UPIC Inquiries: Proceed with Caution

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In 2016 the Centers for Medicare & Medicaid Services (CMS) began consolidating fraud and abuse oversight work into a new set of contractors called Unified Program Integrity Contractors (UPICs). CMS completed the launch of its new UPIC program with very little public fanfare, and not long thereafter temporarily halted UPIC auditing work during the early part of the COVID-19 pandemic. UPICs are broadly authorized to investigate potential fraud and to report findings to government enforcers. Indeed, a report issued last fall by the Department of Health and Human Services-Office of Inspector General (HHS-OIG) underscores that UPICs have substantially more sophisticated data and tools at their disposal than their predecessors, and healthcare providers receiving a UPIC inquiry should undertake a strategic response, recognizing that a broader government investigation could be on the horizon.

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Background on UPICs

UPICs operate in five geographic jurisdictions and engage in program integrity work relating to Medicare, Medicaid, and "Medi-Medi," which involves analyzing billing trends across the Medicare and Medicaid programs. Their primary objectives are to identify potential fraud, waste, or abuse—in other words, more than coding errors—investigate leads with potential merit, and to refer providers as appropriate to other entities for education, administrative penalties, or potential civil or criminal prosecution. In 2019, UPICs screened over 7,000 leads, opened over 4,500 investigations, and referred $373 million in overpayments for recovery.[1]

According to HHS-OIG's UPIC report, which was released in September 2022 and analyzes the calendar year 2019 operations, UPICs received $101 million in funding from CMS, with each of the five UPIC jurisdictions receiving varying amounts depending on historical workload.[2] UPICs are also eligible for what HHS-OIG characterized as "performance-based" awards, although HHS-OIG did not disclose how these incentive payments are calculated.[3]

UPICs do not have a monopoly on auditing work for CMS. For example, Medicare Administrative Contractors (MACs) continue to engage in medical record reviews for CMS, including through the Targeted Probe and Educate program, and Recovery Audit Contractors (RACs) are still undertaking audits addressing a list of CMS-approved coding review projects.[4] UPICs do, however, enjoy a level of primacy above other contractors. CMS maintains a RAC Data Warehouse, and when UPICs initiate an auditing project, they must enter "suppressions" on certain providers, codes, geographies, and time periods under review, so that other CMS auditors know to avoid auditing those same claims.

UPIC Authority and Tools

Unlike other CMS auditors, which generally engage only in reactive auditing activities designed to detect fraud, waste, and abuse, UPICs are expected to engage in both reactive and *proactive* auditing strategies to detect *and prevent* fraud, waste, and abuse.

UPICs undertake reactive auditing work primarily in response to receiving referrals from other stakeholders. For example, CMS requires MACs to forward cases to UPICs where they suspect certain issues, including upcoded claims and misrepresentation about the services provided or the identity of the provider. One way MACs receive notice of potential issues is through the HHS-OIG Hotline, which is a hotline open to the public that solicits complaints about fraud, waste, and abuse. HHG-OIG directs all hotline tips to CMS, which conducts an initial screening and then directs the complaint to the MAC for an initial review. If the MAC believes that the complaint implicates potential fraud, waste, and abuse, it must refer the case to a UPIC for further investigation.

UPICs are also required to implement procedures to receive information from each MAC about voluntary overpayment refunds received. As a result, while each MAC interfacing with a provider may not be aware of the provider's refunds to other MACs, UPICs will have a global view of a provider's overpayment return history. CMS has directed UPICs to investigate any refund where there is a suspicion of inappropriate conduct. UPICs also receive referrals directly from HHS-OIG and CMS, including at quarterly meetings. Finally, UPICs also receive referrals from state-level stakeholders, such as state Medicaid agencies and Medicaid Fraud Control Units.

Beyond their reactive auditing responsibilities, UPICs also are expected to generate their own proactive leads to investigate. They can do so through a variety of means, including analysis of claims data, pursuing a new lead identified in an ongoing investigation, or combining information from different sources, including the news media and conferences. UPICs report their number of proactive investigations to CMS.

To facilitate their work, UPICs can take advantage of coordination across law enforcement stakeholders that is significantly enhanced as compared to the past. These coordination tools include:

- Transformed Medicaid Statistical Information System (T-MSIS): As of August 2021, UPICs can access T-MSIS data for each state, which includes the state's Medicaid spending data. The T-MSIS dataset allows UPICs to access virtually all Medicaid data, without needing to submit piecemeal requests to different states for data.
- Unified Case Management System (UCM): The UCM is a national database in which UPICs enter all of their Medicare and Medicaid projects, leads, and investigations. UPICs document not just the fact that they are conducting an investigation with respect to a particular provider, but also the specific steps taken. For example, if a UPIC engages in a medical record review, the UPIC must log the results in the UCM. UPICs are also expected to input administrative actions such as

payment suspensions and requests for information fulfilled at the request of law enforcement or CMS. Together, the UCM reflects the full picture of UPIC activities across the country. Furthermore, UPICs are not the only entities with access to the UCM. Federal and state law enforcement, CMS, and MACs can also access the system to assess whether a provider of interest to them has been the subject of any UPIC activities.

- Major Case Coordination (MCC) Initiative: CMS established the MCC for Medicare in April 2018 and Medicaid in January 2020, to provide a forum for UPICs to discuss their highest-priority investigations with law enforcement and CMS. These recurring meetings give law enforcement and CMS an opportunity to vet UPIC investigations and weigh in on appropriate next steps, including referrals for administrative penalties or potential prosecution. HHS-OIG noted that within a year of implementing the Medicare MCC, there was a 200% increase in Medicare referrals to law enforcement.[5]

HHS-OIG's 2022 report did not disclose each UPIC's proactive investigation volume. However, HHS-OIG did summarize, by UPIC, the number of investigations opened in 2019 (ranging from 259 to 774 per UPIC jurisdiction) and the number of data analysis projects completed (ranging from 29 to 107).[6] HHS-OIG was critical of the disparity between each UPIC's volume of activity, noting that even after accounting for different volumes of Medicare and Medicaid spending across jurisdictions, the "UPIC that opened the most investigations [in the Southwest region] opened three times as many investigations as the UPIC that opened the fewest investigations [in the Northeast region] for every $100 billion in spending."[7] Acknowledging that disparities in levels of fraud can exist across the country, HHS-OIG nonetheless encouraged CMS to assess whether these differing levels of productivity reflected the relative strengths of each UPIC's performance.[8] CMS agreed with the recommendation, noting that it "tracks UPIC initiatives and findings in detail, and expects UPICs' time and resources spent across Medicare, Medicaid, and Medi-Medi to generate a positive return on investment."[9] This oversight may further spur UPICs to ensure that their projects result in recoveries sufficiently large to justify the renewal of their contracts.

UPIC Investigation Procedures

UPICs' work begins with screening leads—whether those leads were referred to the UPIC or proactively generated—to determine the need for further investigation. Screening activities can include interviews with beneficiaries and/or a complainant, data analysis, analysis of regulations, and coordination with MACs to understand their prior activities with respect to a provider, such as medical record reviews and education. Subject to narrow exceptions, these screening activities all take place without any direct interaction between the UPIC and the provider under review. CMS requires UPICs to complete their screening within 45 days of receiving a lead.

At the conclusion of the screening process, a UPIC closes its investigation if the UPIC determines that the provider does not appear to have engaged in fraud, waste, or abuse. The UPIC may nonetheless refer the provider for appropriate action, such as education from a MAC or a Quality Improvement Organization. If a UPIC determines that a lead warrants further investigation, the UPIC submits information about the lead to CMS through the UCM using a designated "Vetting Form." UPICs are not permitted to transition to a full investigation until CMS approves. If CMS reviews the UPIC's initial findings from the screening process and agrees with the UPIC that additional investigation is appropriate, then the UPIC can launch an investigation. Otherwise, UPICs are required to close the lead.

It is at the investigation stage that providers under scrutiny first come into contact with a UPIC. In addition to engaging in the same types of activities, UPICs can use at the screening stage, UPICs can also take steps that make their investigation apparent to the targeted provider, including by requesting and reviewing medical records and interviewing referring providers. Before contacting a provider, the UPIC must review the UCM to confirm there are no ongoing law enforcement activities regarding that provider. Medical record reviews form a core part of the investigative phase, and CMS encourages UPICs to undertake medical record reviews early in an investigation.

At the conclusion of its investigation, the UPIC makes a decision on whether the potential fraud, waste, or abuse was substantiated. If so, the UPIC refers the matter to law enforcement, generally to HHS-OIG or a U.S. Attorney's Office. If law enforcement accepts the case, they may pursue a variety of healthcare fraud charges, including a False Claims Act case. If law enforcement declines the case, UPICs are supposed to work with CMS to implement administrative remedies, including suspension or denial of payments and the recovery of overpayments, and potentially pursue civil monetary penalties.

If the UPIC decides that the potential fraud, waste, or abuse was not substantiated, but the UPIC did identify errors in claim submission, the UPIC may elect to refer the provider to the relevant MAC for additional education and training, in addition to possibly seeking a broader recovery of overpayments. If the MAC continues to encounter billing issues with the provider, the MAC can refer the provider to HHS-OIG or CMS for the imposition of civil monetary penalties.

Best Practices for Responding to UPIC Inquiries

By the time a provider receives a medical record request, the provider has unknowingly been under a UPIC's microscope for some time: a UPIC has already generated or received a lead, engaged in screening activities, submitted a recommendation to CMS to open an investigation, and received approval from CMS to do so. Although the inquiry is new to the provider, the UPIC already has developed some initial conclusions about the provider's claim submissions. But the good news for a provider in this situation is that if a UPIC is handling the outreach, the provider can generally infer that there is no open law enforcement investigation on the same issue. The provider also still has an opportunity to avoid the UPIC inquiry evolving into a law enforcement matter.

Providers should implement internal procedures that facilitate efficient identification and escalation of any UPIC inquiries to legal and compliance functions. UPICs demand the production of medical records within a very short timeframe, generally about two weeks. Missing the initial production deadline is not a good start to developing a relationship that demonstrates the provider's good faith compliance efforts.

But if meeting the initial production deadline is not feasible, providers should not be afraid to negotiate for a reasonable extension, just like they would when responding to a Department of Justice Civil Investigative Demand. It is particularly important to take the time to carefully organize the records produced, to minimize the risk that the UPIC erroneously fails to identify relevant documentation.

Ideally prior to producing records, but if not in parallel, providers should seek to understand why the UPIC has requested the records. Providers should carefully scrutinize the record request for clues about the issue of concern, and a coder should review the requested medical records to identify potential a pattern of billing errors. An external coder may be preferred at this stage, in order

to introduce a fresh perspective and offer benchmarking insights.

If the records the provider will be producing, or did produce, include errors reflecting receipt of overpayments, the provider should consider working to understand the breadth of the errors, which can also help shed light on the root cause of the errors. For example, are the errors the result of a localized misunderstanding by one practice location, or are the errors instead the result of an enterprise-wide policy that may be inconsistent with the government's interpretation of applicable coding rules? If the company's policies and procedures are at fault, the provider should promptly and proactively implement revised versions and retrain staff. This voluntary action helps demonstrate to the government that the provider takes remediation seriously and as a result, government-mandated remediation is unnecessary.

An important part of a provider's internal review is assessing whether the provider has an obligation to make a broader repayment of overpayments. UPICs issue letters to providers memorializing their findings, and even where cases are not referred to law enforcement, these letters often include language stating that the provider should consider itself on notice that it must exercise reasonable diligence under the 60-day overpayment rule to engage in a broader multi-year lookback and return identified overpayments. The provider's decision in this regard has potential treble damages implications under the False Claims Act and should be carefully considered with input from legal counsel.

Conclusion

Providers accustomed to receiving periodic MAC medical record requests may be inclined to view a UPIC medical record in a similar light. However, unlike a MAC inquiry, a UPIC request for medical records constitutes a tacit disclosure that both a UPIC and CMS have already identified evidence they believe reflects potential fraud, waste, and abuse. This is because the medical record request is preceded by a string of investigative activities that occurred unbeknownst to the provider.

HHS-OIG's September 2022 report lauded UPICs for the promise they hold "for leveraging cross-program consolidation to strengthen oversight by employing new collaborative processes, analytical tools, and technology to conduct program integrity activities."[10] However, HHS-OIG offered several suggestions to enhance the robustness of the UPIC program, particularly with respect to audits of the Medicaid program—recommendations CMS committed to implementing. Providers can expect that UPICs will only continue to grow more sophisticated in how they approach their work and more connected to other stakeholders throughout the life cycle of their investigations.

Endnotes

1. HHS-OIG, UPICs Hold Promise to Enhance Program Integrity Across Medicare and Medicaid, but Challenges Remain at 13 (Sept. 2022), *https://oig.hhs.gov/oei/reports/OEI-03-20-00330.pdf*.
2. *Id*. at 3.
3. *Id*.
4. CMS, Approved RAC Topics, *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Approved-RAC-Topics* (last visited May 23, 2023).
5. *Id*. at 17.
6. *Id*. at 19.
7. *Id*. at 18.
8. *Id*. at 22–23.
9. *Id*. at 35.
10. *Id*. at 21.

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