LEARNER OBJECTIVES

CE Session #22
ZPIC Audits

Upon completion of this presentation, the learner will be able to:

- Understand what ZPICs are, what authority they have, and how they differ from other CMS contractors;
- Realize how ZPIC audits arise, how to prepare for and what to expect from one;
- Recognize potential consequences of a ZPIC audit and how to challenge those findings; and
- Know what is being done to better regulate and monitor ZPICs.

PRESENTER(S):

Scot Hasselman is the Vice Chair of Reed Smith’s Life Sciences Health Industry Group, practicing in the area of health care regulatory law. Scot’s practice encompasses a variety of health law matters with a focus on fraud and abuse issues. He has represented and defended health care companies in lawsuits, regulatory, and program integrity matters before the Centers for Medicare & Medicaid Services, the United States Department of Justice, the HHS Office of Inspector General, and various state agencies. He has also negotiated government settlements and corporate integrity agreements.
Navigating ZPIC Audits: Challenges and Solutions for Florida Health Care Providers

Florida Health Care Association (FHCA)

Scot T. Hasselman and Rahul Narula

Navigating ZPIC Audits – Today’s Topics

- What are ZPICs?
- How do they differ from other CMS contractors?
- What authority do ZPICs have?
- How do ZPIC audits arise?
- What to expect from a ZPIC audit?
- What are potential consequences from a ZPIC audit?
- What types of arguments can be made to challenge ZPICs findings?
- How do I contest the findings from a ZPIC audit?
- What can I do to prepare for a ZPIC audit?
- What is being done to better regulate and monitor ZPICs?
What are ZPICs?

- “ZPIC” stands for Zone Program Integrity Contractors
- Authorized under 42 U.S.C. 1395kk
- In 2009, CMS began to transition responsibility for benefit integrity activities to ZPICs from Program Integrity Contractors (PSCs) as CMS wanted ZPIC zones to be co-extensive with Medicare Administrative Contractor (MAC) jurisdictions
- PSC system was fragmented, awarded by line of business. Unlike PSCs, ZPICs now have oversight of Medicare Parts A, B, DME, Home Health and Hospice
- 7 ZPIC zones replaced 17 PSCs
- 4 contractors awarded 7 ZPIC zones

ZPIC Zones and Contractors

- **Zone 1**: SafeGuard Services, LLC
  American Samoa, California, Guam, Hawaii, Mariana Islands, Nevada
- **Zone 2**: NCI, Inc. (previously AdvanceMed Corporation)
  Alaska, Arizona, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming
- **Zone 3**: Cahaba Safeguard Administrators
  Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, Wisconsin
- **Zone 4**: Health Integrity LLC
  Colorado, New Mexico, Oklahoma, Texas
- **Zone 5**: NCI, Inc. (previously AdvanceMed Corporation)
  Alabama, Arkansas, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, West Virginia
- **Zone 6**: Cahaba Safeguard Administrators (Currently Under Protest)
  Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont
- **Zone 7**: SafeGuard Services LLC (Identified by CMS as a “Hot Zone”)
  Florida, Puerto Rico, U.S. Virgin Islands
What is the primary goal for ZPICs?

- According to CMS: the “primary goal of ZPIC is to identify cases of suspected fraud, develop them thoroughly and in a timely manner, and take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid out and that any mistaken payments are recouped” (See Medicare Program Integrity Manual (PIM), Chapter 4, Section 4.2)
  - Reactive and proactive identification of potential fraud, waste and abuse
  - Distinct from all other CMS Contractors such as MACs and RACs because primary goal is identification of fraud

What authority do ZPICs have?

- Conduct comprehensive data analysis to identify actual or potential payment errors and fraud. The primary source of data is CMS’ National Claims History (NCH) database
- Investigation and auditing of providers – onsite and offsite
- Statistical sampling and extrapolation
- Suspend provider payments
- Determine and collect overpayments
- Refer providers for exclusion from Medicare program
- Refer providers to DOJ and OIG
ZPIC TASK ORDER – STATEMENT OF WORK FOR ZONE 7 - Parts A, B, DME and HH + H

- "Because fraud in South Florida has demonstrated itself in numerous and diverse ways, differing counter approaches must continually change to anticipate and react if the fraud moves to other areas. ZPIC shall assume all workload associated with this high risk area and coordinate with the MAC for addressing these high risk areas."
- Tasks Identified in Zone 7 Statement Of Work:
  - Perform the potential fraud, waste and abuse detection, deterrence and prevention workload within the zone specified within this SOW;
  - Establish and maintain a positive working and networking relationship with the AC and MAC and other internal or external stakeholders;
  - Identification of appropriate corrective actions;
  - Performance of quality investigations;
  - Refer quality potential fraud cases to the Office of the Inspector General (OIG);
  - Develop and introduce innovative data analysis methodologies for the early detection and prevention of abusive use of services, as well as possible fraud, waste and abuse schemes.
  - Address high risk areas in Miami-Dade, Broward and Palm Beach counties in the state of Florida IAW with the Program Integrity Manual (PIM).
  - Coordinate with the appropriate AC and MAC.
  - Coordinate with other ZPICs as applicable.

How are ZPICs different from other CMS contractors?

- **ZPICs**
  - Primary mission is to identify fraud – not a random audit
  - No specification regarding lookback period
  - Unlimited document requests
  - Not paid on contingency fee (performance bonuses exist though)

- **RACs (Recovery Audit Contractors)**
  - Goal to identify and correct improper payments
  - 3 years before start of audit (not before Oct 1, 2007)
  - Document requests vary by provider type
  - Contingency fee structure based on recovery

- **MACs (Medicare Administrative Contractors)**
  - Educate providers; conduct billing
  - Correct the behavior in need of change and prevent future inappropriate billing
  - Recover overpayments
How do ZPIC audits arise?

- **From Data Analysis**
  - A ZPIC could use data analysis to detect high frequency of certain services as compared to local and national patterns, trends of billing, or other information that may suggest the provider is an outlier
  - Example: Nursing Home/Hospice lengths of stay outside the industry norm

- **From Complaints**
  - Employee or Beneficiary complaints to the OIG hotline, Fraud Alerts, or even directly to the ZPIC
  - Example: Former employee calls OIG hotline regarding services rendered by Provider

- **From Referrals**
  - MACs or other contractors and law enforcement agencies may alert ZPIC
  - Example: MAC identifies billing inconsistencies and refers to ZPIC for further analysis

What to expect from a ZPIC audit?

- Review of claims can be pre-pay or post-pay
- Prepayment review occurs when a reviewer makes a claim determination before claim payment has been made
- Post-payment review occurs when a reviewer makes a claim determination after the claim has been paid
- Unlike RACs and MAC’s, ZPICs are not required to notify providers before beginning a review. See Medicare PIM Chapter 3, Section 3.2.2
- May request additional documentation (i.e. medical records) from Provider
  - Providers generally have 30 days from request
- May perform on-site audit and interview employees of the provider
- May interview beneficiaries regarding services rendered by the provider
- **Reminder:** Primary Goal is to determine whether improper payments were made due to fraudulent activity of provider
Statistical Sampling and Extrapolation

- If ZPIC finds “sustained or high level of payment error” may choose to extrapolate overpayment amounts through statistical sample (See Medicare PIM, Chapter 8)
- No CMS guidance regarding what constitutes a “high error rate”
- Provider must receive written notice of extrapolation (unless such estimation is part of a law enforcement investigation into planned or ongoing Medicare fraud)
- Extrapolation of findings to the universe of claims for specified time period
- Can result in significant overpayment determination

Statistical Sampling and Extrapolation (cont’d.)

- Medicare PIM Chapter 8 provides basic guidance regarding sampling methodology ZPIC must follow
- Medicare PIM Chapter 3 and 8 specifies that ZPIC is to provide the following if performing sampling:
  - explanation of why review is occurring
  - list of claims that require medical documentation
  - information on appeal rights
  - time period under review
  - explanation of how results will be extrapolated
  - explanation of methods of recovery if overpayment is found
What are the potential outcomes from a ZPIC Audit?

- **Suspension of payment**
  - Providers can be placed on up to 100% prepayment review by a ZPIC
  - Increasing use of prepayment review.
- **Recoupment of alleged overpayments**
  - ZPIC may extrapolate the damages based on the sample of claims reviewed
- **Referral to enforcement agency such as OIG**
  - Must refer regardless of monetary amount.
  - OIG has 90 days to accept the referral, refer the case to the DOJ or reject the case
- **Revocation**
  - ZPIC determines provider has violated participation agreement.
  - Provider is uncooperative during on-site visit

How do I contest a ZPIC’s findings?

- Providers must use the Medicare Administrative Appeals process to contest ZPIC audit findings regarding overpayment demands
- Suspension of payments is not appealable
- Five levels of administrative appeal:
  - Lengthy process
  - Generally the best chance to overrule ZPIC findings is at ALJ level
- Providers may halt recoupment of overpayment by CMS until “reconsideration” stage
- Medicare interest rate assessed at over 11% accrues during appeal process; refunded on claims that provider is successful
- Generally appeals process is non-adversarial
- Occasionally, at ALJ level, representative from ZPIC will appear and provide testimony as needed
What types of arguments can be made against a ZPIC’s findings?

- **The Claims**
  - Were the clinical findings correct?
  - Did they review all the documentation?
  - Physician/Clinical Expert Opinion

- **The Extrapolation**
  - Were they permitted to extrapolate?
  - Statistical Expert opinion
    - Was the methodology sound?
    - Were the results accurate?
  - Did they comply with Medicare Program Integrity Manual?

Levels of Medicare Appeal Process

- **1st Level – Redetermination (42 CFR 405.940 et seq.)**
  - 120 days to appeal to Medicare Contractor from receiving demand letter
  - Must appeal within 30 days of receiving demand letter to halt recoupment
  - Evidence (such as medical records) may be submitted

- **2nd Level – Reconsideration (42 CFR 405.960 et seq.)**
  - 180 days to appeal to Qualified Independent Contractor (QIC) from receiving Redetermination
  - Must appeal within 60 days of demand letter to halt recoupment
  - Evidence (such as medical records) may be submitted
Levels of Medicare Appeal Process (cont’d.)

- **3rd Level – Administrative Law Judge (42 C.F.R 405.1000 et seq.)**
  - Request for Hearing must be submitted within 60 days of Reconsideration
  - Provider may no longer halt recoupment
  - May request video or live hearing; otherwise telephonic hearing
  - No new evidence may be submitted without “good cause”

- **4th Level – Medicare Appeals Council (42 C.F.R 405.1000 et seq.)**
  - Request MAC review within 60 days of ALJ decision
  - No new evidence; de novo review
  - No hearing; written brief submission

- **5th Level – Federal District Court**
  - Sixty days from MAC’s decision
  - Must meet Amount in Controversy Requirement
  - Substantial evidence review by court

Can ZPICs be held liable for improper audits?

- ZPICs are protected from criminal or civil liability as a result of the activities they perform under their contracts as long as they use due care (See Medicare PIM, Ch 3, Section 4.2.2.2)

- No mechanism exists for Providers to be reimbursed for legal and expert fees associated with contesting ZPIC findings during administrative appeals process

- Unlike RACs, ZPICs are not paid on contingency basis

- However, ZPICs are provided certain performance bonuses by CMS under current contract
What are some strategies for Providers before a ZPIC audit occurs?

- **Develop a Compliance Plan**
  - Conduct annual billing and coding training and seek third party assistance regarding concerns
  - Conduct internal audits
  - Draft policies and procedures in responding to audit requests
  - Mechanism for employees to file complaints anonymously
  - Organized and easy access to past medical records
- **Assign an Audit Point Person**
  - Identify an employee that is familiar with company billing and will be the person in charge of organizing potential audit requests

What are some strategies for Providers upon receiving notice from ZPIC?

- **Awareness**
  - Providers must be timely in their response to ZPIC
  - Do not underestimate the seriousness of ZPIC audit request
  - Non-compliance with ZPIC can lead to suspension or removal from Medicare program
- **Communicate**
  - It is important to communicate with the ZPIC in order to provide the correct requested information
  - ZPICs have authority to deny claims based on incomplete information provided
- **Obtain legal counsel early in the ZPIC audit process**
  - Legal counsel can guide provider through appeals process and advise on collateral fraud issues
  - Legal counsel can assist provider in obtaining independent experts to contest ZPIC findings
- **Internal Review**
  - Perform your own data analysis of the requested records to determine error rate and other potential issues
  - Ensure all information to support claim was provided to ZPIC (i.e. medical records that might help support medical necessity)
Current Outreach Efforts to CMS to Better Monitor and Regulate ZPICs

- American Health Care Association (AHCA) sent letter on June 12, 2012 to Dr. Peter Budetti, Deputy Administrator and Director, for the Center for Program Integrity at CMS stating that:
  - ZPICs are inappropriately targeting SNFs based on high levels of therapy data
  - Use of pre-payment review is unjust and puts provider at financial hardship
  - Seek revisions and clarifications to prepayment review process including: requiring notification be provided to contractor, identify relationship between MAC and ZPIC, and developing a process to allow provider to contest prepayment review determination.

- FHCA members and staff have met with members of Florida’s Congressional delegation about this issue, including Cong. Dennis Ross, Cliff Stearns and Congresswoman Kathy Castor.

- Cong. Kathy Castor submitted questions on the record to Dr. Thomas Doolittle (Deputy Director, Center for Program Integrity at CMS), about ZPIC audits, particularly pre-payment review procedure.

Questions?

Scot T. Hasselman
Washington, D.C.
+1 202 414 5968 (direct dial)
shasselman@reedsmith.com

Rahul Narula
Washington, D.C.
+1 202 414 9270 (direct dial)
rnarula@reedsmith.com
Thank You