Tips and Strategy

The CCT exam tests compliance staff proficiency and provides a resource for healthcare managers to ensure staffing competence.

The exam includes 80 multiple choice questions.

A grading report will appear after you submit your results at the completion of your exam. If a printer is available, you may print your scores. These scores will also be sent to you via email to the email address you provide on your application.

You must attain a score of least 70% in order to successfully pass the exam.
Tips and Strategy

The Exam Study Manual is your greatest resource for passing the exam.

- All of the information on the Exam is in the paper Exam Study Manual or the electronic EXAM Study Manual.
- Use the Knowledge Checks in each section of the guide to understand what types of questions the Exam will ask.
- Use the Glossary at the end of the Exam Study Manual for definitions and acronyms.
- Pay close attention to anything in the Exam Study Manual marked as “TIP” or printed in **BOLD**.
Tips and Strategy

Other Resources

- Flash Cards
- Online sites to create your own quizzes and review games
- Study Buddy/Group

Use CAUTION with online review sites. Existing content has not been reviewed or approved by AAHAM.
Tips and Strategy

AAHAM Study Manual Coaching Kits, electronic and paper manuals

- Offered by National AAHAM Office
- Available at aaham.org through the Certification tab
Exam Overview

- OIG/Fraud & Abuse /HIPAA/Credit & Collection Laws/CLIA
- Civil Monetary Penalties /EMTALA/CERT/HCQIP/ICD10 /Adverse Events /HITECH
- MSP/RAC Recovery Audit Program/ Zone Program Integrity/(MIC) Medicaid Program Integrity/Acronyms
OIG/Fraud & Abuse
/HIPAA/Credit & Collection Laws/CLIA
OIG- What should you know?

Identify the seven elements of an effective compliance program
Identify the benefits of an effective compliance plan
Describe the evaluation and certification/ accreditation process
Identify the four components to OIG Audits
Elements of an effective compliance program

Implementing written policies.
Designating a compliance officer or contact.
Conducting comprehensive training and education.
Developing accessible lines of communications.
Conducting internal monitoring and auditing.
Enforcing standards through well-publicized disciplinary guidelines.
Responding promptly to detected offenses and undertaking corrective action.
Benefits of an effective compliance plan

Improves the quality of patient care.
Initiates immediate and appropriate corrective action.
Identifies and prevents criminal and unethical conduct.
Demonstrates the hospital's commitment to be honest and responsible provider.
Encourages employees to report potential problems.
With early detection and reporting, can reduce a hospital's exposure to civil damages and penalties.
Evaluation and certification/ accreditation process

What is the purpose of a State Survey Agency?

How is a single provider defined?

Define TJC:

Define CLIA:
Four components to OIG Audits

**OAS**=Office of Audit Services

**OEI**=Office of Evaluation and Inspections

**OI**=Office of Investigations

**OCIG**=Office of Counsel to the Inspector General
Fraud and Abuse Prevention Efforts
What you should know?

Define “fraud” and “abuse“.

Identify individuals who can be considered violators of fraud.

List types of contractors that support the efforts to prevent, detect and investigate fraud and abuse.

Identify the five laws governing fraud and abuse.

Four Types of Fraud Alerts
Define “fraud” and “abuse” with examples

<table>
<thead>
<tr>
<th>FRAUD—WILLINGLY AND KNOWINGLY VIOLATING REGULATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorrect reporting of diagnosis codes</td>
</tr>
<tr>
<td>Altering claim forms to obtain higher payment</td>
</tr>
<tr>
<td>Submitting claim at higher level of service</td>
</tr>
<tr>
<td>Using another individual’s Medicare card</td>
</tr>
<tr>
<td>Unbundling or exploding charges</td>
</tr>
<tr>
<td>Billing non-covered or non-chargeable services</td>
</tr>
<tr>
<td>Knowingly billing services or supplies not provided</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ABUSE—IMPROPERLY AND OFTEN KNOWINGLY VIOLATING REGULATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing for a non-covered service</td>
</tr>
<tr>
<td>Misusing codes on the claim</td>
</tr>
<tr>
<td>Charging in excess for services or supplies</td>
</tr>
<tr>
<td>Billing for medically unnecessary services</td>
</tr>
<tr>
<td>Providing services that do not meet professional recognized standards</td>
</tr>
<tr>
<td>Breaches in the assignment of benefit agreement</td>
</tr>
</tbody>
</table>
Five laws governing fraud and abuse

Anti Kickback Statue
False Claims Act
Physician Self-Referral Law (Stark Law)
Social Security Act
United States Criminal Code
Four Types of Fraud Alerts

National (Non restricted) Medicare Fraud Alerts (NMFA)

Restricted Medicare Fraud Alert (RMFA)

Zone Program Integrity Contractor (ZPIC)/CMS Central Office Alert

Waiver Alerts
HIPAA
What you need to know?

Describe the purpose of (HIPAA) Health Insurance Portability and Accountability Act

Explain the intent of the (HCFAC) program

Identify the four Administrative Simplification Provisions

Know the standard transaction formats

Describe the purpose of the Privacy rule and requirements for a Privacy Practices Notice

Know the differences between Administrative, Physical and Technical Safeguards
# Administrative Simplification Provisions

- Electronic transaction code sets
- Privacy requirements
- Security Standards
- National identifier requirements

# Standard Transaction Formats

- Health Care Claim Institutional (837I)
- Health Care Claim Professional (837 P)
- Health Care Claim Dental (837D)
- Health Care Claim Payment/Advice (835)
- Health Care Eligibility Response (270/271)
- Health Care Claim Status (276/277)
- Health Care Review and Response (278)
- Benefit Enrollment and Maintenance (834)
- Payroll Deduct or Payroll Premium (820)
Credit and Collection Laws

Truth in Lending Act
Fair Credit Billing Act
Fair Credit Reporting Act
Fair Debt Collection Act
Telephone Consumer Protection Act of 1991
Clinical Laboratory Improvement Amendments

Types of Certifications/Each Valid for 2 years
- Certificate of Waiver
- Certificate for Provider Performed Microscopy Procedures
- Certificate of Registration
- Certificate of Compliance
- Certificate of Accreditation

Six Accreditation Organizations:
Criteria for Exemptions
Knowledge Check

Willingly and knowingly violating regulations is known as:

A. Abuse
B. Stealing
C. Robbery
D. Fraud
E. Compliance
Civil Monetary Penalties
/EMTALA/CERT/HCQIP/
ICD10 /Adverse Events
/HITECH
Civil Monetary Penalties

**PRIVACY RULE VIOLATIONS**

CMPs of $100 per failure may be placed on a covered entity for failure to comply with a Privacy Rule requirement. That penalty may not exceed $25,000 per year. All criminal sanctions will be enforced by the Department of Justice.

$50,000 - $250,000 Fines and up to 10 years imprisonment

**ADMINISTRATIVE SANCTIONS**

Denial of Provider number application

Suspension of provider payments

Application of Civil Monetary Penalties
Civil Rights Protection in Healthcare

Title VI of the Civil Rights Act protects persons from discrimination based on their race, color, or national origin in programs that received federal financial assistance.

Guarantees equal access to healthcare for Medicare and Medicaid Beneficiaries.

Office for Civil Rights (OCR) is responsible for enforcing the HIPAA Privacy Rule.
EMTALA

Emergency Medical Treatment and Active Labor Act (EMTALA) also known as Federal Anti Dumping statute requires hospitals with emergency room departments to provide a medical screening examination to any individual.

Hospitals with emergency departments are prohibited from refusing to examine or treat individuals.

A hospital that violates one or more anti dumping provisions:
- Subjected to termination of provider agreement
- Civil fines of $25,000 - $50,000 (bed size)

Requirements for a Transfer
CERTS
Comprehensive Error Rate Testing Program

CERT Program monitors and calculates the accuracy and error rates for MAC’s.

Requirements and Recommendations

Review and Analysis

Time frames
ICD10 (International Classification of Diseases) Code Set

Contains nearly 70,000 diagnosis codes and over 70,000 procedures

Groups codes by anatomical site

Each code is between three and seven characters in length

Two types

ICD-10-CM – used for diagnosis codes

ICD-10-PCS – used to list all inpatient claims to identify procedure codes used in an inpatient setting
Reporting Adverse Events

Defined: unanticipated events such as, patient falls, improper administration of pharmaceuticals, and death.

Types of Reporting Systems
- Mandatory
- Voluntary

Understand the advantages and disadvantages of mandatory reporting systems

MedWatch Reporting System
- Encourages providers to report voluntarily serious adverse events as a result of drug reactions.
Knowledge Check

Emergency Medical Treatment and Active Labor Act (EMTALA) is also known as:

A. Federal Anti Kick Back Statute
B. Federal Active Labor Organization
C. Federal Treatment Statute
D. Federal Anti Dumping Statute
E. Federal Joint Commission
HITECH

Health Information Technology for Economic and Clinical Health Act contains specific incentives to accelerate the adoption of the electronic health record.

Goal of HITECH
- EHR (Electronic Health Record)
- EMR (Electronic health record/electronic medical record)

Purpose

Learn the main functions of EHR/EMR
Medicare Secondary Payer

MSP data is gathered to determine coordination of benefits.

Circumstances where Medicare is the secondary payer:

- Working aged
  - Individuals 65 and older with coverage through a Group Health Plan (GHP)
  - Coverage through employed spouse of any age
  - Employer must have at least 20 employees to meet working aged provision
- Individuals under 65, disabled, and covered under a GHP with 100 or more employees
- ESRD
  - During 30-month coordination period (Medicare remains secondary even if beneficiary becomes entitled based on age or disability)
  - Medicare ESRD coverage ends 12 months after no longer requiring maintenance dialysis, 36 months after kidney transplant, or if patient becomes deceased
- Worker’s Compensation
- Black Lung Benefits Act
- Automobile, No-fault or Liability coverage
Recovery Audit Program/RAC

Defined: Created January 2010 to identify improper Medicare payments and fight fraud, waste and abuse in the government program.

Review Processes
  - Automated review
  - Semi-automated review
  - Complex review

Two Types of RAC Denials
  - Full Denial
  - Partial Denial

Fully understand the appeal process
(ZPIC) Zone Program Integrity Contractor/Benefit Integrity Unit

Used by CMS to identify problem areas, investigate potential fraud, and develop fraud cases for referrals to law enforcement.

Understand what each ZPIC is responsible for performing

How is the ZPIC work prioritized

Complaint Process
MIC /Medicaid Integrity Contractors

Private companies that audit under a contract with CMS.

Generally post-payment audits, often using data mining analysis.

Identify the three types:
1. Focused Desk Review
2. Focused Field Audit
3. Comprehensive Audit
Knowledge Check

Which of the following is not a circumstance where Medicare is secondary?

A. Working aged
B. Individuals under 65, disabled, and covered under a GHP with 100 or more employees
C. ESRD - During 30-month coordination period (Medicare remains secondary even if beneficiary becomes entitled based on age or disability)
D. Worker’s Compensation
E. Patient has Dual Eligibility
Q & A

You have Questions

We have Answers

AAHAM
American Association of Healthcare Administrative Management
The Premier Organization for Revenue Cycle Professionals
Maria Brisueno-Burnett, CRCE
Certified Revenue Cycle Executive
AVP of Patient Financial Services
Medstar Health
Certification Chair National AAHAM
maria.burnette@medstar.net

Chelsey Carper, CRCS
Certified Revenue Cycle Specialist
Business Office Manager
Madison Regional Health System
President Rushmore Chapter of AAHAM
Chelsey.Carper@madisonhospital.com

Kristina Gursky, CRCP
Certified Revenue Cycle Professional
Vice President of Healthcare Client Success
IC System, Inc.
kgursky@icsystem.com
Marina Himes, MBA, CCT, CRCS, CRCP, CRCE
Certified Revenue Cycle Executive
Manager of Patient Financial Services
Medstar Health
Board of Directors - MD AAHAM
marina.a.himes@medstar.net

Andrew Politz, MBA, CRCS, CRCP, CRCE
Certified Revenue Cycle Executive
Manager of Patient Financial Services
Medstar Health
Board of Directors - MD AAHAM – Certification Chair
andrew.n.politz@medstar.net

Lori Hyden, CRCE, CRIP
Certified Revenue Cycle Executive
Manager of Patient Financial Services
Medstar Health
lori.a.hyden@medstar.net