



HEALTH CARE FRAUD REPORT



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ZPICs: Medicare and Medicaid Billing Practices Under the Microscope

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With the introduction of the Zone Program Integrity Contractors (ZPICs), health care providers participating in the federal health care programs are seeing a significant change in the way fraud and abuse is detected.

Through the ZPICs, the Centers for Medicare & Medicaid will have for the very first time a contractor with the uniform jurisdiction of auditing the integrity of all Medicare-related claims.

Thus, ZPICs will play an increasingly important role in fraud and abuse detection in the Medicare and Medicaid programs in the coming years. For this reason, providers should understand the role of ZPICs and how to prepare for them.

Reasons for ZPICs

CMS is consolidating the work of 17 Program Safeguard Contractors (PSCs) and eight Medicare Drug Integrity Contractors (MEDICs) into seven ZPIC zones. Two of the seven ZPICs are operational with others expected to begin work soon. CMS began the ZPIC program for several reasons. First, the activities of the PSCs varied substantially with most PSCs having mini-

mal results in proactive data analysis.¹ Thus, there were questions of whether the PSCs were taking the necessary steps to identify potential fraud and abuse.

Additionally, there was no uniformity of jurisdictions or tasks. For example, one PSC could oversee the integrity of Part A claims in one state with an entirely different PSC overseeing integrity of Part B claims in the same state.

The same is true for durable medical equipment, home health, and hospice claims, with MEDICs overseeing the integrity of Part D claims. This complexity required law enforcement officials investigating potential cases of fraud and abuse to work with more than one PSC or an entirely different entity altogether to gain a complete picture of relevant Medicare claims data for a particular provider. To resolve these problems and simplify fraud investigations, one ZPIC will be responsible for all of CMS's benefit-integrity efforts in a given ZPIC zone.

Another reason for the ZPIC program occurred with the passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108-173).

Under this legislation, MMA replaced fiscal intermediaries and carriers with Medicare Administrative Contractors (MACs), a combined entity performing all

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¹ See OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, MEDICARE'S PROGRAM SAFEGUARD CONTRACTOR ACTIVITIES TO DETECT AND DETER FRAUD AND ABUSE 2 (July 2007).

² *Id.*; Brian Petry, *Centers for Medicare and Medicaid Services' Transition from Program Safeguard Contractors (PSCs) to Zone Program Integrity Contractors (ZPICs)*, 57 HEALTH CARE FRAUD 46, 47-50, 53 (Jan. 2009).

³ See Petry, *supra* note 2, at 53.

claims processing functions previously performed separately.

With the MAC reorganization, CMS made the change to ZPIC jurisdictions so that its claims processing and benefit integrity functions coincide. Thus, one ZPIC will review all data from a single zone, comprised of at least one or more whole MAC jurisdictions.

Role of ZPICs

With this consolidation, the ZPICs ultimately will “be responsible for ensuring the integrity of all Medicare-related claims under Parts A and B (hospital, skilled nursing, home health, provider and durable medical equipment claims), Part C (Medicare Advantage health plans), Part D (prescription drug plans) and coordination of Medicare-Medicaid data matches (Medi-Medi).”⁴ Thus, law enforcement now can obtain a complete picture of a provider’s billing for all parts of the Medicare and Medicaid programs. As one CMS representative described it, this improvement “will provide ‘one-stop shopping’ that will eliminate the need to visit several PSCs for data” on a single provider.⁵

In reviewing provider data in their zones, the ZPICs’ specific responsibilities include identifying vulnerabilities in the Medicare program, identifying and investigating potential cases of fraud, and referring cases to law enforcement for possible prosecution.

Other tasks include providing support to law enforcement by conducting data analysis to support fraud investigations or taking administrative action, such as payment suspensions or overpayment demands, against providers.

ZPICs also are expected to generate proactive investigations through “innovative data analysis methodologies for the early detection and prevention of abusive use of services, as well as possible fraud, waste and abuse schemes.”⁶

ZPIC Audits

Unlike other post-payment audits that are merely looking for overpayments, ZPICs are investigating potential fraudulent billing practices. Thus, if a provider is a target of a ZPIC audit, there is either an open investigation or the ZPIC is trying to determine if a fraud investigation should be opened.

A ZPIC investigation may include a written request for records or an on-site visit. The on-site visits generally are unannounced or with little notice, with ZPIC representatives appearing at a provider’s office and presenting a staff member with a records request to be provided on the day of or within a few days of the visit.

Additionally, the ZPIC representative may request interviews of the provider’s personnel, such as physicians, clinical staff, or billing personnel. A ZPIC also may interview beneficiaries to determine if the provider actually provided the services that were billed.

When submitting a written request for records, a ZPIC asks that the provider provide within a specified time frame all information in the requested patients’ medical records that supports the services billed on the dates in question. There is no clear guidance on who bears the costs associated with such copies.

However, informal indications are that such costs are often borne by the provider. After assembling and analyzing information it has generated for a provider, the ZPIC will determine whether to refer the case to law enforcement or to seek repayment through the administrative process.

How Providers Should Prepare for ZPICs

With its emphasis on proactive data analysis, CMS fully intends for the ZPICs to respond more rapidly than in the past to potentially fraudulent billing practices and to conduct more audits and investigations. Thus, a provider’s compliance program that provides for regular assessments is imperative to ensure that it is ready when the ZPICs show up.

These assessments should include data mining of potential risk areas to ensure that appropriate claims are appropriately billed. Frequent education and training of appropriate billing and coding practices also should occur. Any problems detected should be corrected and overpayments repaid. These steps may help to prevent a provider from being a ZPIC target.

Additionally, because of the serious implications of a ZPIC investigation, providers should establish a procedure for responding to ZPIC audits to include at least the following:

Point of Contact Designation. Providers should start with designating the Compliance Officer or another administrator as the point of contact responsible for the audit and request that this person be notified immediately if anyone is contacted by a ZPIC or if a ZPIC appears at any office.

The point of contact should then coordinate the audit, answer any questions, and assist the ZPIC in setting up interviews if requested. The point of contact also should be tasked with notifying the provider’s legal counsel. Legal counsel then can assist in interfacing with the ZPIC and can monitor and document the audit process, including being present during interviews and assisting in document collection.

Establishment of Multi-Disciplinary Committee to Produce Records. When providing records to a ZPIC, providers must ensure that complete documentation is provided to support the services billed. The document collection cannot be left solely to clinical personnel who may not be aware of documentation necessary to support claims from a billing perspective.

To ensure that all appropriate records are produced, providers should consider establishing a multi-disciplinary committee composed of all departments with potentially relevant records to review and respond to any ZPIC requests.

Identification of Records Location. A ZPIC may request records that a provider may not have on-site. A provider also may have multiple sites where records are located or may store records in both paper and electronic form. Thus, providers should develop a list of the locations of its records and how the records are stored.

This list of records should assist providers in responding to a ZPIC’s records request fully and in the time frame requested by the ZPIC. However, if a pro-

⁴ Press Release, Centers for Medicare & Medicaid Services, CMS Enhances Program Integrity Efforts to Fight Fraud, Waste and Abuse in Medicare (Oct. 6, 2008), <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3291>.

⁵ Petry, *supra* note 2, at 53.

⁶ See, e.g., Zone Program Integrity Contractor (ZPIC) Task Order, Statement of Work, Zone 1 – Parts A, B, DME and HH + H, at 3; Zone Program Integrity Contractor, Zone 1 Medi-Medi Task Order, Statement of Work, at 2.

vider is unable to provide all of the records within the time frame set by the ZPIC, the point of contact should request additional time to submit the documentation and should document this agreement.

By developing these procedures before the ZPIC shows up, providers will ensure that they are responding to a ZPIC audit in a thoughtful and deliberate manner.

Conclusion

Armed with the knowledge that a ZPIC audit indicates a potential fraud investigation, providers should take proactive steps to prepare for these audits.

A strong compliance program, as well as proper preparation, regular risk assessments, and personnel training are active steps a provider may take to lessen the impact of a ZPIC's audit.