Compliance Strategies in M&A Due Diligence

HCCA
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Agenda

Background 3
Compliance role in diligence 11
Coding assessment 20
Managing the results 39
Compliance integration considerations 47
Summary comments, discussion & questions 49

The definition of acronyms used in this presentation can be found in Appendix A.
Key health care trends and M&A implications

Current changes in the healthcare landscape, beyond normal reimbursement pressures, pose significant challenges for health care providers; several of these challenges have implications that are causing increased M&A activity.

<table>
<thead>
<tr>
<th>Key Trends</th>
<th>M&amp;A Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountable Care</td>
<td>Evaluating acute partnerships to grow market presence to strengthen care health system bargaining power and command competitive payments and prices</td>
</tr>
<tr>
<td>IT Requirements</td>
<td>Large capital expenditure needs for improvements in quality and safety of care through integrated patient care and compliance to new regulations with all affiliations and partnerships</td>
</tr>
<tr>
<td>Provider Network Expansion</td>
<td>Expanding and strengthening physician, post-acute, and ancillary network for a more comprehensive integrated care delivery system</td>
</tr>
<tr>
<td>New Patient Paradigm</td>
<td>Enhancing the organization’s current service offerings and improving access to care to meet the needs of different types of patients</td>
</tr>
<tr>
<td>Cost Containment</td>
<td>Controlling the cost structure to improve the organization’s financial position and increasing the access to capital</td>
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</tbody>
</table>

Accountable Care — Adjusting to a changing payment model in an ever increasing competitive landscape

IT Requirements — Increasing demand for transparency and direct linkages between payments and quality; to take advantage of incentives and avoid penalties

Provider Network Expansion — Increasing demand for integrated care delivery systems, rising and/or uncertain malpractice caps, and rising need for primary care providers

New Patient Paradigm — Changing the patient’s continuum of care to serve aging, information savvy, and consumer-driven patient populations

Cost Containment — Protecting financial standing in a tough economic environment through radical cost reduction — desire to operate at breakeven at Medicare rates
Current hospital M&A trends — Phase 1

- Physician Practice Acquisitions
- Consolidation of Independent Community Hospitals
- Creation of Larger Regional Hospitals
- Growth of National Chains

Current hospital M&A trends — Phase 2

- More Physician Consolidation
- Big Get Bigger — Super Regionals and National Players
- Convergence between Hospitals and Health Plans
- Vertical Integration: Controlling the Continuum of Care
Due diligence areas

- Financial and tax due diligence
- Commercial and operational due diligence
- IT due diligence
- Security and privacy
- HR due diligence
- Insurance due diligence

- Compliance and integrity
  - Real estate due diligence
  - Sustainability
  - Valuation and purchase price allocation

Due diligence that is more comprehensive
Gives organizations a more complete basis for their decisions

Better integration Business units and functions better understand integration issues and assumptions

Fewer surprises Greater visibility into the target company's risk framework going in means it's less likely you'll hit a land mine later on

Coordination with other areas

Due Diligence

- Legal
- Compliance
- Insurance and Risk
- Accreditation/Quality
- Information Systems
- Supply Chain
- Real Estate
- Finance
- Human Resources/Benefits
- Tax
- In-House Counsel
- Transaction Counsel

Financial and tax due diligence
Commercial and operational due diligence
IT due diligence
Security and privacy
HR due diligence
Insurance due diligence

Compliance and integrity
Real estate due diligence
Sustainability
Valuation and purchase price allocation
## Types of transactions

<table>
<thead>
<tr>
<th>Provider Types</th>
<th>Transaction Structure</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Individual physicians and small group practices</td>
<td>• Merger/member substitution</td>
<td>• Who in the organization is leading transaction?</td>
</tr>
<tr>
<td>• Large multi-specialty group practices</td>
<td>• Asset purchase</td>
<td>• Size and type of transaction determines extent and formality of compliance involvement</td>
</tr>
<tr>
<td>• ASCs, specialty hospitals, joint ventures</td>
<td>• Stock/shares purchase</td>
<td></td>
</tr>
<tr>
<td>• Single community hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Large multi-hospital systems</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Merger and Acquisition — Provider types

### More Examples of Provider Types

- Inpatient rehabilitation
- Skilled nursing facility
- Home health
- Home infusion
- Dialysis companies
- Behavioral health
- Durable medical equipment companies
- Physical therapy companies
- Third party payor billing companies
- Anesthesia practices
- Urgent care clinics
- Clinical laboratories
- Independent diagnostic testing facilities
- Radiation oncology practices
Primary compliance role in M&A due diligence

Evaluating:

- Management assessment of valuation of the target company
- Risk of repayments/recoupments
- Risk of corporate integrity agreement
- Risk of qui tam/whistleblower lawsuits
- Risk of regulatory enforcement actions
- Overall compliance “health” of target company
- Ability and timeline for integrating compliance policies & procedures and overall compliance culture
Compliance role in M&A transactions

Stage I — Preliminary Due Diligence

Stage II — Due Diligence

Integration Planning

Closing Effective Date

Compliance role (1/2)

Stage I
- Pre-MOU/LOI
- Confidentiality
- Limited inquiries and information sharing
- Materiality threshold defined
- Objective: Identify “Red Flags” or “Ice Bergs”
  - Regulatory audits and investigations
  - Pending or planned voluntary disclosures
  - Settlement agreements
  - CIAs or other mandated compliance requirements
  - Disgruntled employees/employee complaints
  - Outstanding enforcement actions/litigation
Compliance role (2/2)

Stage II – Deep Dive, Getting into the Weeds
- Post MOU/LOI signing
- Pre Definitive Agreement
- Objectives: Fiduciary responsibilities, barriers, opportunities, integration planning
- Reporting findings to management/board

Receiving Deal Documents
- Coverage of representation and narrative
- Indemnification and escrow considerations

Integration Planning
- Post Definitive Agreement
- Day 1 closing goals
- Post-closing goals (e.g., 30 days–1 year)

Example scope of services — Regulatory and compliance due diligence

1. Assess target company’s compliance program:
   - Compare to the seven elements of an effective compliance program
   - Reporting structure
   - Organization chart – coverage of key risks

2. Conduct interviews:
   - Compliance officer and others in compliance depending on size of the program
   - Key management and staff to determine how compliance and adherence to federal billing and coverage requirements are incorporated into the operational flow of the organization
     - HIM
     - Case management
     - Revenue cycle
     - Billing
   - Discuss risks and areas of concern

3. Review relevant internal audit and/or compliance audit and monitoring activities to determine the comprehensiveness of the compliance audit plan and appropriateness of audit findings, responses and corrective actions

4. Review external audits, fiscal intermediary and/or CMS/RAC audits, PEPPER reports and related corrective action plans and subsequent follow-up monitoring activities for adherence to federal and state reimbursement requirements

5. Conduct a clinical review on a random sample of patient records and their related billing documents. This review will include propriety of coding, billing, care planning, medical necessity (in accordance with payer coverage policies) and documented evidence of services having been provided for the services billed
Compliance due diligence request

- Compliance program information — background, history, structure
- Organization chart and position description(s) for CO and key staff
- Current code/standards of conduct
- DRA False Claims Act information requirements
- Agendas and minutes for compliance committee (three years)
- Compliance reports to board of directors (three years)
- Compliance policies and procedures, including privacy
- Summary of regulatory audits, investigations and settlements (DHHS–OIG, DOJ, OCR, other federal and state agencies, three years)
- Process for exclusions screening for employees, medical staff and vendors and results of screening (three years)
- PEPPER data for the most recent quarter
- Summary of any matters voluntarily disclosed to federal or state authorities and current status
- Summary of internally identified matters subject to potential disclosure and/or repayment to regulatory authorities and current status
- Correspondence from regulatory authorities citing potential violations of laws and regulations (three years)
- CIAs or other mandated compliance program requirements (current and three years)
- Summary of hotline reports received (three years)
- Internal or external audit reports performed in support of compliance program (three years)
- Summary information on results of third-party payer audits, denials and appeals for major service lines (three years, all payers)
- Example compliance training and education systems, programs and materials

Examples of potential risk include the following:
- Compliance programs that are not fully developed and may not be effective based on the Federal Sentencing Guidelines seven elements of an effective compliance program:
  - Lack of a risk assessment process
  - Lack of compliance program effectiveness evaluation
  - Not all employees trained on compliance
  - Insufficient staffing of compliance department
  - Compliance officer lacks authority
  - Lack of internal auditing and monitoring activities
- Ongoing and past government or third-party payor investigations and/or audits with repayment obligations
- Lack of controls or knowledge of violations around financial arrangements with physicians, Stark and anti-kickback laws
- Coding, claim development
- Medical necessity
- Billing/charging errors
- Denials
- Clinical research
- Many others…

Merger and acquisition — Regulatory and compliance due diligence
Merger and acquisition — Regulatory and compliance due diligence

Considerations:
• Timeframe to complete
• Confidentiality
• Size of target
• Range of services provided by target
• Centralized or decentralized organization
• Knowledge of risks historically for the provider type
• Ability to get data that is accurate, complete and timely
• “Effectiveness” of target compliance program may indicate the amount of time and effort needed by the compliance/coding diligence team
• Coding team:
  – Coding specialties
  – Ability to assess claim form and remittance advice
  – Ability to evaluate medical necessity based on Medicare and other payor requirements
  – Ability to articulate insights to M&A leadership on impact of noted variances
  – Ability to calculate error rates and financial impact
• Deal structure:
  - Asset vs. stock
  - Assuming provider numbers?
The focus of the coding and billing analysis is to assess the degree to which:
1. charges billed on the claim form are consistent with the physician orders and documentation in the patient record,
2. diagnoses described in the patient care records are appropriately coded with ICD-9 diagnosis codes,
3. procedures described in the patient records are appropriately coded with CPT/ICD-9- procedure codes
4. appropriate coding guidelines are utilized and consistently applied to the types of services provided,
5. coverage policies are adhered to, and
6. expected reimbursement has been received from the third-party payors.
Due diligence coding and billing (2/6)

If issues are identified, root causes and unfavorable trends can be further evaluated. For example, interviews may be conducted with key stakeholders such as representatives from:

- HIM,
- PFS, or
- Professional fee coding

Such individuals may be able to provide insights into the coding process:

- Whether individuals responsible for coding and billing are certified and have received adequate training
- Have access to the proper resources to perform their jobs properly
- Existence of a coding quality assurance and auditing and monitoring procedures that result in providing routine feedback on coding to the coders
- Errors result due to high turnover or use of contracted coders

Due diligence coding and billing (3/6)

Billing and Coding — Consequences of Improper Coding

- False claims include, but are not limited to, billing for services not rendered or for misrepresenting actual services rendered in order to obtain higher reimbursement or billing for unnecessary goods and services
- Civil Monetary Penalty:
  - Up to $10,000 for each item or service improperly claimed
  - For kickbacks up to $50,000 per act
  - Damages up to three times the remuneration offered, paid, solicited or received
- In addition, a violator may be subject to exclusion from federal and state health care programs Federal enforcement officials have the ability to exclude from Medicare and Medicaid any investors, officers and managing employees associated with business entities that have committed health care fraud, even if the officer or managing employee had no knowledge of the fraud
- Billing and Coding can impact normalized EBITDA/Cash Flow
Due diligence coding and billing (4/6)
Billing and Coding — Approach

- Sample methodology should be carefully considered:
  - Random sample:
    - Pros: Results can better be applied across the population to estimate a broad range of exposure
    - Cons: Limited sample sizes may miss risk areas and issues may not be identified
  - Focused sample on potential problem areas (high-risk MS-DRGs, observation stays, one-day stays, certain infusion codes, etc.):
    - Pros: Better chances of identifying pertinent issues
    - Cons: Results may not translate to general population
  - Hybrid sample size — both random and focused
  - Pre-bill or post-bill

- Sample size
- Payors
- Date range
- Hospital — evaluate areas to include:
  - Inpatient/outpatient coding
  - Medical necessity:
    - Inpatient admission
    - National and local coverage determinations
  - Employed physicians
  - Non-hospital departments such as ASCs, Clinics, SNF, etc.

Due diligence coding and billing (5/6)
Identify Risk Areas

- PEPPER data
- Prior payor audits
- Prior internal/compliance audits
- Prior compliance effectiveness assessment/risk assessment
- Compliance committee reports
- Denial reports
- Reports to the audit and compliance committee/board
- What does the target CO identify as high risk areas?
- Data mining — look at claims data:
  - Bell curves
  - Outliers
- Industry knowledge
- External sources such as OIG guidance, reports, Fraud Alerts, OIG Work plan, etc.
Due diligence coding and billing (6/6)

Record Request

• Claim form
• Remittance advice
• Medical record
• Case management notes (if conducting inpatient medical necessity)
• Guidelines for selecting emergency department E&M levels
• Coding query process
• Facility specific coding policies
• CDI program information

Hospital — DRG results

• How to sample?
  − High volume/high risk DRG
  − Review PEPPER
  − Short length of stay (LOS)
  − Principal diagnosis from Chapter 16 of the ICD-9 code book (signs and symptoms)
  − High CC/MCC capture rate
• Reporting:
  − number of coding errors:
    ▪ DRG
    ▪ Diagnosis (principal and secondary)
    ▪ Procedures
    ▪ POA
    ▪ Discharge status
• Evaluate use of queries
• Evaluate quality of documentation
• Financial impact — net and total
Examples of findings
Inpatient Coding

• MS-DRG — over or under reporting/coding
• Discharge disposition
• Present on admission
• CC/MCC and other secondary diagnoses
• Clinical documentation improvement

Hospital — Outpatient coding

• How to sample?:
  − Consider how coded:
    ◦ HIM
    ◦ Department
    ◦ CDM generated
    ◦ Coder involvement
  − High volume or high risk departments:
    ◦ Emergency department
    ◦ Observation
    ◦ Ambulatory surgery
    ◦ Infusion/injection
    ◦ Diagnostic
  − Services with a payment impact (vs. bundled services)
Hospital — Outpatient coding results

Reporting

• Errors can be reported as:
  − Number of claims
  − Number of services
  − Financial errors
  − Other variances
• Error type examples:
  − Procedure code
  − Diagnosis code
  − Units
  − Revenue codes
  − Coverage
  − Lack of documentation
  − Lack of, or unsigned physician orders
  − Lack of adherence to NCD/LCD

Medical necessity of admission

This assessment involves evaluating compliance with Two-Midnight rule
• How to sample?
• Focus/short stays and high risk DRGs
• Results, errors can be related to the following:
  − Admission appropriate
  − Orders
  − Certification
• Evaluate:
  − Case management notes
  − Process to cover admissions 24/7 and all points of entry
  − 121 type of bills
Medical necessity of admission
Example of medical necessity inpatient admission review results

<table>
<thead>
<tr>
<th>US$</th>
<th># of Claims</th>
<th>$ Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample Population</td>
<td>12</td>
<td>42,213</td>
<td></td>
</tr>
</tbody>
</table>

Under/(over)payment:

- No physician certification for inpatient care 2 (3,824) (9.1)%
- Physician certification completed after discharge 1 (5,612) (13.3)%
- Criteria for inpatient admission not met 4 (7,514) (17.8)%
- Late order for inpatient only procedure 0 (0.0%)

Total Potential Under/(Over) Payment 7 (16,950) (40.2)%

Coding assessment

Physician

- How to sample?
- Identify where the risk lies:
  - Who codes — physician or coders or some combination?
  - Monitoring performed:
    - E&M bell curves
    - Analysis of CMS physician billing data
    - Comparison of physicians by specialty to peers
  - Prior audits:
    - E&M
    - Procedures
    - Ancillary office services
    - Diagnosis coding
    - Audit trails
    - Site of service and other claim form elements
    - Mid-level billing
    - Teaching physician

- Identify where the risk lies (continued):
  - Training provided
  - Standardization of EMR and coding processes
  - Number and complexity of specialties
  - Use of mid-level providers
  - Involvement of medical students, residents and fellows
Coding assessment

Reporting

- Errors can be reported as:
  - Number of claims
  - Number of services
  - Financial errors
  - Other variances
- Error type examples:
  - Procedure code
  - Not following E&M documentation guidelines
  - Diagnosis code
  - Units
  - Revenue codes
  - Coverage

- Error type examples (continued):
  - Lack of documentation
  - Lack of or unsigned physician orders
  - Cloning/copy/paste
  - Over documentation (medical necessity)
  - Lack of adherence to NCD/LCD
  - Incorrect place of service
  - Improper billing of “Incident to”
  - Improper billing of teaching physician

Example of physician coding review results

<table>
<thead>
<tr>
<th>Count</th>
<th>Original Allowable</th>
<th>Revised Allowable</th>
<th>Reimbursement Variance</th>
<th>Reimbursement Variance Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample Population</td>
<td>70 claims, 83 services</td>
<td>$ 4,960</td>
<td>$ 4,534</td>
<td>$ 1,817</td>
</tr>
<tr>
<td>Total E&amp;M in sample</td>
<td>64</td>
<td>$ 3,088</td>
<td>$ 1,527</td>
<td>$ -</td>
</tr>
<tr>
<td>Overcoded 1 level</td>
<td>17</td>
<td>$ 2,105</td>
<td>$ 789</td>
<td>$ -</td>
</tr>
<tr>
<td>Overcoded 2 levels</td>
<td>8</td>
<td>$ 2,117</td>
<td>$ 432</td>
<td>$ -</td>
</tr>
<tr>
<td>Overcoded 3 levels</td>
<td>1</td>
<td>$ 108</td>
<td>$ 21</td>
<td>$ -</td>
</tr>
<tr>
<td>Undercoded 1 level</td>
<td>5</td>
<td>$ -</td>
<td>$ 2</td>
<td>$ -</td>
</tr>
<tr>
<td>E&amp;M category change</td>
<td>3</td>
<td>$ 76</td>
<td>$ 2</td>
<td>$ -</td>
</tr>
<tr>
<td>Missing documentation</td>
<td>3</td>
<td>$ 177</td>
<td>$ -</td>
<td>$ -</td>
</tr>
<tr>
<td>Missing documentation does not support service</td>
<td>2</td>
<td>$ 343</td>
<td>$ 74</td>
<td>$ -</td>
</tr>
<tr>
<td>Missing documentation does not support a billable service</td>
<td>2</td>
<td>$ 147</td>
<td>$ -</td>
<td>$ -</td>
</tr>
<tr>
<td>Total E&amp;M payment variances under (over)</td>
<td>32</td>
<td>$ 2,485</td>
<td>$ 1,864</td>
<td>$ 1,817</td>
</tr>
<tr>
<td>Procedure Code Variances</td>
<td>19</td>
<td>$ 417</td>
<td>$ 207</td>
<td>$ -</td>
</tr>
<tr>
<td>Undercoded 1 level</td>
<td>10</td>
<td>$ 211</td>
<td>$ 211</td>
<td>$ -</td>
</tr>
<tr>
<td>No/insufficient documentation to support code billed</td>
<td>3</td>
<td>$ 190</td>
<td>$ -</td>
<td>$ -</td>
</tr>
<tr>
<td>Procedure code change</td>
<td>1</td>
<td>$ 22</td>
<td>$ 16</td>
<td>$ -</td>
</tr>
<tr>
<td>Total procedure code variances</td>
<td>12</td>
<td>$ 249</td>
<td>$ 174</td>
<td>$ -</td>
</tr>
<tr>
<td>Total exceptions resulting in no payment variances</td>
<td>17</td>
<td>$ 970</td>
<td>$ 970</td>
<td>$ -</td>
</tr>
</tbody>
</table>
Non-hospital examples

- SNF
- IRF
- Dialysis
- ASC
- Hospital-based clinics
- DME
- Reference laboratories
- IDTF
- LTACH
- CAH
- Home health care
- Hospice care (facility-based)
- Rehabilitation
- Behavioral health

Examples of findings

- Skilled nursing facilities:
  - Physical therapy minutes, RUG assignment, compliance with CMS documentation guidelines
- Inpatient rehabilitation facility/unit:
  - Compliance with CMS documentation guidelines
  - Errors in final DRG assignment by hospital coder
  - Errors in IGC, CMG, and comorbidity coding leading to errors in calculation for payment and 75% rule compliance.
- Behavioral Health — inpatient/outpatient:
  - Lack of detailed level of coding
  - Compliance with CMS documentation requirements for therapies administered
Managing the results

What does it all mean?

How to evaluate the impact
Reporting findings

• Report or memorandum to senior management/board:
  − Executive summary of findings:
    ◦ Highlight significant issues
    ◦ Icebreakers, red flags, deal changers, materiality
  − Summarize information on target company
  − Specifically describe and summarize legal issues reviewed
  − Catalogue documents reviewed
  − Summarize interviews conducted
  − Analyze information and legal issues
  − Estimate and report financial impact where possible
  − Conclude
• Consider any need for an oral report

Reporting considerations

• Understand the amount of detail that different readers will need:
  − Executive summary with high level error rates, potential reasons, implications
  − With each summary table provide narrative description of errors, additional explanation needed and recommendations for improvement
• Provide detailed description of data provided for sampling, the population of claims used for sampling and sampling methodology
• Confirm errors and potential reasons
• Note any opportunities for documentation improvement
• In addition to coding errors, note medical necessity errors, other billing errors (e.g., improperly completed advance beneficiary notices (ABNs), incorrect information on claim form such as site of service, bill type, condition codes, value codes, etc.)
• Denials patterns noted
• Analysis of the results — report potential impact
• Report how to address variances if purchase is completed, prioritize risks. Due diligence can be a roadmap to address/improve coding and compliance.
Due diligence attestation form - results

- See Sample Form
- Scope of review
- Overall conclusion/summary of findings
- Significant issues or potential obstacles
- Major integration task for day 1, day 30, etc.
- Matters that will represent significant post-merger work to integrate
- Savings opportunities

Due diligence results / issues

- Compliance Officer Structure
  - Full-time / part-time
  - Reporting relationship
  - Dedicated staff
- On-going Regulatory Audits / Investigations
  - Federal / State
  - Newly issued
  - Results / Liability
- Issues / Concerns Compliance Program
  - Annual / Monthly sanction screening
  - Compliance Committee (i.e. relationships with other depts.)
  - Risk Assessment / Auditing monitoring process
  - Effective reporting systems (e.g. hotline)
  - Etc. etc. etc.
Additional work or follow up

- Use of consultants
- Data review
- Claims review
- Interviews
- Whole house, de novo - exclusions screening
- Deeper dive into financial relationships with physicians (Stark compliance)
- Operations integration
- Transition support to divested organizations

Managing the results – assessing the risks

- Regulatory violations:
  - Significance
- Business risks:
  - Significance
- Examples:
  - Violation results in major financial loss (e.g., core structure violates AKS and must be abandoned)
  - Violation results in payment of small fine (e.g., local health department inspection report not posted)
- Impact:
  - Price adjustment?
  - Correction as condition of closing?
  - Indemnification escrows?
  - Voluntary disclosures?
Integration

- Major integration tasks from due diligence review
- Follow the seven elements of an effective compliance program
  1. Leadership & oversight
  2. Standards/code of conduct
  3. Educations & training
  4. Risk assessment, auditing & monitoring
  5. Reporting systems
  6. Response & prevention
  7. Enforcement & discipline
- Timing/on-boarding process/team
Contact Information

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## Appendix A - Acronyms

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<th>Description</th>
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<tr>
<td>ASC</td>
<td>Ambulatory surgery centers</td>
</tr>
<tr>
<td>CAH</td>
<td>Critical access hospitals and swing bed management</td>
</tr>
<tr>
<td>CC</td>
<td>Complications on comorbidities</td>
</tr>
<tr>
<td>CDI</td>
<td>Clinical Documentation Improvement</td>
</tr>
<tr>
<td>CDM</td>
<td>Charge description master</td>
</tr>
<tr>
<td>CIA</td>
<td>Corporate Integrity Agreement</td>
</tr>
<tr>
<td>CMS</td>
<td>Center for Medicare and Medicaid Services</td>
</tr>
<tr>
<td>CO</td>
<td>Compliance Officer</td>
</tr>
<tr>
<td>CPT</td>
<td>Current Procedural Terminology</td>
</tr>
<tr>
<td>DHHS</td>
<td>Department of Health and Human Services</td>
</tr>
<tr>
<td>DME</td>
<td>Durable medical equipment</td>
</tr>
<tr>
<td>DOJ</td>
<td>Department of Justice</td>
</tr>
<tr>
<td>DRG</td>
<td>Diagnosis related group</td>
</tr>
<tr>
<td>EBM/TAO</td>
<td>Earnings before interest, depreciation and amortization</td>
</tr>
<tr>
<td>EMR</td>
<td>Electronic medical record</td>
</tr>
<tr>
<td>HIM</td>
<td>Health Information Management</td>
</tr>
<tr>
<td>ICD-9</td>
<td>International Classification of Diseases</td>
</tr>
<tr>
<td>IDT</td>
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<td>LCD</td>
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<td>Long-term acute care hospitals</td>
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<tr>
<td>M&amp;A</td>
<td>Merger and acquisition</td>
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<td>MCC</td>
<td>Major complications or comorbidities</td>
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<td>Memorandum of understanding</td>
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<td>Program for Evaluating Payment Patterns Electronic Report</td>
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<tr>
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<td>Resource utilization group</td>
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<td>SNF</td>
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