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Introduction

The CPCO™ Certification Curriculum is organized to help you prepare for the exam certifying you as a professional compliance officer, as well as prepare you for the role of compliance officer. The Certified Professional Compliance Officer (CPCO™) credential is awarded by AAPC, the primary organization of more than 190,000 medical coders, billers, auditors, and compliance professionals. This study guide, developed in cooperation with AAPC staff can help you understand and practice the concepts, elements, and regulations of compliance.

Healthcare compliance continues to grow and mature as a profession. A compliance program addresses the ever-growing requirements of the various laws, regulations, rules, and guidelines with which medical practices must comply. Providers need a certified compliance professional to help drive the development, implementation, and maintenance of that program. The Patient Protection and Affordable Care Act (ACA), indicates compliance programs will become mandatory as a condition of enrollment in the federal healthcare programs, a requirement confirmed by Inspector General Daniel R. Levinson of the Office of Inspector General (OIG) in his testimony to the House Committee on Energy and Commerce, Subcommittee on Health, September 22, 2010.

CPCO™ Confirms Credibility

As an individual holding AAPC’s CPCO™ credential, you must be able to demonstrate an understanding of the key requirements needed to effectively develop, implement, and monitor a healthcare compliance program for your practice, and to help others in their compliance efforts, based on governmental regulatory guidelines.

CPCOs™ demonstrate knowledge of:

- OIG Compliance program guidance for individual and small group physician practices, clinical laboratories, and third-party billing companies
- Compliance program effectiveness
- Key healthcare fraud and abuse laws, including the False Claims Act, Stark Laws, and Anti-kickback Statute — and the associated penalties
- How the ACA affects medical practices
- Other relevant laws and regulations, including HIPAA, Emergency Medical Treatment and Labor Act (EMTALA), Occupational Safety and Health Administration (OSHA), and Clinical Laboratory Improvement Amendment (CLIA)

- Handling investigations, including self-disclosure protocols
- OSHA compliance as it relates to healthcare entities
- Requirements under Corporate Integrity Agreements (CIAs) and Certificate of Compliance Agreements (CCAs)
- Current investigative activities, such as Recovery Audit Contractors (RACs), Zone Program Integrity Contractors (ZPICs), and Medicaid Fraud Control Units (MFCUs)
- Various risk areas, including items such as gifts/gratuities, conflicts of interest, use of Advance Beneficiary Notices (ABNs), teaching physicians’ guidelines (PATH), and incident-to services

The Curriculum

The CPCO™ Certification Curriculum begins with a view of the history of compliance to help you understand the development of compliance. After a review of the OIG’s Compliance Program Guidance for Individual and Small Group Physician Practices, third-party billing companies, laboratories, and hospitals, you will learn about the Health Insurance Portability and Accountability Act (HIPAA), Clinical Laboratory Improvement Amendments (CLIA), Emergency Medical Treatment and Active Labor Act (EMTALA), and other key compliance requirements. Section reviews provide questions that address the concepts covered in each chapter.
As a Certified Professional Compliance Officer (CPCO™), it will be necessary for you to be aware of the history of healthcare compliance in the United States and be familiar with current healthcare regulations. You will not be required to memorize all the regulations; however, it will be important for you to know where resources are located.

The objectives for Chapter 1 are:

- Forming an understanding of the history of healthcare compliance;
- Understanding the key agencies involved in healthcare compliance development and enforcement; and
- Demonstrating an understanding of key requirements needed to effectively develop, implement, and monitor a healthcare compliance program based on governmental regulatory guidelines.

In 1992, the General Accounting Office (GAO) identified Medicare claims to be at high risk for fraud and abuse. (GAO/HR-93-6, Dec. 1992) Subsequent to this determination, in 1996 the Office of Inspector General (OIG) initiated an audit of the Healthcare Finance Administration (later renamed Centers for Medicare & Medicaid Services (CMS)) Medicare claims payment system. This resulted in an estimated finding of over $23 billion in improper payments, and the beginning of intensified provider audits and calls for compliance.

The first major audit targets were teaching hospitals. The Clinical Practices of the University of Pennsylvania (CPUP) settled with the Department of Justice (DOJ) for $30 million (without admitting any wrongdoing) after an audit identified some of the university’s teaching physicians had inappropriately billed Medicare because the medical records did not sufficiently document their involvement in services that were provided by resident physicians. The audit also determined that some of the teaching physicians had up-coded their claims. (Up-coded: Billed for more complex and, therefore, more expensive services than may have been provided.) These audits are commonly known as Physician at Teaching Hospital (PATH) audits. The PATH audits targeted insufficient medical record documentation to support whether a physician either performed the service or was present when a resident or fellow performed the service. As a result of findings in the 1995 CPUP audit, insufficient documentation supporting the level of service was also targeted.

The OIG and the DOJ created a nationwide initiative to determine if compliance with the Medicare billing rules was being adhered to by other teaching hospitals. Other initiatives followed the PATH audits: Operation Bad Bundle involved clinical laboratories, durable medical equipment (DME), hospice, home health, and many more fraud Initiatives.

The OIG created the first compliance guidance document for hospitals in February 1998. Similar compliance guidance documents were issued for other sectors of the healthcare industry beginning in August 1998. The list of sectors and dates are below. These compliance guidance documents can be found on the OIG website: https://oig.hhs.gov/compliance/compliance-guidance/

<table>
<thead>
<tr>
<th>OIG COMPLIANCE GUIDANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>02-23-1998</td>
</tr>
<tr>
<td>08-07-1998</td>
</tr>
<tr>
<td>08-24-1998</td>
</tr>
<tr>
<td>12-18-1998</td>
</tr>
<tr>
<td>07-06-1999</td>
</tr>
<tr>
<td>10-05-1999</td>
</tr>
<tr>
<td>Compliance Program Guidance for Hospices (64 Fed. Reg. 54031; October 5, 1999)</td>
</tr>
<tr>
<td>11-15-1999</td>
</tr>
<tr>
<td>Compliance Program Guidance for Medicare+ Choice Organizations (64 Fed. Reg. 61893; November 15, 1999)</td>
</tr>
</tbody>
</table>
**Glossary**

**Anti-kickback Statute** - The Anti-kickback Statute (AKS) is a criminal law that prohibits individuals or companies from seeking, receiving, or offering remuneration in exchange for referring patients to receive items or services paid by the government. Remuneration includes both monetary benefits and items such as complimentary meals or lodging. Receiving “excessive” payment or rewards for referrals can also constitute a violation of the AKS.

**Auditing and Monitoring** - Monitoring is an ongoing process of reviewing the operations as they occur in the present. Auditing consists of conducting reviews of risk areas to determine compliance with legal requirements. An audit provides a "snapshot" of compliance at a specific point in time, often in the past.

**Compliance** - Either a state of being in accordance with established guidelines, specifications, or legislation, or the process of becoming so.

**Corporate Integrity Agreement (CIA)** - OIG negotiates corporate integrity agreements with healthcare providers and other entities as part of the settlement of federal healthcare program investigations arising under a variety of civil false claims statutes.

**False Claims Act (FCA)** - The False Claims Act (FCA) provides, in pertinent part, that anyone who knowingly presents, or causes to be presented, to the government a false or fraudulent claim for payment or approval is liable for a civil penalty of not less than $10,957 and not more than $21,916, plus three times the amount of damages. While the FCA imposes liability only when the claimant acts "knowingly," it does not require the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information also can be found liable under the Act (31 U.S.C. 3729(b)). In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false.

**Federal Sentencing Guidelines** - Federal Sentencing Guidelines are rules that set out a uniform sentencing policy for individuals and organizations convicted of felonies and serious (Class A) misdemeanors [1] in the United States federal courts system. The guidelines do not apply to less serious misdemeanors.

**Improper Inducements** - When an organization or individual offers another organization or individual an incentive for the referral of potential clients or patients. An incentive may take the form of cash, non-cash gifts, providing services for the benefit of the referral source or making reciprocal referrals.

---

**EXAMPLE: CORRECTIVE ACTION PLAN**

<table>
<thead>
<tr>
<th>Date of CAP: ________________</th>
<th>Revision Date (If Applicable) ________________</th>
</tr>
</thead>
</table>

Reason for CAP:

Errors or discrepancies were discovered/identified on _______________ (date) through the following mechanism:

Description of resolution for error or discrepancy:

Repayment Complete:  Yes  No  Not Applicable

If Yes: Check Number _________________________, Date __________________, and Amount _________________________:

Legal counsel’s recommendation of reporting corrective action to outside entities:

Billing policies or procedures modified, including date of modification(s):

Education or re-education undertaken as a result of this error/discrepancy, including timeline for completion of training or re-education:

Disciplinary actions taken as a result of this error/discrepancy:

Increased or focused audits and/or oversight will or will not (circle one) will be taken as a result of this error/discrepancy.

Description of audit focus and length of time that increased oversight will be taken, including, if applicable, levels of confidence of correction and continued compliance. (Example: 95%)

CEO/Board of Trustees Notified?  Yes  No  Date of Notification: _______________

Means of Notification: _____________________________________________________

Other reasonable corrective measures taken:
Section 4.1 Review

1. The Affordable Care Act requires providers to refund an overpayment to Medicare within how many days of identification?
   a. 10
   b. 30
   c. 45
   d. 60

2. In a qui tam action, if the government intervenes, the relator is entitled to receive a monetary settlement between?
   a. 5-10%
   b. 10-20%
   c. 15-25%
   d. 31-40%

3. The OIG works within which agency?
   a. CMS
   b. Medicaid
   c. HHS
   d. NGS

4. After hiring, how often should providers check to make sure employees are not on the OIG List of Excluded Individuals?
   a. Annually
   b. Monthly
   c. Quarterly
   d. Once every 10 years

5. Under what circumstances can a relator not file or pursue a qui tam action?
   a. If they are a new employee
   b. The qui tam action is based upon information that has been disclosed to the public
   c. The government already is a party to a civil or administrative money proceeding
   d. Both b and c
Health Insurance Portability and Accountability Act of 1996 (HIPAA)  Chapter 5  

De-identification Methods

Two methods to achieve de-identification in accordance with the HIPAA Privacy Rule:

1. The first is the “Expert Determination” method:

**Privacy Rule Excerpt**

(b) Implementation specifications: requirements for de-identification of protected health information. A covered entity may determine that health information is not individually identifiable health information only if:

(1) A person with appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods for rendering information not individually identifiable:

(i) Applying such principles and methods, determines that the risk is very small that the information could be used, alone or in combination with other reasonably available information, by an anticipated recipient to identify an individual who is a subject of the information; and

(ii) Documents the methods and results of the analysis that justify such determination;

2. The second is the “Safe Harbor” method:

(2)(i) The following 18 identifiers would be removed to de-identify the patient. This includes removal of the individual or of relatives, employers, or household members of the individual:

(A) Names

(B) All geographic subdivisions smaller than a state, including street address, city, county, precinct, ZIP code, and their equivalent geocodes, except for the initial three digits of the ZIP code if, according to the current publicly available data from the Bureau of the Census:

(1) The geographic unit formed by combining all ZIP codes with the same three initial digits contains more than 20,000 people

(C) All elements of dates (except year) for dates that are directly related to an individual, including birth date, admission date, discharge date, death date, and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older

(D) Telephone numbers

(E) Fax numbers

(F) Email addresses

(G) Social Security numbers

(H) Medical record numbers

(I) Health plan beneficiary numbers

(J) Account numbers

(K) Certificate/license numbers

(ii) The covered entity does not have actual knowledge that the information could be used alone or in combination with other information to identify an individual who is a subject of the information

(L) Vehicle identifiers and serial numbers, including license plate numbers

(M) Device identifiers and serial numbers

(N) Web Universal Resource Locators (URLs)

(O) Internet Protocol (IP) addresses

(P) Biometric identifiers, including finger and voice prints

(Q) Full-face photographs and any comparable images

(R) Any other unique identifying number, characteristic, or code, except as permitted by paragraph (c) of this section [Paragraph (c) is presented below in the section "Re-identification"]

Satisfying either method would demonstrate that a covered entity has met the standard in §164.514(a) above. De-identified health information created following these methods is no longer protected by the Privacy Rule because it does not fall within the definition of PHI. Of course, de-identification leads to information loss, which may limit the usefulness of the resulting health information in certain circumstances. As described in the forthcoming sections, covered entities may wish to select de-identification strategies that minimize such loss.

**RE-IDENTIFICATION**

The implementation specifications further provide direction with respect to re-identification, specifically the assignment of
Family Practice

The following analysis shows a distribution of Evaluation and Management (E&M) codes for your practice compared to national Medicare averages for your speciality. This can be used as a tool to evaluate your coding practices and identify any potential patterns that may warrant further scrutiny.

New Pt. E/M Utilization:
Actual vs. National Medicare Averages

<table>
<thead>
<tr>
<th>Code</th>
<th>Actual</th>
<th>Medicare</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>0.4%</td>
<td>1.3%</td>
<td>-0.9 points</td>
</tr>
<tr>
<td>99202</td>
<td>4.4%</td>
<td>15.9%</td>
<td>-11.5 points</td>
</tr>
<tr>
<td>99203</td>
<td>47.2%</td>
<td>45.4%</td>
<td>1.8 points</td>
</tr>
<tr>
<td>99204</td>
<td>46.1%</td>
<td>30.5%</td>
<td>15.6 points</td>
</tr>
<tr>
<td>99205</td>
<td>1.8%</td>
<td>6.9%</td>
<td>-5.1 points</td>
</tr>
</tbody>
</table>

Est. Pt. E/M Utilization:
Actual vs. National Medicare Averages

<table>
<thead>
<tr>
<th>Code</th>
<th>Actual</th>
<th>Medicare</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>0.4%</td>
<td>3.7%</td>
<td>-3.3 points</td>
</tr>
<tr>
<td>99212</td>
<td>3.3%</td>
<td>4.3%</td>
<td>-1 points</td>
</tr>
<tr>
<td>99213</td>
<td>47.8%</td>
<td>48.2%</td>
<td>0.4 points</td>
</tr>
<tr>
<td>99214</td>
<td>46.5%</td>
<td>40.2%</td>
<td>6.3 points</td>
</tr>
<tr>
<td>99215</td>
<td>2%</td>
<td>3.6%</td>
<td>-1.6 points</td>
</tr>
</tbody>
</table>

This next graph represents “same coding,” where all claims are billed out at the same 99213 code. This coding pattern puts a provider at risk for an audit. This coding pattern is not typical and is not likely appropriate.
1. **Answer:** d. Enrollment, Payment, Compliance, Oversight, and Response  
   **Rationale:** The OIG uses five principles in its strategic work planning to assist in effectively focus its audit, evaluation, investigative, enforcement, and compliance efforts. These broad principles underlie the recommendations that OIG makes to HHS and Congress. These five principles are:  
   1. Enrollment: Scrutinize individuals and entities that want to participate as providers and suppliers prior to their enrollment in healthcare programs.  
   2. Payment: Establish payment methodologies that are reasonable and responsive to changes in the marketplace and medical practice.  
   3. Compliance: Assist healthcare providers and suppliers in adopting practices that promote compliance with program requirements.  
   5. Response: Respond swiftly to detected fraud, impose sufficient punishment to deter others, and promptly remedy program vulnerabilities.

2. **Answer:** c. Developing open lines of communication.  
   **Rationale:** By developing open lines of communication, a physician's practice can identify, prevent, and discuss problem areas before they become violations.  
   **Source:** OIG Compliance Program Guidance for Individual and Small Group Physician Practices.

3. **Answer:** d. All of the above  
   **Rationale:** Non-retaliation is essential to an effective compliance program. Fear of retaliation can result in ongoing fraudulent activities when those activities could have been identified and remediated. In an atmosphere of distrust and retribution, whistleblowers are more likely to come forward due to monetary rewards (such as those related to false claims).  
   **Source:** OIG Compliance Program Guidance for Individual and Small Group Physician Practices

4. **Answer:** c. Compliance is a condition of continued employment.  
   **Rationale:** There are two goals a practice should strive for when conducting compliance training: (1) All employees will receive training on how to perform their jobs in compliance with the standards of the practice and any applicable regulations; and (2) each employee will understand that compliance is a condition of continued employment. Compliance training focuses on explaining why the practice is developing and establishing a compliance program. The training should emphasize that following the standards and procedures will not get a practice employee in trouble, but violating the standards and procedures will get a practice employee in trouble.  
   **Source:** OIG Compliance Program Guidance for Individual and Small Group Physician Practices

5. **Answer:** a. Annually  
   **Rationale:** Annual training is called for when the practice has no violations identified.  
   **Source:** OIG Compliance Program Guidance for Individual and Small Group Physician Practices
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