify survey responses from CMS and its contractors.

### **Standards**

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

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## FINDINGS

### **CMS reported \$543 million in new CNC overpayments across all contractors in FY 2010, but only provided detailed information on \$69 million in CNC overpayments for seven contractors**

For FY 2010, CMS reported \$543 million in total new CNC overpayments across all 39 contractors. However, CMS provided detailed data for only seven. These seven contractors processed 22 percent of Medicare payments. CMS determined that these were the only contractors for which HIGLAS had detailed and consistent information on CNC overpayments.

These seven contractors represented 13 percent or \$69.4 million of the total overpayments classified as CNC in FY 2010. The number of CNC overpayments for these contractors ranged from 1 to 55,715, for a total of 70,530.

### ***Citing contractor transitions, mergers, and splits, CMS could not provide data consistently for most contractors***

CMS stated that its inability to provide consistent detailed data for the remaining 32 contractors was caused in part by workloads being transitioned to a new contractor, being added to a contract involving a merger, or being split from a former workload. Since 2005, CMS has been transitioning contractors to meet the competitive contract requirements of contracting reform.<sup>24</sup> Under this reform, CMS has been replacing carriers and fiscal intermediaries with MACs and the transitions were not yet complete as of December 2012.

### ***CMS decided not to transfer all overpayment details to HIGLAS when contractors made the transition from other systems***

Various types of financial data are maintained in HIGLAS. However, CMS stated that during contractor transitions to HIGLAS, it transferred only summary data for years prior to the transition because of the volume of data maintained by the contractor for those prior years. Therefore, at the time of transfer to HIGLAS, the current status of the overpayments was transferred but the original overpayment amounts and any collection activity were not transferred. Once the contractor transferred to HIGLAS, the detailed data for years prior to the transfer were not available in HIGLAS.

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<sup>24</sup> The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 required contracting reform.

***CMS and its contractors lack an automated method for extracting certain CNC overpayment information from its systems***

CMS reported that some of the detailed data OIG requested in January 2012 would have to be searched for manually and then manually entered into a spreadsheet. One contractor alone estimated that it would take 3,421 staff hours to look up and enter principal and interest on its account receivables that became CNC for the milestones requested by OIG. In April 2012, OIG sent a revised request to CMS that aimed to reduce the data collection burden. The revised request allowed CMS to provide available detailed data while not requiring extensive effort on the part of individual contractors.

The details we requested included information on the dollar amount of the overpayment and the amount recovered on certain dates before and after the overpayment became CNC. Without this information for all contractors, CMS would not be able to determine the range of individual overpayments in demand letters, the percentage of overpayment dollars in a specific year that were classified CNC, and the number of days after which debt recoveries fall off.

Even though CMS and contractors maintain automated systems, certain data can be retrieved and manipulated only manually. According to the independent auditors of CMS's financial statements for FY 2011, Medicare contractors ...

continue to rely on a combination of claims processing systems, personal computer-based software applications and other ad hoc systems to tabulate, summarize and prepare information that is reported to CMS. The accuracy of the financial reports remains heavily dependent on inefficient, labor-intensive manual processes that are also subject to an increased risk of inconsistent, incomplete or inaccurate information being submitted to CMS.<sup>25</sup>

***Provider type was not available for 54 percent of the CNC overpayments with detailed data***

One of the variables in HIGLAS is provider type. For 54 percent (38,181) of the CNC overpayments with detailed data, CMS could not provide the provider type. When this information is missing, CMS cannot identify overpayments across provider type, and therefore cannot target its efforts to reduce CNC debt among certain types of providers.

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<sup>25</sup> CMS, *Financial Report Fiscal Year 2011*, p. 119.

The overpayments with missing provider type were all for Part B. CMS reported that the Part A provider type is a mandatory field in HIGLAS, and that some of the Part B provider types were missing because of manual entry of the provider type into HIGLAS or data transfer into HIGLAS.

The 7 contractors with detailed data were responsible for a total of 70,530 CNC overpayments. Of the CNC overpayments with a provider type (32,349), the most common type was internal medicine physician (11,615).

**Ninety-seven percent of CNC overpayments were not recovered for the seven contractors with recovery information and newly classified CNC overpayments were over half a billion dollars annually**

For the seven contractors with detailed data, 97 percent of FY 2010 CNC overpayments were not recovered as of December 31, 2011. The total amount of CNC overpayments for the seven contractors was \$69.4 million, with recoveries of \$2.4 million. The individual CNC overpayment amounts for the seven contractors ranged from \$25 to \$2.8 million.

As shown in Table 2, the annual amount of newly classified CNC overpayments for all contractors was over half a billion dollars from FY 2007 through FY 2010. New CNC debt was highest in FY 2008, when it was almost \$1 billion.

In the 4-year period from FY 2007 to FY 2010, new CNC overpayments for all contractors represented 6 to 9 percent of total overpayments each year.<sup>26</sup> In FY 2010, the cumulative dollar amount of CNC overpayments was \$10.3 billion.

**Table 2: New CNC Overpayments, FYs 2007–2010**

Fiscal Year	Payments	Overpayments	New CNC Overpayments	Cumulative CNC Overpayments
2007	\$300,079,271,648	\$8,949,356,467	\$645,773,093	\$7,636,015,057
2008	\$308,018,573,321	\$10,081,999,497	\$919,048,278	\$8,414,602,533
2009	\$311,435,787,217	\$9,859,838,882	\$896,945,631	\$9,381,427,037
2010	\$335,866,123,715	\$9,626,517,110	\$542,528,449	\$10,308,752,975

Source: CMS, HIGLAS, and CAFM.

<sup>26</sup> These statistics are based on CMS summary financial data. The CNC classification for overpayments in a particular year could be based on overpayments identified and demanded in a previous year. Overpayments identified at the end of a FY may not be classified as CNC until the following FY. CNC overpayments may include overpayments that are under appeal.

## **Contractors reported that some demand letters do not reach providers, or reach providers late, because of inaccurate contact information**

Eight of twenty-three contractors surveyed said they do not encounter difficulties in trying to reduce debt before it becomes CNC. Of the remaining 15, more than half (9) reported issues with the accuracy of provider contact information. These contractors stated that provider names and addresses on demand letters are not necessarily correct or are not the ones that providers have requested be used to ensure prompt response.

HIGLAS creates demand letters and inserts the providers' contact information. Contractors reported that some letters are returned as undeliverable. Some contractors also noted that demand letters do not reach providers that have been terminated from Medicare or are out of business. Other letters do not reach the right contact person in a provider's organization promptly. Part A providers, in particular, want letters sent to an address that is different from the facility address maintained in HIGLAS.

## **CMS and contractors reported that expanding the types of provider identifiers used to offset payments could improve debt collection efforts**

In addition to national provider identification numbers, CMS and contractors reported that other identifiers, such as tax identification numbers and provider transaction access numbers (PTAN),<sup>27</sup> would help with recoveries.

CMS staff has stated that providers can escape offsetting when they change or receive additional national provider identification numbers. Identifying providers by tax identification number would be a more reliable way of collecting overpayments through offsetting. Two contractors also suggested using tax identification numbers to identify affiliated providers and offset their payments to repay providers' overpayments.

As mentioned earlier, Treasury uses tax identification numbers in its payment-offsetting programs. CMS reported that as of May 2011, Treasury's Federal Payment Levy Program (FPLP) began collecting Medicare debts by offsetting Medicare payments for contractors related to the contractor for which the debt was originally identified. FPLP uses a

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<sup>27</sup> Contractors assign PTANs to providers upon enrollment. A provider may have a different PTAN for each of its service locations.

provider's tax identification number, not the provider number, to perform this offset.

Currently, CMS pays fees to Treasury for collecting overpayments through offsetting and other means. CMS reported that collection fees are \$17 per offset. For FY 2010, CMS paid fees of \$6 million on collections of approximately \$39 million. These collections included Treasury Offset Program collections as well as Treasury and private collection agency collections received directly from providers.

CMS could save some of these fees if it used tax identification numbers internally for offsetting purposes. CMS has already begun this process in HIGLAS for certain debts.

Regarding the use of PTANs, one contractor reported that it received CMS approval to cross-reference a provider's PTANs. This allowed the contractor to collect overpayments from a provider who stopped billing under one PTAN but continued to obtain payment under another.

Appendix A lists contractor recommendations for overcoming hindrances to reducing CNC debt.

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## CONCLUSION AND RECOMMENDATIONS

It is critical that CMS make efforts to reduce the number and dollar amount of overpayments that become CNC since these overpayments are unlikely to be recovered. In 2010, CMS reported \$543 million in new CNC debt. However, CMS had difficulty retrieving detailed data about all CNC overpayments from a central source or from all of its contractors in a timely way. The financial data CMS was able to provide for 7 of 39 contractors was too limited to use for a comprehensive contractor- or provider-level analysis of CNC overpayments. Such analysis could help CMS target its efforts to reduce the number and dollar amount of CNC overpayments.

CMS could provide detailed data for only seven contractors, representing 22 percent of Medicare payments. Moreover, no provider type was identified in 54 percent of CNC overpayments for these seven contractors. Without this detailed information, CMS cannot target its efforts to collect overpayments.

Although the detailed overpayment data for seven contractors were too limited to allow an in-depth analysis of all CNC overpayments, CMS's summary data across all contractors show that, each year, half a billion dollars will likely not be recovered. The detailed data for the seven contractors showed that 97 percent of FY 2010 CNC overpayments were never recovered.

Contractors said undeliverable demand letters were a problem and that automated letters from HIGLAS were not always addressed to the location requested by the provider. CMS and some of its contractors said debt recovery would be improved if CMS used additional provider identifiers, such as tax identification numbers, to offset Medicare payments.

We recommend that CMS:

### **Ensure That the HIGLAS Variable for Provider Type Is Populated for All Overpayments**

CMS included the provider type variable in HIGLAS, yet OIG found a substantial number of records in which this variable was blank for Part B overpayments. CMS should ensure that all overpayments, regardless of claim type, have this information. When this variable is populated, CMS will be able to determine which provider types have the greatest CNC debt.

### **Ensure That Demand Letters Are Mailed to the Contacts and Addresses Identified by the Provider**

Contractors reported that HIGLAS does not necessarily send automatic demand letters to the address providers prefer, especially for Part A facilities. To provide contractors with an opportunity to make a voluntary repayment without incurring interest, CMS should take steps to ensure that demand letters are correctly addressed.

### **Use Tax Identification Numbers and PTANs in Addition to Provider Numbers To Offset Payments and Collect Overpayments**

Treasury programs routinely use tax identification numbers to identify providers that are receiving Government payments. CMS has begun using this tool in HIGLAS for certain debts, and we recommend that it use this tool routinely for all debts. By using the tax identification number to identify affiliated Medicare providers whose payments can be offset, CMS can start offsetting without delay and potentially recover more overpayments. Moreover, CMS could save money by reducing the fees it pays to Treasury for certain collections.

CMS should also require contractors to cross-reference PTANs to ensure overpayment collection from providers who stop billing under one PTAN but continue to obtain payment under another. If necessary, CMS should add PTANs as a data element in HIGLAS.

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## AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with one of OIG's three recommendations and stated that, aside from CNC overpayments, its debt collection efforts have been very effective. CMS noted that it collects approximately 80 percent of its debt before the debt becomes CNC and is referred to Treasury.

CMS partially concurred with our first recommendation, that it ensure that the HIGLAS variable for provider type is populated for all overpayments. CMS noted that adding the provider type for all overpayments will not improve its recoupment efforts since the field is not used in the collection process, but stated that it will review the option of making the provider type field mandatory in HIGLAS. OIG continues to recommend that CMS ensure that the provider type field is complete, as CMS may use this information to identify provider types with the greatest CNC debt and to better target its debt collection efforts.

CMS did not concur with our second recommendation, that it ensure that demand letters are mailed to the contacts and addresses identified by the provider. CMS stated that demand letters are already mailed to the addresses identified by providers in the Provider Enrollment, Chain, and Ownership System (PECOS). CMS also stated that it encourages contractors to educate providers on the importance of providing their correct billing address and contact person, and keeping this information updated. A number of CMS's contractors reported problems with providers' contact and address information on demand letters. In a May, 2013 report entitled *Improvements Needed To Ensure Provider Enumeration and Medicare Enrollment Data Are Accurate, Complete, and Consistent* (OEI-07-09-00440), OIG assessed provider enrollment data and found significant problems with the accuracy of providers' address information in PECOS. Therefore, OIG continues to recommend that CMS take additional steps to ensure that demand letters are delivered to correct provider contacts and addresses.

CMS concurred with our third recommendation, that it use tax identification numbers and PTANs in addition to provider numbers to offset payments and collect overpayments. CMS noted that the offsetting function in the version of HIGLAS that it is using does not allow for offsetting across business entities. CMS stated that HIGLAS is based on a commercial off-the-shelf product and the most current version of the product has been upgraded to allow for this functionality. However, CMS has been directed by the Office of Management and Budget to not upgrade to the newer version of the software. CMS noted that it hopes to be allowed to implement the newer version, which would allow for faster

collection of overpayments, increased collections through offset, and ultimately a reduction in CNC debt. OIG agrees that tax identification numbers should be used to offset overpayments across all business relationships and hopes that CMS will be granted the opportunity to upgrade to the newer system soon.

CMS stated that it disagrees with OIG's finding that CMS was able to provide detailed information on CNC overpayments for only seven contractors. CMS stated that it had decided not to transition to HIGLAS detailed information to support previous years' overpayment data. Rather, the detailed information remained in former Medicare contractors' legacy systems. CMS stated that data for the remaining contractors were available, but that providing the detailed information for those 32 contractors would involve an extensive amount of Medicare contractors' and CMS resources to obtain the data.

OIG requested that CMS provide detailed information regarding CNC overpayments for all 39 CMS contractors. However, as noted in the findings of this report, CMS indicated that detailed overpayment information for 32 contractors would have to be searched for and entered manually. One CMS contractor alone estimated that it would take 3,421 staff hours to look up and enter the information that OIG requested regarding the contractor's CNC overpayments. OIG only accepted from CMS detailed CNC overpayment information for the seven contractors because these were the only contractors with detailed data that CMS was able to provide in a timely way and without extensive staff resources.

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

## APPENDIX A

### Contractor Recommendations Regarding Currently Not Collectible Debt

Fifteen contractors said they encounter issues that make it difficult to reduce the number and/or dollar amount of currently not collectible (CNC) overpayments. The table below contains a list of issues identified by the contractors and their suggestions for addressing the issues.

Issue	Number of Contractors That Identified Issue (n = 15)	Contractor Recommendations
Inaccurate Contact Information for Provider	9	Send demand letters to specific contacts and not to generic addresses at large facilities.
		Implement a programming change for the Healthcare Integrated General Ledger Accounting System (HIGLAS) to pull the appropriate address for demand letters from the provider file of the Part A claims processing system.
		Similar to the Do Not Forward process for undeliverable checks, if an overpayment demand letter is returned as undeliverable, make no further payments until the provider updates its address with Medicare.
		Conduct more frequent validation of provider address information.
Bankruptcy Cases	6	Pass legislation that clarifies bankruptcy rules regarding Government debts.
		Look at the bankruptcy process involving the Office of the General Counsel, the regional office, and the contractor community. Perhaps a central data repository would improve coordination. Contractors wait a considerable time for direction on disposition and status of various bankruptcy areas.
Appealed Overpayments	5	Allow offsetting of certain overpayments in appeal. This would require legislative and regulatory change regarding the limitation on recoupment provisions [§ 935 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003].
		Have HIGLAS wait to classify overpayment as CNC until the appeal process is completed.
Overpayments Not Collected From Affiliated Providers, Terminated Providers, and Other Sources	5	Establish an automated process similar to the Non Treasury Disbursing Office levy process as a way to recover overpayments. For example, a process could automatically offset a provider's tax refund or other Government payments if there are outstanding Medicare overpayments in HIGLAS.
		Provide contractors with Medicaid contact names for States within their jurisdiction to begin establishing processes for recoupment against Medicaid funds.
		Change the system to collect nondemanded Part A overpayments (i.e., those initiated by providers) by offsetting affiliated providers. Currently, Part A nondemanded overpayments are not collected from affiliated providers.
		Establish regulation, change manual, and change Statement of Work to allow collection from related organizations. Currently, if the debt is uncollectible for a provider that has a related organization, the contractor is not able to pursue recovery from the related organization.
		Provide contractors with the option of bypassing the automatic classification when they have knowledge that the debt is collectible. CNC classification is currently controlled by HIGLAS.
		Change the system to automatically recover overpayments based on shared tax identification number.
		Do not allow providers to reenroll in Medicare if they have past Medicare debts.

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Issue	Number of Contractors That Identified Issue (n = 15)	Contractor Recommendations
Insufficient Use of Automation and Technology	3	Automate the daily phone call list (for Part A overpayments delinquent 45 days and for Part B overpayments delinquent 60 days) within HIGLAS.
		Automatically generate notification to the overpayment area if an extended repayment loan is in default status. Currently, the overpayment staff has to manually look for defaulted loans.
		Create an automated flag within reports of Medicare Recovery Audit Contractor appeals if an account in appeal status has reached a problematic level of aging. Currently, collection staff has to look through reports using various report filters.
		Create a portal through which providers can look up how much they owe the Medicare program.
		Create a portal through which providers can input both their credit balance adjustments and their quarterly Comprehensive Error Rate Testing page. This would significantly lower administrative costs to the program.
		Further automate communication between the Centers for Medicare & Medicaid Services' (CMS) Debt Collection System, Department of the Treasury (Treasury), and contractors.
Part A Held Funds	2	Make changes in HIGLAS to release held funds for the amount of overpayments without releasing the hold on payments. If a Part A provider is on full payment hold for any reason, including failure to submit a cost report, HIGLAS holds payments but does not apply them to outstanding debts. This lack of debt recovery leads to increased CNC debt.
Threshold for Demand Letter and Treasury Referral <sup>1</sup>	2	Reevaluate dollar threshold for referrals to Treasury. Currently, individual overpayments less than \$25 are not referred to Treasury even if the demand letter involved multiple overpayments greater than \$25 in the aggregate. CMS policy requests contractors to submit these debts for "write off—closed" instead of submitting the aggregate amount to Treasury.
		Raise Part B threshold amount for demand letter from \$10 to \$25 to be consistent with the \$25 threshold for referring overpayments to Treasury. Currently, Part B overpayments less than \$10 are considered under threshold and no demand letter is sent for these amounts.
Other	3	Allow contractors to receive contingency fees for debts collected over a certain age based upon uncollectible status. This will give them an incentive to increase collections through various legal means such as offset through affiliated companies or collection through current employers.
		Allow contractors greater flexibility in approving requests for extended repayment.

Source: Office of Inspector General survey, March 2012.

<sup>1</sup> CMS requires contractors to send demand letters to providers to collect Part A overpayments of \$25 or more and Part B overpayments of \$10 or more. Parts A and B debts under these thresholds can be aggregated to meet the threshold amount and then demanded. Debts under \$25 are not eligible for Treasury referral and CMS does not require aggregation of amounts under this threshold.

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## APPENDIX B

### Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*  
Washington, DC 20201

**DATE:** MAR 27 2013

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

**FROM:** Marilyn Tavenner /S/  
Acting Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: "Medicare's Currently Not Collectible Overpayments," (OEI-03-11-00670)

Thank you for the opportunity to review and comment on the OIG draft report referenced above. The OIG set out to describe details of a certain class of Medicare Part A and B overpayments that were identified in fiscal year (FY) 2010 and classified under financial accounting rules as "currently not collectible" (CNC) by December 31, 2011. OIG also wanted to identify the annual dollar amount of new CNC overpayments from FYs 2007 and 2010. Additionally, OIG wanted to identify issues that hinder efforts to reduce the number and dollar amount of overpayments that become CNC, and to identify strategies for reducing the number and dollar amount of overpayments that become CNC.

The Centers for Medicare & Medicaid Services (CMS) appreciates the time and resources OIG has invested in this review of CNC overpayments. CMS is committed to using its resources to collect overpayments in a manner that is cost effective, efficient, and ensures compliance with statutory and regulatory requirements. Outside of this class of overpayments, CMS' debt collection efforts have been very effective. Based on an internal review of the Medicare contractor financial reporting for the past four fiscal years, CMS collects approximately 80 percent of its debt prior to the debt becoming CNC and prior to its debt being referred to the Department of the Treasury (Treasury). This percentage was calculated using the Medicare contractor's accounts receivable reports for FYs 2009 and 2012.

The CMS uses various tools to aggressively pursue the collection of overpayments throughout the timeline of a debt. CMS uses the CNC accounting classification for debts that are over 180 days delinquent. A CNC classification does not stop or hamper CMS collection strategies. CMS aggressively goes after all debts by issuing demand letters, making phone calls, recouping current payments, working with debtors who request an extended repayment schedule (ERS), issuing intent to refer letters, and referring debt to Treasury for collection.

The CMS' most successful collection tool is internal recoupment, where the Medicare contractor recoups overpayments from subsequent payments to the debtor. Another successful tool CMS uses to collect debts is approving an ERS. An ERS can be granted for a period of up to 60

months and includes charging the debtor interest. This process allows the provider or supplier an opportunity to pay the debt over a reasonable period of time and increases the chance that the debt will be paid in full.

Although CMS is generally successful in collecting most provider debts, we do encounter problems collecting debts when the provider is in bankruptcy or is no longer in business. In addition, certain Medicare debts are determined many years after payment is made. This occurs most often in cases of OIG reviews or actions by law enforcement. In these situations, it can be difficult to collect because the provider may have gone out of business.

The CMS disagrees with OIG's finding that CMS was only able to provide detailed information on CNC overpayments for seven contractors. When CMS transitioned Medicare contractors into the Healthcare Integrated General Ledger Accounting System (HIGLAS), CMS made a business decision that current year data balances be transitioned in detail and data balances for previous years be transitioned in summary. The detailed data to support previous year's data remained in the former Medicare contractors' legacy systems. This limited CMS' ability to provide the data in the exact manner the OIG was requesting. As a compromise and in order to meet OIG's timeline, CMS was able to provide the detailed information for seven contractors. This did not mean that CMS could not provide the detailed information for the other 32 contractors, but that it would involve an extensive amount of Medicare contractors and CMS resources to obtain the data of prior years to transition to HIGLAS. Therefore, as a compromise, the OIG agreed to accept only the data for the seven contractors that were in HIGLAS for the entire period requested. HIGLAS is a dual entry accounting system and is not able to provide such ad hoc reporting in the manner requested by OIG. The HIGLAS system has been audited and there is documentation to support the financial activity in our audited financial statements (see <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CFOReport/index.html?redirect=/cforeport/>), "Treasury Report on Receivables and Debt Collection Activities."

#### **OIG Recommendation**

Ensure that the HIGLAS variable for provider type is populated for all overpayments.

#### **CMS Response**

The CMS partially concurs with this recommendation. Currently, the provider type is automatically populated for all batch interface transactions. Adding the provider type in HIGLAS for all overpayments will not make CMS any more effective in recouping overpayments since this field is not used in the collection process. CMS will review the option of making the debtor type field mandatory when manually creating a customer's record. CMS may consider this addition in the future, along with other Agency initiatives.

**OIG Recommendation**

Ensure that demand letters are mailed to the contacts and addresses identified by the provider.

**CMS Response**

The CMS non-concurs with this recommendation because demand letters are already mailed to the addresses identified by the providers. CMS understands the importance of mailing demand letters to the proper address. Currently provider address information originates in the Provider Enrollment, Chain, and Ownership System (PECOS) and is sent to HIGLAS. Providers directly submit their address information to PECOS at enrollment and revalidation. Additionally, providers are legally required to update any changes, including changes in address, within 90 days of the change. The letter generation process relies on a provider listing the correct billing address and contact person, and keeping that information updated. CMS encourages contractors to provide education to providers in their respective jurisdiction on the importance of providing their correct billing address, contact person, and keeping this information updated.

**OIG Recommendation**

Use tax identification numbers and provider transaction access numbers in addition to national provider numbers for the collection of overpayments.

**CMS Response**

The CMS concurs with this recommendation. Current HIGLAS functionality provides the ability to offset/net using the tax identification numbers. CMS' HIGLAS netting priority policy is based on the customer relationship, provider-National Provider Identifier, affiliate relationship, and chain relationship. However, this capability allows "netting" only across workloads within the same business entity.

HIGLAS is based on a commercial-off-the-shelf (COTS) product, and expansion of the offset/netting function across business entities is offered in the most current version of the COTS software. In accordance with OMB Directive M-10-26, dated June 28, 2010, and subsequent OMB review of the Department of Health and Human Services financial systems (which includes HIGLAS), CMS has been directed to not upgrade to the newer version of the software. It would not be efficient for CMS to modify the older version of this software by developing expanded offsetting/netting when the upgraded version already contains this feature. Hopefully CMS will be allowed to implement the newer version of this software which would allow for faster collection of overpayments, increased collections through offset, and ultimately a reduction in CNC.

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## ACKNOWLEDGMENTS

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 Office of Evaluation and Inspections staff from the Philadelphia regional office who contributed to the report include Conswelia McCourt, Amy Henderson Riley, and Amy Sernyak; central office staff who provided support include Scott Manley and Debra Roush.

# Office of Inspector General

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