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Recent Medicare ZPIC Audits Target Skilled Nursing Facilities For Prepayment Review

Zone Program Integrity Contractors ("ZPICs") have essentially taken over the role formerly held by Program Safeguard Contractors to perform program integrity functions under Medicare, focusing on the detection and prevention of fraud, waste, and abuse. As part of the implementation of the Medicare Modernization Act for contracting reform, the Centers for Medicare & Medicaid Services ("CMS") established seven program integrity zones for the ZPIC program based on the Medicare Administrative Contractor ("MAC") jurisdictions.[1] Each ZPIC is responsible for the early detection of suspected fraud, waste, and abuse in its own zone and may take several actions, including identifying potential overpayments to be referred to the MAC for recoupment.

Recently, several nursing facility providers have reported having ZPIC audits that appear to target those facilities that provide certain levels of high intensity therapy for prepayment audits. These audits are reportedly conducted by the ZPICs, in close collaboration with the MACs, and have resulted in providers being placed on prepayment review for lengthy and undetermined periods of time. Additionally, Medicare does not have an established timeframe for a reviewer to issue an initial claim determination in the prepayment review process. As a result, these providers face significant financial hardship and an interruption in cash flow when placed on prepayment review.[2]

In some instances, the nursing facility provider first becomes aware that it has been placed on prepayment review when it receives an Additional Documentation Request ("ADR") from the ZPIC or the MAC in response to the submission of a claim to the MAC. In other instances, the nursing facility

1 The current ZPICs and their zones are:
- Safeguard Services (Zone 1): CA, HI, NV, American Samoa, Guam, the Mariana Islands
- AdvanceMed (Zone 2): WA, OR, ID, UT, AZ, WY, MT, ND, SD, NE, KS, IA, MO, AK
- Cahaba (Zone 3): MN, WI, IL, IN, MI, OH, KY
- Health Integrity (Zone 4): CO, NM, TX, OK
- Advance Med (Zone 4): AR, LA, MS, TN, AL, GA, NC, SC, VA, WV
- Zone 6 (TBD): PA, NY, DE, MD, Washington D.C., NJ, MA, NH, VT, ME, RI, CT
- Safeguard Services (Zone 7): FL, Puerto Rico, Virgin Islands

2 Under the Medicare Skilled Nursing Facility Prospective Payment System ("SNF PPS"), nursing facility providers are typically paid on a prospective basis for any skilled services rendered. In contrast, the prepayment review process requires that the Medicare reviewer (i.e., ZPIC) make an initial claim determination after the services are rendered, but prior to any claim payment being made.

provider receives an unannounced site visit from the ZPIC to obtain the additional documentation. After the claim is reviewed, the provider receives an Explanation of Benefits ("EOB") from its MAC for each claim indicating approval or denial of the claim. However, unlike other Medicare audit programs, such as the Recovery Audit Contractor program, the ZPIC is not required to review and make a determination on the claim in any particular timeframe after receiving the documentation requested.

In addition, while providers should be removed from prepayment review after achieving an "acceptable" approval rate on the audited claims, CMS has not identified in regulations or any guidance what an "acceptable" approval rate to be taken off prepayment review might be.

Further, Medicare currently has no formal process for a provider to contest being placed on prepayment review or obtain clear guidance on how to be released from such review. Because any release from prepayment review is provided at the sole discretion of the Medicare contractor, the only remedy for a provider is to appeal each claim in the Medicare appeals process in hopes of improving its approval rate to some undisclosed level.

Given the lack of transparency in the prepayment review process and the indefinite timeframe for such activities, many smaller nursing facility providers have expressed concerns about their financial viability and their ongoing ability to provide skilled services to their patients. Associations representing nursing facilities, such as the American Health Care Association, have requested that CMS provide further clarification and guidance on the prepayment review process in order to ensure greater consistency and transparency for providers facing such audits.