Navigating UPIC Audits: Strategies for Successful Appeals

What are UPICs?
UPIC stands for Unified Program Integrity Contractor.

UPICs are independent contractors for the Centers for Medicare & Medicaid Services (CMS), similar to Recovery Audit Contractors (RACs) but with a different focus. While RACs focus exclusively on Medicare, UPICs oversee both Medicare and Medicaid with their primary focus being on fraud detection and investigations. UPICs run surveillance by data mining claims using proprietary software. They get "tips" or referrals from Medicare Administrative Contractors (MACs), other contractors, law enforcement agencies, providers, and individuals.

Why are UPICs important?
UPIC letters should not be ignored! UPICs are powerful entities that can impose severe administrative penalties – including payment suspensions, overpayment recoveries, civil monetary penalties, and even revocation and deactivations. They have the authority to impose automated edit claim denials, and non-automated review claim denials. Additionally, they can make referrals to law enforcement agencies and are even bonused for doing so.

What strategies and methods do UPICs employ?
UPICs investigate instances of suspected fraud, waste, and abuse. Their methods may include provider site visits and beneficiary interviews. They may look for falsification of documents and billing for services or items not rendered. UPICs conduct their own audits of providers, frequently extrapolating their findings, which can result in large recoupments. They look for outliers by profiling billing patterns looking for higher than expected utilization or other unusual patterns.

Who are the UPICs and what are their service jurisdictions?
UPIC contracts operate across five geographical jurisdictions in the United States: Midwest, Northeast, West, Southeast, and Southwest. UPICs have their own geographical jurisdictions that do not line up with RAC jurisdictions. The UPICs and their jurisdictions follow:

- CoventBridge Group (Midwest)
- Safeguard Services (Northeast and Southeast)
- Qlarant Integrity Solutions (West and Southwest)

CMS maintains an easy-to-find Review Contractor Directory with an interactive map to help guide users to the information they are seeking (CMS, Review Contractor Directory - Interactive Map).

How are UPICS incentivized by CMS?
"CMS expects UPICs' time and resources spent across Medicare, Medicaid, and Medi-Medi to generate a positive return on investment." (Murrin, 2022). UPICS must generate profits to be successful, and are bonused in part on their ability to do that. UPICs are eligible for performance-based award fees and other bonus criteria including quality and timeliness. Effective coordination between the UPICs and other program integrity contractors is also considered.

The CMS Center for Program Integrity (CPI) "established expectations for UPICs to prioritize high dollar, high risk investigations." (CMS, 2024).

What are the levels of UPIC appeal?
UPICs follow a similar appeal structure to RACs.

The levels are as follows:

1. Redetermination
2. Reconsideration
3. Administrative Law Judge (ALJ) Hearing
4. MAC Review
5. Federal District Court

The **redetermination** appeal must be filed within 120 days of the initial decision. In our experience, LW Consulting, Inc. (LWCI) has rarely seen successful appeals at this level. This makes sense considering the UPIC's financial incentives and that, at this level, the UPIC would be overturning their own findings.

A **reconsideration** appeal involves the process of having a Qualified Independent Contractor (QIC) review audit results, appeal arguments, and statistical plan arguments. Reconsideration appeals are filed within 180 days of the redetermination notice. This is the last opportunity to bring in new supporting documentation to the case. In LWCI's experience, appeals are only slightly more likely to be accepted at this level but successful appeals remain uncommon.

An **ALJ Hearing** presents the best opportunity for overturning the denial – if there is a reasonable basis for appeal. This is the first opportunity to present the case live and have the benefit of expert witness testimony.

The **MAC review and Federal District Court** are used less frequently. Most providers are ready to accept the ALJ decision. There are times when providers are motivated to pursue these levels. The MAC may decline the review. If declined, the provider is free to move to Federal District Court. The cost of this process is prohibitive to many.

Strategies for UPIC Appeals

In LWCI's opinion, every time a provider receives a request for documentation from a UPIC, the provider will benefit from hiring a health law attorney to guide the audit response strategies and submission process. Attorneys will typically bring in consulting experts, including well credentialled auditors, physical therapists, occupational therapists, speech therapists, nurses, physicians, statisticians – whatever expertise is needed to support the case.

Having these experts available throughout the process and especially at an ALJ hearing can be the difference between winning and losing. The consultants should be brought on as early as possible, but no later than the reconsideration level appeal, so that all appropriate arguments can be developed, and supplemental documents can be identified and submitted. If it is decided that individual patient appeal letters are to be developed, this is the time to craft the patient story and humanize the care experience using quotes from providers and patients where they appear in the medical record.

While some experts advocate "appeal everything," in LWCI's experience, that is perhaps more valid at the redetermination and reconsideration levels than it is at the ALJ level. In LWCI's experience, the first two levels of appeal sharpen the arguments and allow for additional document collection and submission as well as time to craft the patient story. In some cases, it is helpful to gather clinical documentation from other providers to support the case, especially if the clinical history and conservative treatments tried are relevant to establishing or bolstering medical necessity.

Strategies for UPIC Appeals cont.

Once a provider is at the ALJ level, in LWCI's experience, the most successful appeals are grounded in at least some evidence that a service was medically necessary and that the service was provided by qualified providers who documented at least some of the key components for the service rendered. If it is not possible to find some valid basis for appeal, it is LWCI's experience that ALJ level judges appreciate that at least some claims are not appealed. It seems to convey a sense of goodwill in the process rather than reflexive opposition to every finding as well as a nuanced understanding of the governing regulations. However, it is LWCI's opinion that as long as there is a reasonable (or even slim) basis, the finding should be appealed.

The ALJ decision is not necessarily an "all or nothing" decision. LWCI has frequently seen decisions where partial "credit" is given when a code is not supported but a different (usually lower-reimbursed) code is acceptable. Evaluation and management leveling is a good example of this. Frequently, the documentation will meet the criteria for a lower level of service, but not the higher level the service was billed at.

Due to the complexity and time that would be required to argue individual claims, it can be helpful to think about the categories or "buckets" that claims can be reasonably assigned to and then make blanket arguments for all claims in a "bucket." LWCI has seen that to be an effective strategy when there are a few different denial reasons and claims can logically be assigned to a "bucket." Judges seem to appreciate the efficiency of this approach.

About LW Consulting, Inc.
Our dedicated team supports attorneys in negotiations with the OIG, U.S. Attorneys, and State Agencies concerning allegations of false claims and worthless services. We also support attorneys working on federal and commercial payor appeals for denials based on medical necessity, coding, billing, impossible day scenarios, therapy schedule audits, and other disputed claims.

From expert testimony to billing/coding support, our team offers essential services to help shift the momentum in your client's favor. We are recognized as experts in appeals at all levels, with experience across the healthcare continuum.

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Sources

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