ZPIC Audits / UPIC Audits: The Impact of Transmittal 768 on the Medicare Appeals Process Timeline

(April 12, 2018): A big concern with the Medicare appeals process is the ghastly backlog at the Office of Medicare Hearings and Appeals (OMHA) for an Administrative Law Judge (ALJ) hearing coupled with the government's authority to recoup alleged overpayments after the second level of appeal (reconsideration). There is renewed buzz regarding the backlog and potential recourse given the Fifth Circuit's decision on March 27, 2018 in ***Family Rehabilitation, Inc. v. Azar*, No. 17-11337**, which affirmed the possibility for providers to sue for an injunction to prevent Medicare Administrative Contractors (MACs) from recouping overpayments until administrative appeals are concluded under the collateral-claim exception. But what about the snail-like pace of postpayment reviews at the very beginning of this process? As discussed below, Medicare's Transmittal 768 may alleviate this continuing problem to some extent.

I. Continuing Delays by ZPICs / UPICs in Completing an Initial Review - Overview of the Problem:

Before claims are appealable, they have to be denied on review. A major source of massive extrapolated alleged overpayments are postpayment reviews by Zone Program Integrity Contractors (ZPICs) and their successor Unified Program Integrity Contractors (UPICs). Our experience has been that these reviews usually take many months, even years. This is in spite of the fact that providers are required to turn over the requested records in somewhere between 15 and 30 days, maybe even 45 days if the provider requests an extension. The investigators typically remain tight-lipped throughout the review and investigation process. Inquiries about the status of a review are usually met with no response or cryptic feedback like "The review findings will be provided at the conclusion of the review." In the meantime, providers are expected to sit on their hands. Then one day, a letter arrives which often reflects an unmanageable alleged overpayment figure for the provider and the provider is left to dispute the alleged overpayment through "Medicare's Byzantine four-stage administrative appeals process" – in the words of Circuit Judge Jerry E. Smith in ***Family Rehabilitation, Inc. v. Azar***.

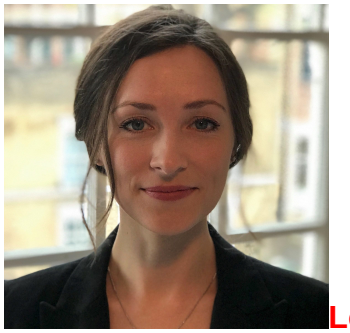
II. New Timelines Under Transmittal 768 for ZPICs / UPICs to Complete a Postpayment Review:

There has been a development that may effectuate speedier postpayment reviews by ZPICs and UPICs. The Centers for Medicare and Medicaid Services (CMS) issued guidance**,** which imposes a new timeline and requirements on these contractors effective March 1, 2018. Specifically, the transmittal adds the following requirements to Chapter 3 of the Medicare Program Integrity Manual:

> **"*the UPICs / ZPICs shall complete postpayment medical review and provide the lead investigator with a final summary of the medical review findings that includes reference to the allegations being substantiated/not substantiated by medical review, reasons for denials, and any observations or trends noted within 60 calendar days*" and "*[t]he counting for the 60-day time period begins when all of the documentation is received by the UPIC / ZPIC contractor*."**

Please note, however, that this is an internal timeline for the contractors (as between the medical reviewer(s) and lead investigator), meaning that providers should not expect to receive the postpayment audit results within 60 days of having submitted the records to the UPIC / ZPIC. However, Transmittal 768 may be useful to put pressure on the contractors when reviews are pending for months or years on end.

For a detailed discussion of the ZPIC program and process, please see: **ZPIC Audits.**



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