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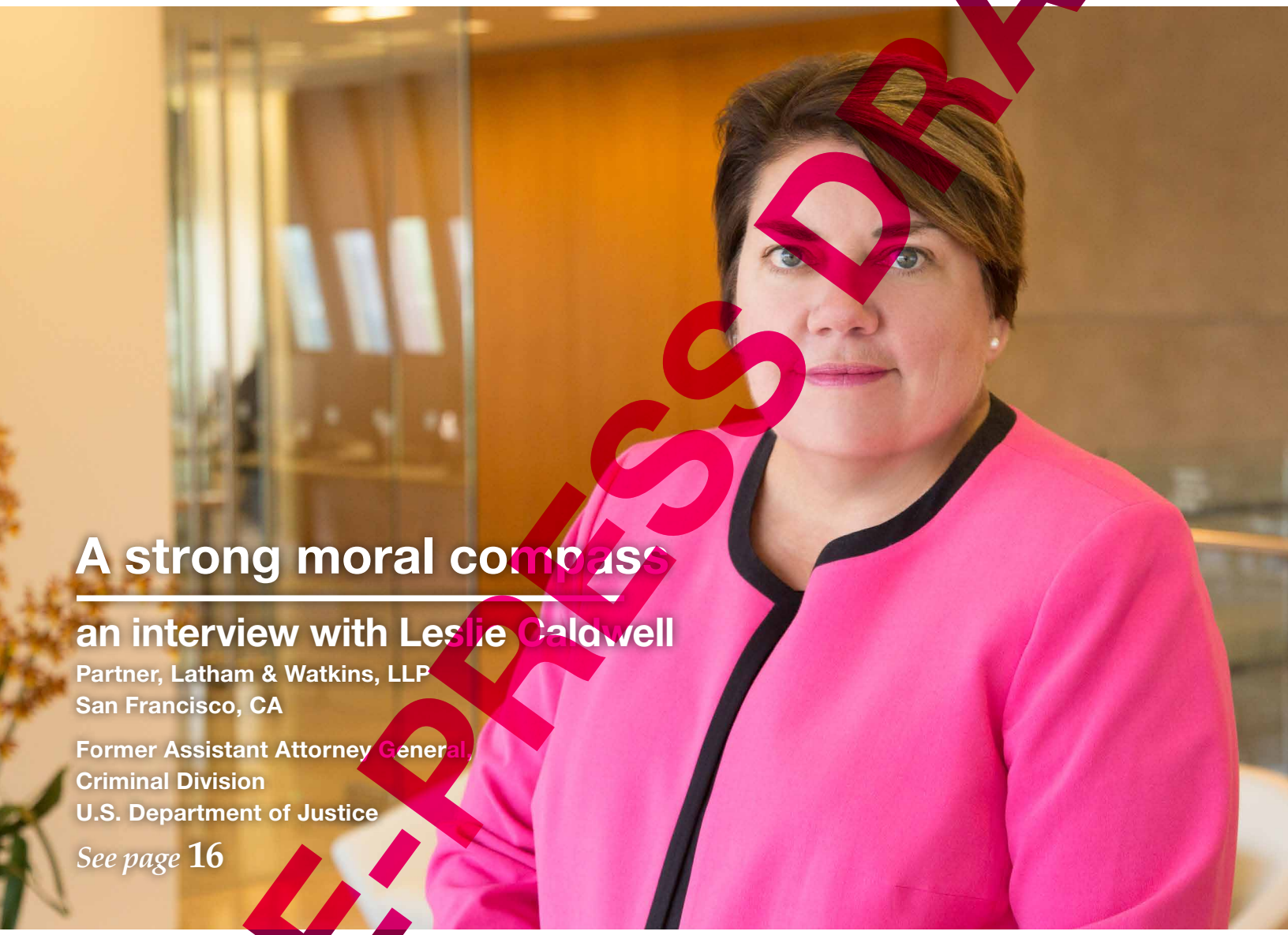

A strong moral compass

an interview with Leslie Caldwell

Partner, Latham & Watkins, LLP
San Francisco, CA

Former Assistant Attorney General,
Criminal Division
U.S. Department of Justice

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> A corporate culture that truly emphasizes and values compliance, rather than the prospect of criminal prosecution, is the best deterrent to corporate criminal wrongdoing.

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ARTICLES

Compliance TODAY

EXECUTIVE EDITOR: Roy Snell, CHC, CCEP-F, CEO, HCCA
roy.snell@corporatecompliance.org

NEWS AND STORY EDITOR/ADVERTISING: Margaret R. Dragon
781-593-4924, margaret.dragon@corporatecompliance.org

COPY EDITOR: Patricia Mees, CHC, CCEP, 888-580-8373
patricia.mees@corporatecompliance.org

DESIGN & LAYOUT: Pete Swanson, 888-580-8373
pete.swanson@corporatecompliance.org

PROOFREADER: Bill Anholzer, 888-580-8373
bill.anholzer@corporatecompliance.org

PHOTOS ON FRONT COVER & PAGE 16: Jeff Firestone, GittingsLegal Photography

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by Stephen Bittinger, Esq. and Jenna Godlewski, Esq.

The UPIC evolution

» The new CMS integrity auditor will be the Unified Program Integrity Contractor (UPIC).
» The UPIC can audit a practice's billing to all federal payers.
» The UPIC will likely operate like current ZPICs.
» Practices can prevent costly audits by implementing CMS compliance policies.
» If faced with a UPIC investigation, seek experienced legal counsel.

Stephen D. Bittinger *(stephen@bitt-law.com) is a Partner and Jenna K. Godlewski (jenna@bitt-law.com) is an Associate at Westlake, Ohio-based Bittinger Law, LLC.*

Is your practice ready for a complete evolution of the level of reimbursement scrutiny under the Centers for Medicare & Medicaid Services (CMS's) new regimen? The Unified Program Integrity Contractor (UPIC, CMS's newest fraud, waste and abuse auditor) is an entirely new animal. The UPIC was formed as part of the Comprehensive Medicaid Integrity Plan (CMIP) for fiscal years 2014-2018[1] to wrap Medicaid and all other federally funded reimbursement integrity reviews into a single audit. Medicaid spending is projected to increase by $119 billion through 2018. The primary goals of the CMIP are to: (1) improve Medicaid data and expand its use in integrity work; (2) improve state management capacity to protect Medicaid integrity; and (3) improve state management capacity to protect Medicaid integrity.

Consolidating program integrity functions

Currently, Medicaid integrity work is handled by a myriad of state agencies and private contractors. Medicare is overseen by the Medicare Audit Contractors (MACs) who refer fraud, waste, and abuse investigations to seven Zone Program Integrity Contractors (ZPICs) for issues involving Medicare Parts A and B, durable medical equipment (DME), home health and hospice, and Medicare-Medicaid data matching. Medicare Parts C and D integrity efforts are handled by a single Medicare Drug Integrity Contractor (MEDIC). Federal military payers, such as Tricare, have special investigative units that handle their fraud investigations.


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The purpose of the UPIC is to integrate Medicare and Medicaid integrity work. The UPIC program is funded by CMS's multiple awards of indefinite delivery/indefinite quality contracts. Several firms have been awarded $2.5 billion in support of audit, oversight, antifraud, waste, and abuse efforts. Current contract recipients include Health Integrity (Western zone); Safeguard Services (Northern-Eastern zone); and AdvanceMed (Mid-Western zone).

The intent is to unify the existing CMS program integrity functions, currently carried out by multiple contractors, into a single contract to improve its capacity to anticipate and adapt to healthcare fraud, waste, and abuse across all federal payer programs. Each UPIC will be responsible for one of five geographic jurisdictions. The UPICs will take over the

work handled by ZPICs, but no specific timeframe has been released other than a deadline of implementation in 2018.[2]

The impact of the UPIC on healthcare practices will be a higher level of unified scrutiny across Medicare, Medicaid, and all other federal payers, including military insurers, such as Tricare, and private insurers with Medicare Advantage plans. The stakes will be higher, because billing errors for all patients with federal insurance coverage will be exposed at the same time. Although we have yet to see how the UPICs will operate, it is likely that each UPIC will conduct its audits under the same premises and modes of operation as the ZPICs. Providers will be targeted for being statistical "outliers" from their provider peers. Practices should expect small records requests to probe for issues, and then larger sample records requests that the UPIC will use to support stratified samples and extrapolations. There is also the possibility of office "raids," (more kindly called "unannounced visits") by UPIC investigators demanding records and interviews. It is likely that practices will receive stock denials for a broad scope of claims based on technical grounds for covered services that benefitted patients.

Historically, the realities of a ZPIC investigation can have extremely harsh consequences for practices. ZPIC auditors use their authority to extrapolate actual overpayments into very significant overpayments. The cost of defending these audits, along with the threat of potential fraud being reported to the OIG or FBI, often coerces practices into agreeing to unfounded repayment demands and inappropriate payment suspension. Many of the contractors awarded a UPIC contract are current ZPIC contractors. Because a UPIC has its compensation tied to its recoveries, just like a ZPIC, it is justifiable to assume that a UPIC will use the same aggressive investigative and auditing techniques as the ZPICs.

Proactive recommendations

Practices must be proactive with their compliance policies to avoid review and prepare to defend against a UPIC investigation. We recommend the following:

- **Designate a compliance official**: Select an employee to be responsible for implementing and enforcing a comprehensive compliance plan.
- **Draft, implement, and enforce a compliance plan**: All practices serving Medicare and Medicaid patients must have an active, living compliance plan that addresses all areas of compliance including, but not limited to, CMS coverage guidelines, billing and coding protocols, staff hiring and training protocols, documentation guidelines, and Health Insurance Portability and Accountability Act (HIPAA)/Health Information Technology for Economic and Clinical Health Act (HITECH) requirements. Enforcement is critical. If employees fail to comply with the plan, real consequences such as additional training, mandatory training, and probation periods should be enforced.
- **Billing and coding**: Hire trained and experienced certified billing and coding experts to manage and monitor your CMS and private payer billing.
- **Proper documentation**: Provide sufficient descriptions of the patient's complaints, diagnoses, and treatment in the medical record. Ensure that all services billed are properly accounted for in the patient's medical record.
- **Conduct quarterly compliance reviews**: For each quarterly compliance review, the compliance officer and compliance team must review CMS coverage policies and CMS state guidelines to ensure continued compliance.
- **Internal audits**: Conduct periodic and random audits of patient medical records,

billing documentation, service codes, and provider signatures, and promptly repay any overpayments found due to remain compliant.

- **External audits**: Hire third-party experts to conduct annual or semi-annual baseline compliance audits for the practice. Implement the expert's advice in the day-to-day operations of the practice.

Defending against an audit

If faced with a UPIC audit, we recommend proven strategies to defend against integrity investigations, including:

- **Open communication with the investigator:** It is important to immediately determine the basis for initiating the audit and the scope of the audit (both in length of time and scope of services), as well as to express openness and cooperation with the audit.
- **Request to self-audit:** Propose to the investigator that your practice hire an expert to review claims within the scope specified to determine any issues and disclose any overpayments.
- **Self-audit even if your request is denied:** If the investigator denies the request to self-audit, conduct one anyway in order to refute and defend against the findings made by the UPIC. If any overpayments are identified, refund to the MAC to beat the investigator to the punch.
- **Corrective actions:** Quickly establish a thorough corrective action plan for any medical necessity or billing errors found during your self-audit review.
- **Education and training:** Implement the corrective actions and document the implementation process and training provided to your practitioners and staff.

If the UPIC determines a significant overpayment has occurred, an appeal may be necessary. It is necessary to hire legal counsel to help you understand your rights as a provider regarding recoupment, claims withholding issues, and the appeal process.

Conclusion

The implementation of the UPICs by CMS may increase the exposure of your practice, depending on the volume of patients that have Medicare, Medicaid, or other federally funded insurance. It is expected that UPICs will operate like current ZPICs with data mining that leads to voluminous document requests and the potential for large overpayment demands. Establishing compliance protocols and oversight within your practice ahead of the UPIC implementation is critical to avoiding potential investigations. If a UPIC does open an investigation, be prepared to defend against the audit and subsequent appeal process.

1. DHHS: Centers for Medicare & Medicaid Services: Comprehensive Medicaid Integrity Plan, Fiscal Years 2014 - 2018. Available at http://bit.ly/2woRsrw
2. DHHS: CMS: Unified Program Integrity Contractor (UPIC) Umbrella Statement of Work (USOW) Draft. April 24, 2014. Available at http://bit.ly/2woLyqu