Unified Program Integrity Contractor Audits

Respond with Speed, Precision, and Timeliness

BDO

As a healthcare provider, laboratory, supplier, or home health company, you've likely encountered the term Unified Program Integrity Contractor (UPIC). For many, especially first-time recipients, a UPIC audit can be overwhelming. If you're unfamiliar with these audits or unsure what to expect — read on.

If you've received a UPIC audit, don't panic — but do act quickly:

- Stay calm and review correspondence carefully.
- Plan your time-sensitive response strategically.
- Be proactive — communicate early and request an extension if needed.
- Retain a coding, billing & auditing professional, engage an experienced healthcare attorney. Be sure to protect related internal and external communications under attorney client privilege. BDO's team includes professionals ready to serve as expert witnesses should an appeal reach the Administrative Law Judge (ALJ) level.

Before you respond, it's important to understand exactly what a UPIC audit is and how it works. UPICs perform fraud, waste, and abuse (FWA) detection, deterrence, and prevention activities for Medicare and Medicaid claims. Specifically, the contractor performs integrity program-related activities associated with Medicare such as Parts A, B, Durable Medical Equipment (DME), Home Health & Hospice. The UPICs operate in five separate geographical jurisdictions.

Understanding a UPIC Audit

The concept of the Unified Program Integrity Contractor lies within the Medicare Program Integrity Manual, Chapter 4, which provides details about measuring, correcting, and preventing overpayments (and underpayments). The primary goal of the Centers for Medicare & Medicaid Services (CMS) program integrity is to pay claims correctly. In order to fulfill this overarching principle, contractors are used in different ways to monitor and ensure payment accuracy for services rendered. There are several types of review contractors who participate in the Fee-for-Service (FFS) compliance programs:

Contractor	Role
Unified Program Integrity Contractors (UPICs)	Identify and investigate potential cases of FWA in Medicare and Medicaid*
Medicare Administrative Contractors (MACs)	Process medical claims and review Medicare payments for accuracy and perform Targeted Probe and Educate (TPE) reviews
Supplemental Medical Review Contractors (SMRCs)	Conduct medical reviews to identify and address potential errors like incorrect Medicare payments or coding
Comprehensive Error Rate Testing (CERT) Contractors	Review samples of processed claims and conduct medical record reviews to measure error rates in Medicare FFS payments
Recovery Audit Contractors (RACs)	Conduct automated and complex post-payment reviews on approved topics to identify improper payments and collection of overpayments and underpayments

*Note: UPICs are the only contractors that safeguard both the Medicare FFS and Medicaid programs against FWA.

Upon referral, UPICs may, as appropriate:

- Request medical records and documentation.
- Conduct interviews with beneficiaries, complainants, or providers.
- Conduct site verification.
- Conduct an onsite visit.
- Identify the need for a prepayment or auto-denial edit.
- Institute a provider payment suspension.
- Refer cases to law enforcement.

Tip: If a patient or beneficiary were contacted by an investigator, would they be able to clearly explain why they are receiving services from your organization? In order to do so, they need to understand the purpose and value of the services provided. Providers and suppliers must communicate clearly with the patient and keep accurate and robust documentation to support transparency and compliance.

While every UPIC audit looks different, the below steps outline critical points of an investigation or formal review of suspicious claim aberrancies:

1. INITIAL ERROR IDENTIFICATION.

The MACs complete data analytics to identify potential claim errors, many of which are remedied internally. Those posing significant financial risk to the Medicare Trust Fund are referred to the UPIC for further investigation. Examples of the data under analysis include:

- Volume of visits
- Dollars reimbursed
- Location of care
- Types of services
- Types of providers
- Types of ownership

Lead or tips sources can also be identified through states, law enforcement, CMS, internet or newspaper articles, complaints, or suspected beneficiary harm.

2. INVESTIGATION AND AUDIT.

Once the UPIC receives approval to launch a formal investigation, it will typically contact the provider in question to request documentation or a site visit. Audits are conducted on either a pre- or post-payment basis. Medical record reviews are completed to identify errors such as:

- Services not medically necessary
- Services not rendered as billed
- Services not reasonable or necessary
- Technical requirements not met

> **Tip:** Misinterpretation of applicable Local Coverage Determinations (LCDs) or National Coverage Determination (NCDs) by the UPIC reviewer is common. Carefully review the relevant policies, identify denial errors, and submit appeals with thorough supporting documentation when necessary.

A critical component in the UPIC's effort to root out FWA is the ability to conduct statistical sampling. Statistical sampling provides a means of gaining information about the provider's entire universe of claims data in a given timeframe, without the need to examine the universe in its entirety. Sampling enables valid generalizations about the universe, which allows a valid error rate prediction.

Sampling is used when it is not administratively feasible to review every sampling unit in the target population. Further information about statistical sampling can be found in the Medicare Program Integrity Manual (MPIM) Chapter 8, Section 8.4.1.2.

Once a sample has been produced, the UPIC will send the provider a written request for medical records, additional documentation requests (ADRs), to properly evaluate the claims submitted for payment. The UPIC provides a list of documents for the provider to include in the response. A record review of each claim is completed.

> **Tip:** Many providers and suppliers miss their opportunity to respond to a UPIC audit because they overlooked the letter or notification in the mail. It's critical to monitor your U.S. mail regularly so you don't miss a critical letter or notification.

Failure to submit the requested records by the due date (30 calendar days after receipt of the ADR) will result in the denial of the claims and may result in penalties up to and including revocation of Medicare billing privileges.

> **Tip:** A high error rate during pre-payment review signals a post-payment audit. To avoid a high error rate in pre-payment review, strengthen documentation and compliance proactively.

3. REVIEW RESULTS LETTERS.

Review results to confirm the UPIC's findings. The UPIC calculates the error rate and provides a summary of findings to include denial bases.

- Pre-Payment Review Results
  - Upon completion of medical review, the provider receives a results letter along with a disk containing detailed provider education for each adjusted claim line. The education includes:
    - Denial explanations
    - Relevant citations
    - Claim-specific feedback

Tip: Appeals of claim decisions from pre-payment results can be made at this point if the provider believes there has been an incorrect determination. Questions or appeals can be directed, in writing, to the UPIC project manager; proactively engaging can help clarify the process and available options.

  - Post-Payment Review Results
    - Upon completion of medical review, the provider receives a results letter and, if applicable, the overpayment determination. Overpayment can be extrapolated based on the UPIC's statistical analysis. It's important to note that this is not a demand letter, it is a notification. The UPIC submits all findings and supporting documentation to the MAC. The MAC will then send the demand later with information on overpayment due, repayment, and available appeal options, as noted in Step 4 below. As a reminder, Medicare billing privileges can and are being revoked under certain circumstances.
- Suspension Notice
  - Suspension notices are most often issued after medical review or a probe. The suspension can be based on:
  - Reliable information that an overpayment exists; specifically, that a pattern of improper billing practices exists.
  - Credible allegations of fraud, which can come from:
    - Hotline complaints
    - Claims data mining
    - Patterns identified through audits
    - Law enforcement investigations
  - The suspension may last until the resolution of the investigation.
  - A rebuttal statement may be submitted within 15 calendar days of receipt of the notice.
  - Based on pertinent information submitted and all information known to the UPIC, CMS will determine whether the suspension should be removed or should remain in effect within 15 days of receipt of the complete rebuttal package, consistent with 42 C.F.R. § 405.375.
  - The UPIC will notify the provider, in writing, of the determination to either continue or lift the suspension. This notification will include the specific findings that support the decision, along with a formal statement of determination.

Tip: A payment suspension may be issued when the UPIC, law enforcement, or CMS determines that a credible allegation of fraud exists against a provider or supplier.

4. INITIAL REQUEST FOR OVERPAYMENT/DEMAND LETTER.

The purpose of this letter is to inform the provider or supplier that a Medicare payment has been received in error and to request repayment. Should a provider dispute the findings, the appeal process begins. A provider or supplier can submit a rebuttal statement before an offset or recoupment takes place if received within 15 days from the date of the demand letter to explain why recoupment should not be initiated.

A provider or supplier has 120 days from the date of the overpayment/demand letter to initiate an appeal.

Tip: A rebuttal is not a formal appeal. A formal appeal is required to stop recoupment.

Appeal

There are five levels to the formal appeal process:

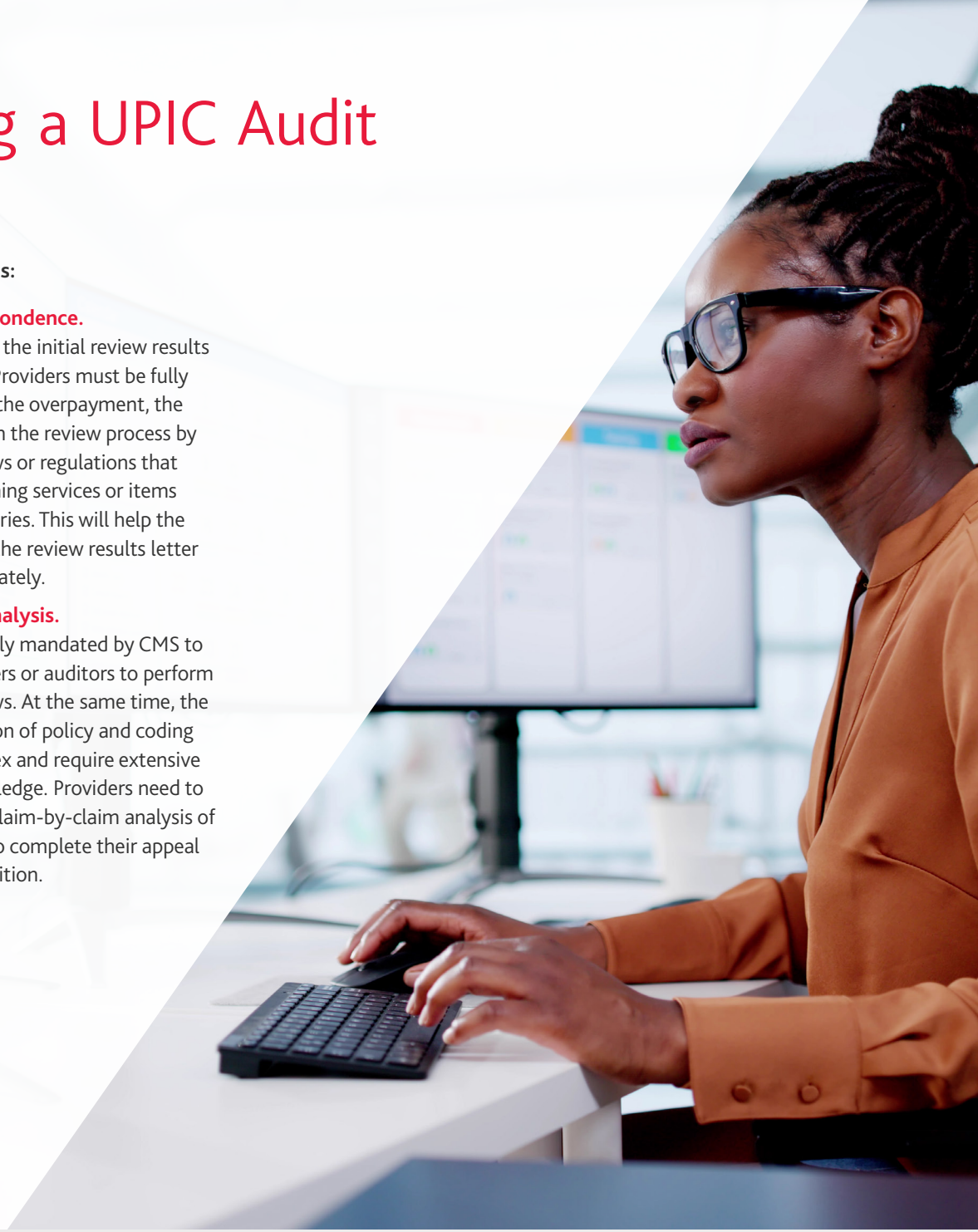
Appeal Level	Summary	Provider Timeline	Authority Timeline
First Level of Appeal: Redetermination	Providers can request a redetermination of the claim by MAC personnel who were not involved in the initial determination.	The request must be submitted in writing within 120 days of receipt of the initial determination.	The MAC typically gives its decisions to all relevant parties within 60 days of receiving the redetermination request.
Second Level of Appeal: Reconsideration	Providers can request an independent review of the initial determination and the redetermination by a Qualified Independent Contractor (QIC).	The request must be submitted in writing within 180 days of receiving the redetermination decision.	The QIC generally gives its decision to all relevant parties within 60 days of receiving the reconsideration request.
Third Level of Appeal: ALJ Hearing	Providers can request a hearing before an Administrative Law Judge (ALJ) with the Office of Medicare Hearings and Appeals (OMHA), which is independent of CMS.	The request must be submitted in writing within 60 days of receiving the reconsideration decision.	The ALJ will generally issue either a decision, dismissal order, or remand to the QIC within 90 days from receipt of the hearing request.
Fourth Level of Appeal: Review by The Medicare Appeals Council	Providers can request a review by the Medicare Appeals Council ('the Council').	The request must be submitted in writing within 60 days of receipt of the OMHA's decision or dismissal.	If providers request a review of the OHMA decision, the Council will review within 90 days of receipt of the request.
Fifth Level of Appeal: Judicial Review in Federal District Court	Providers can request review of the Medicare Appeal Council's decision in federal court.	The request must be submitted within 60 calendar days after receipt of the Council's decision.	No specific timeline.

Tip: Timely and accurate responses can help prevent unnecessary scrutiny and maintain good standing with contractors and agencies. Enhance accountability with proactive communication in a compliance-heavy environment.

Best Practices for Appealing a UPIC Audit

To appeal a UPIC audit, providers should consider the following best practices:

- **Act Quickly.**
  Providers have very little time to file their appeals, and missing a deadline can result in waiving your right to appeal. It's crucial to know exactly how much time you have at each stage of the process and file your requests accordingly.
- **Maintain Thorough Documentation.**
  Providers will need to submit all relevant medical records and supplier documentation for services rendered as part of their response to the review results letter. Being able to provide accurate, complete, and robust documentation is critical to support your claims. Strong internal controls are key to avoiding issues related to incomplete documentation, such as documentation without the proper electronic signatures.
- **Understand Correspondence.**
  It's important to read the initial review results letter very carefully. Providers must be fully aware of the basis of the overpayment, the authorities involved in the review process by the UPIC, and any laws or regulations that apply to those furnishing services or items to Medicare beneficiaries. This will help the provider understand the review results letter and respond appropriately.
- **Conduct a Denial Analysis.**
  UPICs are not explicitly mandated by CMS to employ certified coders or auditors to perform medical record reviews. At the same time, the analysis and evaluation of policy and coding guidelines are complex and require extensive experience and knowledge. Providers need to conduct a thorough claim-by-claim analysis of any denials in order to complete their appeal and support their position.

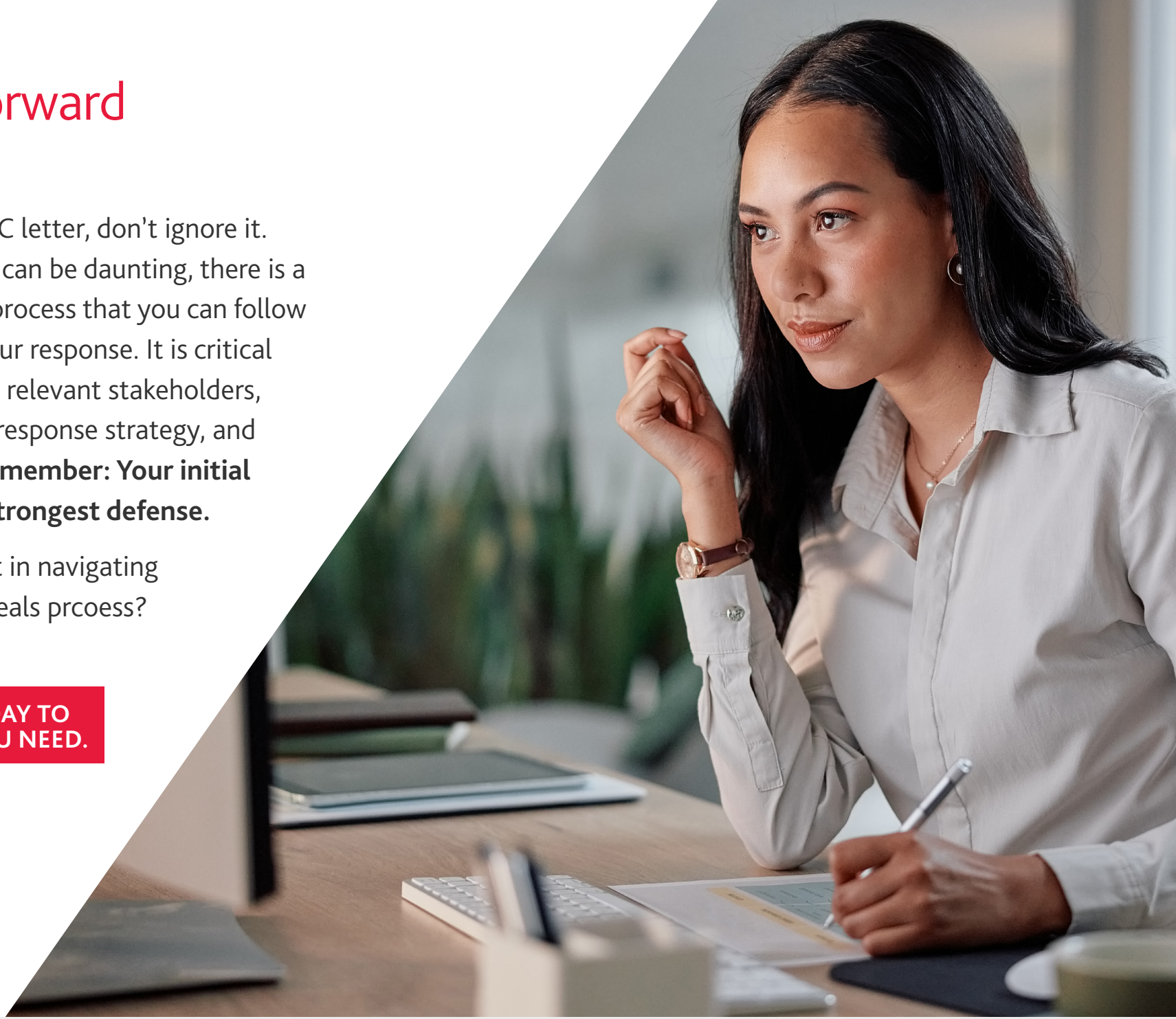


Moving Forward

If you receive a UPIC letter, don't ignore it. While a UPIC audit can be daunting, there is a very clear appeals process that you can follow to help navigate your response. It is critical to quickly notify all relevant stakeholders, develop a detailed response strategy, and file your appeal. **Remember: Your initial response is your strongest defense.**

Looking for support in navigating the UPIC audit appeals prcoess?

CONTACT US TODAY TO GET THE HELP YOU NEED.



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