



DEPARTMENT OF HEALTH AND HUMAN SERVICES

## OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



May 18, 2012

**TO:** Marilyn Tavenner  
Acting Administrator  
Centers for Medicare & Medicaid Services

**FROM:** /Daniel R. Levinson/  
Inspector General

**SUBJECT:** Obstacles to Collection of Millions in Medicare Overpayments (A-04-10-03059)

The attached final report provides the results of our review of the Centers for Medicare & Medicaid Services efforts to recover Medicare overpayments identified through Office of Inspector General (OIG) audits.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that the OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at [Brian.Ritchie@oig.hhs.gov](mailto:Brian.Ritchie@oig.hhs.gov). We look forward to receiving your final management decision within 6 months. Please refer to report number A-04-10-03059 in all correspondence.

Attachment

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**OBSTACLES TO COLLECTION OF  
MILLIONS IN  
MEDICARE OVERPAYMENTS**



Daniel R. Levinson  
Inspector General

May 2012  
A-04-10-03059

# ***Office of Inspector General***

<http://oig.hhs.gov>

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

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# *Notices*

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**THIS REPORT IS AVAILABLE TO THE PUBLIC**  
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Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

## **OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS**

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

## EXECUTIVE SUMMARY

### BACKGROUND

The Presidential Memorandum entitled *Finding and Recapturing Improper Payments* (75 Fed. Reg. 12119 (March 15, 2010)) directs agencies to use every tool available to identify and reclaim the funds associated with improper payments that the Federal Government has made. The memorandum notes that reclaiming these funds is a critical component of the proper stewardship and protection of taxpayer dollars. Office of Management and Budget (OMB) Circular A-123, Appendix C, *Requirements for Effective Measurement and Remediation of Improper Payments*, part I, section L (2006), states that Federal agencies should take all necessary steps to prevent, detect, and collect improper payments. The Department of Health and Human Services (HHS) has identified Medicare as a program that may be susceptible to significant improper payments pursuant to the Improper Payments Information Act of 2002 and OMB Circular A-123, Appendix C, part I (2006). Title XVIII of the Social Security Act (the Act) established Medicare, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers Medicare.

Pursuant to the Inspector General Act of 1978, 5 U.S.C. Appendix 3 (IG Act), the Office of Inspector General (OIG) was established to provide independent assessments of HHS programs and operations, including CMS; help promote economy and efficiency; and keep the HHS Secretary and Congress informed about problems and deficiencies in the administration of HHS programs and operations. Under the IG Act, it is the “duty and responsibility” of an Inspector General to conduct audits of agency expenditures. To fulfill this obligation, the HHS OIG conducts audits of CMS, as well as CMS grantees and contractors, relating to Medicare operations.

To recover questioned Medicare payments, the Medicare contractors must first reopen the original payment determination. For “good cause,” a Medicare contractor may reopen a payment determination at any time within 4 years of the date the original payment determination was made (42 CFR § 405.980 (b)(2)). Once a payment determination has been reopened, the contractor may then seek to recover the overpayment. Section 1870 of the Act governs the recovery of overpayments. Section 1870(b) of the Act bars recovery from providers that are “without fault” and deems a provider to be “without fault” 3 years after the year in which the original payment was made. For purposes of this report, the time period for reopening and/or recovering overpayments is referred to as the “statute of limitations.”

During the 30-month period ended March 31, 2009, OIG issued reports recommending that CMS collect approximately \$418 million in Medicare overpayments. In its written responses to these reports, CMS did not agree to collect \$2 million of the \$418 million. This review focused on the remaining \$416 million that CMS agreed to collect, sometimes noting that it would collect in accordance with its policies and procedures. This is referred to as the “sustained overpayment amount” throughout this report.

## **OBJECTIVE**

Our objective was to determine the extent to which CMS had collected sustained overpayment amounts identified in OIG audit reports.

## **SUMMARY OF FINDINGS**

As of October 8, 2010, CMS had not collected the majority of overpayment amounts identified in OIG audit reports. Of the 154 OIG audit reports with sustained overpayment amounts totaling \$416,287,546, CMS reported collecting \$84,168,502. Specifically, CMS reported collecting the full sustained amounts totaling \$83,272,666 for 113 reports and partial sustained amounts totaling \$895,836 for 8 reports. However, CMS did not collect the remaining \$332,119,044. CMS's collections were limited because of time constraints imposed by the statute of limitations on overpayment collections. In addition, it did not provide its contractors with adequate guidance for collecting overpayments and did not have an effective system for monitoring its contractors' collection efforts.

Furthermore, we could not verify the \$84,168,502 that CMS reported collecting, and we identified inaccuracies in the reported amount. These issues arose because CMS did not have adequate systems for (1) documenting overpayment collections identified in OIG audit reports or (2) detecting data entry errors. Therefore, CMS had no assurance that the overpayment collections information that it reported to other parties was accurate.

## **RECOMMENDATIONS**

We recommend that CMS:

- pursue legislation to extend the statute of limitations so that the recovery period exceeds the reopening period for Medicare payments;
- ensure that its Audit Tracking and Reporting System (ATARS) is updated to accurately reflect the status of audit report recommendations;
- ensure that CMS staff record collections information consistently in ATARS;
- collect sustained amounts related to OIG recommendations made after our audit period to the extent allowed under the law;
- verify that the \$84,168,502 reported as collected has actually been collected; and
- provide specific guidance to its contractors concerning (1) the timeframe in which the contractor must take action to collect an overpayment, (2) how to report collections, (3) the type of documentation that the contractor must maintain to substantiate an overpayment collection, and (4) how to report reasons for not collecting overpayments.

## **CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, in response to our first recommendation, CMS said that it would explore the possibility of pursuing legislative proposals. CMS concurred with our second, third, and sixth recommendations and discussed actions it had taken or planned to take to implement them. CMS partially concurred with our fourth recommendation and did not concur with our fifth recommendation.

In regard to our fourth recommendation, CMS said that it would collect only sustained amounts in OIG recommendations that are for claims that can be reopened and that it would make collections when it is cost beneficial to reopen and review the claims. CMS also said that it has limited medical review resources and must focus reviews on the most “error-prone claims.”

We recognize that CMS has limited medical review resources. However, we do not believe that CMS must always perform medical review to determine which claims were paid in error before collecting overpayments.

To assist CMS in its collection efforts, we transmit, with every audit report, data containing the population of claims from which a sample was reviewed. Providing these data significantly limits the amount of additional work and resources necessary for CMS to identify the claims at issue and to recover the related overpayments.

In regard to our fifth recommendation, CMS said that it has policies to ensure that Medicare contractors accurately account for all overpayment collections and that, if a contractor reports making a collection related to an OIG audit, CMS considers that report proof that a collection has been made. CMS also said that it believed that OIG-identified overpayments were accurately accounted for in CMS financial reports.

We do not agree that a contractor’s report proves that a collection has been made. We could not verify the \$84,168,502 that CMS reported collecting, and we identified inaccuracies in the reported amount. Additionally, our audit identified inaccuracies in the ATARS data that CMS used to prepare its financial reports.

CMS’s comments are included in their entirety as the Appendix.

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## INTRODUCTION

### BACKGROUND

The Presidential Memorandum entitled *Finding and Recapturing Improper Payments* (75 Fed. Reg. 12119 (March 15, 2010)) directs agencies to use every tool available to identify and reclaim the funds associated with improper payments that the Federal Government has made. The memorandum notes that reclaiming these funds is a critical component of the proper stewardship and protection of taxpayer dollars. Office of Management and Budget (OMB) Circular A-123, Appendix C, *Requirements for Effective Measurement and Remediation of Improper Payments*, part I, section L (2006), states that Federal agencies should take all necessary steps to prevent, detect, and collect improper payments. The Department of Health and Human Services (HHS) has identified Medicare<sup>1</sup> as a program that may be susceptible to significant improper payments pursuant to the Improper Payments Information Act of 2002 and OMB Circular A-123, Appendix C, part I (2006).

Pursuant to the Inspector General Act of 1978, 5 U.S.C. App. 3 (IG Act), the HHS Office of Inspector General (OIG) provides independent assessments of HHS programs and operations, including CMS; helps promote economy and efficiency; and keeps the HHS Secretary and Congress informed about problems and deficiencies in the administration of HHS programs and operations. Under the IG Act, it is the “duty and responsibility” of an Inspector General to conduct audits of agency expenditures. To fulfill this obligation, the HHS OIG conducts audits of CMS, as well as CMS grantees and contractors, relating to Medicare operations. During the 30-month period ended March 31, 2009, OIG issued reports recommending that CMS collect approximately \$418 million in Medicare overpayments. In its written response to these reports, CMS did not agree to collect \$2 million of the \$418 million. This review focused on the remaining \$416 million, which CMS agreed to collect, sometimes noting that it would collect overpayments in accordance with its policies and procedures. This is referred to as the “sustained overpayment amount” throughout this report.

### Audit Resolution

Overpayments identified by the OIG in audit reports are “questioned costs” as defined by section 5(f)(1) of the IG Act. A “management decision” is defined by section 5(f)(5) of the IG Act as the issuance of a final decision by a Federal agency concerning its response to an Inspector General audit report findings and recommendations. Section 5(f)(3) of the IG Act defines a “disallowed cost” as a questioned cost that a Federal agency has “sustained” in a management decision. A “final action” is defined by section 5(f)(6) of the IG Act as the completion of all actions that a Federal agency has concluded in its management decision are necessary with respect to the findings and recommendations in an audit report.

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<sup>1</sup> Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers Medicare.

The Federal Acquisition Streamlining Act of 1994 (FASA),<sup>2</sup> as amended by the National Defense Authorization Act for Fiscal Year 1996,<sup>3</sup> established statutory deadlines for the prompt resolution of audit recommendations. FASA, as amended, requires Federal agencies to make management decisions on all findings and recommendations in each Inspector General audit report within 6 months after issuance. FASA also requires Federal agencies to complete a final action on each management decision within 12 months of each Inspector General report. In addition, section 8(a)(4) of OMB Circular A-50 Revised, *Audit Followup*, requires that agency management maintain accurate records regarding the status of audit report recommendations from resolution through corrective action.

### **Process for Concurring With Office of Inspector General Report Recommendations**

Consistent with the requirements of the FASA, CMS policy states that all audit recommendations in OIG reports should be resolved within 6 months of the report issuance date. As detailed in the HHS *Financial Accounting Policy Manual*, section 10-41-V, CMS uses the OIG Clearance Document (OCD) to report its management decisions and actions taken on both monetary and nonmonetary recommendations. The OCD lists each audit report recommendation and indicates CMS's concurrence or nonconcurrence with each recommendation. In the case of a concurrence, CMS describes the action it has taken or plans to take to address the recommendation.

The OCD reflects CMS's final management decision as shown in its formal response to each audit report. In the case of recommendations to collect overpayments, CMS may concur with the recommendation but elect to sustain an amount that differs from the amount recommended for collection. When concurring with a recommendation to collect overpayments, CMS sometimes stated on the OCD that it would recover the overpayments "consistent with the Agency's policies and procedures." CMS showed the amount that it agreed to recover as a sustained amount on the OCD. CMS considers recommendations to be cleared when it creates and submits the completed OCD to OIG and OIG accepts it.

According to the HHS *Financial Accounting Policy Manual*, section 10-41-V part 1, G, the CMS "originating official" and an "approving official" sign the OCD to certify that it represents CMS's official position. OIG uses these OCDs to determine the final disposition of OIG audits. OIG also uses the information in the OCDs for reporting to Congress.

CMS categorizes OIG audit reports as either internal or external reports. Internal reports are issued to the CMS Administrator, and officials in the CMS Central Office in Baltimore, Maryland, resolve the associated recommendations and prepare the OCD. External reports are issued to parties other than the CMS Administrator (e.g., Medicare contractors, specific physicians, and hospitals), and officials in CMS's Kansas City regional office resolve the associated recommendations and prepare the OCD.

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<sup>2</sup> P.L. No. 103-355 § 6009.

<sup>3</sup> P.L. No. 104-106 § 810.

## **Medicare Contractors**

CMS has delegated to Medicare contractors the responsibility for reopening and recovering most Medicare overpayments identified in OIG reports.<sup>4</sup> CMS sometimes instructs the Medicare contractors via the Joint Signature Memorandums (JSM) to follow applicable recovery rules in Federal regulations and to consider the costs and benefits of recovery when initiating collection of overpayments.<sup>5</sup>

### **Reopening and Recovering Overpayments**

#### *Period for Reopening Overpayments*

To recover questioned Medicare payments, the Medicare contractors must first reopen the original payment determination. Section 1869(b)(1)(G) of the Act and 42 CFR part 405, subpart I, govern the reopening process. For “good cause,” a Medicare contractor may reopen a payment determination at any time within 4 years of the date the original payment determination was made (42 CFR § 405.980 (b)(2)).

#### *Period for Recovering Overpayments*

Once a payment determination has been reopened, contractors may then seek to recover the overpayment from providers and suppliers. Section 1870 of the Act governs the recovery of overpayments. The Secretary of HHS has interpreted section 1870(b) of the Act as barring the recovery of overpayments from providers that are “without fault.” Section 1870(b) of the Act also states that a provider is deemed to be without fault 3 years after the year in which the original payment was made unless there is “evidence to the contrary.” For purposes of this report, the time period for reopening and/or recovering overpayments is referred to as the “statute of limitations.”

### **Centers for Medicare & Medicaid Services’ Audit Recommendation Tracking**

CMS uses the Audit Tracking and Reporting System (ATARS) to monitor the status of OIG recommendations. CMS manually enters collections data that it receives from Medicare contractors into ATARS periodically during the year and at the end of the fiscal year (FY). According to the *ATARS User Manual*, ATARS is used to generate semiannual reports summarizing CMS’s collection activities during the immediately preceding 6-month period. CMS categorizes the collection information that it enters into ATARS as costs that were recovered through collection, offset, or property in lieu of cash. Additionally, ATARS provides the status of OIG recommendations—both monetary and nonmonetary—during the reporting period.

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<sup>4</sup> The CMS Central Office is responsible for collecting overpayments related to the Medicare Advantage and Medicare prescription drug programs.

<sup>5</sup> Chapter 3 of the *Medicare Financial Management Manual* provides additional collection guidance to contractors.

## **Health Care Fraud and Abuse Control Program Report**

To help combat fraud and abuse in health care programs such as Medicare and Medicaid, Congress enacted the Health Care Fraud and Abuse Control (HCFAC) program as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).<sup>6</sup> CMS, HHS, and the Department of Justice (DOJ) jointly administer the HCFAC program. HIPAA requires that HHS and DOJ issue a joint annual report (HCFAC report) to Congress on (1) amounts deposited to the Federal Hospital Insurance Trust Fund pursuant to HIPAA (also known as HCFAC deposits) for the previous FY and the source of those amounts and (2) amounts appropriated from the Medicare Trust Fund for HCFAC activities each year and the justification for the expenditure of those amounts. The amount of Medicare overpayments collected based on OIG-recommended audit disallowances has historically been included in the HCFAC report and is a major element reported by HHS.

### **OBJECTIVE, SCOPE, AND METHODOLOGY**

#### **Objective**

Our objective was to determine the extent to which CMS had collected sustained overpayment amounts identified in OIG audit reports.

#### **Scope**

During the 30-month period ended March 31, 2009, OIG issued reports recommending that CMS collect approximately \$418 million in Medicare overpayments. Our review focused on the \$416 million in Medicare overpayments that CMS had sustained in OCDs. We selected OIG audit reports with recommendations to collect overpayments greater than \$1,000 that were issued during FYs 2007 (38 reports) and 2008 (65 reports) and the first 6 months of FY 2009 (51 reports) to CMS, CMS contractors, or Medicare providers. We chose this period to account for the time that it takes CMS to make management decisions and to collect overpayments. Of the 154 audit reports we analyzed with recommendations for overpayment collections, 145 were external reports (which are ultimately resolved by a CMS regional office) with recommendations to collect sustained overpayments totaling \$112,898,159 and 9 were internal reports (which are ultimately resolved by the CMS headquarters office) with recommendations to collect sustained overpayments totaling \$303,389,387.

To determine the amounts CMS collected, we reviewed an ATARS report as of June 6, 2010, for each of the 145 external OIG reports. For each of the nine internal reports, we reviewed an ATARS report as of October 8, 2010. We also obtained updated ATARS reports that reflected additional amounts collected as of July 31, 2011, for both internal and external reports.

Our review did not require an understanding or assessment of CMS's overall internal control structure. We limited our review of CMS's internal controls to gaining an understanding of its

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<sup>6</sup> P.L. No. 104-191, § 201, 110 Stat. 1936, 1992 (Aug. 21, 1996).

controls over the collection of overpayments that were based on OIG audit recommendations. We did not perform a review of the HHS *Agency Financial Report* (AFR) or the HCFAC report.

We performed fieldwork at the CMS regional offices in Kansas City, Missouri; Atlanta, Georgia; and Chicago, Illinois, and the offices of selected Medicare contractors from April 2010 through February 2011. We also performed fieldwork at OIG and CMS Central Offices in Baltimore and the OIG Atlanta regional office through February 2012.

## **Methodology**

To accomplish our objective, we:

- reviewed applicable Federal requirements;
- reviewed CMS policies and procedures for resolving audit recommendations and collecting overpayments;
- interviewed selected CMS central office staff, CMS regional office staff, and Medicare contractors concerning their processes for audit resolution, including the reporting and collecting of overpayments;
- reviewed audit resolution and overpayment collection documentation pertaining to the 154 audit reports provided by CMS central office staff, regional office staff, and Medicare contractors to determine whether reported overpayment collections had actually been made;
- analyzed the OCDs, ATARS reports, and corrective action plans for each of the audits to determine CMS's reason for not collecting the overpayments; and
- discussed the results of our review with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

## **FINDINGS AND RECOMMENDATIONS**

As of October 8, 2010, CMS had not collected the majority of overpayment amounts identified in OIG audit reports. Of the 154 OIG audit reports with sustained overpayment amounts totaling \$416,287,546, CMS reported collecting \$84,168,502. Specifically, CMS reported collecting the full sustained amounts totaling \$83,272,666 for 113 reports and partial sustained amounts totaling \$895,836 for 8 reports. However, CMS did not collect the remaining \$332,119,044. CMS's collections were limited because of time constraints imposed by the statute of limitations on overpayment collections. In addition, it did not provide its contractors with adequate

guidance for collecting overpayments and did not have an effective system for monitoring its contractors' collection efforts.

Furthermore, we could not verify the \$84,168,502 that CMS reported collecting, and we identified inaccuracies in the reported amount. These issues arose because CMS did not have adequate systems for (1) documenting overpayment collections identified in OIG reports or (2) detecting data entry errors. Therefore, CMS had no assurance that the overpayment collections information that it reported to other parties was accurate.

## **FEDERAL REQUIREMENTS**

Pursuant to the Federal Claims Collection Act of 1966 (FCCA),<sup>7</sup> as amended, and 45 CFR sections 30.2 and 30.10, CMS must aggressively and timely collect all overpayments and audit disallowance determinations. Chapter 3, section 10 of the *Medicare Financial Management Manual* states that, once a Medicare contractor determines that an overpayment has been made, it must attempt recovery of the overpayment in accordance with CMS regulations.

Section 1869(b)(1)(G) of the Act and 42 CFR part 405, subpart I, govern the reopening process. For “good cause,” a Medicare contractor may reopen a payment at any time within 4 years of the date the original payment was made (42 CFR § 405.980 (b)(2)). Section 1870 of the Act governs the recovery of overpayments. Section 1870(b) of the Act bars recovery from providers that are “without fault” at any time and deems providers to be “without fault” 3 years after the year in which the original payment was made unless there is “evidence to the contrary.” OMB Circular A-50 Revised, *Audit Followup*, requires that agency management maintain accurate records regarding the status of audit report recommendations from resolution through corrective action.

## **UNCOLLECTED OVERPAYMENTS**

### **Majority of Overpayment Amounts Not Collected**

As of October 8, 2010, CMS had not collected the majority of overpayment amounts that OIG recommended for collection during the 30-month period ended March 31, 2009. During this period, OIG recommended that CMS collect \$417,636,708 in overpayments. CMS sustained \$416,287,546. Of this amount, CMS reported that it had collected only \$84,168,502 (20 percent) and that the remaining \$332,119,044 (80 percent) was uncollected (Table 1).

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<sup>7</sup> FCCA, P.L. No. 89-508 § 3(a). This provision is codified at 31 U.S.C. § 3711(a)(1).

**Table 1: Medicare Overpayments—Reported as Collected and Uncollected**

<b>Description</b>	<b>Internal<sup>8</sup> as of Oct. 8, 2010 (9 Reports)</b>	<b>External as of June 6, 2010 (145 Reports)</b>	<b>Total (154 Reports)</b>
Sustained Amounts	\$303,389,387	\$112,898,159	\$416,287,546
Collected Amounts	12,781,050	71,387,452	84,168,502 <sup>9</sup>
<b>Uncollected Balance</b>	<b>\$290,608,337</b>	<b>\$41,510,707</b>	<b>\$332,119,044<sup>10</sup></b>

Although CMS officials gave various reasons for not collecting sustained overpayments, CMS's records did not always contain explanations. Therefore, we were unable to determine why some of the OIG-recommended amounts had not been collected.

For 113 reports, CMS reported collecting the full amounts of the sustained overpayments. As of October 8, 2010, CMS had not collected all sustained overpayments related to the remaining 41 of the 154<sup>11</sup> reports covered by our review:

- For eight reports with sustained overpayments totaling \$240,738,364, CMS reported \$895,836 in overpayment collections. The documentation CMS provided did not explain why the contractors did not collect the balance of \$239,842,528.
- For 21 reports with sustained overpayments totaling \$28,401,335, CMS reported no overpayment collections and gave us no explanations.
- For the remaining 12 reports with sustained overpayments totaling \$63,875,181, CMS gave us the following reasons for not collecting the overpayments:
  - For 10 with sustained overpayments totaling \$61,598,979, the statute of limitations for collecting the sustained overpayments had expired.
  - For two with sustained overpayments totaling \$2,276,202, the providers were no longer in business, and the contractors could not collect the overpayments.

<sup>8</sup> Internal reports are issued to the CMS Administrator, and external reports are issued to parties other than the CMS Administrator (e.g., Medicare contractors, specific physicians, and hospitals).

<sup>9</sup> CMS collected \$1,690,635 in excess of the sustained amounts in addition to the \$84,168,502 that it reported as collected based on OIG recommendations.

<sup>10</sup> A total of \$236,170,028 in sustained amounts from two reports makes up the majority (71 percent) of the uncollected balance.

<sup>11</sup> We determined the collection status of each report based on our review of CMS's comments in ATARS and the OCDs.

Table 2 provides a breakdown of the \$332,119,044 of uncollected overpayments by reason and type of report.

**Table 2: CMS-Reported Reasons for Uncollected Amounts**

	<b>Internal as of Oct. 8, 2010 (7 reports)</b>	<b>External as of June 6, 2010 (34 reports)</b>	<b>Total (41 reports)</b>
No Reason Provided in ATARS or OCDs (These amounts remained open for collection. <sup>12</sup> )	\$241,085,719 (4 reports)	\$27,158,144 (25 reports)	\$268,243,863 (29 reports)
Reopening and Recovery Periods Beyond Statute of Limitations	49,522,618 (3 reports)	12,076,361 (7 reports)	61,598,979 (10 reports)
Provider No Longer in Business	0	2,276,202 (2 reports)	2,276,202 (2 reports)
<b>Total</b>	<b>\$290,608,337</b>	<b>\$41,510,707</b>	<b>\$332,119,044</b>

As of July 31, 2011, CMS reported that it had collected an additional \$13,147,884, or 5 percent, of the \$268,243,863 related to the 29 reports categorized as open for collection since the June and October 2010 ATARS reports. (These additional collections are not reflected in Table 2.)

### **Statute of Limitations**

Although CMS reported that \$268,243,863 remained in open collection status, we determined that the reopening and recovery periods imposed by the statute of limitations had now expired for these overpayments.

### **Inadequate Guidance and Monitoring**

CMS delegated responsibility for collecting sustained overpayments to Medicare contractors and provided guidance in the JSM. However, this guidance was not sufficient to ensure that contractors (1) documented reasons for not collecting overpayments and (2) reported the status of their collection efforts to CMS. The guidance did not include instructions on maintaining adequate documentation or reporting collections to CMS. In addition, CMS did not adequately monitor contractor collection efforts or ensure that contractors were consistent in their collection efforts. CMS did not require supporting documentation from the contractors to verify how much they had actually collected or to determine whether they had made reasonable efforts to collect the overpayments. Moreover, CMS accepted without independent verification whatever form of support the contractors provided.

<sup>12</sup> According to the 2010 AFR, CMS listed the uncollected balance on the two reports listed in footnote 10 as being in active collection status although the recovery period had expired. According to the 2011 AFR, CMS listed the balances on these two reports, which constitute 71 percent of the \$332,119,044 uncollected balance, as being beyond the statute of limitations.

When concurring with recommendations to collect overpayments, CMS sometimes stated on the OCD that it would recover the overpayments “consistent with the Agency’s policies and procedures.” As noted above, CMS reported that \$268,243,863 remained in open collection status in ATARS even though the reopening and recovery periods had expired. CMS did not always update this information in ATARS. As a result, CMS did not have accurate records regarding its collection efforts, which is contrary to OMB Circular A-50.

## **UNVERIFIABLE AND INACCURATE COLLECTIONS INFORMATION**

We could not verify the \$84,168,502 that CMS reported collecting, and we identified inaccuracies in the reported amount. Because of these issues, CMS had no assurance that the overpayment collections information that it reported to other parties was accurate.

### **Unverifiable Collections**

We visited 3 of the 11 CMS regional offices. We selected these three regional offices because they had reported the majority of the collected amounts for external reports. Two of the three offices reported collecting approximately \$30,730,408 of \$37,865,992 in overpayments associated with external reports. However, we were unable to verify that the \$30,730,408 CMS reported as collected had actually been collected or from which entities. Contractor officials in these regions gave us various documents (e.g., letters, system screen prints of adjusted claims, spreadsheets with claim adjustments listed, and email) to support collections. CMS stated that a phone conversation between CMS and the contractor or an email from the contractor stating that collections had been made was sufficient to support that an overpayment collection had been made. These types of documentation might have shown that an adjustment had been made, but without specific details, we could not match these adjustments to a corresponding OIG recommendation. Therefore, we could not verify that CMS had collected the overpayments identified in the OIG recommendation.

We also could not verify the accuracy of the overpayment collections that CMS reported for the nine internal reports. CMS had reported collections of \$12,781,050 of the \$303,389,387 in sustained overpayments. As with the external reports, the documentation that CMS gave to us was not sufficient for us to verify that the entire \$12,781,050 had been collected or from which entities.

We could not verify the amounts that CMS had reported as collected because CMS did not (1) routinely require supporting documentation from the contractors to verify whether the contractors had actually collected the OIG-recommended overpayments or (2) validate the information it had received. Moreover, for some of the reports we reviewed, the Medicare contractor had been replaced and did not leave historical information about collections for the new contractor.

## **Inaccurate Collections Information in Centers for Medicare & Medicaid Services Audit Databases**

CMS informed us that some of the information about reported collections was inaccurate because CMS staff members were inconsistent in how they recorded collections in ATARS. Instead of recording incremental collections, CMS staff members recorded cumulative collections, resulting in overstated yearly totals in ATARS. CMS gave us a spreadsheet that showed ATARS collections were overstated by \$24 million during FYs 2006 through 2011.<sup>13</sup> Information on overpayment collections in ATARS is routinely communicated outside HHS in various reports, including HHS's annual AFR. However, because of the inaccuracies in CMS's audit databases, these reports contained inaccurate information.

We attempted to obtain detailed support from CMS for the \$24 million it claimed it overstated. Although CMS provided the number of audits affected and the total dollars, it did not provide the overstatement amount by year, which would have enabled us to verify the accuracy of the overstated amount.

## **Inaccurate Collections Information Reported to Others**

Because collections information in ATARS was unverifiable and inaccurate, CMS had no assurance that the information about overpayment collections that it reported to other parties for the 30-month period ended March 31, 2009, was accurate. Because multiple parties use Medicare payment data for various payment calculations and analyses, it is important that the data be accurate. Parties that use Medicare payment data include CMS's Office of the Actuary and the Medicare Payment Advisory Commission.<sup>14</sup> The Trustees of the Medicare Trust Fund also use Medicare data when preparing the annual report of the financial status of the Medicare Trust Fund.

## **RECOMMENDATIONS**

We recommend that CMS:

- pursue legislation to extend the statute of limitations so that the recovery period exceeds the reopening period for Medicare payments;
- ensure that ATARS is updated to accurately reflect the status of audit report recommendations;
- ensure that CMS staff record collections information consistently in ATARS;

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<sup>13</sup> Of the \$24 million, CMS identified \$586,776 applicable to the three internal reports covered by this audit. The remaining \$23,349,391 pertained to audits that are outside the scope of this review. These three ATARS corrections are included in the \$84 million that CMS reported as collected.

<sup>14</sup> As required by Congress, the Medicare Payment Advisory Commission reviews and makes recommendations for Medicare payment systems.

- collect sustained amounts related to OIG recommendations made after our audit period to the extent allowed under the law;
- verify that the \$84,168,502 reported as collected has actually been collected; and
- provide specific guidance to its contractors concerning (1) the timeframe in which the contractor must take action to collect an overpayment, (2) how to report collections, (3) the type of documentation that the contractor must maintain to substantiate an overpayment collection, and (4) how to report reasons for not collecting overpayments.

## **CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, in response to our first recommendation, CMS said that it would explore the possibility of pursuing legislative proposals. CMS concurred with our second, third, and sixth recommendations and discussed actions it had taken or planned to take to implement them. CMS partially concurred with our fourth recommendation and did not concur with our fifth recommendation. CMS's comments are included in their entirety as the Appendix.

### **Collect Sustained Amounts Related to Office of Inspector General Recommendations Made After Our Audit Period to the Extent Allowed Under Law**

#### *Centers for Medicare & Medicaid Services Comments*

CMS said that it would collect only sustained amounts in OIG recommendations that are for claims that can be reopened and that it would make collections when it is cost beneficial to reopen and review the claims. CMS also said that it has limited medical review resources and must focus reviews on the most "error-prone claims."

#### *Office of Inspector General Response*

We recognize that CMS has limited medical review resources. However, we do not believe CMS must always perform medical review to determine which claims were paid in error before collecting overpayments. For audits of individual entities, such as specific physicians and hospitals, CMS may collect the amounts identified as being in error without expending significant resources.

For cases of internal audits that reviewed a national sample of claims or external audits conducted at the contractor level, CMS would need to determine which claims were paid in error before recovering overpayments. To assist CMS in these collection efforts, we transmit, with every audit report, data containing the population of claims from which a sample was reviewed. Providing these data significantly limits the amount of additional work and resources necessary for CMS to identify the claims at issue and to recover the related overpayments.

## **Verify That the \$84,168,502 Reported as Collected Has Actually Been Collected**

### *Centers for Medicare & Medicaid Services Comments*

CMS said that it has policies to ensure that Medicare contractors accurately account for all overpayment collections. CMS also said that it believed that OIG-identified overpayments were accurately accounted for in CMS financial reports. CMS further said that if a contractor reports making a collection related to an OIG audit, CMS considers that report proof that a collection has been made. CMS also said that because of the age of the reports, records may no longer be available and that thus it would be extremely difficult to verify this information at this time.

### *Office of Inspector General Response*

We do not agree that a contractor's report proves that a collection has been made. As discussed in the "Unverifiable and Inaccurate Collections Information" section on page 9 of this report, we could not verify the \$84,168,502 that CMS reported collecting, and we identified inaccuracies in the reported amounts. Additionally, our audit identified inaccuracies in the ATARS data that CMS used to prepare its financial reports. Therefore, we do not agree that CMS accurately accounted for OIG-identified overpayments, and we continue to recommend that CMS verify that the \$84 million it reported as collected has actually been collected.

## **OTHER MATTER**

Effective March 23, 2010, The Patient Protection and Affordable Care Act<sup>15</sup> added section 1128J(d), "Reporting and Returning Overpayments," to the Act. This section requires a person who has received an overpayment to report and return the overpayment within 60 days after the date the overpayment was identified or, if applicable, 60 days after the corresponding cost report is due. This requirement may affect overpayment recoveries related to OIG audit findings, and we plan to work with CMS as it implements this requirement.

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<sup>15</sup> P.L. No. 111-148 § 6402(a).

# **APPENDIX**

## APPENDIX: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES COMMENTS



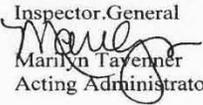
DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Centers for Medicare &amp; Medicaid Services

*Administrator*  
Washington, DC 20201

**DATE:** APR 06 2012

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

**FROM:**   
Marilyn Tavenner  
Acting Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: Obstacles to Collection of Millions in Medicare Overpayments (A-04-10-03059)

Thank you for the opportunity to review and comment on the OIG revised draft report titled "Obstacles to Collection of Millions in Medicare Overpayments" (A-04-10-03059). OIG set out to determine the extent to which Centers for Medicare & Medicaid Services (CMS) had collected approximately \$416 million in overpayments identified in OIG audit reports during a 30-month period ending March 31, 2009.

The CMS appreciates the time and resources OIG has invested to review this issue. CMS is committed to using its resources to collect identified overpayments in a manner that is cost effective and ensures that CMS complies with the statutory and regulatory framework of overpayment collections.

Each year CMS receives a number of reports from OIG that identify issues involving improper payments. These reports often involve recommendations to collect overpayments in varying amounts. Some of these are based on actual claim reviews performed by OIG, while others are based on extrapolated values projected by OIG.

The CMS is committed to collecting the overpayments identified in OIG audit reports. OIG reports that more than \$332 million in overpayments identified in OIG audit reports remains uncollected by CMS (Table 2, page 8). However, a significant majority of these overpayments primarily relates to claims that exceed the period for reopening or recovery. For example, two internal OIG reports accounted for \$236.8 million, which was 81 percent of the total \$290.6 million in uncollected overpayments. Both of these OIG reports were issued after the claims review or recovery periods were over. Specifically, one report was issued in June 2007 and the claim review period was 1999 – 2003. The second report was issued in January 2008 and the claims review period was 2001 – 2003. In both cases, CMS' ability to recover the overpayments was affected by the four-year reopening limitation in 42 C.F.R. §405.980(b), and the limitations on overpayment recovery in Section 1870 of the Social Security Act (collectively referred to in the report as the "statute of limitations" provisions).

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In addition, at the time OIG conducted its review and identified overpayments that CMS had not recovered, our Audit Tracking and Reporting System (ATARS) reported that \$268.2 million remained in open collection status. In researching these amounts, it was discovered that the reopening and recovery periods had actually expired for most, if not all, of these overpayments. While CMS had failed to update and close the overpayments in the ATARS system, CMS has begun taking steps to improve ATARS so that it will accurately reflect the status of overpayments identified by OIG audits.

In order to address the time between OIG's review of claims and reporting to CMS, we established a workgroup and held several discussions with OIG on ways to ensure that the information related to the actual claims is provided to CMS in a timely manner. This would allow contractors to begin collecting these amounts as soon as possible. CMS has also begun efforts to improve the overall tracking and reporting process of these overpayments.

We have reviewed the report and have responded to your recommendations.

**OIG Recommendation**

Pursue legislation to extend the statute of limitations so that the recovery period exceeds the reopening period for Medicare payments.

**CMS Response**

The CMS will explore the possibility of legislative proposals that would extend the statute of limitations.

**OIG Recommendation**

Ensure its Audit Tracking and Reporting System (ATARS) is updated to accurately reflect the status of audit report recommendations.

**CMS Response**

The CMS concurs with this recommendation. CMS has begun a review of its reporting in the ATARS system. We will make necessary changes to reflect the outcomes of the recovery work performed. Going forward CMS will ensure that corrective action plans and recoveries are clearly described and reported.

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**OIG Recommendation**

Ensure that CMS staff record collections information consistently in ATARS.

**CMS Response**

The CMS concurs with this recommendation. It is CMS' intent to consistently and accurately record collection efforts. Whenever OIG recommends that CMS collect overpayments, CMS will record the amounts it sustains for collection.

**OIG Recommendation**

Collect sustained amounts related to OIG recommendations made after our audit period to the extent allowed under law.

**CMS Response**

The CMS partially concurs with this recommendation. CMS will collect only sustained amounts in OIG recommendations that are for claims that can be reopened and where it is cost beneficial to reopen and review claims. CMS has limited medical review resources and must focus reviews on the most error-prone claims. Due to these resource constraints, CMS must prioritize our review efforts. However, CMS will continue to consider issues identified in OIG reports when developing medical review and recovery audit strategies.

**OIG Recommendation**

Verify the portion of the \$84,168,502 reported as collected has actually been collected.

**CMS Response**

The CMS does not concur with this recommendation. CMS requires Medicare contractors to separately report overpayments related to OIG reports in order to track this information in Clarity and ATARS. If a contractor reports a collection related to an OIG audit, then CMS considers this proof and uses this information to manually update Clarity and ATARS to indicate that a collection has occurred. Due to the age of the reports, records may no longer be available and thus, it would be extremely difficult to verify this information at this time.

It should be noted that CMS has policies in place to ensure that Medicare contractors accurately account for all overpayment collections, including those from OIG reports. CMS believes that OIG-identified overpayments are accurately accounted for in CMS financial reports. CMS performs bank reconciliations and reviews financial reports to ensure its accuracy and completeness. CMS will continue to improve its tracking and reporting of the collections related to actual sampled overpayment claims. Furthermore, CMS will explore ways to automate the tracking of OIG related collections in the future.

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**OIG Recommendation**

Provide specific guidance to its contractors concerning (1) the timeframe in which the contractor must take action to collect an overpayment, (2) how to report collections, (3) the type of documentation that the contractor must maintain to substantiate an overpayment collection, and (4) how to report reasons for not collecting overpayments.

**CMS Response**

The CMS concurs with this recommendation. CMS is reviewing processes to improve the tracking, reporting, and documenting of collection activities for OIG-identified overpayments. CMS has already begun to revise the reporting and tracking processes for OIG recommendations, and timeframes have been established for closing those recommendations if overpayments are determined to be uncollectible.

The CMS has also expanded its reporting requirements and provided additional direction to contractors related to closing audit reports. CMS is more closely monitoring contractors' responses to ensure that quarterly reporting is completed timely and accurately, and that contractors provide sufficient documentation to substantiate collection amounts. CMS will continue to improve its tracking and reporting of the collections related to actual sampled overpayment claims. CMS and OIG have worked to improve the timeliness with which CMS receives data from OIG. This improvement should allow CMS to provide OIG-identified claim overpayments to the contractors sooner in order to begin the collection process. In addition, CMS will work to ensure that the contractors provide explanations for items that cannot be collected. CMS is currently exploring ways to automate the tracking of collections related to OIG reports in order to eliminate the manual input process.