Medical Practice Compliance

News, tools and best practices
to assess risk and protect physicians

ALERT

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IN THIS ISSUE

Despite restrictions, extrapolation alive and well in Medicare audits

Many of your peers are learning an alarming and potentially costly lesson – reports of the demise of extrapolation in Medicare audits have been greatly exaggerated.

Extrapolation – also called statistical sampling – is a process used by auditors to project the number of billing errors found in a sample of your claims to all of your clams.

The Medicare Modernization Act of 2003 was supposed to limit extrapolation to situations where "there must be a sustained or high level of payment error, or documentation that educational intervention has failed to correct the payment error," says Peter Ashkenaz, spokesperson for CMS. At the time, experts said language in the law would severely limit use of extrapolation and it was seen as a win for you and your peers.

But Medicare auditors have wide latitude regarding the size and type of sampling, the way the billing error is determined and even the actual billing error rate.

*(see **Extrapolation**, pg. 5)*

Beware accruing interest on RAC overpayments

When you receive a repayment demand from your recovery audit contractor (RAC) and need to repay CMS, weigh carefully how to return the funds. Make the wrong choice and you could end up needlessly paying additional interest on the overpayment.

When you determine a RAC's finding of an overpayment is correct and you need to repay money, you have two options – you can repay the money up front, or allow CMS to take it back by offset. When you decide to let CMS recoup the money out of future payments and it doesn't happen in a timely fashion you'll owe interest as well, which CMS will also recoup by offset.

"Interest begins accruing [on an overpayment] as soon as the adjustment occurs. If payment is sent in prior to day 31 any interest assessment is waived," explains Peter Ashkenaz, spokesperson

*(see **RAC overpayments**, pg. 8)*

Share these 4 tips for transmitting PHI to providers and patients

HIPAA and state privacy laws have raised the stakes when response to a medical record request from another provider goes astray. And now individual staff members could be held responsible for breaches. However, a few simple rules can protect staff, the practice and patients from the effects of an accidental breach of protected health information (PHI). Share these four tips with your staff to keep everyone safe:

PHI transmittals to patients

1. Be wary when a patient calls and asks you to send his medical records, advises Anne Paone Gallagher, CPC, the practice administrator at Great Valley Cardiology in Scranton, Pa. "If they call, we make them verify their address and check in our computer," Gallagher explains. If the address the patient gives doesn't match, the patient has to come to the office and present an I.D. to pick up his records, Gallagher explains.

Note: Requests from patients who haven't been seen three years or more should receive extra scrutiny. Ask for a request in writing so you have a signature and date on file, Gallagher says.

2. Unsecured emails are a no-no. "We do not want PHI out there on the World Wide Web," says Veronica Gleason, billing and HIPAA compliance manager for Western Nephrology in Wheat Ridge, Colo. Tell patients your policy is to protect them. Explain that you can't send or respond to emails because there's no way to control unsecured emails, Gleason recommends.

Note: Western Nephrology makes an exception to this policy for deaf patients. "They have a signed authorization in their chart," Gleason says.

TIP: If clinical staff resist restrictions on how they communicate with patients, remind them that unlike an EMR-linked email portal, these communications won't wind up in the patient's medical record, says David Harlow of the Newton, Mass.-based Harlow Group and, author of the HealthBlawg.

PHI transmittals to providers

3. Keep in-house emails behind a secure portal. Unless you have a secure portal for emails, your staff should not email PHI to one another. At Western Nephrology, staff can only email PHI by logging in to the practice's password-protected internal email system.

4. Protect transmittals to other providers. "Most of the providers in our area are on the same EMR," so we can email them directly from the patient's chart.

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When sending information to providers who aren't on the network, Great Valley Cardiology sends an electronic fax from their computer system to the provider. **Note:** Restrict this responsibility to billing and clinical staff, Gallagher recommends. "We don't allow switchboard staff to send this information."

Case study: Ophthalmology practice bears brunt of $4 million ZPIC auditing mistake

Going through a zone program integrity contractor (ZPIC) audit can be a harrowing experience, even when you're found to be billing correctly *(MPCA 6/14/10)*. Just ask Eye Specialty Group in Memphis, Tenn.

ZPIC AdvanceMed (Zone 5) showed up unannounced at the eight-physician ophthalmology practice in November 2006, asking to audit 120 charts for a period from January 2004 through May 2006 in what it called a "routine" audit, says Thomas Brown, the practice administrator. The practice had no idea it had a billing problem prior to the ZPIC showing up, notes attorney Howard Bogard, with Burr & Forman, Birmingham, Ala., who helped the practice through the ordeal.

The practice heard nothing after it sent the charts for 18 months, then was notified it had been overpaid by $27,000. But the ZPIC, using extrapolation *(see story, pg. 1)*, applied the billing error rate it found in the 120 charts to all of the practice's claims for the same time period, and assessed a whopping $3,966,500 overpayment.

The practice challenged the audit. And in so doing, AdvanceMed was found to not have the experience to review ophthalmology claims, says Bogard. "[AdvanceMed] applied evaluation and management (E/M) codes to eye codes, and E/M codes require that you obtain mental status, which we hadn't done since we were billing eye codes," explains Brown.

After a two year fight, Eye Specialty Group finally got the findings reversed by an administrative law judge (ALJ) at the third level of appeal in spring of 2010. The ALJ also determined that the error rate on the few overpayments found was too low to apply extrapolation.

The $4 million bill was reduced to $2,810, including $312 in interest. The appeals process, meanwhile, took two years and cost the practice $350,000.

"It probably cost AdvanceMed $50,000 to do the audit. So it cost $400,000 [$350,000 plus $50,000] to collect about $3,000," notes Brown.

What's even more galling: After the ALJ ruled in the practice's favor, CMS appealed a legal issue of the ALJ's ruling, sending the case to the Medicare Appeals Council, the fourth level of appeal. However, providers have to start repaying Medicare by the second level of appeal, so the practice paid thousands of dollars through the fourth level of appeal, even though all of the parties knew by the ALJ's ruling that the actual overpayment owed would be less than $3,000. Medicare eventually paid the practice back $55,000, without interest. "It was a bitter pill for the doctors to swallow," says Bogard.

Note: High overpayment demands are not unusual because the ZPICs will use extrapolation whenever the billing error rate in a sample is more than about 10%, says Bogard. Tim Johnson, with Jackson Davis Healthcare in Denver has seen many physician practices and DME providers dealing with ZPIC overpayment demands ranging from several thousand dollars to more than $2 million.

AdvanceMed declined to comment when contacted by *Medical Practice Compliance Alert*, deferring to CMS. CMS has not responded to our request to comment.

Eleven tips to deal with ZPICs

Zone Program Integrity Contractor (ZPICs) audits are like other Medicare or Medicaid audits in some ways, but very different in others. Here are 11 tips specific to ZPIC audits (transitioning from Program Safeguard Contractor or PSC audits) that will help you avoid one or reduce your chances of getting in trouble:

1. Follow CMS payment rules, even when they're not the industry norm, says Tim Johnson, with Jackson Davis Healthcare in Denver. These will be the criteria that the ZPICs will use. "Play by their rules if you're going to accept money from a government program," says Wayne van Halem, President, the van Halem Group, Atlanta, and audit advisor to Waterloo, Iowa-based VGM Group.

2. Make sure your billing error rate is low to avoid extrapolation. Conduct routine self-audits to correct billing errors and keep your billing error rate low enough so the ZPIC can't use extrapolation, suggests Howard Bogard, with Burr & Forman, Birmingham, Ala.,

and attorney for Memphis-based Eye Specialty Group, which got burned by a ZPIC audit *(see story, pg. 3)*. Obtain a report from your MAC to see where your practice's billing stands statistically, especially when you use a billing agency. The report allows you to verify the agency isn't overbilling or making other billing mistakes, says attorney Rafael Gaitan, with Gaitan Morales, Miami.

3. Ensure your records are well documented and complete before you send them to a ZPIC auditor. "In the eyes of Medicare, if it's not documented, it wasn't done and won't be paid," says van Halem. Review your records in light of coverage and payment rules to make sure you can justify the claims.

4. When you don't have adequate documentation, try to obtain it from another provider. Example: When the ZPIC audits surgical procedures, you may be able to augment your medical documentation with records created by the hospital where the surgery was conducted, says Bogard.

5. When you uncover billing issues while reviewing and pulling the requested documentation, don't just send the documentation. Tell the ZPIC what you found and what steps you're taking to correct the problem. This helps demonstrate you didn't intend to commit fraud, says Johnson.

6. Understand the impact of your practice on other providers, and vice versa. Since the ZPICs have jurisdiction over all providers in its region, your practice's actions can impact a related provider or referral source, and vice versa. **Example:** When your physicians don't adequately document something when prescribing a home health service and the home health agency gets dinged by the ZPIC as a result, the ZPIC can then turn around and audit your practice, warns van Halem.

7. Be prepared to contact your MAC for clarification regarding your claims. The ZPICs have not been communicative about problems they find with claims, warns van Halem.

8. Assess your cash reserves and sources of revenue. If the bulk of your practice comes from Medicare, make sure you have adequate cash reserves to cover a cash flow problem, especially if you end up in prepayment review, suggests Gaitan. Diversify your book of business so you have revenue streams from payers other than Medicare, he adds.

9. Don't be afraid to appeal when you disagree with the determination. Eye Specialty Group was able to show that AdvanceMed made a mistake when it applied E/M requirements to eye codes that the practice had billed, and got the original $4 million overpayment demand down to less than $3,000.

10. Be familiar with your ZPIC's rules and policies because they vary, warns Bogard. **Example:** The error rate to use extrapolation for AdvanceMed is 10%, but it's not the same for other ZPICs, says Bogard. "It's a moving target," he warns.

11. Consider Meddefense insurance. This insurance protects against some of the expenses of regulatory action *(MPCA 4/19/10)*. "It may give physicians peace of mind," says Gaitan.

Use compliance report, incident log forms to document compliance efforts

Reduce your compliance risk by encouraging your employees to report compliance concerns *(MPCA 4/5/10)*. But this only works when you document that you actually investigated the issues brought to your attention.

"Doctors aren't too good about documenting investigations," warns Donna Beaulieu, compliance officer for Quality Physician Services in Stockbridge, Ga. An effective investigation requires you to start a file and document the steps you take so you can prove you did it later, she adds.

Your investigation should determine first if the complaint is valid and needs to be addressed. You'll also send a message to your employees that they can feel confident bringing issues to your attention, says David Zetter, president of Zetter Healthcare Management Consultants in Mechanicsburg, Pa., who trains physician offices in compliance.

Internally, use a log form to categorize and track complaints and identify possible patterns and trends. A compliance report form allows your employees to easily, conveniently and, if necessary, anonymously report their concerns. Your compliance manager or designated staffer in charge of compliance is the one who investigates when you receive a compliant and reports back findings.

TIP: Respond to all complaints in a timely manner to build an environment of trust and be able to catch and correct problems sooner, advises Roy Snell, CEO, Health Care Compliance Association, Minneapolis.

When you find something, such as a billing error, take the steps to correct it.

We've emailed *Medical Practice Compliance Alert* subscribers two key tools – a sample Compliance Report Form and a sample Incident Log Form – that you can adapt to use in your practice. They were emailed along with the electronic version of this issue. If we don't have your email address, call our customer service department at 1-877-602-3835 to supply your email address and get your free tools. Both come from DecisionHealth's new *Compliance Program Builder for Physician Practices*. To order yours, ask for product code H5100 when you call.

Physician gets $200,000 after blowing whistle on colleague, hospital

The whistleblower who reports one of your physicians for bad billing isn't always a disgruntled employee – it's sometimes another physician in the practice.

Dr. Steven Radjenovich, formerly on the medical staff of Wheaton Community Hospital and Medical Center in Wheaton, Minn., filed a whistleblower action against fellow medical staff member Dr. Stanley Gallagher and the facility, claiming they knowingly made false claims to Medicare for unreasonable and unnecessary hospital admissions.

The rural hospital has only 15 beds, an average daily census of 5 patients, and only 4 physicians on its active medical staff, according to Jesse Tischer, CEO/administrator. The hospital and Dr. Gallagher settled the suit for $846,461, rather than admit liability or incur the costs of litigation, according to announcements made January 4, 2010 by both the hospital and the Department of Justice.

This case may not have been about doing the right thing, but "this may well have been a personal issue between the two doctors," according to Charles Miller, spokesperson for the Department of Justice.

Whistleblower cases are often filed because of a falling out or business or personal dispute between providers; sometimes there's a personality clash, notes attorney Patric Hooper, with Hooper Lundy Bookman, Los Angeles.

Note that Dr. Radjenovich will receive 25% of the settlement, or $203,150. He currently practices in Alexandria, Minn.

Neither physician was available for comment.

Bottom line: Make sure your nose is clean. "A strong compliance plan is always useful; ensuring the consistent application of your compliance plan is even more useful," recommends Tischer.

Don't assume your billing and claims will be kept under wraps. "The DOJ has these cases all the time. Many times [providers] made mistakes and had no malicious intent. But they're still charging the government for these services and owe the money," says Miller.

Extrapolation

(continued from pg. 1)

"When we do an extrapolation, the sample and the determined errors are unique to the provider and the issues being researched by the contractor. A sustained or high level of payment error may be determined by audits, data analysis, provider history, or even allegations of wrongdoing by employees," Ashkenaz says.

Medicare's contractors are currently applying extrapolation with zeal. The ZPICs apply it "in every case where appropriate criteria is met," although they can use discretion in extenuating circumstances, according to Ashkenaz. A Medicare contractor could review a sample size of 2%, find an error rate of 20% and extrapolate the 20% error rate to all claims, warns Don Bell, senior vice president and general counsel, National Association of Chain Drug Stores, Alexandria, Va.

Example: A Medicare auditor reviewed a sample of claims of a small durable medical equipment (DME) provider and found that its DME delivery slips were missing two elements out of seven, resulting in an overpayment of $12,000. But the auditor extrapolated the finding to all claims, demanding repayment of $1.5 million, according to Wayne van Halem, president, the van Halem Group and audit advisor to Waterloo, Iowa.-based VGM Group.

What's worse: The recovery audit contractors (RACs) are also allowed to use extrapolation, and are expected to start doing so in the not-too-distant future, says Amy Reese, CMS' Project Officer for RAC Region C. When the RACs start using extrapolation, they may be even more zealous and overpayment demands will potentially be even higher, because the RACs, unlike the ZPICs, are paid on a contingency fee basis, warns attorney Paul Shaw, with KL Gates in Boston.

From the
DECISIONHEALTH® PROFESSIONAL SERVICES
Case Files

Case #37: The case of the misplaced medical decision-making

The client:
A mid-sized multispecialty group in the Southwest

The audit:
DecisionHealth Professional Services was called to perform chart audits for established patient E/M services for practice physicians and non-physician practitioners (NPPs) to ensure the practice was correctly documenting the E/M claims being billed and paid.

Our audit focused on both overcoding and undercoding by the physicians. Even though Medicare and private payer audits are far more likely to reveal overcoding, when a practice undercodes services it is also considered a significant compliance challenge.

The compliance risk:
The practice was adequately documenting the patient's past family and social history (PFSH) and the exam for the service being billed. However, Medicare rules are clear that it is ultimately the medical necessity of the service that "is the overarching criterion for payment of the service in addition to the individual requirements of the CPT code." In some cases, it appears the physicians and NPPs were overdocumenting for the patient's presenting problems, or not documenting all presenting problems. The result was the appearance that the services were too intense for the code selected.

Background:
Selection of an E/M code is based on the intensity of the documented service for three areas – history, exam and medical decision-making. When it is an established patient E/M visit, you choose the code based on the level of service for your choice of two of these three areas. For new patients, code selection is based on the documentation of all three components. But when it is an established patient, you are technically allowed to base your code selection on the documented history and exam, without consideration of medical decision-making.

Note that the documentation of history and exam are often procedural steps – it is technically possible to document an advanced level history and exam for any patient, without consideration of whether the intensity of the visit or medical decision-making warranted that documentation.

The rule:
CMS states its position on E/M code selection clearly in the Internet Only Manual's Claims Processing Manual, Pub. 100-04, Ch. 12, Sec. 30.6.1: "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported."

The investigation:
The histories and exams that were being documented by this practice and reviewed in the audit were typically a precise match to the intensity level required for billing the codes themselves.

We were concerned that the history and exam elements being recorded were often the same for multiple patients despite vastly different presenting problems. This was not a case of cloned notes *(MPCA 12/1/08)*, but a case where the physicians were documenting standard elements for every patient. Typically, the history and exam will include documentation to reflect any related concerns had

Case Files

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by the physician, but varied based on the patient's presenting problem. The problem was that the patient presenting problems and the service intensity did not justify the codes selected in the opinion of the auditors themselves.

It appeared the practice physicians had a very good understanding of the documentation intensity for each code, but struggled to adapt code selection (and documentation levels) to the nature of the patient's problem.

Recommended Corrective Action Plan:
We trained practice physicians on the importance of relating the documentation to the nature of the patient's presenting problem, or making it clear that elements of the patient's history and exam must be related to the reason the patient was visiting or a medically necessary follow-up for a previous problem, which would also be documented for the current visit.

We explained to the physicians that they were taking a serious compliance risk by not carefully considering why they were documenting, and to contain documentation to needed issues related to the current visit. We also trained the physicians on how to apply the PFSH portion of the history from a previous visit to the current visit in order to document more effectively. The physician is not required to re-write PFSH from a previous visit that is already in the patient's chart, but should document that it was reviewed with the patient during the current visit and document any updates or changes. The date should be documented.

When doing the exam, relevant negative systems should be documented and explained, but we informed the doctors they did not have to elaborate or expand on normal systems related to the presenting problem or unrelated systems.

On the internet:

- Medicare Claims Processing Manual, Ch. 12, Sec. 30.6.1: *www.cms.gov/manuals/downloads/clm104c12.pdf* (pg. 33)

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4 ways to fight government's use of extrapolation

You can't expect to avoid government audits in the current regulatory climate, warns Wayne van Halem, president, the van Halem Group and audit advisor to Waterloo, Iowa-based VGM Group. But that doesn't mean you need to accept extrapolation in every instance – know your rights and challenge extrapolation used in error.

"Auditors will apply the wrong rules, the wrong tests," notes Thomas Brown, practice administrator, Eye Specialty Group, Memphis, Tenn. Challenge extrapolation when you can to try and reduce or eliminate an overpayment demand.

When you pay an extrapolated overpayment demand without challenge, you "invite repeated demands for additional recoveries and permit continuation of improper recovery techniques," warns attorney Raymond Pepe, with KL Gates, Harrisburg, Pa.

You may need help from a statistician for some extrapolation challenges, but others you can challenge on your own by reviewing your records and the policies and procedures applicable to the audit, says Pepe.

You need to be able to undercut and rebut the auditor's assumptions and findings. If you can rebut a number of the findings, you can really cut down the amount of the overpayment, advises attorney Paul Shaw, with KL Gates in Boston. At that point, the auditor will sometimes just ask for a compromise settlement on the few claims left, he adds.

Here are four strategies to fight extrapolation:

1. The audit findings are wrong or inaccurate. Sometimes auditors apply the wrong codes, deadlines or coverage criteria, mistakenly say that a service was medically unnecessary, or make other errors. **Example:** The ZPIC that audited Eye Specialty Group erroneously applied the wrong evaluation and management codes to the practice's claims. The overpayment bill was reduced to $2,810.

2. The auditor didn't follow the rules of extrapolation. Auditors are required to follow Medicare's rules and its own policies when using extrapolation. Use it in you favor when you find out they don't. **Example:** When an auditor's billing error threshold rate is 10%, and the auditor applied extrapolation to a billing error rate of 9%, challenge the use of extrapolation, says Pepe.

3. The sampling is not appropriate. Sometimes the auditor has followed the rules, but pulled an unreliable sample. **Example:** When the auditor only samples paid claims, not all claims submitted, the auditor can't determine if a denied claim was reversed or if the provider had been underpaid, says Don Bell, senior vice president and general counsel, National Association of Chain Drug Stores, Alexandria, Va. The findings of these disallowed claims should have been offset against the audited claims, says Pepe. Use that to argue that the use of a biased sample may itself form the basis for disqualifying the use of extrapolation, he adds.

4. The errors found were inadvertent or CMS contributed to the error. There are occasions where the provider's billing arguably shouldn't be subject to harsh assessments. **Example:** When a complex technical requirement is subject to different interpretations or Medicare had previously paid a certain claim in the past, you may be able to argue that the overpayment assessment should be reduced or extrapolation is inappropriate, says Pepe.

RAC overpayments

(continued from pg. 1)

for CMS. When you don't pay by day 31, interest begins to accrue – when you haven't repaid the money or appealed by day 41, CMS will begin automatic recoupment of the overpayment and the interest, warns Day Egusquiza, president, AR Systems, Inc, Twin Falls, Idaho. The interest rate is currently 10.875%.

Interest still accrues when you appeal, because recoupment does not occur. When you appeal after recoupment has started, it stops the process, but you're not refunded any money already recouped pending the outcome of the appeal. If you win on appeal, you won't pay any interest, but if you lose, you may owe interest, notes Ashkenaz.

Unfortunately, the application of interest to RAC overpayments hasn't received much attention, perhaps because changes to the appeal process that allow you to halt recoupment when you appeal are new, suggests Ashkenaz.

What to do: When you opt to repay CMS for the overpayment and don't want to pay any interest on top of it, either send a check before day 31 or contact your MAC for an immediate offset, which requires a form to be completed, says Egusquiza. "Make the decision [to pay or appeal] rapidly. Offset itself actually doesn't cost more, [it's the delay in repayment that causes the problem]," she points out.

Note: While the RACs get paid on a contingency fee basis, they do not receive any contingency fee on interest assessed on an improper payment, notes Ashkenaz.

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Medical Practice Compliance ALERT

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QUICK COMPLIANCE QUIZ

Zone Program Integrity Contractors

Be prepared for Zone Program Integrity Contractors (ZPICs) – they're the latest auditors unleashed by Medicare to find billing errors done at your practice.

Instructions: Distribute this Quick Compliance Quiz to make sure your staff understands how ZPICs audit claims. **Suggested reading for staff:** *Medical Practice Compliance Alert,* June 14 and June 28 issues.

1. What type of Medicare contractor is in the process of being replaced by the Zone Program Integrity Contractors?

- ☐ Recovery Audit Contractors
- ☐ Program Safeguard Contractors
- ☐ Departmental Appeals Board

2. How many ZPICs will be in place at the conclusion of the transition to cover the entire country?

- ☐ 2
- ☐ 5
- ☐ 7
- ☐ 11

3. What leads to 90% of ZPIC reviews and audits?

- ☐ Data analysis
- ☐ Probe audits
- ☐ Whistleblower complaints

4. True or False. The government is spending $311 million to fund ZPICs in the 2010 fiscal year.

- ☐ True.
- ☐ False.

5. When the ZPIC audited Eye Specialty Group, it audited 120 claims and demanded a repayment of nearly $4 million. Why?

- ☐ The audit involved high dollar claims.
- ☐ A fraud penalty was assessed under ZPIC rules.
- ☐ The ZPIC used extrapolation to apply its findings to more claims.

Answers

1. Program Safeguard Contractors

Teaching point: The Zone Program Integrity Contractors (ZPICs) are in the process of replacing Program Safeguard Contractors (PSCs) throughout the country. The transition is expected to be finished in 2010. ZPICs will specifically deter and fight fraud, though they will look for the same types of billing patterns as other auditors to look for aberrations of differences from national norms.

2. 7

Teaching point: Ultimately, there will be seven ZPICs, down from a high of 18 PSCs. They will align more closely with the Medicare Administrative Contractor regions and will look at all claims billed within the MAC territory.

3. Data analysis.

Teaching point: ZPICs are primarily tasked with fighting fraud, but the high majority of their audits will start with proactive data analysis, which will lead to audits based on the findings that raise red flags to the ZPICs. The ZPICs do not have disclose the data points which will set off alarms and lead to further review. Other audits will be triggered by complaints to the Medicare Administrative Contractor (MAC), which is instructed to refer instances that appear to be fraudulent.

4. True.

Teaching point: Audits have become a point of emphasis in different areas of the Medicare program and the ZPICs are no different. Congress is finding that money spent investigating physician claims – as well as other types of health care claims – usually end up bringing back even more money to the government. In 2007, PSCs brought in $835 million based on their investigations, according to the HHS Office of Inspector General (OIG). The $311 million in projected 2010 spending is a 50% increase over 2009.

5. The ZPIC used extrapolation to apply its findings to more claims.

Teaching point: ZPICs and other auditors are still permitted to use extrapolation when they can show that the mistakes they find are excessively high – such as a billing error rate of around 10%. Previous legislation attempted to limit, but did not eliminate, use of extrapolation. The option of extrapolation makes it imperative that you are well prepared to fight the errors being found by ZPIC auditors – and other auditors as well.