


Navigating the ZPIC Audit & Steps to Minimize Risks



Halcyon Rehabilitation

Objectives

- Understand the role, authority and audit approach of Zone Program Integrity Contractors (ZPICs).
- Discuss issues that are high priority for ZPICs.
- Explore steps that can be pursued by providers to prepare and respond to ZPIC audits.
- Discover effective tips to implement in order to minimize risks associated with auditing methodology.

Halcyon Rehabilitation


What are ZPICs?

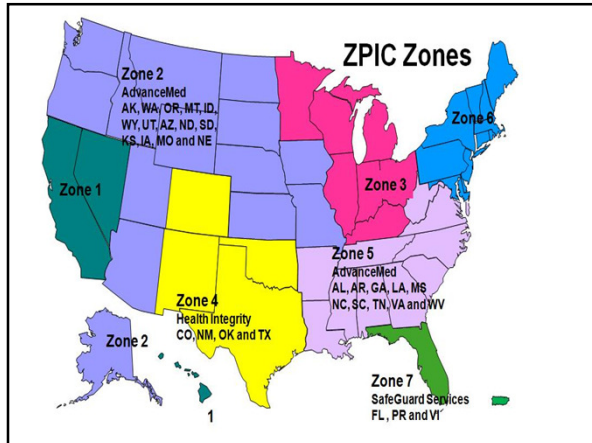
- Zone Program Integrity Contractors (ZPICs) are independent contractors hired by CMS to perform a wide range of medical review, data analysis and Medicare audits.
- While ZPIC audits are similar in many ways to other Medicare audits currently being performed nationwide they do differ in one very important aspect – potential Medicare fraud implications.
 - Goal is to detect and prevent Medicare fraud, waste and abuse.
- ZPIC audits are not random → they are specifically targeted.

Halcyon Rehabilitation

ZPIC Contractors


- The ZPIC contractors associated geographically include:
 - SafeGuard Services LLC → FL, CA, HI, NV
 - AdvanceMed Corporation/NCI → GA, MS, LA, AL, KS, MO, AK, AZ, ID, IA, MT, NC, NE, ND, OR, SC, SD, TN, UT, VA, WA, WV, WY
 - Cahaba Safeguard Administrators → IL, IN, KY, MI, MN, OH, WI, CT, DE, ME, MD, MA, NH, NJ, NY, PA, RI, VT
 - Health Integrity LLC → CO, TX, NM, OK
- ZPIC "Hot Spot" Zones → FL, IL, CA, NY, & TX





ZPIC Responsibilities

- ZPICs are generally responsible for one or more of the following CMS focus areas:
 1. Pre-payment or post-payment medical review of claims;
 2. Data analysis;
 3. Benefit integrity and/or fraud detection;
 4. Cost report audits and;
 5. Provider/supplier education.
- ZPICs are paid a bonus by CMS based on the amount of overpayments they identify. ZPICs use "innovative data analysis methodologies" for early fraud detection/prevention.




ZPIC Review Areas

- Claim Characteristics
 - Diagnoses
 - Procedures
- Utilization Patterns
 - High Volume
 - High Cost Services
- Billing Patterns
 - ↑'d UH RUGs
 - ↑'d RUGs with Low ADL scores


ZPIC Triggers

- Improper or Inaccurate Billing
 - High claim rejection rates
 - High claim recoupment rates
- Utilization Screens
 - Higher utilization than neighboring providers
 - High clinical case mix assignment
 - Medicare admission patterns
- LOS Outside Industry Norms
- Use of Data Mining




Authority of ZPICs

- Conduct Audits & Review Claims
- Conduct interviews with facility staff, beneficiaries and management
- Require facility staff to sign affidavits following interviews
- Initiate administrative sanctions
- Refer providers and beneficiaries to law enforcement
- Conduct unannounced or limited notice site visits
- Request medical records & documentation (no limit)
- Subject the provider to pre-payment or post-payment review of existing or future claims
- Apply statistical sampling & extrapolation to billing & coding errors found




Staff Interview

- On-site ZPICs typically include an interview of the Director of Rehabilitation.
- Interview includes technical, managerial, and clinical questions covering:
 - Licensure, job description, and responsibilities
 - Professional connections to the DON and Administrators
 - Previous titles
 - Chain of command within therapy company
 - Productivity, caseload management, and staffing
 - Documentation and communication with the facility staff
- Providers have the right to have legal counsel present during interviews.




Prepayment Audits

- Full Prepayment Audit → Provider does not receive payment for any item or service until the provider proves, to the ZPIC's satisfaction, that the claim for the item or service is medically necessary and properly payable.
- Partial Prepayment Audit → Provider does not receive payment for a particular item or service until the provider proves, to the ZPIC's satisfaction, that the claim for the item or service is medically necessary and properly payable.




Extrapolation

- Extrapolation is the process of using statistical sampling in a review to calculate and project (extrapolate) alleged overpayments made in connection with Medicare claims.
- Basically, ZPICs seek out errors in an alleged "statistically relevant sample" of the provider's Medicare claims and then calculate and apply the "error rate" to the entire universe of claims covering a given period of time.
- Allows ZPICs to avoid actually reviewing each of the Medicare claims.




Potential Outcomes of a ZPIC Audit

- ZPIC may refer the case to law enforcement for criminal prosecution, civil litigation through the False Claims Act, and impose a civil monetary penalty (CMP) or other sanctions.
- ZPIC may refer the audit results, including the statistical calculation of an extrapolated overpayment, to the Medicare Administrative Contractor (MAC) for collection of the overpayment demand.
 - In this circumstance, a provider has the right to appeal the overpayment determination through the five-step Medicare appeals process.
- ZPIC may determine that provider education is the appropriate resolution for the audit.
 - This result is the best outcome for a provider as it means that the provider will not be assessed an overpayment demand or other potential sanction.




Preparing For a ZPIC Audit

- Ensure you are following all Medicare policies and procedures, including any applicable coverage decisions, when billing Medicare claims.
- Conduct periodic internal audits to confirm that your documentation supports the claims that are billed. If billing vulnerabilities are identified, correct the problems and repay any overpayments that may have resulted from the billing mistakes.
- Create an audit plan that includes the designation of a point person, such as the compliance officer, for coordinating a response to a ZPIC audit, and the development of policies and procedures for gathering information and responding to the ZPIC's requests.




Preparing for a ZPIC Audit

1. Conduct an internal review of the primary services you provide and make sure your documentation is in order.
2. Review the Documentation Requirements section for each item you provide. When a ZPIC audits a claim, they are auditing to make sure the requirements outlined in the LCDs and related Articles are met. Develop documentation checklists for your files to assure you always have all the necessary documentation.
3. Make sure your files are orderly and consistent.




Preparing for a ZPIC Audit

4. Whenever possible, get as much clinical documentation up front for the services you provide. It is much easier to get the documentation you need at the time the service is ordered rather than having to go back if faced with one of these audits.
5. Make sure your referral sources know the guidelines and conditions for which items they order are covered.
6. Make sure all documentation is legible and ALL signatures are legible. *(if not legible signatures have the name printed/typed below the signature)*




What Do I Do with a ZPIC Request?

1. Begin compiling the documentation immediately. This will take a team of individuals to assist with compilation.
2. The ZPICs expect you to provide them clinical documentation to support the need for the items they are auditing and have requested documentation on. Provide **complete** documentation! Don't rush the process but meet deadlines.




What Do I Do with a ZPIC Request?

3. Conduct a comprehensive review of the documentation prior to submitting them to the ZPIC.
4. If you identify issues in your review, notify the ZPIC immediately and prepare a corrective action plan to address those issues internally.
5. Retain exact duplicate copies of the documentation you submit to the ZPIC.
6. Develop and initiate an action plan for any issues identified.




What Do I Do with a ZPIC Request?

7. If you can not meet the deadline imposed by the ZPIC (usually 15 days); then call and request an extension. Regulations provide that the ZPIC can not render a decision on a claim for failure to respond until after the 45th day. Therefore, you will always be able to request an extension to 30 days in the minimum. They have the discretion to extend further if necessary.
8. If the number of claims are too large for you to respond in a timely manner you may ask them to accept a smaller number of claims (especially if it is a pre-pay audit and they are going to pull additional claims as you bill.)




ZPIC Response

1. Within 30 days of the letter from the ZPIC, you will receive an actual overpayment demand letter from the DMEMAC.
2. Review the specific denial reasons in the audit results letter from the ZPIC and begin attempting to get supporting documentation to counter the denials.
3. You technically have 120 days to file your appeal request; however, the contractor will begin collection proceedings on the 41st day. So, you should either:
 - Refund the overpayment in 30 days and then begin preparing your appeal.
 - Request a repayment plan within 30 days.
 - Submit a valid request for Redetermination prior to the 41st day.




ZPIC Response

4. If you submit a valid request before the 41st day, the limitation on recoupment provisions applies and the MAC can not collect the overpayment while the appeal is pending. The same process applies for the second level of appeal (QIC) as well. (Reconsideration request must be received before the 61st day in order to stop collection of overpayment. Keep in mind that interest will begin accruing on the 30th day from the identification of the overpayment.)
5. If unsuccessful at Redetermination and Reconsideration, then request an ALJ Hearing and if you have not satisfied the overpayment by this time, then refund the money or request a repayment plan.




Tips to Prepare

- Focus on Compliance → Now more than ever, an active, robust compliance program is absolutely necessary. Providers must also have good training and education programs to ensure that the clinical, operations and billing staff members are up to date on any billing changes and to make sure they are billing correctly.
- Beware of Audit Triggers → ZPICs and other audit contractors will quickly discover outliers. These are the easy-to-spot mistakes such as repeatedly using incorrect codes, an abnormal increase in utilization over a given time, or duplicate claims.




Tips to Prepare

- Get Up to Date → Find out who your ZPIC contractor is in your jurisdiction. Learn as much as you can about the ZPIC in your area. Check out its Web site and take note of any discussion about target audit areas. It's also a good idea to pay close attention to the OIG Work Plan, which is published annually in October. Note areas of concern outlined in the report and ensure that your facility is in complete compliance with those areas.
- Ensure Good Supporting Documentation → If you have a claim, make sure you have the supporting documentation in place so you can retrieve it easily and send it to the ZPIC in the event of an audit.




Tips to Prepare

- Audit Regularly → Even with adequate training, mistakes may still occur. Providers should perform regular internal audits to ensure correct coding practices, clinical compliance, and that records support what is being billed. Conduct frequent education & training! Develop internal auditing P & P!
- If you discover an error, it's important to correct it promptly and repay any overpayments that may have resulted. By correcting billing errors, you demonstrate compliance with the law and show that you have a strong internal compliance program in place.
- Develop P & P for responding to audit requests!




Tips to Prepare

- Respond to Inquiries Quickly → Set up a system to flag requests for documentation or additional information from ZPIC contractors. Because these entities are new, you might not notice the mailed requests, which may or may not arrive on CMS letterhead. If they do not get to the right place in a timely fashion, your organization runs the risk of not responding in the required period, which is typically 30–45 days. If you miss that time frame, you could end up with a demand for a refund.




ZPIC Appeal Process

- If the provider elects to appeal a claim reviewed by a ZPIC, then the ZPIC forwards its records on the case to the appropriate MAC so that it can handle the appeal.
 - **Redetermination:** submit to MAC within 120 days of the ZPICs decision. MACs have 60 days from receipt to respond with a decision.
 - **Reconsideration:** submit to QIC within 180 days of the redetermination decision. QICs have 60 days to respond with a decision.
 - **ALJ Hearing:** submit within 60 days of the reconsideration decision. A determination will be issued within 90 days of review.
 - **Medicare Appeals Council:** file within 60 days of the ALJ's decision. A determination will be issued within 90 days of review.
 - **US District Court Review:** requests to file suit in the US District Court must be filed within 60 days of the Appeal Council's decision.




Suggestions for Handling Appeals

- **CMS Payment Criteria** → Several U.S. courts have held that a provider's adherence to CMS payment criteria trumps all in the evaluation of claim denials. In fact, the courts have held that - when CMS payment criteria exists for a given focus area - CMS MUST use the payment criteria when evaluating claims for payment.
- **Develop CMS Criteria-Based Case Summaries for all "Winnable" ZPIC Appeals** → Nothing speaks louder in the ZPIC appeals process than providers that painstakingly tie CMS payment criteria to medical records documentation and present an evidence-based argument for payment.




Suggestions for Handling Appeals

- **Submit all required documentation during the first 2 stages of the ZPIC appeals process** → It is critical that you file all the supporting documentation relating to a given case no later than the Reconsideration stage. After this stage, it is extremely difficult to add supporting documentation to a case under appeal.
- **Remain Organized** → It is critical that packets of documentation submitted are presented in an orderly manner and that they are technically and clinically complete.



Defensible Documentation



Halcyon
rehabilitation

Proactive Clinical Preparedness

- **Defensible Documentation** –
 - Care should be taken to ensure that required elements are present on the therapy documentation to avoid a **technical denial**.
 - The top three reasons for technical denials are as follows:
 1. Lack of Order Compliance
 2. Incomplete Documentation
 3. Non-compliance with physician's signatures and supervising co-signatures

Halcyon
rehabilitation

Proactive Clinical Preparedness

Order Compliance


- Orders to evaluate (and treat as indicated) from the attending physician.
- Clarification orders per facility policy.
- Continuation/clarification orders must be written per facility policy.
- The date that the order is written in clarification must match the date of the change documented on the UPOC.
- Discharge orders upon completion of the episode of care.

Halcyon
rehabilitation

Proactive Clinical Preparedness

Documentation Completion


- All documentation should be completed within 24 hours of initiation.
- All documentation should be completed *on or before* the document is due, such as the Weekly Progress Report.
- Barring emergency, therapists should not exit the workplace with outstanding or incomplete documentation.
- A checklist can be used to verify completion and filing in the medical record or EMR, per individual facility policy.



Proactive Clinical Preparedness

Signature Compliance


- The Plan of Care must be signed and dated by the attending physician or NPP.
- The physician must certify that the therapy is medically necessary via *signature and date* within 30 calendar days of establishment.
- The physician must also sign and date any UPOCs.
- If the date is missing from the Physician's signature, the DOR/therapist should write "received on (date)" and initial.
- Failure to obtain physician's certification puts the claim at immediate risk for denial.
- Co-signatures by the supervising therapist should be present on progress reports written by therapy assistants.



Proactive Clinical Preparedness


Defensible Documentation – The Plan of Care:

- Supportive primary & secondary medical and treatment diagnoses.
- Clear Medical Necessity in the referral process and the documentation of the reason for referral.
- Evidence-based assessment procedures (standardized tests, protocols).
- PLOF, CLOF, and goal levels of function clearly documented.
- LOS/frequency justified given underlying impairments and functional deficits identified.



Proactive Clinical Preparedness


- **Defensible Documentation – The Episode of Care:**
 - Justification of medical necessity for UPOCs and continuation of skilled services.
 - Assistant supervision documented with supervisory visit completed as required.
 - Caregiver education initiated early and throughout the EOC.
 - Goal adjustment and progression evident.
 - Discharge Summary complete with brief documentation of skilled services provided since SOC and clear patient outcomes at time of discharge.



Proactive Clinical Preparedness


Defensible Documentation - Goal Advancement & Revision:

- Weekly Progress Reports & UPOCs should show a constant updating of the short-term goals.
- STGs must show adjustment to support patient progress towards the LTG(s).
- New short-term goals should be added intermittently to address all impairment areas.
- Little or no patient progress on goals once adjusted should be closely examined to determine appropriateness of continuation.
- Discharging skilled services until the patient can actively participate may be appropriate in some situations.




Proactive Clinical Preparedness

- **Systems Organization:**
 - Co-signatures & Supervisory Requirements
 - EMR vs. co-signing by hand – how is this tracked?
 - Obtaining Physician's Signatures
 - Who is responsible and how is this tracked?
 - Incomplete Documentation:
 - Should be no clinician exiting on Friday at 5 pm with outstanding documentation.
 - Supervisor should monitor weekly, then at EOM.
 - Proper systems must be in place to ensure the Medical Record is complete.
 - Recommend a final check-off for a complete medical record.




7 Elements of a Payable Claim

- **Element #1:** Medical Necessity – In addressing this element, a provider should ask the following question: “Were the services administered medically necessary?”
- **Element #2:** Services Were Provided – The second issue addressed is whether the services at issue were actually provided.
- **Element #3:** No Statutory Violations – Are the services “tainted” by any statutory or regulatory violation, such as the Stark Law, federal Anti-Kickback or a False Claims Act violation?




7 Elements of a Payable Claim

- **Element #4:** Meets all Coverage Rules – Do the services meet Medicare’s coverage requirements?
- **Element #5:** Full and Complete Documentation – Have the services rendered been properly and fully documented? Is all documentation present and filed?
- **Element #6:** Proper Coding – Were the services rendered correctly coded?
- **Element #7:** Proper Billing Practices – Were the services rendered correctly billed to Medicare?




ZPIC Questions to Ask Yourself


- Which of your departments has primary responsibility for managing ZPIC audits?
- What is your current state of preparation for managing ZPIC Audits?
- Do you have a solid system for conducting regular internal medical record audits?
- Are physician’s signing and dating your documents timely?
- Is documentation being completed timely and present in the medical record?



Q & A



Thank you for attending
Halcyon Rehab's seminar!



The 7 Stages of Zone Program Integrity Contractor Audits and Appeals

STAGE 1

ZPIC Review (Initial Determination)

ZPICs identify target areas based on:

- Investigations
- OIG and law enforcement instructions
- Congressional mandates
- Data Mining

ZPIC sends medical records request letter to providers asking for specific claims. Providers have 15 to 30 days to submit documentation. Approximately 6 to 18 months later, ZPIC will send results letter. Often denials of 70 to 100% of claims. Days or weeks after receipt, providers will get demand letter from Medicare administrative contractor (MACs).

STAGE 2

Rebuttal

Must be filed within **15 days** of date of demand letter.

Rebuttal offers providers the first opportunity to provide explanation and argument regarding audit results and process. However, because of the tight filing deadline, focus should be on reasons why contractors should not begin recoupment activities. However, not legally necessary to continue appeals process.

Recoupment – Recoupment (a.k.a. offset or withhold) is a government action which takes future payments and applies them to alleged overpayments, regardless of whether providers have had a fair chance to defend the claims. It may begin 41 days after the date of the demand letter.

STAGE 3

Redetermination

Must be filed within **120 days** of receipt of the demand letter.

Must be filed with **30 days** of **date** of the demand letter to delay recoupment.

Redeterminations are filed with the Medicare administrative contractor who originally sent the demand letter. Because the MACs work so closely with the ZPICs, providers should not expect to win many claims at this level.

The MACs have 60 days to issue a decision (unless providers send in additional information after appeal, which increases the MACs' deadline by 14 days.)

STAGE 4

Reconsideration

Must be filed within **180 days** of receipt of redetermination decision (or, if partially favorable, receipt of revised overpayment).

Must be filed with **60 days** of **date** of redetermination decision to delay recoupment.

Must file any and all documentation at this stage

Reconsiderations are filed with Qualified Independent Contractors (QICs), who independently evaluate claims and statistical sampling procedures. However, providers have no opportunity for oral argument or hearing. QICs have 60 days to issue a decision (unless supplemental information is submitted, which increases the QICs' deadline by 14 days.)

STAGE 5

ALJ Appeal

Must be filed within **60 days** of receipt of reconsideration decision (or, if partially favorable, receipt of revised overpayment).

Most important stage for providers

ALJ appeals are filed with the Office of Medicare Hearings and Appeals. During this appeal, providers may explain their documentation and other relevant information to an Administrative Law Judge (ALJ), who will then make a ruling based on the hearing and his review. Although ALJs have 90 days to issue a decision, this process generally takes several months.

STAGE 6

MAC Appeal

Must be filed within **60 days** of receipt of ALJ decision.

If there is an error of law in the ALJ's decision or the decision was not based on the weight of the evidence, a provider may appeal to the Medicare Appeals Council (MAC). However, providers have no opportunity for oral arguments and the MAC have overturn favorable portions of ALJ decisions.

The MAC has 90 days to issue a decision, and it may decline to review a case altogether if there does not appear to be error in the ALJ's decision.

STAGE 7

Federal District Court

Must be filed within **60 days** of receipt of MAC decision.

Finally, a provider may file a complaint with the Federal District Court in its jurisdiction. This appeal is heard in an actual courtroom before a judge, with witnesses and testimony. This is a very formal and expensive matter.

Interest begins to accrue 30 days after demand letter until overpayment repaid or claims found favorable.

Recoupment may begin 30 days after QICs decision.

