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THE UPIC REVOLUTION

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Presentation Overview

1. Objectives of the UPIC Program
2. Historical Context of UPIC Program
3. Scope and Implementation of the UPIC Program
4. Preparing for the UPIC
5. Fundamental of Audit Defense

UPIC Objectives

Comprehensive Medicaid Integrity Plan ("CMIP"), FFY 2014-2018

- HHS recurring 5FY plan for ensuring Medicaid integrity (i.e. fraud, waste, and abuse)
- UPIC program is HHS response to ACA implementation that projects $119 billion increase in Medicaid spending over FY2014-2018
- Details: See CMS UPIC Umbrella Statement of Work ("USOW") (04/24/2014)

UPIC Objectives

CMIP: Primary Goals

- Improve Medicaid data and expand the use of this information for integrity work
- Improve state management capacity to protect Medicaid integrity
- Improve federal management capacity to protect Medicaid integrity

UPIC Objectives

CMIP: 6 Primary Factors

1. Simplify and Streamline – increased federal spending in UPIC program will heavily influence state control over Medicaid program.
2. Identifying Fraudulent Providers – UPIC will collaborate with state agencies to identify and remove fraudulent providers.
3. Shared Accountability – federal and state will have shared accountability for developing and delivering “cost-effective” healthcare to Medicaid beneficiaries.

UPIC Objectives

CMIP: 6 Primary Factors

4. Fraud Prevention – through provider screening, periodic revalidation, and temporary suspension of of payments for “credible allegations of fraud.”
5. Oversight of Financial Policies – federal will oversee state plans, waivers, and financial management for grant-making to the states.
6. Strengthen Medicaid Integrity – federal and state auditors will share data, coordinate audits, and collaborate with state and federal law enforcement agencies.

UPIC History

Integrity Contractor History

- Program Safeguard Contractors (“PSCs”) were slowly replaced by Zone Program Integrity Contractors (“ZPICs”) from 2009 through 2011.
- Some PSCs were awarded ZPIC contracts and are currently operating under both.
- ZPICs are tasked with investigating fraud, waste, and abuse for Medicare Parts A, B, DME, Home Health and Hospice, and Medicare-Medicaid data matching.

UPIC History

Integrity Contractor History

- Medicare Parts C and D integrity efforts are handled by a single Medicare Drug Integrity Contractor (“MEDIC”)
- ZPICS and MEDIC work collaboratively under the authority of the Center for Program Integrity (“CPI”) in CMS.
- Key Note: Medicaid integrity work is currently handled by a myriad of state agencies and private contractors, and some of the ZPIC contractors also perform state level work.

UPIC History

Integrity Contractor History

Zone	ZPIC	States/Territories
1	Safeguard Services	California, Hawaii, Nevada, Samoa, Guam, and Mariana Islands
2	AdvanceMed	Washington, Oregon, Idaho, Utah, Arizona, Wyoming, Montana, Dakotas, Nebraska, Kansas, Iowa, Missouri, Alaska
3	Cahaba	Minnesota, Wisconsin, Illinois, Indiana, Michigan, Ohio, and Kentucky

UPIC History

Integrity Contractor History

Zone	ZPIC	States/Territories
4	Health Integrity	Colorado, New Mexico, Texas, and Oklahoma
5	AdvanceMed	Arkansas, Louisiana, Mississippi, Tennessee, Alabama, Georgia, Carolinas, and Virginias
6	Safeguard Services (2016)	Pennsylvania, New York, Delaware, Maryland, District of Columbia, New Jersey, Massachusetts, New Hampshire, Vermont, Maine, Rhode Island, and Connecticut
7	Safeguard Services	Florida, Puerto Rico, and Virgin Islands

UPIC History

Integrity Contractor History

- Outliers – integrity work has traditionally focused on identifying providers that are statistical outliers from their peers.
- Threat of Fraud – integrity contractors consistent representations to providers that they are under investigation for fraud that could be reported to the OIG/HHS/FBI often coerces providers into submission to overly aggressive audit tactics, improperly supported repayment demands, and unnecessary payment suspensions.

UPIC History

Integrity Contractor History

- Cross-Referrals – integrity contractors have consistently cross-referred providers under investigation to other CMS contractors for review (e.g. Quality Improvement Organization (“QIO”) Program contractors for potential referral to OIG).
- External Referrals – integrity contractors also regularly refer providers under investigation to federal and state law enforcement agencies for investigation (e.g. FBI and AG) and private payors managing federal funds (e.g. BlueCross, Humana, etc.).

UPIC History

Integrity Contractor History

- Stock/Canned Denials – one of the most difficult challenges of understanding and defending against ZPIC audit results has been the historical use of standardized/general grounds for the denial of claims without specific reference to individual documentation
- External Coverage Denial – another difficulty has been the denial of claims on the basis of a MAC coverage position from outside the jurisdiction of the ZPIC
- Extrapolations – used with great uncertainty because of the numerous cases currently in litigation

UPIC Scope and Implementation

UPIC Contractors

- In mid-to-late 2016, CMS awarded multiple 10-year, $2.5B IDIQ (“indefinite delivery/indefinite quantity”) UPIC contracts in support of CMS’s audit, oversight, antifraud, waste, and abuse general budget.
- Recipients: (1) AdvanceMed; (2) Health Integrity, LLC; (3) HMS Federal; (4) Noridian Healthcare Solutions; (5) Safeguard Services, LLC; (6) StrategicHealthSolutions, LLC; and (7) TriCenturion.

UPIC Scope and Implementation

UPIC Mission

- UPIC contractors are tasked to “combine and integrate existing CMS program integrity functions carried out by multiple contractors into a single contract to improve its capacity to swiftly anticipate and adapt to the ever changing and dynamic nature of those involved in healthcare fraud, waste, and abuse across the Medicare and Medicaid program integrity continuum.”
- Let’s take some time to break that down.

UPIC Scope and Implementation

UPIC Implementation Process

- The work completed by the ZPICs and PSCs will be phased out and the UPICs will transition into the primary audit and investigation body over the next two to three years.
- To date, neither CMS nor UPICs have released specific timeframes beyond the SOW deadline for implementation of 2018.
- From current experience with ZPIC investigations, the volume of new investigations appears to have dwindled with only extreme outliers currently receiving new notices while these contractors are preparing for the UPIC integration and role out.

UPIC Scope and Implementation

UPIC Implementation Process

- Despite UPIC unifications, CMS will continue with other audit programs:
  1. Supplemental Medical Review Contracts (“SMRC”) – have dramatically increased
  2. Recovery Audit Contracts (“RAC”) – seem to have reached a steady pace
  3. Managed Care Reviews (“MCR”) – broadening in scope
- Impact: Providers will face a higher level of unified scrutiny across Medicare, Medicaid, and supplemental plans all at the same time.

Preparing for the UPIC

Proactive Compliance Strategies

- Compliance Team – every medical entity must ensure their compliance officer and reporting team is fully educated on their duties to ensure compliance across Medicare and Medicaid reimbursement.
- Compliance Plan – every compliance plan (now required to be a current, “living” plan of action) must include a specific protocol for cross-checking Medicare and Medicaid claim data, in addition to CMS coverage guidelines, billing and coding protocols, staff hiring and training protocols, documentation guidelines, and HIPAA/HITECH.

Preparing for the UPIC

Proactive Compliance Strategies

- Compliance Enforcement – despite providers' chagrin with compliance, it is more necessary than ever them to make time to participate in development and training for the compliance plan. Staff, as well as providers, must have real and apparent consequences for failure to adhere, including additional training, mandatory observation, and escalation proceedings.
- Billing and Coding – hiring certified and experienced billing and coding experts to manage and monitor payor policies and billing practices is more essential than ever.

Preparing for the UPIC

Proactive Compliance Strategies

- Proper Documentation – provide sufficient descriptions of the patients' complaints, diagnoses, and treatments in the medical record. Ensure that all service billed are properly accounted for in the patients' medical records.
- Conduct Quarterly Compliance Reviews – at least once a quarter, the compliance team must review all payor coverage policies, guidelines, and handbooks. A complete "new search" for payor guidelines on all services must be performed to ensure adherence.

Preparing for the UPIC

Proactive Compliance Strategies

- Internal Audits – conduct periodic and random audits of patient medical records, billing documentation, services codes, provider signatures, and EOBs.
- External Audits – hire a third party expert to conduct annual or semi-annual baseline compliance audits. Take the advice and implement that into every day operations.
- Tracking – make sure that all payor document requests and reimbursement denials are tracked carefully to detect and correct problems before they rise to level of external review by an auditor.

Fundamental of Audit Defense

- While we wait to see exactly how the UPIC program will operate once audits and investigations begin, it is most likely that each UPIC will conduct audits under the same premises and modes of operation as they each previously used under the ZPIC/PSC contracts.
- Expect:
  1. small initial records requests to probe for issues;
  2. larger sample records requests to be used to support stratified samples and extrapolations; and
  3. office raids (know your rights).

Fundamental of Audit Defense

- Rise to the Level of Scrutiny – unified investigations will immediately expose any insufficiencies for all federally funded reimbursement. This increased risk necessitates providers raising their level of compliance efforts to prevent potential disaster.
- Communication – cautious, but open, communication with investigators is essential to determine the basis for initiation of an audit and to determine the scope (both in length of time and breadth of services). Initiate communication to express cooperation and to determine investigator's motives.

Fundamental of Audit Defense

- Self-Audit – self-auditing can be one of the most effective tools to preventing fiscal collapse. Hire an independent expert to review claims targeted by the UPIC to determine an objective assessment of non-compliant reimbursement and disclose overpayments prior to the UPIC producing their extrapolated findings. Self-disclosure may be the only escape from the nightmare of the CMS appeal process.
- Self-Audit Anyway – request that the UPIC permit a self-audit in lieu of the UPIC completing their review. If denied, do it anyway and beat them to the punch.

Fundamental of Audit Defense

- Corrective Actions – quickly establish a thorough corrective action plan for any medical necessity or billing errors found during the self-audit. Disclose this plan to the UPIC and the claims administrator collecting the overpayment disclosure.
- Education and Training – implement the corrective actions and document the implementation process and training provided to providers and staff.
- Review Compliance Failure History – complete an internal investigation into the origin of the reimbursement error and develop a protocol for prevention to be added to the compliance plan.

Fundamental of Audit Defense

- If a UPIC determines a significant overpayment occurred, an appeal may be necessary:
  1. seek legal counsel regarding your rights as a provider as applied to recoupment and claims withholding;
  2. expedite appeal time to prevent early recoupment by CMS; and
  3. understand the administrative appeal process to make an informed decision on whether other strategic options outweigh the long and tedious wait to be heard by an administrative law judge (“ALJ”).

Summary

- Implementation of the UPIC Program will increase provider exposure based upon the volume of Medicare and Medicaid claims.
- UPICs will likely operate much like the current ZPICs/PSCs with the enhanced abilities of collaboration across federal and state agencies and across multiple reimbursement data sets.
- Preparation in advance by establishing compliance oversight and protocols is essential.
- Conduct periodic and random reviews to ensure compliance.
- If your providers are subject to a UPIC investigation, know your rights.

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