

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services



**News Flash** – The Centers for Medicare & Medicaid Services (CMS) has made changes to the Medicare Overpayment Notification Process. If an outstanding balance has not been resolved, providers previously received three notification letters regarding Medicare Overpayments, an Initial Demand Letter (1st Letter), a Follow-up-Letter (2nd Letter), and an Intent to Refer Letter (3rd Letter). CMS would send the second demand letter to providers 30 days after the initial notification of an overpayment. Recent review has determined that the majority of providers respond to the initial demand letter and pay the debt. Currently recoupment action happens 41 days after the initial letter. The remittance advice which describes this action serves as another notice to providers of the overpayment. Therefore, effective Tuesday, November 1, 2011, the second demand letters are no longer being sent to providers. Provider appeal rights will remain unchanged. If an overpayment is not paid within 90 days of the initial letter, providers will continue to receive a letter explaining CMS' intention to refer the debt for collection.

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## **The Role of the Zone Program Integrity Contractors (ZPICs), Formerly the Program Safeguard Contractors (PSCs)**

**Note:** This article was revised on February 29, 2012, to add Hawaii and several territories to ZPIC Zone 1 and to add Puerto Rico and the Virgin Islands to ZPIC Zone 7 of the table on page 2. All other information is the same.

### **Provider Types Affected**

This Special Edition MLN Matters® Article is intended for all physicians, providers, and suppliers who submit claims to Medicare contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), carriers, A/B Medicare Administrative Contractors (MACs), Durable Medical Equipment (DME) MACs, and Home Health and Hospice (HH+H) MACs for services and supplies provided to Medicare beneficiaries.

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## Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 established the Medicare Integrity Program (MIP). MIP was established, in part, to strengthen the Centers for Medicare & Medicaid Services' (CMS') ability to detect and deter potential fraud, waste, and abuse in the Medicare program. MIP allows CMS to carry out program safeguard functions effectively and efficiently. As part of this program, CMS created new entities, Program Safeguard Contractors (PSCs), to perform program integrity functions.

On December 8, 2003, the Medicare Modernization Act (MMA) was signed into law. Section 911 of the MMA directed implementation of Medicare Fee-For-Service Contracting Reform. This required CMS to use competitive procedures to replace its current FIs and carriers with a uniform type of administrative entity, referred to as Medicare Administrative Contractors (MACs).

As a result of these changes, seven program integrity zones were created based on the newly-established MAC jurisdictions. New entities entitled Zone Program Integrity Contractors (ZPICs) were created to perform program integrity functions in these zones for Medicare Parts A, B, Durable Medical Equipment Prosthetics, Orthotics, and Supplies, Home Health and Hospice and Medicare-Medicaid data matching. Medicare Part C and D program integrity efforts are handled separately by one national contractor known as the Medicare Drug Integrity Contractor (MEDIC) (Health Integrity, LLC is the current MEDIC). The ZPICs and the MEDIC work under the direction of the Center for Program Integrity(CPI) in CMS.

The following table lists all of the ZPICs and their zones.

| ZPIC                     | Zone | States in Zone  |
|--------------------------|------|---|
| Safeguard Services (SGS) | 1    | California, Hawaii, Nevada, American Samoa, Guam, and the Mariana Islands   |
| AdvanceMed               | 2    | Washington, Oregon, Idaho, Utah, Arizona, Wyoming, Montana, North Dakota, South Dakota, Nebraska, Kansas, Iowa, Missouri, Alaska      |
| Cahaba                   | 3    | Minnesota, Wisconsin, Illinois, Indiana, Michigan, Ohio, Kentucky   |
| Health Integrity         | 4    | Colorado, New Mexico, Texas, and Oklahoma   |
| AdvanceMed               | 5    | Arkansas, Louisiana, Mississippi, Tennessee, Alabama, Georgia, North Carolina, South Carolina, Virginia, West Virginia                |
| Under Protest            | 6    | Pennsylvania, New York, Delaware, Maryland, D.C., New Jersey, Massachusetts, New Hampshire, Vermont, Maine, Rhode Island, Connecticut |
| Safeguard Services (SGS) | 7    | Florida, Puerto Rico, Virgin Islands  |

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## Medicare Fraud

Fraud frequently arises from false statements or misrepresentations made that are material to entitlement or payment under the Medicare Program. A violator may be a provider, a beneficiary, or an employee of a provider or some other business entity including a billing service. Providers have an obligation, under law, to conform to the requirements of the Medicare Program. Fraud committed against the program may be prosecuted under various provisions of the United States Code and could result in the imposition of restitution, fines, and, in some instances, imprisonment. In addition, a wide range of administrative sanctions (such as deactivation or revocation of Medicare enrollment or billing privileges, suspension of payments, or exclusion from participation in the Medicare Program) and civil monetary penalties may be imposed when facts and circumstances warrant such action. An investigation that demonstrates potential fraud may be referred to law enforcement for further investigation.

## Contacts for Reporting Potential Fraud

Beneficiaries may report Medicare fraud by calling 1-800-MEDICARE or the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) hotline at 1-800-HHS-TIPS (1-800-447-8477). Providers may report fraud by calling the DHHS Office of Inspector General hotline at 1-800-HHS-TIPS (1-800-447-8477).

## ZPIC Functions

The primary goal of ZPICs is to investigate instances of suspected fraud, waste, and abuse. ZPICs develop investigations early, and in a timely manner, take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid. They also identify any improper payments that are to be recouped by the MAC. Actions that ZPICs take to detect and deter fraud, waste, and abuse in the Medicare Program include:

- Investigating potential fraud and abuse for CMS administrative action or referral to law enforcement;
- Conducting investigations in accordance with the priorities established by CPI's Fraud Prevention System;
- Performing medical review, as appropriate;
- Performing data analysis in coordination with CPI's Fraud Prevention System;
- Identifying the need for administrative actions such as payment suspensions and prepayment or auto-denial edits; and,
- Referring cases to law enforcement for consideration and initiation of civil or criminal prosecution.

In performing these functions, ZPICs may, as appropriate:

- Request medical records and documentation;
- Conduct an interview;
- Conduct an onsite visit;

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- Identify the need for a prepayment or auto-denial edit and refer these edits to the MAC for installation;
- Withhold payments; and,
- Refer cases to law enforcement.

ZPICs also support victims of Medicare identity theft. A provider or supplier who believes that he/she may have had their provider information stolen and used to submit Medicare claims for which payment was made can request that the ZPIC for their zone investigate the case. The ZPIC will then work with CMS to determine the appropriate remedial action to assist the provider. Guidance on how to avoid and report Medicare identity theft and information on current scams can be found at <http://www.cms.gov/MedicareProviderSupEnroll/downloads/ProviderVictimPOCs.pdf> on the CMS website.

### Non-ZPIC Functions

The following are some of the major functions that the ZPICs do not perform. These functions are performed by the MAC:

- Claims processing, including paying providers/suppliers;
- Provider outreach and education;
- Recouping monies lost to the Trust Fund (the ZPICs identify these situations and refer them to the MACs for the recoupment);
- Medical review not for benefit integrity purposes;
- Complaint screening;
- Claims appeals of ZPIC decisions;
- Claim payment determination;
- Claims pricing; and
- Auditing provider cost reports.

### **Additional Information**

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More information about Medicare contracting reform is available at <http://www.cms.gov/MedicareContractingReform> on the CMS website.

The Medicare Learning Network® (MLN) brochure titled "The Medicare Appeals Process: Five Levels to Protect Providers, Physicians and Other Suppliers," which is designed to provide education on the Medicare Part A and B administrative appeals process, is available at <http://www.cms.gov/MLNProducts/downloads/MedicareAppealsprocess.pdf> on the CMS website.

The MLN fact sheet titled "Medicare Fraud & Abuse: Prevention, Detection, and Reporting," which is designed to provide education on preventing, detecting and reporting Medicare fraud and abuse, is

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available at [http://www.cms.gov/MLNProducts/downloads/Fraud\\_and\\_Abuse.pdf](http://www.cms.gov/MLNProducts/downloads/Fraud_and_Abuse.pdf) on the CMS website.

For the latest educational products designed to help Medicare Fee-For-Service providers understand – and avoid – common billing errors and other improper activities, please visit the MLN Provider Compliance web page at [http://www.cms.gov/MLNProducts/45\\_ProviderCompliance.asp](http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp) on the CMS website.

**News Flash - It's Not too Late to Give and Get the Flu Vaccine.** Take advantage of each office visit and protect your patients against the seasonal flu. Medicare will continue to pay for the seasonal flu vaccine and its administration for all Medicare beneficiaries through the entire flu season. The Centers for Disease Control and Prevention (CDC) also recommends that patients, healthcare workers and caregivers be vaccinated against the seasonal flu. **Protect your patients. Protect your family. Protect yourself. Get the Flu Vaccine—Not the Flu. Remember: The flu vaccine plus its administration are covered Part B benefits. The flu vaccine is NOT a Part D-covered drug.** For more information on coverage and billing of the flu vaccine and its administration, and related provider resources, visit [2011-2012 Provider Seasonal Flu Resources](#) and [Immunizations](#). For the 2011-2012 seasonal flu vaccine payment limits, visit [http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10\\_VaccinesPricing.asp](http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp) on the Centers for Medicare & Medicaid Services (CMS) website.

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