Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE OVERPAYMENTS IDENTIFIED BY PROGRAM SAFEGUARD CONTRACTORS

Daniel R. Levinson
Inspector General

May 2010
OEI-03-08-00031

EXECUTIVE SUMMARY

OBJECTIVE

To determine the number, dollar amount, and claim type of Medicare overpayments that program safeguard contractors (PSC) identified and referred to claims processors for collection in 2007.

BACKGROUND

This report and a companion Office of Inspector General (OIG) report, entitled C*ollection Status of Medicare Overpayments Identified by Program Safeguard Contractors*, OEI-03-08-00030, are our response 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.

For this report, we collected 2007 overpayment referrals from all 18 PSCs in operation in 2007. We also collected from CMS information on the dollar amount of Medicare payments for which PSCs had oversight responsibility in 2007. We use the term "size of oversight responsibility" to refer to the amount of these Medicare payments.

FINDINGS

PSCs referred $835 million in overpayments to claims processors for collection in 2007; however, two PSCs were responsible for 62 percent of this amount. All 18 PSCs referred a total of 4,239 overpayments to claims processors for collection in 2007. These overpayments totaled $835 million. PSCs differed substantially in the dollar amounts of overpayments they referred for collection in 2007. PSCs referred from $3 million to $266 million in overpayments for collection, with a median of $15 million. Two PSCs were responsible for 62 percent, or $519 million, of $835 million in overpayments referred for collection. Both of these PSCs covered at least one State that has a

large population of Medicare beneficiaries and is considered by CMS to be vulnerable to fraud and abuse. However, these PSCs were not the only PSCs that covered at least one State considered vulnerable to fraud and abuse.

The amounts of overpayment dollars that PSCs referred for collection were not always related to the size of PSCs' oversight responsibility. For example, the PSC with the most overpayment dollars referred for collection ($266 million) had the third smallest oversight responsibility ($5 billion) of all 18 PSCs.

While Part B payments represented 29 percent of PSCs' oversight responsibility, Part B overpayments accounted for 89 percent of PSCs' overpayment dollars referred for collection. Of the $835 million in PSC overpayments referred for collection, $747 million, or 89 percent, was for Part B claims. The remaining $88 million, or 11 percent of overpayments referred for collection, was for Part A. However, Part B payments represented 29 percent of all PSCs' oversight responsibility ($87 billion of $296 billion), and Part A payments represented 71 percent of all PSCs' oversight responsibility ($209 billion of $296 billion). Thirteen of eighteen PSCs have responsibility for both Parts A and B. Of these 13 PSCs, 8 had greater overpayment dollars for Part B.

Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) made up 45 percent of Part B overpayment dollars that PSCs referred for collection ($335 million of $747 million) and 12 percent of PSCs' oversight responsibility for Part B ($10 billion of 87 billion). Of PSC overpayments referred for collection, the dollars referred for every $1 million of oversight responsibility were 79 times higher for DMEPOS ($33,210) than for Part A ($420) and 6 times higher than other types of Part B ($5,368).

Two provider types made up 80 percent of the overpayment dollars. These two types of providers were physicians ($336 million) and DMEPOS suppliers ($335 million).

RECOMMENDATIONS

PSCs were established to strengthen CMS's ability to detect and deter fraud and abuse in Medicare Parts A and B. PSCs conduct investigations of potential fraud and abuse; refer cases to law enforcement; and take administrative actions, such as referring

overpayments to claims processors for collection and return to the Medicare program.

In this report, we found that PSCs' overpayment amounts varied and were not always related to the size of their oversight responsibility. We also found that there were greater overpayment amounts for Part B than Part A, even though Part A represents the greater amount of PSCs' oversight responsibility.

Based on the substantial differences between individual PSCs' overpayment referrals and the significant difference between Part A and Part B referrals, we recommend that CMS:

Determine why certain PSCs have low levels of overpayment dollars referred for collection compared to their oversight responsibility. CMS should determine whether these PSCs are taking all necessary steps to identify overpayments during their investigative work.

Determine why certain PSCs have low Part A overpayment dollars referred for collection compared to their Part B overpayment dollars referred for collection. CMS should determine whether these PSCs are taking all necessary steps to identify Part A overpayments.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with both recommendations. In response to the first recommendation, CMS agreed that there has not been a clear correlation between the levels of overpayment dollars recovered and the scope of PSCs' oversight responsibility. 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 believes that the new strategy should address OIG's concerns regarding the gap between scope of responsibility and level of dollars recovered.

In response to the second recommendation, CMS stated that in the new ZPIC contracting strategy, each ZPIC has responsibility for all claim types in its geographic zone and is required to have staff with expertise in each claim type. CMS also stated that this approach will allow for greater recoveries as overpayment issues can be identified across multiple payors and benefit categories. CMS reported that it will

monitor both overpayment and collection activities to ensure that its contractors are adequately performing their oversight responsibilities.

OIG believes it is too early to determine whether the ZPIC contracting strategy will address all the issues in this report. Until the transition from PSCs to ZPICs is complete and the results of ZPICs' overpayment identification activities are evaluated, CMS's monitoring of overpayment and collection activities is critical. OIG believes that until the ZPICs are fully transitioned, CMS should also monitor the overpayment activities of the remaining PSCs.

TABLE OF CONTENTS

INTRODUCTION

OBJECTIVE

To determine the number, dollar amount, and claim type of Medicare overpayments that program safeguard contractors (PSC) identified and referred to claims processors for collection in 2007.

BACKGROUND

This report and a companion Office of Inspector General (OIG) report, entitled *Collection Status of Medicare Overpayments Identified by Program Safeguard Contractors*, OEI-03-08-00030, 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,[1] 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 how PSCs are performing regarding the number and dollar amount of overpayments that they refer 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.[2] When they do so, they are required to refer overpayments that they identify to Medicare claims processors for collection and return to the Medicare program.[3]

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.

---

[1] 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.

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

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

In 2007, CMS had 18 benefit integrity task orders with PSCs, which are 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 Part A and Part B 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 from PSCs to ZPICs 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.[4]

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

[4] 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.

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 their 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.[5] 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.[6] The dollar amount that 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.

[5] CMS, *Medicare Program Integrity Manual*, § 3.8.1.

[6] CMS, *Medicare Financial Management Manual*, Pub. No. 100-06, ch. 4, §§ 10 and 80.2.

METHODOLOGY

Scope

We reviewed PSC data on overpayments that each PSC referred to claims processors for collection in 2007.

Data Sources and Data Collection

Centers for Medicare & Medicaid Services. From CMS's Program Integrity Group in the Office of Financial Management, we collected the following information:

- a list of PSCs and their jurisdictions in 2007;
- the dollar amount of each PSC's oversight responsibility for 2007 by Part A, Part B (excluding DMEPOS), and DMEPOS; and
- contact information for each PSC.

Program safeguard contractors. We collected information from all 18 PSCs during the timeframe May to October 2008. We requested information regarding each overpayment that each PSC referred to claims processors for collection in 2007. The information included:

- the date that the overpayment was referred to the claims processor,
- the dollar amount of the overpayment,[7]
- the provider name and identification number,
- the provider type (e.g., hospital), and
- the claim type (e.g., Part A).

Analysis

PSCs provided information for 4,242 overpayment referrals. 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 overpayment referrals for this report.[8] For each PSC, we identified the total dollar amount of overpayments referred for collection and calculated its percentage of aggregated PSC overpayments referred for collection. We also compared the total

[7] For one PSC for which the claims processor had to calculate the overpayment, we used the claims processor's information as the overpayment amount.

[8] Of the 4,239 overpayments, only 1 was made to a beneficiary.

overpayment dollars it referred for collection with its oversight responsibility and calculated the dollar amount of overpayment referrals for every $1 million in oversight responsibility.

We reviewed each PSC's overpayment referrals by claim type and summarized the dollar amounts of overpayments by Part A and Part B (including DMEPOS). We compared these dollar amounts with the PSC's oversight responsibility by Part A and Part B (including DMEPOS). We also calculated the percentage of Part B overpayment dollars that represented DMEPOS overpayments.

We summarized all overpayment referral data by individual PSC and for all PSCs. We also reviewed and summarized overpayment referrals by provider type.

We assigned an identification number, from 1 to 18, to the 18 PSCs in our review. We use these identification numbers in our report to enable the reader to identify information related to the same PSC across the different tables without disclosing details on specific PSCs.

Limitations

We did not independently verify the dollar amount of Medicare payments provided by CMS or the overpayment referral data provided by PSCs.

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.

PSCs referred $835 million in overpayments to claims processors for collection in 2007; however, two PSCs were responsible for 62 percent of this amount

All 18 PSCs referred a total of 4,239 overpayments to claims processors for collection in 2007. These overpayments totaled $835 million. However, the dollar amounts of overpayments referred varied substantially by PSC. As shown in Table 1, PSC 1 referred $266 million in overpayments. This amount was more than 100 times greater than PSC 18's amount. The median dollar amount of overpayments referred for collection was $15 million.

Table 1 also shows that two PSCs (PSC 1 and PSC 2) were responsible for 62 percent, or $519 million, of the $835 million in total PSC overpayments referred for collection in 2007. Both of these PSCs

Table 1: Overpayments That PSCs Referred for Collection in 2007

PSC	Number of Overpayment Referrals	Dollar Amount of Overpayments	Percentage of Total Overpayment Dollars
1	353	$265,887,671	32%
2	203	$252,721,299	30%
3	123	$53,669,785	6%
4	1,409	$52,667,600	6%
5	65	$38,796,266	5%
6	495	$35,004,560	4%
7	21	$27,486,724	3%
8	71	$19,299,679	2%
9	97	$15,957,395	2%
10	344	$13,442,469	2%
11	451	$12,171,683	1%
12	47	$11,647,722	1%
13	82	$10,951,325	1%
14	245	$10,655,761	1%
15	107	$4,478,215	1%
16	19	$3,951,992	Less than 1%
17	72	$3,721,667	Less than 1%
18	35	$2,544,128	Less than 1%
Total	**4,239**	**$835,055,941**	

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

covered at least one State that has a large population of Medicare beneficiaries and is considered by CMS to be vulnerable to fraud and abuse. However, these PSCs were not the only PSCs that covered at least one State considered vulnerable to fraud and abuse.

The amounts of overpayment dollars that PSCs referred for collection were not always related to the size of PSCs' oversight responsibility

Although PSCs might be expected to differ in the dollar amounts of overpayments referred for collection, the amounts of PSC overpayments in 2007 did not always correspond to the size of PSCs' oversight responsibility in 2007. As shown in Table 2, PSCs with the largest overpayment amounts did not always have the largest oversight responsibility (Medicare payments). PSC 1 referred the most

Table 2: Comparison of PSC Overpayment Dollars Referred for Collection and PSC Oversight Responsibility in 2007

PSC	Dollar Amount of Overpayments Referred for Collection	Oversight Responsibility Ranking From Largest to Smallest	Dollar Amount of Oversight Responsibility (Medicare Payments)	Dollar Amount of Overpayments Referred for Collection for Every $1 Million in Oversight Responsibility
1	$265,887,671	16	$4,732,243,732	$56,186
2	$252,721,299	5	$19,980,994,913	$12,648
3	$53,669,785	1	$62,447,462,696	$859
4	$52,667,600	18	$2,162,988,566	$24,349
5	$38,796,266	2	$31,516,939,545	$1,231
6	$35,004,560	14	$7,062,482,499	$4,956
7	$27,486,724	7	$17,947,334,212	$1,532
8	$19,299,679	13	$8,490,980,519	$2,273
9	$15,957,395	17	$3,177,404,337	$5,022
10	$13,442,469	3	$28,093,398,172	$478
11	$12,171,683	9	$15,960,804,802	$763
12	$11,647,722	11	$10,179,022,445	$1,144
13	$10,951,325	4	$21,695,035,563	$505
14	$10,655,761	8	$16,227,439,361	$657
15	$4,478,215	12	$10,100,139,551	$443
16	$3,951,992	15	$5,720,592,445	$691
17	$3,721,667	10	$11,236,890,885	$331
18	$2,544,128	6	$19,634,590,542	$130
Total	**$835,055,941**		**$296,366,744,785**	

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

overpayment dollars for collection ($266 million), but it had the third smallest oversight responsibility ($5 billion) of all 18 PSCs. In addition, PSCs 3 and 4 referred similar amounts of overpayment dollars for collection, $54 million and $53 million, respectively, but had vastly different oversight responsibility, $62 billion and $2 billion, respectively.

PSC 4, which had the lowest oversight responsibility ($2 billion), referred $24,349 in overpayments for every $1 million of its oversight responsibility. This is in contrast to PSC 16 that had $6 billion in oversight responsibility but referred $691 in overpayments for every $1 million in oversight responsibility.

Fourteen of eighteen PSCs referred less than $5,000 in overpayments per $1 million in oversight responsibility. The range in oversight responsibility for these 14 PSCs was $6 billion to $62 billion.

While Part B payments represented 29 percent of PSCs' oversight responsibility, Part B overpayments accounted for 89 percent of PSCs' overpayment dollars referred for collection

Of the $835 million in PSC overpayments referred for collection in 2007, $747 million, or 89 percent, was for Part B claims. The remaining $88 million, or 11 percent, was for Part A claims. However, Part B payments represented 29 percent of all PSCs' oversight responsibility ($87 billion of $296 billion), and Part A payments represented 71 percent of all PSCs' oversight responsibility ($209 billion of $296 billion). Table 3 provides the Part A and Part B overpayment amounts and oversight responsibility for each PSC.

Thirteen of eighteen PSCs have responsibility for both Parts A and B. Of these 13 PSCs, 8 had greater overpayment dollars for Part B. The range of overpayment dollars by PSCs for Part B is $366,709 to almost $266 million. For Part A, the range is $421,033 to almost $37 million.

DMEPOS made up 45 percent of Part B overpayment dollars that PSCs referred for collection and 12 percent of PSCs' oversight responsibility for Part B

Of the $747 million in Part B overpayments that PSCs referred for collection, $335 million, or 45 percent, was for DMEPOS claims. Of the $87 billion in PSC oversight responsibility for Part B payments, $10 billion, or 12 percent, was for DMEPOS payments.

The overpayment dollars PSCs referred for every $1 million of oversight responsibility were much higher for DMEPOS than for either Part A or the portion of Part B representing claims other than DMEPOS (e.g., physician services). For every $1 million of oversight responsibility for DMEPOS, PSCs referred $33,210 in DMEPOS overpayments. This $33,210 was 79 times the amount PSCs referred in Part A overpayments ($420 for every $1 million) and 6 times the amount they referred in Part B other than DMEPOS overpayments ($5,368 for every $1 million).

Table 3: PSC Overpayments and Oversight Responsibility by Parts A and B
(Table is sorted by Part B overpayment dollars.)

PSC	Part A Overpayment Dollars	Part A Oversight Responsibility (Medicare Payments)	Part B Overpayment Dollars	Part B Oversight Responsibility (Medicare Payments)
1	No Part A Responsibility	No Part A Responsibility	$265,887,671	$4,732,243,732[1]
2	$3,481,851	$12,070,613,345	$249,239,448	$7,910,381,568
4	No Part A Responsibility	No Part A Responsibility	$52,667,600	$2,162,988,566[1]
5	$866,508	$21,707,089,556	$37,929,758	$9,809,849,989
6	No Part A Responsibility	No Part A Responsibility	$35,004,560	$7,062,482,499
3	$36,555,396	$52,756,042,136	$17,114,389	$9,691,420,560
8	$2,750,087	$4,279,908,962	$16,549,592	$4,211,071,557
9	No Part A Responsibility	No Part A Responsibility	$15,957,395	$3,177,404,337[1]
11	$421,033	$11,193,436,002	$11,750,650	$4,767,368,800
10	$2,311,651	$19,021,729,177	$11,130,818	$9,071,668,995
13	$1,482,400	$15,227,410,607	$9,468,925	$6,467,624,956
7	$19,179,904	$13,733,706,121	$8,306,820	$4,213,628,091
12	$4,319,131	$7,424,014,110	$7,328,591	$2,755,008,335
14	$5,647,201	$12,442,205,187	$5,008,560	$3,785,234,174
17	$1,158,425	$8,053,052,238	$2,563,242	$3,183,838,647
15	$3,670,740	$7,384,097,684	$807,475	$2,716,041,867
18	$2,177,419	$18,419,225,539	$366,709	$1,215,365,003
16	$3,951,992	$5,720,592,445	No Part B Responsibility	No Part B Responsibility
Total	**$87,973,738**	**$209,433,123,109**	**$747,082,203**	**$86,933,621,676**

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

[1]This PSC has oversight responsibility for DMEPOS claims only.

Two provider types made up 80 percent of the overpayment dollars

The overpayment dollars for both Parts A and B by provider types ranged from $2,982 to $336 million. Two types of providers made up 80 percent of the overpayment dollars referred for collection. These two types of providers were physicians ($336 million) and DMEPOS

suppliers ($335 million). Provider types with the next highest amounts of overpayments were ambulance suppliers ($38 million), clinical labs ($29 million), and home health providers ($29 million). Appendix B contains the number of overpayment referrals and overpayment dollars for each provider type.

RECOMMENDATIONS

This OIG report presents the number, amount, and claim type of overpayments that PSCs identified and referred to claims processors for collection in 2007. A companion OIG report, entitled *Collection Status of Medicare Overpayments Identified by Program Safeguard Contractors*, OEI-03-08-00030, presents the status of collections, as of June 2008, for these PSC overpayment referrals.

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 in high-fraud regions to focus on quick response to fraud and administrative actions. Because of the emphasis on administrative actions and the Medicare dollars at risk, it is important for CMS to know the actual amount of Part A and Part B overpayments that PSCs and ZPICs refer to claims processors.

In 2007, PSCs referred overpayments for collection that totaled $835 million; two PSCs were responsible for 62 percent of this amount. Although PSCs referred between $3 million and $266 million in overpayments, the amounts of PSCs' overpayment dollars were not always related to the size of PSCs' oversight responsibility (i.e., dollar amounts of Medicare payments). PSCs' oversight responsibility was $296 billion. Of this $296 billion, 71 percent was for Part A payments and 29 percent was for Part B payments. However, PSC overpayment referrals for Part A claims represented 11 percent of all PSC referrals, and Part B claims represented 89 percent of all PSC overpayment referrals.

Based on the substantial differences between individual PSCs' overpayment referrals and the significant difference between Part A and Part B referrals, we recommend that CMS:

Determine why certain PSCs have low levels of overpayment dollars referred for collection compared to their oversight responsibility

For PSCs that have low levels of overpayment dollars compared to their oversight responsibility, CMS should determine whether these PSCs are taking all necessary steps to identify overpayments during their investigative work.

Determine why certain PSCs have low Part A overpayment dollars referred for collection compared to their Part B overpayment dollars referred for collection

For PSCs that have low levels of Part A overpayment dollars compared to their Part B overpayment dollars, CMS should determine whether these PSCs are taking all necessary steps to identify Part A overpayments.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with both recommendations. In response to the first recommendation, CMS agreed that there has not been a clear correlation between the levels of overpayment dollars recovered and the scope of PSCs' oversight responsibility. CMS stated that one of the limitations of the original PSC structure was that PSCs were organized by specific payment type and geographical area. CMS explained that in an effort to improve its ability to more effectively fight fraud and abuse, it has established the new ZPIC contracting strategy. The new strategy allows ZPICs to review claims across all benefit categories. CMS believes that the new strategy should address OIG's concerns regarding the gap between scope of responsibility and level of dollars recovered.

In response to the second recommendation, CMS stated that the PSC contracting strategy limited the effectiveness of certain PSCs to collect larger amounts of overpayments. Under the new ZPIC strategy, each ZPIC has responsibility for all claim types in its geographic zone and is required to have staff with expertise in each claim type. CMS stated that this approach will allow for greater recoveries as overpayment issues can be identified across multiple payors and benefit categories. CMS also reported that it will monitor both overpayment and collection activities to ensure that its contractors are adequately performing their oversight responsibilities.

OIG believes it is too early to determine whether the ZPIC contracting strategy will address all the issues in this report. Until the transition from PSCs to ZPICs is complete and the results of ZPICs' overpayment identification activities are evaluated, CMS's monitoring of overpayment and collection activities is critical. OIG believes that until the ZPICs are fully transitioned, CMS should also monitor the overpayment activities of the remaining PSCs.

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

APPENDIX ~ A

Table A-1: Benefit Integrity Task Orders in 2007

Program Safeguard Contractors	Number of Benefit Integrity Task Orders
AdvanceMed	3
Cahaba Safeguard Administrators, LLC	2
Computer Sciences Corporation	1
IntegriGuard, LLC	1
SafeGuard Services, LLC	6
TriCenturion	3
TrustSolutions, LLC	2
Total	**18**

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

APPENDIX ~ B

Table B-1: Parts A and B Overpayments That Program Safeguard Contractors Referred for Collection in 2007 by Provider Type

Provider Types	Number of Overpayment Referrals	Dollar Amount of Overpayments	Percentage of Overpayment Amount[1]
Physician Services	1,375	$336,047,666	40%
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Provider	1,859	$334,512,666	40%
Ambulance Services	66	$38,101,173	5%
Clinical Laboratory or Independent Diagnostic Testing Facility	191	$29,310,457	4%
Home Health Agency	52	$29,266,860	4%
Hospital	331	$26,400,051	3%
Outpatient Rehabilitation Facility	17	$18,581,818	2%
Hospice	10	$12,906,242	2%
Physical Therapist or Occupational Therapist	27	$5,132,068	1%
Skilled Nursing Facility	46	$3,301,257	Less than 1%
Partial Hospital Program	2	$403,935	Less than 0.1%
Rural Health Clinic	1	$335,685	Less than 0.1%
Psychology Services	7	$256,973	Less than 0.1%
Social Work Services	227	$238,852	Less than 0.1%
End Stage Renal Disease Facility	2	$97,814	Less than 0.1%
Radiology Services	15	$69,041	Less than 0.1%
Ambulatory Surgical Center	3	$66,875	Less than 0.1%
Beneficiary	1	$2,982	Less than 0.1%
Other[2]	7	$23,526	Less than 0.1%
Total	**4,239**	**$835,055,941**	

Source: Office of Inspector General analysis of responses from program safeguard contractors (PSC) and claims processors.

[1]The percentages in this column add up to more than 100 percent because of rounding.

[2]Includes six referrals for other provider types and one referral for which the PSC did not specify provider type.

APPENDIX - C

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: FEB 0 2 2010

TO: Daniel R. Levinson
Inspector General

FROM: Charlene Frizzera /S/
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicare Overpayments Identified by Program Safeguard Contractors" (OEI-03-08-00031)

Thank you for the opportunity to comment on the Office of Inspector General's (OIG) draft report entitled, "Medicare Overpayments Identified by Program Safeguard Contractor." The Centers for Medicare & Medicaid Services (CMS) appreciates the time and resources the OIG has invested to research and report on this issue.

Pursuant to the authority set forth in section 1893 of the Social Security Act, CMS created the Program Safeguard Contractors (PSCs) in 1999 in order to provide a more focused effort for detecting and preventing fraud and abuse, and to act as liaisons for law enforcement activities. Under the PSC model, companies competing to become a PSC could choose the Medicare issues on which they wanted to bid. For example, one PSC could focus only on program integrity issues related to physician claims, while another PSC might focus solely on claims related to Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS), and a third PSC might focus on both physician and inpatient claims. This structure created an environment where CMS had 18 different PSC task orders with varying levels of focus resulting in a coordination of effort that was often times challenging. One of the limitations of the original PSC structure was that the PSCs were organized by specific payment type and geographic area. There are geographic sections of the country where there is very little fraud and sections where there is a tremendous amount of fraudulent activity. The number of claims for which a PSC has oversight responsibility does not necessarily correlate to the amount of fraud that is found in a geographical location. As a result, there was not a strong correlation of the level of overpayments and the size of a PSCs oversight responsibility.

In an effort to improve CMS' ability to more effectively fight fraud and abuse, CMS established the new Zone Program Integrity Contractor (ZPIC) contracting strategy. This change from the PSCs to the ZPICs represents a significant shift in CMS' approach to utilizing benefit integrity contractors. One of the primary benefits of the ZPIC strategy is

the requirement that a ZPIC must be able to review Medicare provider/supplier claims across all benefit categories. Instead of 18 PSC task orders, CMS will only have seven ZPIC contracts. This consolidation of contractor management allows CMS to achieve economies of scale by streamlining data and IT requirements, facility costs, overhead, as well as CMS' costs related to acquisition, management and oversight. The ZPIC strategy should also make it much easier for law enforcement to navigate our systems and retrieve data, provide for better coordination with the States and Medicare contractors, and increase security of protected health information. To date CMS has awarded four ZPIC contracts, two of which have been operational since February 1, 2009, and the other two have been under protest, but will become operational by mid-2010. Barring further protests of ZPIC awards, we anticipate completing the full transition from PSCs to ZPICs by the end of 2010.

OIG RECOMMENDATION

Determine why certain PSCs have low levels of overpayment dollars referred for collection compared to their oversight responsibility.

CMS RESPONSE

CMS concurs. CMS agrees that historically there has not been a clear correlation between the levels of overpayment dollars recovered and the scope of PSCs' oversight responsibility. While there have been many factors that contributed to this gap, one of the primary reasons was the limitation of PSCs to look at just one particular benefit category in a limited geographic area. This was one of the primary reasons that CMS decided to develop the new ZPIC contracting strategy which allows the ZPICs to review claims across all benefit categories in a broader geographic region. In some instances, the ZPIC will be able to look across benefit categories for the entire nation. This change in approach to CMS' benefit integrity contracting strategy should address the OIG's concerns regarding the gap between the scope of responsibility and the level of dollars recovered.

OIG RECOMMENDATION

Determine why certain PSCs have low Part A overpayment dollars referred for collection compared to their Part B overpayments dollars referred for collection.

CMS RESPONSE

CMS concurs. This is another instance in which the historical structure of the PSC contracting strategy limited the effectiveness of certain PSCs to collect larger amounts of overpayments through Medicare claims processors, such as fiscal intermediaries, carriers, and Medicare Administrative Contractors. In the new ZPIC contracting strategy, each ZPIC has jurisdiction for all claim types in its geographic zone and is required to perform

cross-claims analysis to determine if there are any patterns or relationships across claim types. Each ZPIC is also required to have a team of staff with expertise in each claim type (A, B, DMEPOS, home health and hospice). This approach will allow for greater recoveries as overpayment issues can be identified across multiple payors and benefit categories. As a result, the ZPICs will be able to identify overpayments quicker and ultimately should increase recoveries. We will monitor both overpayment and collection activities to ensure that our contractors are adequately performing their oversight responsibilities.

The CMS appreciates the effort that went into this report, and we look forward to continuing to work with the OIG on this and other issues related to potential fraud and abuse in the Medicare program.

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 principal Office of Evaluation and Inspections staff from the Philadelphia regional office who contributed to the report include Conswelia McCourt and Cynthia R. Hansford; other central office staff who contributed include Scott Manley.

Office of Inspector General

http://oig.hhs.gov

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

Office of Audit Services

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

Office of Evaluation and Inspections

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

Office of Investigations

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

Office of Counsel to the Inspector General

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