

Inside the ZPICs

The permanent RAC program thus far has focused more on hospitals and large physician practices, experts say. ZPICs are another story.

“ZPICs are going after everything from single-doc shops to home health to clinics and chiropractors,” says Robert Liles, a healthcare attorney with Liles Parker, a Washington, D.C., law firm specializing in health care compliance. “ZPICs really don’t have any hesitation to go after the smaller providers out there.”

Liles, who has represented dozens of providers in both RAC and ZPIC appeals cases, considers ZPICs more “threatening” to providers because they do not have to get CMS approval for the issues they choose to target. Unlike RACs, ZPICs also do not have to provide education to providers or post their areas of focus publicly.

While ZPICs aren’t paid based on how much money they recoup from provider, they still have a strong financial incentive to be relentless in targeting your claims, Liles believes. “If ZPICs aren’t out there aggressively going after providers, and they can’t show they got X amount in overpayments, CMS is going to look over at the other guys competing for contracts,” he says. “If the ZPICs don’t perform, they’re going to lose their contract. That just makes common sense.”

How ZPICs operate

In a ZPIC audit, the auditor will typically send a letter requesting documentation for a number of claims. Providers are usually given 30 days to comply. If the ZPIC identifies an overpayment, it will notify the provider’s MAC, which will issue the overpayment demand letter. The provider can pay the overpayment, allow it to be paid via recoupment or appeal. If no payment or request for extended repayment plan is received within 30 days, the overpayment is delinquent and begins to accrue interest.

The five-level appeals process – redetermination, reconsideration, administrative law judge hearing, department appeals board review and federal court review – is the same as the RAC appeals process (*see chapter 9*). Overpayment collection is prohibited during appeals at the first two levels.

Sometimes the ZPIC conducts an unannounced site visit. The auditors take photos, copies of drivers’ licenses and records and turn the agency upside down. (*See p. 31 for more about on-site inspections.*)

ZPICs more onerous than RACs

While RACs have received more media attention, the PSCs/ZPICs are actually more worrisome for home health agencies. Unlike the RACs, which are focused on finding billing errors, PSCs/ZPICs are focused on uncovering fraud. They all have benefit integrity units, which are there to initiate fraud investigations. Every audit has the potential to be a fraud referral to law enforcement. Although they can conduct random reviews, it’s more likely that they’ve identified a billing error or specific issue from either data analysis or a complaint that triggers an audit, and they know what they’re looking for – even if they don’t share that information with the provider undergoing the audit. About 90 percent of PSC/ZPIC audits are a direct result of proactive data analysis. The rest is from complaints made to the MACs, which then refer the issue to the PSC/ZPIC.

minimize the likelihood of overlapping audits and overburdening providers. And we've done some extensive work with states in terms of education and assistance for them to get their [Medicaid RAC] programs up and running.”

However, it is not yet known how this – and the many other – audit programs will work once they are operational. CMS has stated that it will work closely with the states, the Department of Justice, the Office of Inspector General, the Medicaid fraud control units and the respective states and the Medicare contractors to make sure that auditors are not duplicating services or audits that may be actually be going on or jeopardize any investigations that maybe going on, and that it plans to clear all audit leads with those parties as the start of any kind of audit process. What actually occurs remains to be seen.

12 tips to deal with Medicaid audits

To prepare for Medicaid investigations and enforcement, you should:

1. **Review your policies for compliance with your state's Medicaid program.** Be prepared for increased activity regarding your Medicaid billing. Audit your Medicaid claims to see whether irregularities or aberrant patterns exist.
2. **Watch for differences between Medicare and Medicaid** – and their fraud prevention programs and procedures. For example, the limits on RACs regarding the number of medical records that can be requested in a time period don't apply to the MICs.
3. **Review denied Medicaid claims.** Determine the reason for the denial and correct the problem. Denied claims can trigger a MIP audit. Look especially for denials that recur in coding or medical necessity.
4. **Treat a Medicaid fraud investigation as seriously as a Medicare investigation.** They have the same ramifications.
5. **Improve communication and education between leadership and operations,** which often can be disconnected. For instance, the home health agency's management may not know that employees are billing Medicaid improperly.
6. **Make sure your compliance program meets any requirements.** For example, if you're currently operating under a corporate integrity agreement, make sure that you're complying with it. If your state has a mandatory compliance program, such as New York, make sure that your program is adequate. (**Note:** The health care reform law requires providers to have compliance programs, though CMS has not yet outlined the requirements for those programs.)
7. **Perform early case assessment** if you get wind of a Medicaid fraud investigation against you.
8. **Don't assume that you can fly under the radar.** Those days are over.
9. **Screen potential employees and contractors** to ensure that you don't hire individuals or entities that have been excluded from the Medicare or Medicaid programs. Work performed by excluded people or entities is not reimbursable, and any such payments constitute overpayments and are subject to recoupment. (You can look to see who is excluded at www.oig.hhs.gov/fraud/exclusions.asp.)
10. **Keep an eye on developments in your state.** For example, North Carolina Medicaid posted on its website that it will be contacting Medicaid providers in North

Getting a demand letter without a record request

If you receive an overpayment demand letter without the RAC asking for medical records relating to the claim or claims in question, you've undergone an automatic review.

You'll be notified about the results of an automated review only if your RAC found an overpayment. RACs are trying to find "low-hanging fruit" with automatic reviews; in other words, your RAC believes you made a blatant mistake, such as duplicate billing. Those are the mistakes that would instantly raise a red flag in a computerized analysis, which is how automatic reviews are done.

Take the following steps:

1. **Review the RAC's findings to see whether you made a mistake.** Make sure you understand why the claim or claims were flagged.
2. **Determine why an overpayment was found** in an automatic review. Common reasons include:
 - a. An established statute, policy or national coverage determination/local coverage determination specified that a service was not covered, so any payment for it is considered overpayment.
 - b. "Medically unbelievable" services. A service is medically unbelievable if it makes no sense anatomically or is medically unreasonable when it involves the same patient, same date of service and same provider.
 - c. Failure to respond to a medical record request for a complex review on time. According to CMS, that gives the RAC the right to consider any claim for which records were requested to be improperly paid.
3. **Determine whether an appeal is warranted if the RAC's findings were incorrect.** In most cases, you'll want to appeal unless the overpayment is less than the money you'd lose from staff productivity spent preparing and processing the appeal. (*For more about appeals, see chapter 9.*)
4. **Implement corrective action immediately if the RAC's findings were correct.** That will help you avoid repeating the mistake and attracting continued scrutiny.
 - a. If necessary, ask to pay the overpayment on a payment plan.
 - b. Ask the RAC to forgive some of the amount you owe. Given the state of the economy, you can make that argument if returning the overpayment would financially destabilize your home health agency, says Sean Weiss, vice president of DecisionHealth Professional Services and chief compliance officer for DecisionHealth.

Paying overpayments

RAC overpayments will be collected through recoupment (or if requested, in installments). Unlike your RHHI/MAC, RACs can't make claim adjustments, though because your RHHI/MAC handles RAC appeals, you may still receive a claim adjustment as part of a RAC appeal. RACs will turn delinquent accounts over to the U.S. Department of the Treasury.

Interest will accrue from the date of the final determination and will be charged on an overpayment balance for every 30 days that the payment is delayed. Any payments received will first be applied to any interest accrued, then to the remaining balance.