OIG Report Summary

MEMORANDUM

Date: September 29, 2017

Subject: ENHANCEMENTS NEEDED IN THE TRACKING AND COLLECTION OF MEDICARE OVERPAYMENTS IDENTIFIED BY ZPICS AND PSCS

OVERVIEW

On September 29, 2017, the Department of Health and Human Services Office of Inspector General (OIG) published the report titled, "ENHANCEMENTS NEEDED IN THE TRACKING AND COLLECTION OF MEDICARE OVERPAYMENTS IDENTIFIED BY ZPICS AND PSCS." The report is part of OIG's continued efforts to examine overpayments by Medicare. OIG reviewed overpayments that were referred by program safeguard contractors (PSCs) and zone program integrity contractors (ZPICs) to Medicare administrative contractors (MACs). In fiscal year 2014, 80% of overpayments referred by ZPICs and PSCs were not collected. OIG found shortcomings in how the contractors tracked and reported overpayments. In this report, the OIG recommends CMS to improve and standardize the tracking and reporting of overpayment referrals and collections. OIG also recommends CMS to require surety bonds for home health providers and other at-risk providers.

BACKGROUND

Previous OIG reports found that there were no significant payment recoveries from PSC. As of June 2008, MACs collected 7% of the total overpayments referred by PSC. In a separate report, OIG found that were not keeping track of overpayment referrals. In response to these findings, CMS stated that it was improving reporting and tracking standards, but OIG did not find this to be the case in a report conducted in 2011. In 2016, OIG continued to find differences in overpayment referrals between the contractors and recommended CMS to identify and address issues and develop best practices that can be shared with contractors. CMS agreed with the recommendations.

PSCs and ZPICs refers the overpayment amounts to MACs, but MACs make the final decision on the amount providers must refund. Once the MAC decides on the overpayment amount, a demand letter is sent to the provider. The provider may repay the overpayment immediately, MACs may withhold the amount from future billings, or the provider may appeal the request. If overpayment is unpaid for over 120 days, the MACs will either refer the unpaid amount to the Department of the Treasury or collect the payment from the surety for DME suppliers that have surety bonds.

ZPIC and PSC report workload statistics such as the amount and number of referrals that were sent to MACs to CMS on a monthly basis. MACs are required to keep track of collection of payments and report payments deposited in the Medicare trust fund to CMS monthly. MACs also send a monthly report to PSCs and ZPICs on the amount collected. MACs are in a joint operating agreement with PSCs and ZPICs, which outlines the tasks each contractor is responsible for and is intended to promote cooperation.

REVIEW

The study reviewed overpayments referred to MACs in FY 2014. OIG collected data from ZPICs (6), PSCs (4), and MACs (16) that were in operation as of December 2015. Due to ZPIC 3 not being able to provide data due to changes in contractors, the OIG used referral data from MACs associated with ZPIC 3.

In total, ZPICs and PSCs referred $559 million in overpayments but referral amounts varied across the different contractors.

Exhibit 3. Distribution of Overpayment Referrals and Dollars by ZPIC and PSC in FY 2014

ZPIC/PSC	Amount Referred	Percentage of Total Amount Referred
ZPIC 5	$159,256,463	28%
ZPIC 7	$123,249,353	22%
ZPIC 3[1]	$89,203,327	16%
ZPIC 4	$80,313,745	14%
ZPIC 2	$39,526,105	7%
EA BISC	$31,246,510	6%
ZPIC 1	$17,581,573	3%
PA BISC	$11,512,991	2%
NE BISC	$3,525,202	1%
DME PSC	$3,522,088	1%
Total	**$558,937,358**[2]	**100%**

Source: OIG analysis of ZPIC and PSC data for overpayments referred in FY 2014.
[1] Because ZPIC 3 was unable to provide overpayment referral data for FY 2014, we used the overpayment referral data reported by its associated MACs to calculate the amount referred.
[2] The amounts referred do not add up to the total because of rounding.

The highest number of overpayment referrals were from Part B (60%) and DME (20%). Largest dollar amount of referrals was from home health and hospice which made up 43% of total overpayment referral amounts.

MACs only collected 20% of total overpayment referral amount. The overpayment collection varied across the contractors.

Exhibit 6. MAC Collection Rates for FY 2014 ZPIC- and PSC-Referred Overpayments

MAC	Total Amount Sought for Collection	Total Amount Collected	Collection Rate
DME B	$24,769,170	$56,533	**< 1%**
J15	$20,066,952	$1,559,820	**8%**
J6	$39,155,699	$4,360,747	**11%**
JE	$1,951,916	$223,961	**11%**
JK	$40,513,062	$4,834,557	**12%**
JM	$134,192,729	$19,257,589	**14%**
JH	$84,880,694	$14,220,124	**17%**
J8	$10,246,196	$2,714,224	**26%**

JJ	$21,663,257	$5,938,983	**27%**
DME C	$18,053,038	$6,061,003	**34%**
JF	$15,674,260	$6,082,960	**39%**
JL	$12,932,825	$5,107,016	**39%**
DME D	$18,299,710	$7,078,323	**39%**
JN	$26,308,240	$10,592,425	**40%**
J5	$10,363,724	$5,355,563	**52%**
DME A	$3,167,527	$2,559,222	**81%**
Total	**$482,238,999**	**$96,003,049**[1]	**20%**

Source: OIG analysis of MAC data for overpayments referred by ZPICs and PSCs in FY 2014 and collected by MACs as of September 30, 2015.

[1] The amounts collected do not add up to the total because of rounding.

MACs stated that collecting overpayments were a challenge if:

- provider was no longer in business;
- provider filed for bankruptcy; and
- provider was revoked from participating in Medicare.

Due to the nature of PSC/ZPICs' work of identifying wasteful and fraudulent claims, the providers they are referring are possibly providers that are no longer participating in Medicare.

FINDINGS

OIG found that overpayments referred by PSCs and ZPICs did not match MACs' data. The discrepancy in data differed by $130 million. MACs did not have an explanation for why the data differed from PSCs and ZPICs, but MACs explained that it may be due to the differences in how MACs and PSCs/ZPICs count referrals.

OIG also found that the description and specificity of joint operating agreements between the auditors and MACs varied across the joint agreements. The lack of standardized reporting for both collections and referrals have caused issues with both auditors and MACs from tracking collections and referrals. MACs also expressed issues with needing to manually calculate transactions for the collections report due barriers created by using the electronic Healthcare Integrated General Ledger Accounting System (HIGLAS). This reliance on manual effort may have resulted in some errors.

LIMITATIONS OF REVIEW

1. OIG did not independently verify the reports from contractors, but reviewed that data for consistency.
2. At the time of the review, MACs had one to two years to collect overpayments.

OIG RECOMMENDATIONS

1. CMS to share best practices on identification of overpayments with ZIPCs and UPICs to improve identification of overpayments.
2. CMS develop strategies for MACs' to collect overpayments referred by ZIPCs and UPICs.
3. CMS to standardize reporting of overpayment referrals and collection reports by collaborating with ZIPCs, UPICs, and MACs.

4. CMS should require ZIPCs, UPICs, and MACs to use unique identifiers for every overpayment.
5. CMS should require surety bond for home health provider and consider surety bond requirement for other health providers to improve collection of overpayments

CMS COMMENTS

CMS stated it is transitioning PSCs and ZPICs to UPICs, and UPICs' ability to review both Medicare and Medicaid may enhance program integrity. CMS also stated it was creating the Unified Case Management system which is intended to improve collaboration between the auditors and MACs.

CMS agreed with OIG's recommendations except for the recommendation on requiring surety bonds. CMS is reviewing how to implement a surety bond requirement without increasing provider burden.