

CCT Exam Study Manual Update for 2020

This document reflects updates made to the instructional content from the
CCT Exam Study Manual – 2019
to the 2020 version of the manual. This does not include updates to
Knowledge Checks and Answers, the Glossary, punctuation, grammar or capitalization.

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

Edit(s) to page 2-26: Medicaid Fraud Control Units (MFCUs)

The MFCUs, created by Congress in 1977, are federal- and state-funded law enforcement entities that investigate and prosecute provider fraud and violations of state law pertaining to fraud in the administration of the Medicaid program. In addition, the MFCUs are required to review complaints of resident abuse or neglect in nursing homes and other healthcare facilities.

~~Currently, MFCUs operate in 49 states and in the District of Columbia. Forty-four of the MFCUs are located as part of Offices of State Attorneys General; the remaining six are in other state agencies.~~

Currently, MFCUs operate in all 50 states, the District of Columbia, and some U.S. territories. Most of the MFCUs are located as part of Offices of State Attorneys General; others are in other state agencies.

Edit(s) to page 2-92: Review Processes

While the Recovery Auditors utilize their own internal methods and tools to identify potential claims for review, they do not develop their own coverage, coding, or billing policies. Recovery Auditors follow ~~three~~ **two** review processes to identify improper payments:

- Automated review – uses various types of analytics to identify improper payments. This review is usually done without a human review of the medical records.
Exception: If the RAC identifies an issue considered to be “clinically unbelievable” (i.e., a situation where non-coverage or incorrect coding exists but there is no Medicare policy, Medicare articles, or Medicare-sanctioned coding guidelines), the RAC may seek approval from CMS to proceed with an automated review. Unless CMS approves the issue for the automated review, the RAC must make its determinations through complex review.
- ~~▪ Semi-automated review – is determined by data mining but records may be sent to justify the charges.~~
- Complex review – requires a review of the medical record documentation to determine whether there is an improper payment. Complex medical review is used where there is a high probability that the service is not covered or where no Medicare policy, Medicare article, or Medicare-sanctioned coding guideline exists. Complex copies of medical records are required to provide support for the overpayment.

Edit(s) to page 2-94: Administrative Law Judge (ALJ) Hearing

There is a requirement for the minimum amount in controversy before an ALJ hearing can be requested. This amount is recalculated each year and may change. For calendar year ~~2019~~ **2020**, the amount in controversy is ~~\$160~~ **\$170**. If this minimum is met, an ALJ hearing can be requested within 60 days of the receipt of the reconsideration. ALJ hearings are usually held by video teleconference or by the telephone. The ALJ will

render its decision within 90 days of the hearing request date. This time can be extended, however, if the ALJ deems necessary.

Edit(s) to page 2-94: Judicial Review

The amount required to request a Judicial Review hearing is recalculated each year and may change. For calendar year ~~2018~~ 2019, the amount in controversy was ~~\$1,600~~ \$1,630. For ~~2019~~ 2020, the amount in controversy rises to ~~\$1,630~~ \$1,670. If the denial issue is still in controversy following the Appeals Council's decision, a judicial review before a U.S. District Court judge can be done. The provider must file the request for review within 60 days of receipt of the Appeals Council's decision.