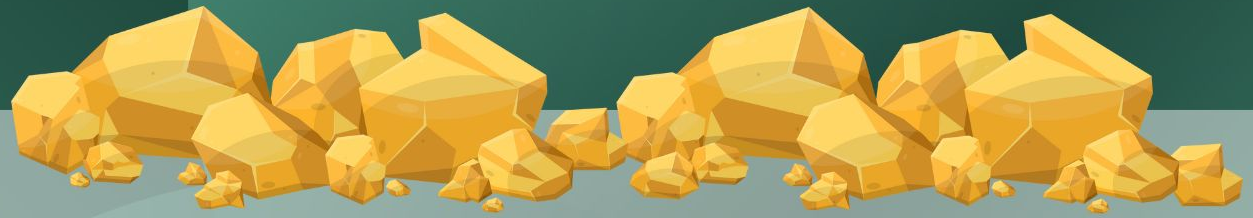

CEU Check in Code

4166

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A special Thank You to our friends at

LittleStar ABA THERAPY

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Disclaimer

The information in this presentation has been prepared by the speakers and reflects the most current information on the subjects to be discussed at the time it is being presented.

Before acting on any information discussed in this presentation, you should evaluate the appropriateness of the content relating to the topic of interest for your organization, any relevant additional information needed, and know that this presentation should not serve as a substitute for professional legal advice.

Recap of Session

- With the advocacy work completed for insurance autism mandates, providers are turning to health plans as the primary funder of ABA services for Autism.
- Insurance companies make periodic changes to their policies and billing rules. It can be difficult to remain current with these changes or to understand a payer policy and how to apply it in revenue cycle management processes. Providers have experienced an increase in denials received which creates an obstacle for getting paid for services rendered in good faith for families.
- It's also more important than ever to cultivate a culture of compliance across the organization to ensure that all areas of the practice are working towards passing audits.

Discussion Topics

- Where to find the best sources of information from payers
- Why denials are received
- How to identify and extrapolate the data in order to use it to dispute the denials in a comprehensive manner
- The difference between monitoring and auditing
- How a compliance program can improve processes

Finding the Gold BINGO

Statute	Preauthorization	Data	Coding Coalition	Rejection
CO	Clinical	Timely Filing	Retrospective	Partners
Credentialing	Autism Law Summit	Gold Nugget	Medically Unlikely Edits (MUEs)	Denial Rates
Denials	Binders	Modifiers	Fee Schedules	Recoupment
Provider Express	Corrective Action Plan	Education	Monitoring	NPI

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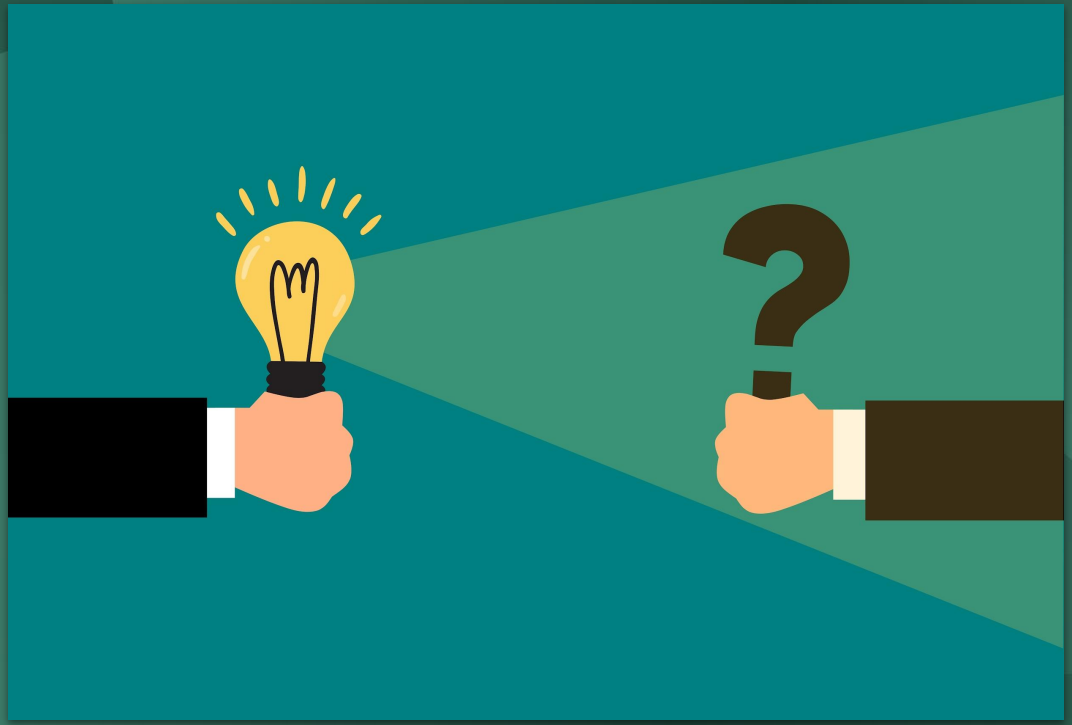

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Payer Policies

Amber Broadway, CMRS, CPCO
Director of Operations
Comprehensive Billing Consultants

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Who is a payer?

Law Insider Dictionary

“Health care payer means any employer, health plan, health maintenance organization, insurance company, management services organization, or any other entity that pays for, or arranges for the payment of, any health care service provided to any patient, whether that payment is made in whole or in part”

What is the purpose of a Payer Policy?

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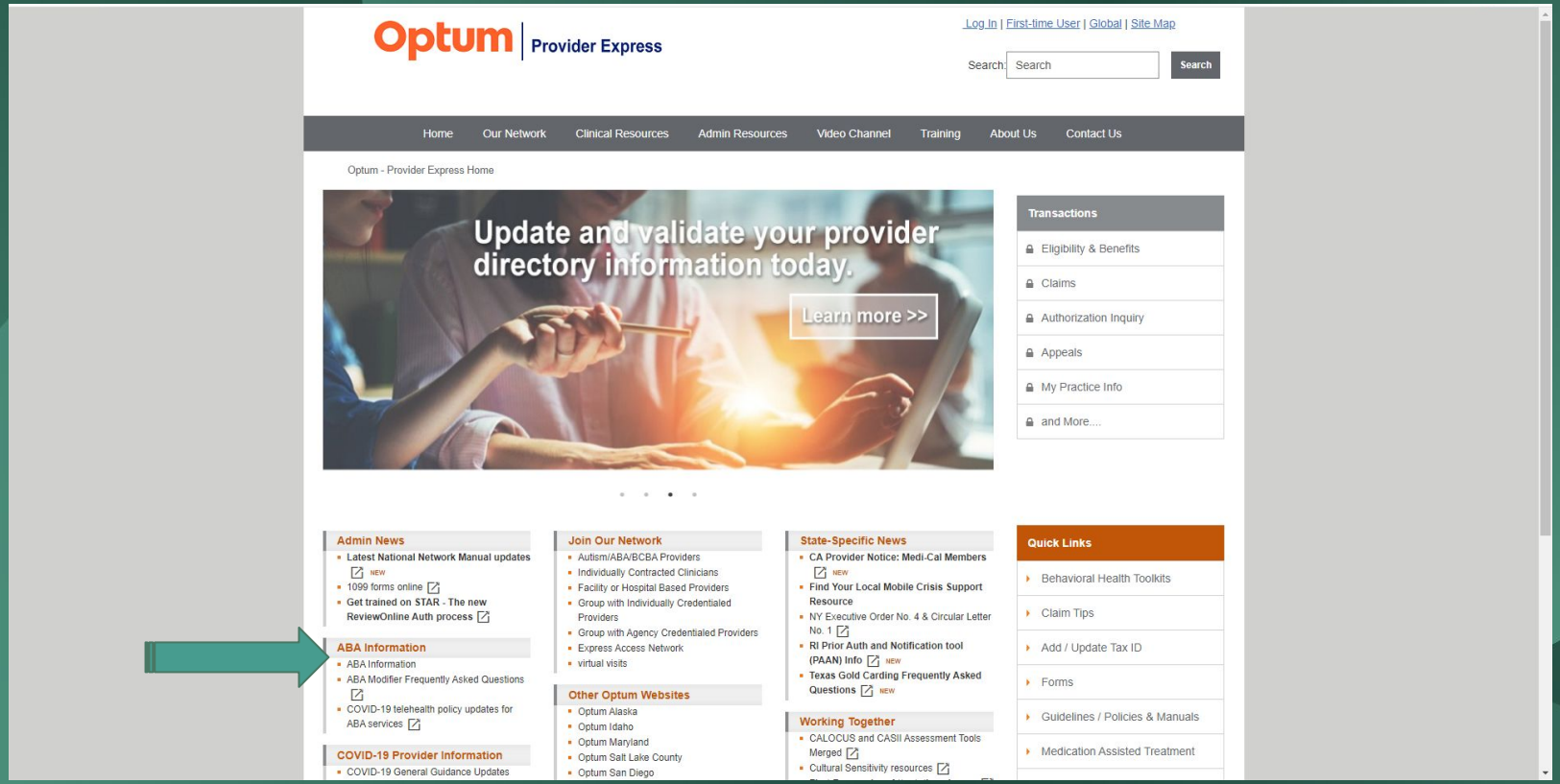
Where do we find Payer Policies?

Funder Websites

Optum: Provider Express

TRICARE
- Humana Military
- Tricare-West
- TRICARE Operations Manual
- TRICARE Policy Manual

Medicaid
- State Website
- Statutes
- Mandates



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Home | Our Network | Clinical Resources | Admin Resources | Video Channel | Training | About Us | Contact Us

Optum - Provider Express Home > Clinical Resources > Applied Behavior Analysis Information

Applied Behavior Analysis Information

Optum is recruiting Board Certified Behavior Analysts (BCBA) in solo private practice and qualified agencies that provide intensive ABA services in the treatment of ASD, for our ABA provider network.

If you are a master's or doctoral level BCBA providing intensive ABA in private practice, or are employed by an ABA agency that treats ASD clients, you may qualify for this unique network.

To learn more about the process for applying to the network and the clinical protocols your participation in this network would require you to follow, please review the materials below.

Please contact our Provider Service Line at 877-614-0484 with any questions regarding your participation and group model verses facility model.

COVID-19 updates to telehealth policies for ABA services

Read the COVID-19 ABA Telehealth Policy here

Commercial ABA Program

- FAQ - ABA Using CPT Codes
- ABA Agency Provider Orientation
- ABA Agency Quick Reference Guide
- ABA virtual visits

Provider Express Resources & Tutorials

- Overview of online tools that improve workflow and efficiency
- How to become a registered Provider Express user (Brief video overview of obtaining your Optum ID)
- ABA online eligibility and benefit inquires (Brief how-to video overview)
- How to view ABA authorizations online (You see what we see - brief video overview)

State Medicaid ABA Programs

Alaska Medicaid Autism Services
AZ AHCCCS ABA Program
CA Medi-Cal ABA Program
Hawaii QUEST ABA Program
Healthy Louisiana ABA Program
ID Medicaid Behavior Modification and Consultation Program
Indiana Medicaid ABA Program
KanCare Autism Program
Kentucky Medicaid ABA Program
MA MassHealth ABA Program
MN Medicaid EIDBI Program
MS CAN / CHIP Autism Program
NC Medicaid Research-Based Intensive Behavioral Health Treatment Program
NE Heritage Health ABA Program
New Jersey Medicaid ABA Program/Developmental Services
New York Medicaid ABA Program
OH Public Health Care Program (OHPHCP) ABA Program

Q16. Is it possible to bill for supervision and the Behavior Technician's services at the same time?

A16. Yes. When supervision is provided, you may bill concurrently for both Supervisors and

Behavior Technicians, billing with 97153 and 97155. Please refer to **abacodes.org** for guidance on coding and billing for the new codes.

Q17. Is it possible to bill for supervision and group services at the same time?

A17. Yes, when supervision is provided, you may bill concurrently for both Supervisors and Behavior Technicians, billing with 97153 and 97154. Please refer to **abacodes.org** for guidance on coding and billing for the new codes.

Q18. Who can bill with the HN modifier?

A18. Under industry standards, the HN modifier is defined as a bachelor's level provider. Under Optum's ABA program, the approved bachelor's level provider is a BCaBA.

Q19. Who can bill with the HM modifier?

A19. Under industry standards, the HM modifier is defined as less than a bachelor's degree. Under Optum's ABA program, the approved provider for this modifier is a Behavior Technician.

Q20. How do we bill for an ABA Supervisor?

A20. Billable services for an ABA Supervisor (Behavior Analyst or licensed BH clinician on staff providing program oversight) should be billed with the applicable CPT code(s) with no modifier.

Q21. Can direct services (97153) and parent training (97156) be billed concurrently?

A21. Yes, those are separate and distinct services delivered to different family members by different providers and may be billed concurrently. Please refer to www.abacodes.org for guidance on coding and billing for the new codes.

Q22. Is it possible to bill for team meetings?

A22. Team meetings are covered only as supervision if the member, the Supervisor and the Behavior Technician are present. When supervision is provided, you may bill under 97153 and 97155 following applicable Current Procedural Terminology (CPT®) guidelines. Team meetings, without the child/parent present, are not a covered service.

Q23. Is treatment planning covered? Required? Are there a minimum or maximum number of hours?

A23. Treatment planning (no longer a separate billable service), that is part of an initial or concurrent assessment, is covered under 97151. Ongoing treatment planning is bundled within the Codes for direct service (e.g., 97153) and is not a separately billable service.

- Guidelines for ABA Services Using CPT Codes
- Guidelines for Pennsylvania BHRS Services Only Using CPT Codes
- Request Form for Indiana ABA Services ONLY
- Request Form for Commercial in Arizona, Indiana, New Jersey, New Mexico, Ohio, Tennessee and Washington - electronic submission
- If you have been directed by a letter requesting additional information by our National ABA Team click here to submit
- Request for UHSS/BIND/NTCA providers - electronic submission

ABA Retrospective Review Process

- ABA Retrospective Review Cover Form

Guidelines/Manual

- Optum ABA Policy
- Optum Network Manual (National)

ABA Agency Site Audit and Record Review Tools *(sample forms that are utilized during the ABA Agency credentialing/site audit review and resource guide)*

- ABA Agency Tool
- ABA Record Tool
- ABA Provider Clinical Audit Preparation Guide

Join Our Autism/ABA Network

Contact Us – Provider Service Line - **877-614-0484**

Documentation Requirements

ABA providers are required to have a separate record for each member that contains the following documentation:

- Comprehensive assessment establishing the autism diagnosis
- All necessary demographic information
- Complete developmental history and educational assessment
- Functional behavioral assessment including assessment of targeted risk behaviors
- Behavioral/medical health treatment history including but not limited to:
  - known conditions
  - dates and providers of previous treatment
  - current treating clinicians
  - current therapeutic interventions and responses
- Individualized treatment plan and all revisions to the treatment plan, including objective and measurable goals, as well as parent training, barriers to progress, response to interventions
- Daily progress notes including:
  - place of service
  - start and stop time
  - who rendered the service
  - the specific service (e.g., parenting training, supervision, direct service)
  - who attended the session
  - interventions that occurred during the session
- All documentation must be legible
- All documentation related to coordination of care; including with school related services rendered via an IEP. Attempts to coordinate care is acceptable if other providers will not collaborate
- All documentation related to supervision of paraprofessionals
- If applicable and available, a copy of the child's Individualized Education Plan (IEP)
- If applicable and available, progress notes related to Early Intervention Plan or Pre-school/Special Education Program or allied health services
- Certification and credentials of the professionals providing the ABA therapy.

Optum ABA Policy

Network Manuals

Optum Network Manual

Table of Contents

providerexpress.com

United Behavioral Health and United Behavioral Health of New York, I.P.A., Inc. operating under the brand Optum

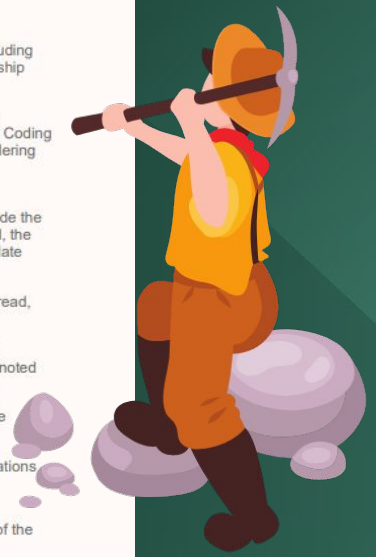
September 2022
BH4161a_07/2022

Treatment Record – Content Standards

When billing services for more than one family member, separate treatment records must be maintained.

Optum requires that all non-electronic treatment records are written legibly in blue or black ink. All treatment records must include the following:

- The Member's name or identification number on each page of the record
- The Member's address; employer or school; home and work telephone numbers, including emergency contacts; marital or legal status; appropriate consent forms; and guardianship information
- The date of service, either start and stop time or total time in session (for time-based services), the Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS)/Revenue (REV) code billed, notation of session attendees, the rendering Clinician's name, professional degree, license and relevant identification number as applicable
- Treatment record entries should be made on the date services are rendered and include the date of service; if an entry is made more than 24 hours after the service was rendered, the entry should include the date of service, date of the entry and a notation that this is a late entry
- Clear and uniform modifications; any error is to be lined through so that it can still be read, then dated and initialed by the person making the change
- Clear documentation of medication allergies, adverse reactions and relevant medical conditions; if the Member has no relevant medical history, this should be prominently noted
- Clear and uniform medication tracking that provides a comprehensive summary of all medications taken by the patient from the onset of care through discharge includes the following (applicable for all prescribers):
  - Standing, P.R.N. and STAT orders for all prescription and over-the-counter medications
  - The date medications are prescribed along with the dosage and frequency
  - Informed Member consent for medication, including the Member's understanding of the potential benefits, risks, side effects and alternatives to the medications



Optum Network Manual

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Texas Medicaid Provider Procedures Manual

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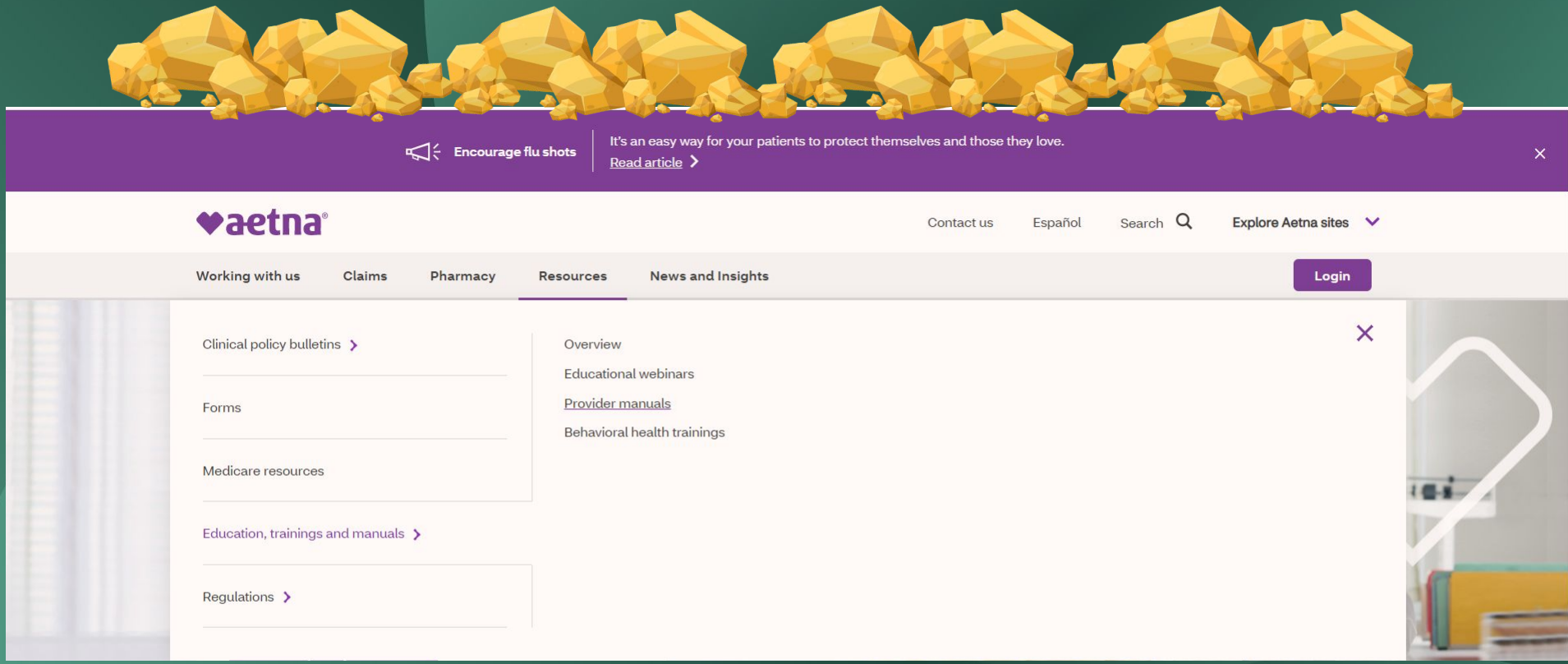
What if I can't find the policy on the site?

- Some payer policies are only available if you have a login to the provider portal. This is often the case with a Blue Cross Blue Shield plan.
- While a search engine can be your friend, it is better to go straight to the horse's mouth - or website - for payer policy information.
- Find the search feature on the website and utilize some keyword searches.

Keywords for ABA Policy:
Applied Behavior Analysis
BCBA
97155
ABA

To find the Network Manual or Provider Manual:
Search under Providers or Login
Resources
Manuals



Aetna - Resources for Healthcare Professionals

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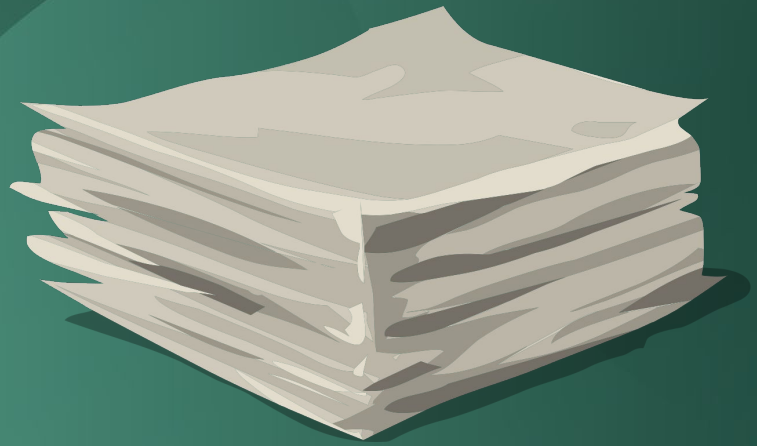
Paper or Digital?



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Maintaining Files of Payer Policies

File type doesn't matter

Organization

- By funder
- By year
- By update
- By contract status

Every Search - A New Adventure

Regardless -

When you are seeking specific information always search the site FIRST

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When do I find the time for maintenance?

No Surprises Rules FAQ - CMS

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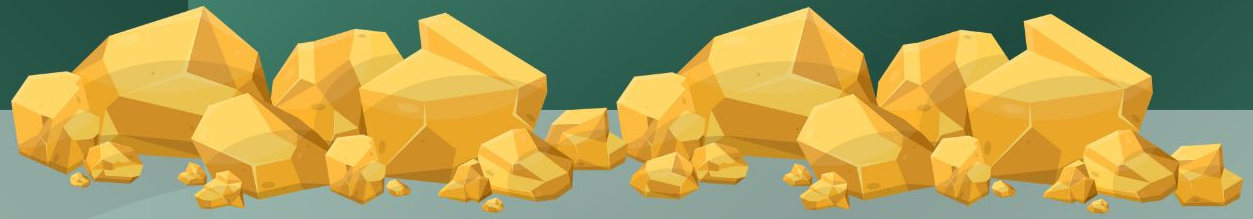

Fool's Gold

Searching contracts for payer guidelines

Only searching for ABA Policy

Relying on saved payer policy on file

Relying on email bursts from funder for updates

Vague policy that does not answer question or provide guidelines - Reach out to your representative!

OON does not mean you don't have to follow payer policy

Relying on word of mouth or social media for payer information

Gold Nuggets

Download most recent ABA *and* Network Policy - *and archive all policies with date*

Look for:
Concurrent billing rules
Credentialing/provider level requirements
Timely filing deadlines
Modifiers
Documentation and Evaluation requirements
Excluded services

Utilize most strict funder's guidelines to establish best practices

Ctrl+F is your friend!

Documented payer policies can be critical when it comes to appealing denials

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EOB Denial Codes

Chris Lowe, CMRS
Chief Operations Officer
ABA Therapy Billing and Insurance Services

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What are CARC codes?

CO	**Contractual Obligation** *Start: 05/20/2018*
OA	**Other Adjustment** *Start: 05/20/2018*
PI	**Payor Initiated Reduction** *Start: 05/20/2018*
PR	**Patient Responsibility** *Start: 05/20/2018*

835 Claim Adj. Reason code	835 Description of ANSI code (note will not print on 835)	Group Codes	835 Line Level Adjustment
1	Deductible amount	PR	Deductible
2	Coinsurance Amount.	PR	Coinsurance
8	The procedure code is inconsistent with the provider type/specialty(taxonomy).	OA	Non - Covered

RARC Codes - What are they?

M62	Missing/incomplete/invalid treatment authorization code Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
M63	We do not pay for more than one of these on the same day Start: 01/01/1997 | Stop: 01/31/2004 Notes Consider using M86
M64	Missing/incomplete/invalid other diagnosis Start 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)

Why should I care?

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Are CARC & RARC codes on rejected claims?

Claim denials fall into three categories

1. Administrative
2. Clinical
3. Policy

Patient Responsibility

1	**Deductible Amount** Start: 01/01/1995
2	**Coinsurance Amount** Start: 01/01/1995
3	**Co-payment Amount** Start: 01/01/1995

Vague - Fools Gold?

16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare POLICY Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 03/01/2018
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO) Start: 01/01/1995 | Last Modified: 06/02/2013

Digging Deep

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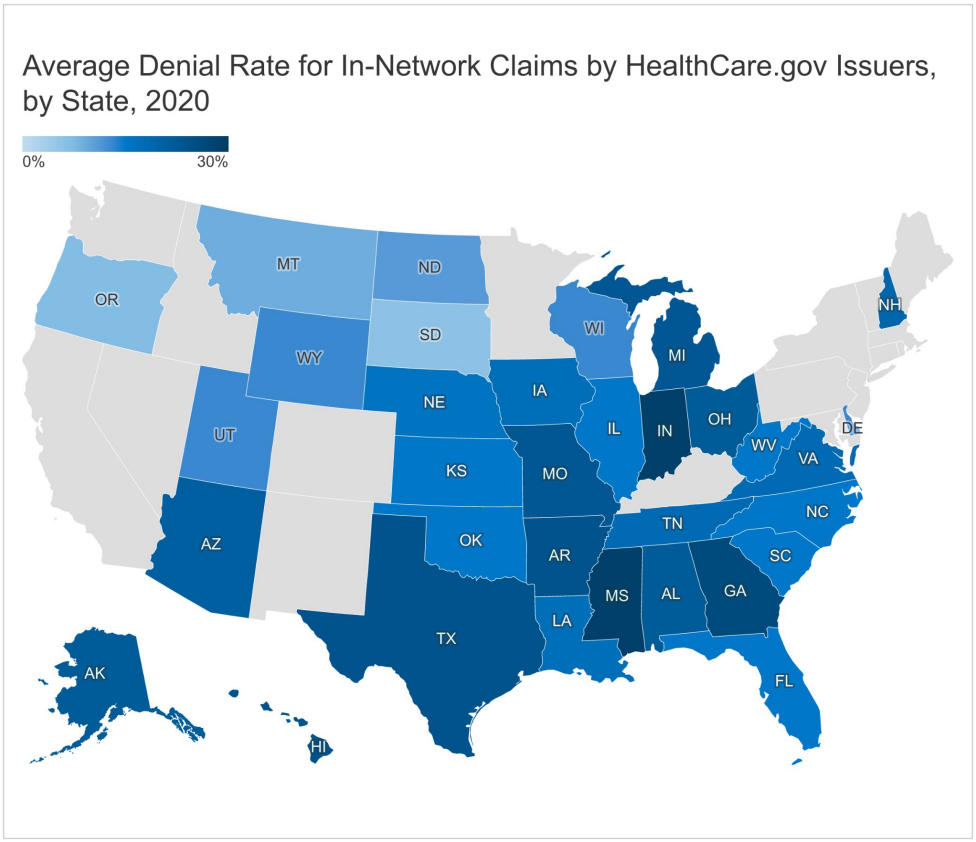
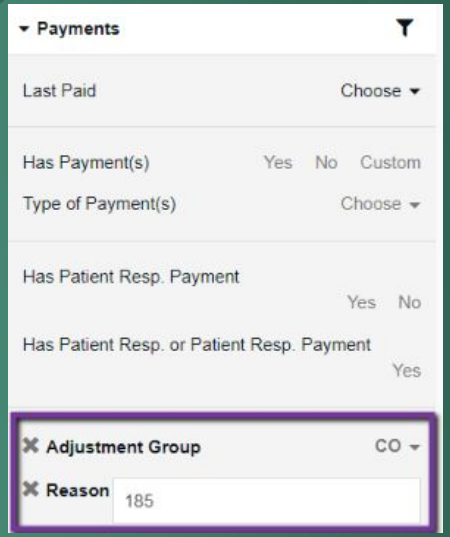

Average Denial Rate for In-Network Claims by HealthCare.gov Issuers, by State, 2020
0%
30%
MT
ND
OR
SD
WY
NE
IA
WI
MI
NH
UT
IL
IN
OH
DE
KS
MO
WV
VA
AZ
OK
AR
TN
NC
SC
MS
AL
GA
TX
LA
FL
AK
HI

Cause of Denials	Percentage
Registration / Eligibility	26.60%
Missing or Invalid Claim Data	17.20%
Prior Authorization/ Certification	11.60%
Service Not Covered	10.60%
Registration/Eligibility (26.6%)	
Coordination of Benefits	41.5%
Benefit Maximum	28.4%
Plan Coverage	23.3%
Other	6.8%
Missing or Invalid Claim Data (17.2%)	
Unspecified Billing Issue	73.2%
Missing/Invalid EOB	17.5%
Other	9.3%
Authorization/Pre-Certification (11.6%)	
Invalid Authorization	61.2%
Authorization Denied	25.9%
Services Exceed Authorization	7.5%
Other	5.4%

HOW?



Adj: CO - Contractual Obligations | 185 - The rendering provider is not eligible to perform the service billed | 0.00 - Notes: HL08252021 - "Nonpar provider within participating group"

185	The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Insanity:
Doing the same thing over and over again and expecting different results

ALBERT EINSTEIN

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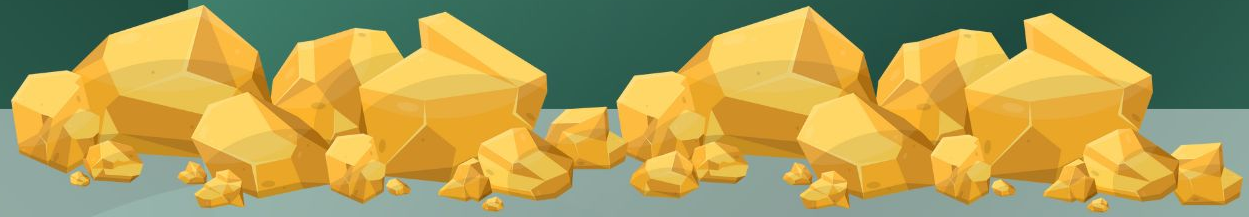

GOLD NUGGET

Know your representatives

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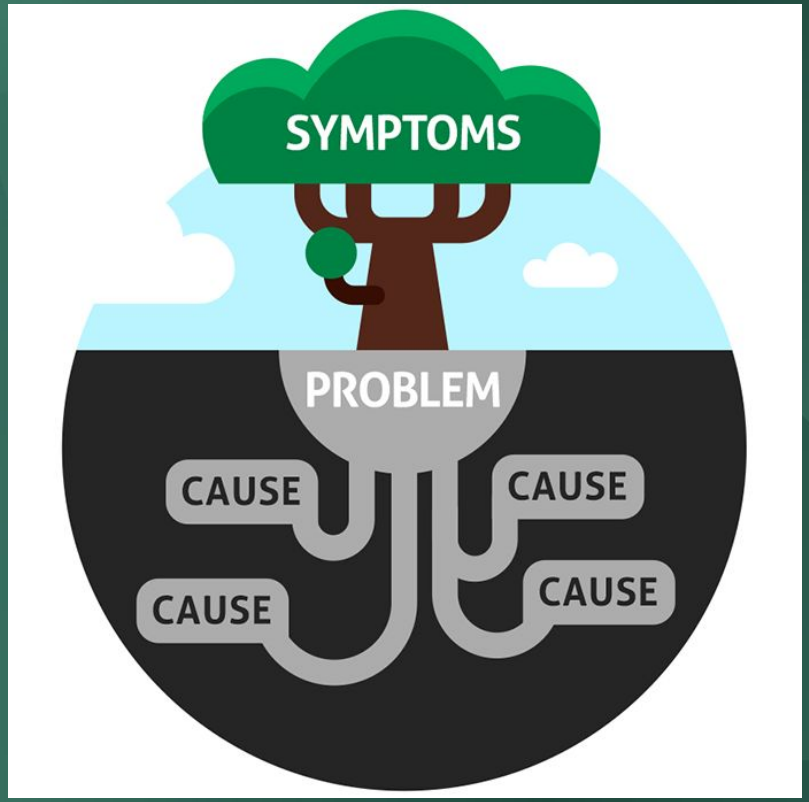

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Medical Record Requests Recoupments and Overpayments

Sarah Schmitz, CMRS-I, CPB, CPC
Founder and President
Comprehensive Billing Consultants

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Medical Record Request

My claim was submitted and now I got a letter requesting I send in documentation for that service….

Why and What do I do with this?

What are they looking for?

They want to make sure your practice is meeting the payer policies they have inplace

They are looking to make sure that your documentation supports the services that were billed.

They are required to audit claim records to help prevent Fraud,Waste and Abuse

Is a Medical Record Request a HIPAA Violation?

NO

Under the Privacy Rule, covered entities and business associates can disclose PHI without signed authorization for treatment, payments or healthcare operations. Some examples could include:

- Coordination of care for treatment purposes
- Sending records to the insurance company for payments
- Using the records for business activities such as quality assurance and employee training

HIPAA -Privacy Rule

A central aspect of the Privacy Rule is the principle of minimum necessary use and disclosure of PHI

A covered entity must make reasonable efforts to use, disclose and request only the minimum amount of Protected Health Information needed to accomplish the intended purpose of the use, disclosure or request.

What if we found an error in the records that were requested?

FOOLS GOLD!!!

While Debbie our admin staff was reviewing the records she noticed there was an error in the session note for the session times. Debbie went ahead and “fixed” the error before it was sent to the funder. That should be perfectly fine right?

Real Gold!!!!!!

Only the rendering provider should amend or make an addendum to an entry in the medical record.

What do I send?

Only make a copy of the records for the specific date of service requested

Review your medical record to ensure the claim was billed and coded correctly.

If there is additional documention in the medical record that will help support the claim make sure you include this.

Attach copies of the medical record request letter, the claim form, the EOB, all supporting documentation for that date of service.

Ensure you send the records with tracking so that when you follow up on the receipt of the package, you have a paper trail in your records that they were received.

Document in your A/R tracking system a copy of the request and a copy of everything that was included in the package. Again this will help in the event the records are “Lost” after they receive them. You won’t have to work so hard the second time around.

Recoupment Request

I got a refund/recoupment request from the funder and it said I owed money back for a claim that was paid 3 years ago! The letter stated I have to pay it right away or they will take it out of my next payment……..

What does Oklahoma say about this?

Oklahoma has statute §36-1250.5.

Acts by an insurer constituting unfair claim settlement practice states the funder can not request a refund or recoupment from a healthcare provider more than **24 months** after a payment is made.
(Unless the payment was made due to fraud or the provider has previously agreed to pay for a overpayment of a claim)

What does Texas say about this?

Texas Laws § 3.70-3c A carrier must request refunds for overpayments to physicians and providers within **180 days** of the physician´s or provider´s receipt of the payment. If the carrier does not make the request for refund within the 180-day deadline, the carrier forfeits the refund of the overpayment. A physician or provider has **45 days to appea**l a notice of overpayment. A carrier may recover an overpayment if all appeal rights have been exhausted and the physician or provider has not made arrangements to refund the overpayment to the carrier on or before the 45th day from the date of receipt of the notice of overpayment. A carrier may recover an overpayment in the case of fraud or material misrepresentation by a physician or provider.

(This does not apply to TX-Medicaid claims)

What does Tricare have to say about this?

Pursuant to federal law, Tricare is authorized to seek refunds of overpayment for dates of service as far back as **10 years**, Per Title 32: Subtitle A, Chapter: 1,Subchapter M, Part 199.11-Overpayments recovery. (f) (6) (E) (v)).

Self-Discovered Overpayments

We made an error and we were overpaid……. Do I just wait (not say anything) till the funder discovers it? Do I get to keep it if it past the recoupment law timeframe? Who knew an overpayment could be this much trouble??

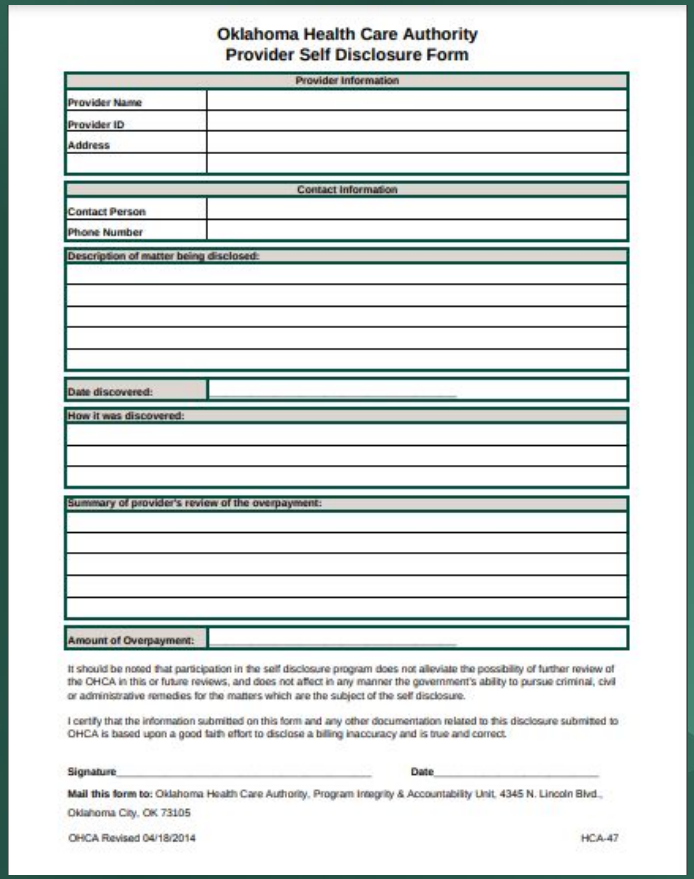
Self-Discovered Overpayments

Oklahoma Health Care Authority (OHCA) states:

Federal Policy related to handling of errors and overpayments is Public Law 111-148, expected to be codified at 42 U.S.C. Sec. 1320a7k(d)(2), requires Medicaid contracted providers to have a proficient and time-sensitive process for identifying errors and overpayments. Providers are obligated to report and explain any documentation that includes the Oklahoma Health Care Authority (OHCA) electric claim numbers (ICNs) and repay overpayments within 60
calendar days of identification. Those providers that fail to disclose, explain and repay the overpayment in a timely manner may be subject to liability under the Federal False Claims Acts.

I want to give it back but I don't know how or who to contact…

OHCA Self Disclosure Form



Oklahoma Health Care Authority
Provider Self Disclosure Form

Provider Information	
Provider Name	
Provider ID	
Address	

Contact Information	
Contact Person	
Phone Number	

Description of matter being disclosed:

Date discovered:	

How it was discovered:

Summary of provider's review of the overpayment:

Amount of Overpayment:	

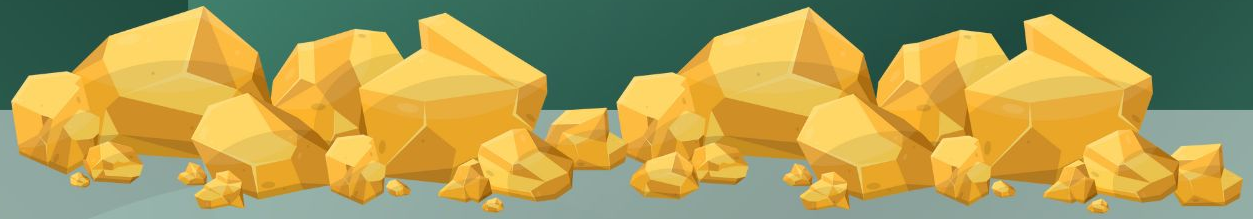
It should be noted that participation in the self disclosure program does not alleviate the possibility of further review of the OHCA in this or future reviews, and does not affect in any manner the government's ability to pursue criminal, civil or administrative remedies for the matters which are the subject of the self disclosure.

I certify that the information submitted on this form and any other documentation related to this disclosure submitted to OHCA is based upon a good faith effort to disclose a billing inaccuracy and is true and correct.

Signature_____ **Date**_____

Mail this form to: Oklahoma Health Care Authority, Program Integrity & Accountability Unit, 4345 N. Lincoln Blvd., Oklahoma City, OK 73105

OHCA Revised 04/18/2014 HCA-47



Fool's Gold

- Always pay the recoupment request, no questions asked.
- Overpayments are mine to keep until the funder discovers it.
- Anyone in the practice can update, fix, add an addendum or make an amendment to the session note.

Gold Nuggets

- First check your state recoupment laws.
- You have 60 days to return an overpayment once you have identified an overpayment.
- Only the rendering provider of the service should make an addendum or amendment to a session note.

Monitoring and Auditing

Michele Silcox-Beal, CPMA, CMRS
Founder and CEO
MKS Consulting
ABA Therapy Billing and Insurance Services

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Compliance Program – Resource (Where and What?)

1. **Conduct internal monitoring and auditing.**
2. Implement compliance and practice standards.
3. Designate a compliance officer or contact.
4. Conduct appropriate training and education.
5. Respond appropriately to detected offenses and develop corrective action.
6. Develop open lines of communication with employees.
7. Enforce disciplinary standards through well-publicized guidelines

https://oig.hhs.gov/compliance/compliance-guidance/

AUDITING

Auditing is the process of examining the medical record verifying information and gathering baseline information to identify risk areas.

Auditing represents evaluation activities completed by individuals independent of the process on a periodic basis.

Continuous auditing enables internal audit to continually gather from processes data that supports auditing activities.

MONITORING

Monitoring is an ongoing process of reviewing coding practices and the adequacy of the documentation by individuals who may not be independent of the process.

Monitoring should be conducted regularly, and may include auditing and reviewing utilization patterns, computerized reports, and reimbursement.

Continuous monitoring enables management to continually review business processes for adherence to and deviations from their intended levels of performance and effectiveness.

Scheduling an Audit Routine

01 MONITORING

- Monitoring should be scheduled regularly as part of the “pre-scrub” of billing prior to submission of claims.
- Monitoring can also be scheduled post claims submission on a weekly or monthly basis for a more in-depth review, depending on the size of the organization.

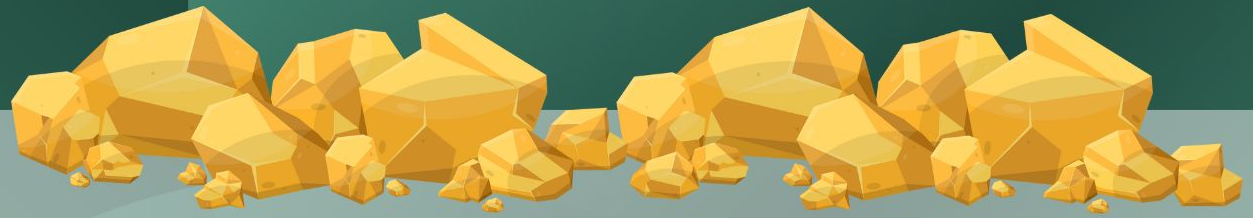
02 AUDITING

- Periodic audits can be scheduled monthly, quarterly or at minimum annually.
- Audits follow a more specific guideline and are part of an organization’s compliance program, are documented and kept on file.

Prospective vs Retrospective Audit

- A prospective audit is performed prior to claim submission so that variances in the coding may be corrected prior to claim submission.
- If the documentation does not support the codes that are to be billed, the coding should be corrected based on the audit findings.
- When a prospective audit is performed, it must be completed in a timely manner to avoid delays in claims submission.

- A retrospective audit is performed on claims that have already been submitted for payment.
- If variances are found between the codes supported and the codes submitted, decisions must be made concerning potential corrections, including refunding of overpayments.
- Providers and payers may retrospectively review claims submission and payment trends to ensure correct coding and billing practices.
- To perform a retrospective audit, an auditor reviews the medical record documentation, encounter form, claim form, remittance advice and the payer policies to determine if and where there are errors in the process.



Finding the Gold while Monitoring or Auditing Session Notes

Fool's Gold

- Signing session notes with initials and relying on the typed full name and credential to be enough
- Place of Service changed when submitting claims, not matching session note
- Diagnosis code assumptions without proof of diagnosis on file

Gold Nuggets

- Start and Stop times that match actual face to face time
- Narrative summary that provides details of the session per the payer policy
- Client identification on all pages of session note

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Compliance Program

Improving Processes

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Using Payer Policies in your Compliance Program

MONITORING - Prospective

- Adopt Prospective auditing methods to monitor claims prior to submission
- Identify specific outlier or new Payer Policies to review specific claims
  - (eg TRICARE specific requirements)
- Audit for accurate Rendering provider on claims

AUDITING - Retrospective

- Audit a specific data set related to a Payer Policy update (eg Optum modifier change as of 9/15/22)
- Audit a specific data set to ensure that the proper Rendering Provider is used on claims
- Audit to validate concurrent billing policies are followed

Using Denial Codes in your Compliance Program

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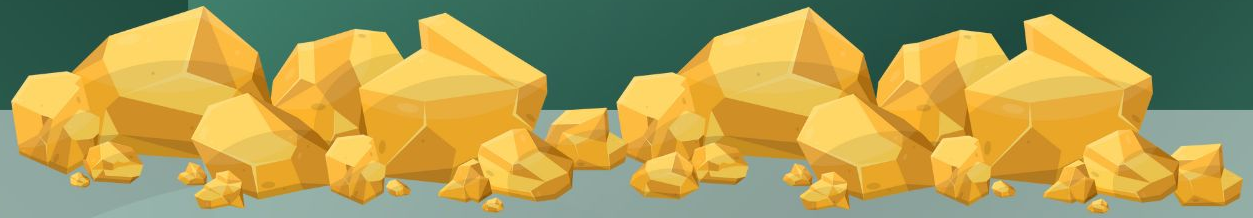
Identifying Overpayments in your Compliance Program

The Reverse False Claims Act: A Relatively Unknown, but Increasingly Provision of the FCA

The reverse false claims provision permits the government or relators to pursue defendants who are alleged to have hidden or reduced an obligation to pay the government through false statements, or who have violated the 60-day payment rule's obligation to return "identified overpayments".

- Overpayments can be reviewed during Monitoring of Payments received or review of Recoup letters.
- Overpayments can also be part of the Compliance Program Auditing.

Reverse False Claims Act - JDSUPRA.com



Finding the Gold in your Compliance Program

Fool's Gold

- Monitoring or Auditing a limited number of records and determining there is not a need for continued review because no errors or limited mistakes were found.

Gold Nuggets

- Maintaining consistency with Monitoring and Auditing to avoid drift.
- Building a Culture of Compliance in your organization.

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thank you

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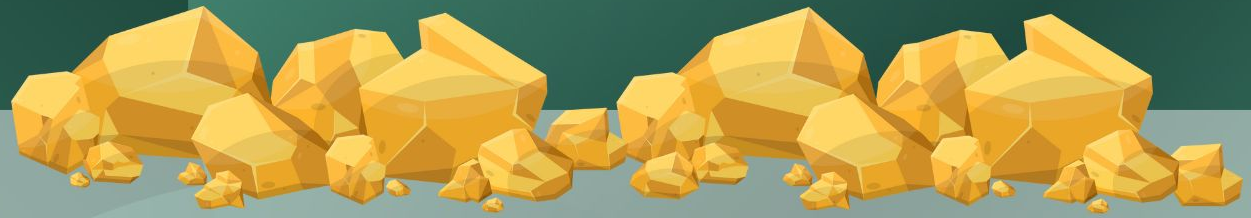

CEU Check out Code

8193

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