

# **CCT Exam Study Manual Update for 2018**

This document reflects updates made to the instructional content from the  
*CCT Exam Study Manual 2017*  
to the 2018 version of the manual. This does not include updates to  
Knowledge Checks and Answers, the Glossary, punctuation, grammar or capitalization.

## **Table of Contents**

Edit(s) to page 2-13: Special Considerations in Individual and Small Group Physician Practices.....	2
Edit(s) to page 2-25: The Anti-Kickback Statute .....	2
Edit(s) to page 2-26: False Claim Act.....	2
Edit(s) to pages 2-28 and 2-29: Self-Disclosure/Self-Reporting.....	2
Edit(s) to pages 2-30 and 2-31: Types of Fraud Alerts.....	3
Edit(s) to pages 2-46 and 2-47: Telephone Consumer Protection Act of 1991 (TCPA) .....	4
Edit(s) to page 2-57: Types of Certificates .....	5
Edit(s) to page 2-64: Comprehensive Error Rate Testing (CERT) Program .....	5
Edit(s) to page 2-76: The ICD-10 Code Set.....	6
Edit(s) to pages 2-80 and 2-81: Purpose and Functions of EHRs/EMRs .....	6
Edit(s) to pages 2-89 and 2-90: Recovery Audit Program.....	6
New topic and edit(s) on pages 2-97 and 2-98: Medicaid Integrity Program.....	8

Note: Unless otherwise stated, information in yellow below has been inserted and information struck through has been deleted.

### **Edit(s) to page 2-13: Special Considerations in Individual and Small Group Physician Practices**

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**TIP:** Be ready to state these seven recommendations for an effective compliance plan for individual and small group physician practices

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### **Edit(s) to page 2-25: The Anti-Kickback Statute**

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~~**NOTE:** The Medicare and Medicaid Patient and Program Protection Act of 1987 provided authority to the OIG to exclude an individual entity from participation in the Medicare and state healthcare programs if it is determined that the party has engaged in a prohibited remuneration scheme. Since federal law prohibits payment for services furnished by an excluded individual, this was thought to be a more effective way of regulating abusive business practices than is the case under criminal law.~~

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### **Edit(s) to page 2-26: False Claim Act**

The False Claims Act contains “qui tam,” or whistleblower, provisions. This is a unique mechanism in the law that protects whistleblowers from retaliation and allows them to sue, on behalf of the government, in order to recover the stolen funds. Reports indicate the DOJ recovered \$2.9 billion in fiscal year 2015 in connection with whistleblowers under the False Claims Act.

During fiscal year 2016, the federal government won or negotiated over \$4.7 billion in judgements or settlements under the False Claims Act.

### **Edit(s) to pages 2-28 and 2-29: Self-Disclosure/Self-Reporting**

Based on the insights gained from ORT, the OIG published a detailed Provider Self-Disclosure Protocol (SDP) in October 1998 to promote voluntary disclosure of potential violations. Self-reporting offers an offending provider the opportunity to minimize the potential cost and disruption of a full-scale investigation and negotiate a fair monetary settlement.

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In addition, the Open Letter states that “...the best evidence that a provider’s compliance program is operating effectively occurs when the provider, through its compliance program, identifies problematic conduct, takes appropriate steps to remedy the conduct and prevents it from recurring, and makes a full and timely disclosure of the misconduct to appropriate authorities.”

Since the original publication, three more Open Letters to Health Care Providers have been issued in 2006, 2008, and 2009.

The OIG's Provider SDP provides a specific and detailed process that can be relied upon by all participants in the healthcare industry as one that OIG will consistently follow. The SDP was updated April 17, 2013, and should be referenced by any provider considering self-disclosure. The benefit, eligibility, and guidance of self-disclosure are included in this document, which can be found at:

<https://oig.hhs.gov/compliance/self-disclosure-info/files/provider-self-disclosure-protocol.pdf>

### **Edit(s) to pages 2-30 and 2-31: Types of Fraud Alerts**

There are five types of Fraud Alerts:

- ~~National Medicare Fraud Alert~~
- ~~Restricted Medicare Fraud Alert~~
- ~~CMS Central Office Alert~~
- ~~Program Safeguard Contractor and Zone Program Integrity Contractor BI Unit Alert~~
- Waiver Alerts

There are four types of Fraud Alerts:

1. National (Nonrestricted) Medicare Fraud Alert (NMFA)
2. Restricted Medicare Fraud Alert (RMFA)
3. Zone Program Integrity Contractor (ZPIC) BI Unit Alert/CMS Central Office Alert
4. Waiver Alert

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*TIP:* Know the four types of Fraud Alerts. Additional information follows.

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### **National (Nonrestricted) Medicare Fraud Alert (NMFA)**

This alert is the most commonly issued Fraud Alert. NMFAs do not identify specific providers or other entities suspected of committing fraud. Instead, they focus on a particular scheme or scam and serve as a fraud detection lead. Because CMS and OIG use a comparable numbering system, CMS National Medicare Fraud Alerts are identified as "CMS NMFA" followed by the alert number.

### **Restricted Medicare Fraud Alert (RMFA)**

These alerts are issued when specific providers are identified as being suspected of engaging in fraudulent or abusive practices or activities. Medicare Contractors may issue local Restricted Alerts as they deem appropriate, subject to distribution limits. These alerts are identified as "CMS RMFA" followed by the alert

number. The content of these alerts is not disclosable to the public even under the Freedom of Information Act. They are intended solely for the use of those parties appearing on the audience line.

## **ZPIC/CMS Central Office Alert**

Zone Program Integrity Contractors (ZPICs) and Medicare Administrative Contractors (MACs) must ensure that Medicare pays the right amount for covered and correctly coded services rendered to eligible beneficiaries by legitimate providers. ZPICs prepare a CMS Central Office Alert if any of the following occurs:

- The ZPIC units need to notify CMS of a scheme that is about to be publicized on the national media.
- The case involves patient abuse or a large dollar amount (approximately \$1 million or more) or potential for widespread abuse.
- The issue involves a politically sensitive testimony on a fraudulent or abusive practice.

## **Waiver Alert**

Section 1115A(d)(1) of the Social Security Act authorizes the Secretary of HHS to waive certain fraud and abuse laws as necessary solely for purposes of testing payment and service delivery models developed by the Center for Medicare and Medicaid Innovation.

## **Edit(s) to pages 2-46 and 2-47: Telephone Consumer Protection Act of 1991 (TCPA)**

The TCPA was passed by the U.S. Congress in 1991 and signed into law by President George H. W. Bush as public Law 102-243. It amended the Communications Act of 1934. The TCPA is codified as 47 U.S.C 227.

The TCPA restricts telephone solicitations (in other words, telemarketing) and the use of automated telephone equipment. The TCPA limits the use of automatic dialing systems, artificial or prerecorded voice messages, SMS (Short Message Service, or text) messages, and fax machines. It also specifies several technical requirements for fax machines, auto dialers, and voice messaging systems — principally with provisions requiring identification and contact information of the entity using the device to be contained in the message.

The Controlling the Assault of Non-Solicited Pornography and Marketing Act (CAN-SPAM Act) made a minor amendment to the TCPA to explicitly apply the TCPA to calls and faxes originating from outside the U.S.

## **General Provisions**

Unless the recipient has given prior express consent, the TCPA and Federal Communications Commission (FCC) rules under the TCPA generally:

1. Prohibit solicitors from calling residences before 8 a.m. or after 9 p.m., local time.
2. Require solicitors to maintain a company-specific "do-not-call" (DNC) list of consumers who asked not to be called; the DNC request must be honored for five years.

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In the event of a violation of the TCPA, a subscriber may sue for up to \$1500 \$500 for each violation or to recover actual monetary loss, whichever is higher. In addition, the subscriber may seek an injunction. In the

event of a **willful** violation of the TCPA, a subscriber may sue for up to three times the damages (\$1,500) for each violation.

### **Edit(s) to page 2-57: Types of Certificates**

5. Certificate of Accreditation (COA) – Issued to a laboratory on the basis of the laboratory’s accreditation by an accreditation organization approved by CMS. This type of certificate is issued to a laboratory that performs nonwaived (moderate- and/or high-complexity) testing and meets the standards of a private non-profit accreditation program approved by the HHS.

### **Certificate of Waiver**

To receive a COW under CLIA, a laboratory must only perform tests like the glucose meter test which the FDA and the Centers for Disease Control and Prevention (CDC) have determined to be so simple that there is little risk of error. In addition, these tests are exempted from most CLIA requirements and the laboratories that perform them receive no routine inspections.

Waived laboratories must meet only the following requirements under CLIA:

1. Enroll in the CLIA program;
2. Pay applicable certificate fees biennially; and
3. Follow manufacturers' test instructions.

The types of tests waived under CLIA has increased from eight to approximately 100 tests since the inception of the program in 1992; thereby, the number of laboratories issued a COW has grown exponentially from 20% to 69% of the approximate total of the 236,000 laboratories enrolled.

### **Edit(s) to page 2-64: Comprehensive Error Rate Testing (CERT) Program**

The Comprehensive Error Rate Testing (CERT) program, instituted by CMS, monitors and calculates the accuracy and error rates for all Medicare Administrative Contractors (MACs). It also monitors the accuracy of Medicare payments to fiscal intermediaries (FIs), carriers, and Durable Medical Equipment Regional Carriers (DMERCs) until the transition to MACs is completed. The intent of the CERT program is to protect the Medicare Trust Fund by identifying errors and assessing error rates, at both the national and regional levels. Findings from the CERT program are used to identify trends that are driving the errors, such as errors by a specific provider type or service, and assist with allocation of future program integrity resources. The CERT error rate is also used by CMS to evaluate the performance of Medicare contractors.

A separate program, the Hospital Payment Monitoring Program (HPMP), is responsible for monitoring payments to inpatient acute care hospitals.

## Edit(s) to page 2-76: The ICD-10 Code Set

The International Classification of Diseases code set (ICD-10, for the tenth revision) was implemented by the World Health Organization and is used by every healthcare facility or provider covered by HIPAA.

ICD-10:

- Contains close to 70,000 diagnosis codes and over 70,000 procedure codes
- ~~Consists of longer codes than previous code sets, which means they can provide more clinical detail on diagnosis codes and procedures~~
- Provides more clinical detail on diagnosis codes and procedures than the previous code set (ICD-9)

## Edit(s) to pages 2-80 and 2-81: Purpose and Functions of EHRs/EMRs

The ultimate goal of EHRs/EMRs is to improve patient safety at the same time as providing quality of care for the public. The benefits of EHRs include better health care by improving all aspects of patient care including safety, effectiveness, patient-centeredness, communication, education, timeliness, efficiency, and equity.

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~~There are four main functions of EHRs/EMRs:~~

The main functions of EHRs/EMRs are:

1. Computerized prescription ordering
2. Capture of physician notes
3. Reporting of test results (Laboratory and Radiology components)
4. Order entry for tests
5. Accurate billing records

## Edit(s) to pages 2-89 and 2-90: Recovery Audit Program

### Introduction

In Section 302 of the Tax Relief and Health Care Act of 2006, Congress mandated that a national Recovery Audit Program be created by January 1, 2010 to identify improper Medicare payments and to help fight fraud, waste, and abuse in the government program. ~~The program is required for all 50 states and started as a demonstration project in six states.~~

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*Goal:* The goal of the Recovery Audit Program is to identify overpayments or underpayments made on healthcare claims for services provided to Medicare beneficiaries.

*Mission:* The Recovery Audit Program's mission is to reduce Medicare improper payments. It was felt that this could be accomplished through the efficient detection and collection of overpayments, the identification of underpayments, and the implementation of actions that will prevent future improper payments.

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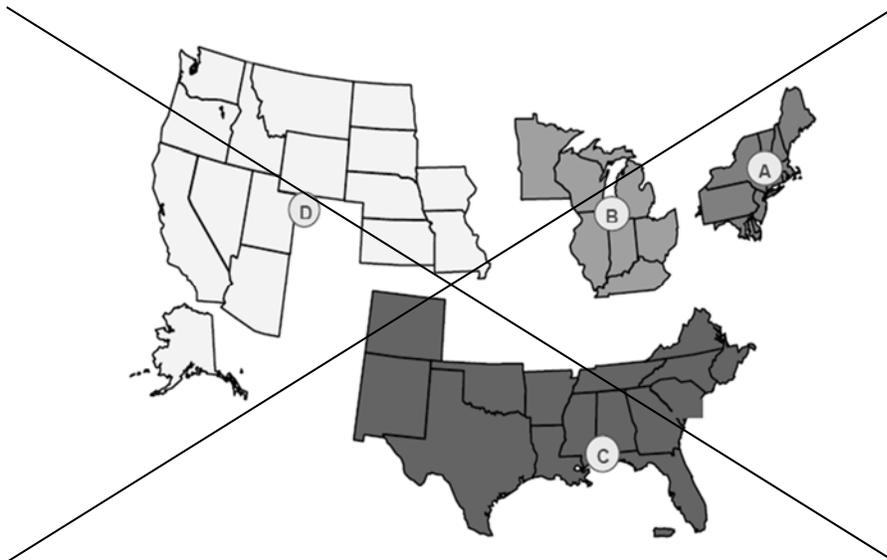
To create the program, Medicare awarded four contracts to Recovery Audit Contractors (RACs) to help guard the operations of the Medicare Trust Fund. The RACs assigned to the demonstration states recouped over \$900 million in overpayments. The program also returned over \$38 million back to healthcare providers for underpayments of charges.

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## RACs and Their Regions

The four RACs and their specific regions are:

- Region A – Diversified Collection Services, Inc. (DCS)
- Region B – CGI Federal (CGI) of Fairfax, Virginia
- Region C – Connolly, Inc. (Connolly)
- Region D – HealthDataInsights, Inc. (HDI)



American Hospital Association,  
RAC National Program and Contractor Information

## RACs and Their Regions

In October 2016, Medicare awarded five contracts to RACs to help guard the operations of the Medicare Trust Fund:

- Region 1 – Performant Recovery, Inc.
- Region 2 – Cotiviti, LLC
- Region 3 – Cotiviti, LLC
- Region 4 – HMS Federal Solutions

- Region 5 – Performant Recovery, Inc.

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**NOTE:** For more information on RACs, see [www.cms.hhs.gov/RAC](http://www.cms.hhs.gov/RAC).

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## **New topic and edit(s) on pages 2-97 and 2-98: Medicaid Integrity Program**

### **Medicaid Integrity Program**

CMS has two broad responsibilities under the Medicaid Integrity Program:

1. To hire contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues
2. To provide effective support and assistance to States in their efforts to combat Medicaid provider fraud and abuse

Although the States are primarily responsible for combating fraud in the Medicaid program, CMS provides technical assistance, guidance, and oversight in these efforts. Fraud schemes often cross state lines, and CMS strives to improve information sharing among the Medicaid programs and other stakeholders.

### **Medicaid Integrity Contractors**

Medicaid Integrity Contractors (MICs) are private companies that conduct audit-related activities under a contract with CMS. MICs conduct post-payment audits of all types of Medicaid providers and, where appropriate, identify overpayments.

Medicaid Integrity Contractors (MICs) are the entities hired by CMS to conduct audit-related activities as part of the Medicaid Integrity Program. MICs conduct post-payment audits of all types of Medicaid providers and, where appropriate, identify overpayments.

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- Comprehensive audit – includes detailed investigations of all areas relevant to the proper payment of Medicaid funds to the provider being audited. Comprehensive audits will usually take place on the provider's premises where the on-site documentation is required; services and processes are rendered or if the provider needs to be observed by the MIC.

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**NOTE:** For more information on the Medicaid Integrity Program, visit <http://www.cms.gov/MedicaidIntegrityProgram>.

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