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CMS Gives UPICs More Powerful Policing Role; ‘This Raises the Risk Level’ for Providers

By Nina Youngstrom

Sweeping changes to the *Medicare Program Integrity Manual* will make CMS’s unified program integrity contractors (UPICs) more of a force to be reckoned with, and providers will feel it with voluntary repayments, exclusions and other areas related to fraud, waste and abuse, attorneys say.

Effective Oct. 12, UPICs are required to have “formal and informal communication” with state survey agencies, the HHS Office of Inspector General (OIG), Department of Justice (DOJ), Medicaid agencies, other Medicare contractors, state surveyors “and other organizations as applicable to determine information that is available and that should be exchanged to enhance program integrity activities,” according to Medicare Transmittal 10984, released Sept. 9.[1]

“They are the goliaths that will have to be dealt with,” said attorney Judy Waltz, with Foley & Lardner LLP in San Francisco. “The idea that all this investigative information becomes well-coordinated among the various enforcers is pretty amazing and scary.” Providers should recognize when they hear from a UPIC how serious it is, she said.

“This raises the risk level especially because you have an entity being assigned a role of aggregating information across different touchpoints,” said former CMS legal officer Brenna Jenny, with Sidley Austin LLP in Washington, D.C. Providers will “begin to engage with a powerful new central audit function designed to police the landscape of all administrative reviews and fraud investigations across relevant state and federal actors.”

The *Medicare Program Integrity Manual* also said UPICs will keep files on providers and suppliers who have been the target of complaints; prepayment edits; investigations by UPICs, OIG or DOJ; prosecutions by U.S. attorneys; and any civil, criminal, or administrative action for Medicare or Medicaid violations.

UPICs perform program integrity activities in Medicare Parts A and B, durable medical equipment, prosthetics and orthotics supplies, home health and hospice and Medicaid. They have access to the unified care management (UCM) system, a national database used by CMS, OIG, the FBI, and other Medicare enforcers and contractors with a stake in Medicare and Medicaid fraud investigations.

But the new manual provisions up the ante. “The UPICs are specifically being directed to identify proactive leads. They’re not just passive reviewers,” Jenny explained. “They are now directed to use their creativity and resources to develop and follow up on leads.”

UPICs Will Investigate Some Voluntary Refunds

The manual provision on voluntary refunds “is one of the biggest things that jumped out at me,” Jenny said. Although it’s positive for providers that CMS acknowledged most errors aren’t committed knowingly or intentionally and therefore aren’t fraudulent, CMS clearly has concern that voluntary refunds can signal broader

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compliance issues in an organization, she explained. According to the manual, “the UPIC shall perform an investigation on any voluntary refund where there is suspicion of inappropriate payment or if a provider/supplier is under an active investigation.” Also, UPICS must establish a mechanism for communicating and gathering information from Medicare administrative contractors (MACs) about voluntary refunds. “That’s important, and it’s not necessarily going on right now,” Jenny said. As explained in the manual, “the UPIC shall establish a mechanism whereby the MAC notifies the UPIC on a regular basis of all voluntary refunds it received.”

On a related note, Jenny said UPICs have been telling providers more frequently to do internal reviews when there’s a relatively high error rate and make additional repayments. If a provider doesn’t do a retrospective review and the UPIC finds the same or similar error during the course of another review, or based on information from other government entities or contractors, there’s a much greater risk “it could trigger a referral to OIG and the prior refusal to conduct a broader review and return overpayments could be viewed by the government as rising to the level of reckless disregard,” which is the mens rea for the False Claims Act, Jenny said. “Providers need to carefully consult with legal and compliance about next steps if they receive such a letter from a UPIC.”

UPICs to Review Potential Exclusion Cases

Waltz was struck by the manual’s language on UPICs’ role in exclusions and Medicare suspensions, two of the most serious sanctions that can be imposed on providers and suppliers and which often put an end to their business. “How all this plays out will be very interesting,” she said. “The UPICs are like the new sheriff in town.”

The manual states that “the UPIC shall review and evaluate abuse cases to determine if they warrant exclusion action. Examples of abuse cases suitable for exclusion include, but are not limited to:

- “Providers who have a pattern of adverse QIO [quality improvement organization] or MAC findings;
- “Providers whose claims must be reviewed continually and are subsequently denied because of repeated instances of overutilization;
- “Providers who have been the subject of previous cases that were not accepted for prosecution because of the low dollar value;
- “Providers who furnish or cause to be furnished items or services that are substantially in excess of the beneficiary’s needs or are of a quality that does not meet professionally recognized standards of health care (whether or not eligible for benefits under Medicare, Medicaid, title V or title XX);
- “Providers who are the subject of prepayment review for an extended period of time (longer than 6 months) who have not corrected their pattern of practice after receiving educational/warning letters;
- “Providers who have been convicted of a program related offense (§1128(a) of the Social Security Act); or
- “Providers who have been convicted of a non-program related offense (e.g., a conviction related to neglect or abuse of a beneficiary, or related to a controlled substance) (§1128(a) of the Social Security Act).”

UPICs also may recommend that CMS or OIG levy civil monetary penalties on providers under their respective authorities. In terms of OIG civil monetary penalties, “if a referral is not made or a referral is declined, the UPIC shall consider other administrative remedies, which, at a minimum, may include revocation of assignment privileges, establishing prepayment or post payment medical reviews, and referral of situations to state licensing boards or medical/professional societies, where applicable,” the *Medicare Program Integrity Manual* states.

The marching orders for the UPICs go beyond fraud and abuse. The manual says they will “refer instances of

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apparent unethical or improper practices or unprofessional conduct to state licensing authorities, medical boards, the QIO, or professional societies for review and possible disciplinary action. Additionally, referrals should be made to the Medicare survey and certification agency."

The program integrity manual update has additional revisions that envision a bigger role for UPICs. "It's pretty deep and broad and very well thought out," Waltz said. Until now, audits and investigations have been more piecemeal. "This is much more focused," she noted. UPICs also will have regular meetings with regional CMS and OIG offices.

But UPICs won't act unilaterally. If they act on leads and targets, the investigations have to be vetted by CMS, Jenny noted. Also, OIG has an item on its Work Plan about UPICs, with a report due in 2022.[2] OIG's Office of Evaluations and Inspections is examining the results of the UPICs' work and in particular the success of their coordination with OIG.

1 CMS, "Updates to Chapters 1, 3, 4, 5, 8 and 9 of Publication (Pub.) 100-08," Pub. 100-08, *Medicare Program Integrity Manual*, Trans. 10984 (September 9, 2021), https://go.cms.gov/3ke8Z0T.
2 "Results of UPICs' Benefit Integrity Activities," Work Plan, HHS Office of Inspector General, accessed September 16, 2021, https://bit.ly/3kcX2Ze.

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