Provider Self-Audit Protocol

Effective compliance programs are essential to any provider navigating the complex world of government benefit programs. Self-audits can be an important tool in the compliance process. The Department of Health Care Finance (DHCF) believes the utilization of compliance programs by providers serves as a positive step towards ensuring the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements. In addition, an effective compliance program, which incorporates self-audits, assists providers in preventing the submission of erroneous claims or engaging in unlawful conduct involving the health care programs.

A provider has an obligation to ensure that claims submitted to the Medicaid program are proper. When in the course of regular business, as part of a compliance program, or as a result of a self-audit a provider determines that payments made to the provider were in excess of the amount due from the Medicaid program, the provider is obligated to return the improper amounts to the state Medicaid agency, DHCF. Providers should return the improper amounts to DHCF, Division of Program Integrity (DPI) along with supporting information that will allow DPI to validate the overpayment amount. References, examples, and explanations of the necessary supporting information are set forth below.

Self-audits are generally voluntary, although a provider might be required to perform self-audits as part of a settlement or other performance improvement agreement such as a corrective action plan (CAP) with DHCF. However, even if it is not required, a self-audit can give peace of mind that a provider and its employees are accurately complying with the appropriate laws and procedures. A good compliance plan, including self-audits, can decrease the risk of enforcement action by DHCF or other authorities.

This guide will explain how self-audits can be conducted. If you have any questions about this guide, feel free to contact DPI at the address provided in the last section, below.

Additional Guidance and Information:

The Department of Health and Human Services-Office of Inspector General (HHS-OIG) has developed a series of voluntary compliance program guidance documents directed at various segments of the health care industry which is available at: http://oig.hhs.gov/compliance/compliance-guidance/index.asp.

The Centers for Medicare and Medicaid Services (CMS) has a webpage which provides information and guidance on provider self-audits titled, **"Program Integrity: Self-Audit Toolkit"**, and is available at**: https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/audit-toolkit.html**.

Self-audits

A self-audit is an audit, examination, review, or other inspection performed both by and within a given physician's or other health care professional's practice or business. In other words, a self-audit is audit work that the entity does for itself.

The general steps in the self-audit process are:

- Identify risks;

- Audit those risks;

- Document the audit; and

- Review and act on the results.

Identifying the risks

A methodical, measured, and proactive approach to compliance and control starts with identifying and prioritizing known and suspected risks. Regardless of how it is done, risk assessment seeks answers to two key questions:

1. Which compliance issues and risks are of greatest concern?
2. Where is the entity most vulnerable to these risks?

Considering what is of "greatest concern" can be broken down into three factors:

- Existence—does a risk exist?
- Significance—does it matter?
- Materiality—how much does it matter?[1]

These questions help order and structure a more efficient risk assessment. They also provide a simple way to arrange and publish risk information in a single document.

Identify the Risks—Prioritizing with Scores

For any given endeavor there may be numerous risks. Part of conducting an effective self-audit includes prioritizing the most important of these many risks to audit. There is flexibility to choose the scoring system used to assess the existence, significance, and materiality of the identified risks, as long as it is well-defined and applied consistently to all risks. One approach to prioritizing risk, suggested by the American Institute of Certified Public Accountants (AICPA), is to assess them as:

- High—risks that repeat, are hard to detect, are very likely to occur, or are of significant impact;
- Medium—risks occurring less often but which are still difficult to detect; or
- Low—risks that are unlikely or of small potential impact.[2]

This simple framework is easily used to assess general risk areas such as documentation, policy, training, and monitoring. Then, the risk assessment group scores the relative risk in each area identified. Using an odd number of scorers can help break ties.

A common risk assessment method is the "Audit Risk Model."[3] The model illustrates an example for scoring a risk assessment using 3=High, 2=Medium, and 1=Low. This approach determines which risks to audit by prioritizing based on the nature of the risks identified. This model is described mathematically as:

$$AR \text{ (Audit Risk)} = IR \text{ (Inherent Risk)} \times CR \text{ (Control Risk)} \times DR \text{ (Detection Risk)}$$

Where:

AR = Total risk

IR = Risk remaining when all controls (for example: policy, procedure) are removed

CR = Risk that a control will fail to timely detect or prevent an error

DR = Risk that audit procedures will not detect an error after it occurs[4]

Table 2. Audit Risk Model illustrates an example:

Control Area	Inherent Risk	Control Risk	Detection Risk	Product
Documentation	1	1	2	2.00
Policy	2	1	2	4.00
Training	2	3	1	6.00
Monitoring	3	2	2	12.00

Additional risk assessment focused on the legal, financial, operational, and reputational impact of each risk might further clarify audit priorities.

Audit the risks

Once you have identified and prioritized your risks, you must actually audit them. According to the references, auditing and monitoring have two key components:

1. A standards and procedures review.
2. A claims submission audit.[5]

Reviewing your standards and procedures allows you to check that your processes are all set up in the right way, while a claims submission audit allows you to review the output from those processes. Together they help give a holistic picture of compliance in the organization.

Standards and Procedures Review— Overview

Operational standards and procedures both manage internal control and compliance as well as create the boundaries that limit behavior and manage risk. Consistent with HHS-OIG guidance, DHCF recommends that an individual(s) in the provider's practice be charged with the responsibility of periodically reviewing the practice's standards and procedures to determine if they are current and complete. If the standards and procedures are found to be ineffective or outdated, they should be updated to reflect changes in Government regulations or compendiums generally relied upon by physicians and insurers"[6] (i.e., changes in Current Procedural Terminology (CPT) and ICD [International Classification of Diseases]CM codes). Compliance programs generally contain the following seven components:

- Conducting internal monitoring and auditing;
- Implementing compliance and practice standards;
- Designating a compliance officer or contact;
- Conducting appropriate training and education;
- Responding appropriately to detected offenses and developing corrective action;
- Developing open lines of communication; and
- Enforcing disciplinary standards through well-publicized guidelines.

This list is not all-inclusive or mandatory for voluntary compliance programs, and may be limited due to financial and staffing resource constraints, but provides guidance on a step by step approach. [7] [8]

Accordingly, a general assessment of compliance and control might include determining the presence and extent of:

- A working compliance and fraud, waste, and abuse risk assessment process and document;
- Systematic efforts to build a strong ethical culture;
- Current written policies, procedures, conduct standards, and adherence mechanisms;
- Confidential, anonymous reporting mechanisms known to staff;
- Up-to-date, job-specific, timely, and assessed compliance and fraud, waste, and abuse training;
- Good monitoring and oversight of key functions by outside entities;
- Systems for tracking and resolving allegations and detected noncompliance;
- Use of exclusion and debarment lists to screen providers and suppliers;
- Monitoring/auditing in high fraud areas; and
- A clear, communicated process for reporting fraud, waste, and abuse.[9]

Documenting and demonstrating the nature, scope, and timing of your organization's activities in these general areas help demonstrate a commitment to compliance. In contrast, poor documentation of standards and procedures suggests operational risk. Therefore, assessing the availability, adequacy, acceptability, and accuracy of documentation in the areas discussed can provide good risk intelligence.

Standards and Procedures Review— General Method

At the heart of the standards and procedures review process is using observation and the structured application of criteria to "test" whether the controls function as they should. Focus first on higher-scored risks, but be ready to refocus if testing reveals that something is riskier than originally thought or if prior risks have been addressed, thereby making room for other risks in the risk assessment. Control testing works best when disinterested parties, such as people from other departments, determine if the control is in place and works properly. If testing establishes that the control is absent, misplaced, or ineffective, be prepared to act promptly to put a stronger control in place. Consider reviewing the risk assessment at least quarterly to assess progress and add or delete risks.

Standards and Procedures Review— Financial Management

When auditing to detect and control improper payment risk, a good first step is testing whether basic financial management controls are in place:

- Are (preferably automated) books closed and reported on a monthly basis?
- Are regular balance sheets and income statements generated?
- Are financial statements externally audited? Have opinions been favorable?
- Are credit balances refunded?
- Are costs, prices, and expenses rational? Are journal entries, write-offs, and major discounts small in number and amount?

Standards and Procedures Review— Operations Management

Next, see if basic operations controls are in place and working. This includes such controls as:

- Criminal, exclusion, suspension, and debarment checks on all staff;
- Limitations on sole-source or emergency procurements;
- Up-to-date lists of contracts, accounts, related balances, and status information;
- Clear, complete, and well-monitored contracts designed to require few change orders;
- Documentation requirements for key processes;
- Segregation of authorization, allocation, appropriation, and expenditure duties;
- Required documentation of control failures and their consequences;
- Communication about and action on risk assessments;
- A claim system with working edits, audits, and related trackers;
- Documentation on disposition of complaints by consumers and office staff; and
- Monitoring of and action on purchases just under criterion threshold amounts or duplicate/voided invoices.

A vital control is keeping up with diagnosis and procedure codes. ICD-10-CM[10] is currently used worldwide for morbidity and mortality statistics, reimbursement systems, and automated medical decision support. The American Medical Association (AMA) publishes the related CPT.[11] Practice software typically uses these codes. Review the software periodically to ensure it is current.

Claims Submission Audit—Overview

The second key component of auditing and monitoring is the claims submission audit. Claim audits involve reviewing bills and medical records "for compliance with applicable coding, billing, and documentation requirements. The individuals from the physician practice involved in these self-audits would ideally include the person in charge of billing … and a medically trained person (e.g., registered nurse or preferably a physician) …"[12] The HHS-OIG compliance criteria suggests conducting an initial, or baseline, audit examining three months of claims services followed by at least annual monitoring.[13] Where possible, consider monitoring in either random or regular intervals throughout the year, rather than in a single large audit project. This periodic process raises some key questions:

- How many claims do I test?
- Which claims do I test?
- What do I look for?
- How do I test them?

The best answers to these questions may vary from practice to practice, business to business, and even audit to audit within the same entity. In each case, the goal is to design an audit process that gives useful qualitative and quantitative information on the existence, significance, and materiality of risks across the whole practice or enterprise.

Claims Submission Audit—How Many Claims Should be Tested

There are several methods to select the number of claims to be tested.

- A provider may perform a 100 percent review of claims. This option is recommended in instances where a case-by-case review of claims is administratively feasible and cost-effective.
- A provider may select a number of claims, using the suggested minimum sampling sizes below, judgmentally or using random sampling from a population of claims.
- A provider may also use a statistically valid random sample approach. DPI can be contacted for assistance in completing the sample.

The AICPA suggests a minimum sample size of 11 per item type, assuming the expectation of no errors.[14] However, establishing fixed sample sizes for every audit does not consider risk assessment. Correlating level of risk with sample size is common in auditing. For example, Table 3. Control Testing Sample Size, comes from the nation's largest audit project, the A-133 Single Audit, again expecting no errors.[15]

Control Testing Sample Size Table	
Significance of Control and Inherent Risk of Compliance Requirement	**Minimum Sample Size**
Very significant and higher inherent risk	60
Very significant and limited inherent risk or moderately significant and higher inherent risk	40
Moderately significant and limited inherent risk	25

These sample sizes are not hard criteria but show how risk can affect the scope of audit and monitoring work.

Claims Submission Audit—Which Claims Should Be Tested

A thorough risk assessment provides good information about which types of claims to test. Within the identified risk area, look at the claims with greatest volume, value, or error likelihood first.

While claims can be chosen judgmentally, random sampling enables the auditor to project error rates and improper payment amounts to the relevant population. Regardless of the claims sampling method, it is best if those involved in the delivery or administration of the sampled item not select them for audit. Also, it is often the case that the entity's usual and customary practices and processes are best

represented if neither the time frame covered by the sampled claims nor the schedule of audit work is announced in advance.

When pulling a claim sample, include enough information to fully characterize the medical, financial, and administrative aspects of the claim by examining such basic elements as:

- Beneficiary demographic data—name, ID number(s), birth date, age;
- Claim information—claim number, line number, first date of service, actual date of service, procedure code(s), procedure description(s);
- Payment information—billed amount, paid amount, third party liability amount, copayment amount, crossover amount, check number, receipt number; and
- Provider information—numbers and addresses for referring provider, consulting provider, rendering provider, principal provider, and billing provider, with appropriate differences.

Claims Submission Audit— What Do I Look For?

Auditors, monitors, evaluators, and investigators often look for overpayments by applying structured individual criteria (attributes) in one, some, or all of six general, ordered areas. Like other aspects of self-audits, these attributes can vary from project to project. These attributes can also become risk assessment elements and may themselves have related sub-attributes. For example, testing "acceptability of documentation" might involve determining if all required signatures are present, if all required numbers and codes are present and correct, and so on. A checklist based on the compliance criteria specific to a given project can be a big help. If a claim fails an attribute test, an improper payment likely occurred, and an error is generally taken on subsequent attributes. The six general, ordered areas are:

1. Availability of documentation.
2. Adequacy of documentation.
3. Acceptability of documentation.
4. Allowability of service.
5. Appropriateness of service.
6. Accuracy of payment.

When defining attributes, recall that improper payments generally arise when services are:

- Not documented;
- Not rendered;
- Not covered;
- Not medically necessary;
- Billed as a consultation rather than an office visit;
- Accompanied by inappropriate (or absent) modifier(s);
- Double-billed;
- Misrepresented (incorrect location, date, time, sequence, frequency, quantity, description, staff, licensure, etc.);
- Upcoded;

- Unbundled;
- Fragmented (separate claims for procedures on different dates that comprise the major procedure); and
- Under(over)utilized.[16]

If a billing service is used, you are still responsible for errors, even if the biller made the mistake.[17] If possible, test the claim against the original records. Test against electronic data or reproductions only if no other option exists.

Claims Submission Audit— How Claims Should Be Tested

The criteria that apply to a given claim generate the specific attributes used to evaluate that claim. HHS-OIG has published practice-specific criteria in such areas as nursing facilities, research grants, hospitals, pharmaceuticals, hospices, medical equipment, clinical labs, and home health.[18] Specific criteria and guidance for claim submission are available from applicable Federal or State regulations, program rules, oversight entities, claims administration agreements, audit and program integrity units, and professional associations. Certain data elements, medical record contents, and claims documentation warrant inspection, regardless of service or product type. The next sections discuss these three areas separately.

Claims Submission Audit— Data Elements

Before testing claims, it is wise to test the reasonableness and integrity of the relevant data to ensure that they are sufficient, appropriate, valid, and reliable. Among the things to inspect are:

- Lots of blanks, zeroes, unreasonable values, corrections, edits, and adjustments;
- Large-volume or large-value transactions;
- The count of unduplicated beneficiary numbers per beneficiary name and vice versa;
- A count of dates of birth and first date of service per beneficiary name and number;
- The count of addresses per beneficiary name and beneficiary number and vice versa;
- A count of claims, procedure codes, and diagnosis related groups per beneficiary name and number; and
- The total billed, paid, third-party liability and collection, copayment, and crossover pay

Examine basic descriptive statistics, such as the:

- Average number of claims, line-item details, dates of service, and dollars per beneficiary;
- Average number of line-item details, dollars, and beneficiaries per claim;
- Average dollar value of a beneficiary, claim, and line-item detail; and
- Average beneficiaries, claims, line-item details, and dollars per unit time.

Claims Submission Audit—Claim Documentation

When examining claim documentation, some of the things to look for include:

- All requested records located and appropriately secure, as per applicable policies.
- Billings consistently at the appropriate level for a given procedure.
- Dates of service reasonably related.

- Copayments and deductibles collected and not waived.
- Activity logs, ledgers, journals, deposits, checks, and bank statements track and balance.
- Narratives, clinical/treatment notes, and claim information match.
- Date-of-service changes documented and related to claims.
- Dates in treatment notes, claims, and financial documentation in sequence.
- Beneficiary eligibility routinely checked, with face-to-face encounter, as required.
- Informed consent obtained and documented.
- Treatments and surgeries medically necessary and appropriate.
- Number of hours claimed plausible.
- Service dates match appointment dates and copayment receipt dates.
- Services delivered are age, gender, and provider appropriate.
- Service provided or ordered must be authenticated by the author -- the one who provided or ordered that service. Authentication may be accomplished through the provision of a hand-written or an electronic signature; however, stamp signatures are unacceptable, with one exception (physical disability).
- Appropriate authorizations obtained and documented.

Document the Audit

An important feature of every audit is creating an accurate, complete record of your efforts to collect risk data, address risks, and prevent and remedy improper payments. Some helpful documentation hints are:

- Develop standard forms for claim audits, EOBs, and interviews; and
- Create a summary of your audit process using a "W-question" format, or use the same document structure auditors use, such as:
  - Source (where the information came from);
  - Purpose (why you gathered it);
  - Procedures (what you did with it);
  - Results (what you learned); and
  - Conclusion (what it means).

Documentation should provide "reasonable assurance that the evidence is sufficient and appropriate to support the auditors' findings and conclusions."[19, 20] In other words, the goal is to document enough information to persuade an interested but uninformed third party that the findings, conclusions, and assertions in the audit are reasonable and to demonstrate you used a reasonable process to reach them. Consider using a professional coder, peer, partner, or other qualified person to review your audit.[21] It is sometimes difficult to know whether to stop a test or an audit. A potentially useful rule-of thumb is that if additional data adds no new information, or if the same message starts coming from multiple sources, your evidence may well be sufficient to stop the audit process.

A Provider Self-Audit Worksheet and Provider Self-Audit Worksheet Explanation document are available on the DPI website. The worksheet is an example of a format that could be used to submit a self-audit to the Agency. It is not the required format but is designed to ensure that you furnish DHCF, DPI with all of the information that is necessary to validate and accept your self-disclosure.

Review and Act on the Results— General View

Finally, even a well-documented audit will not be helpful if your organization does not review and learn from the results. Follow these steps after audit work to maximize your benefits:

1. Review and analyze your audit documents, preferably with compliance staff.
2. Determine if issues identified through the audit are significant, material, and systemic and in which part(s) of the control system those issues reside.
3. Feed audit results back into your risk assessment and revise it accordingly.
4. Consider what you could easily and effectively do to control the key risks.
5. Brainstorm with staff on how to control or minimize the key risks found.
6. Introduce controls based on what you have learned.
7. Release audit results, revised risks, and new controls to your staff.
8. Document your control changes in policy and procedure.
9. Train and educate individuals whose work is implicated on the concerns identified and the related changes to process, policy, and procedure after each self-audit and at least annually thereafter.

Make sure to correct improper payments, using applicable criteria.

DHCF Verification

The extent of DPI verification effort will depend, in large part, upon the quality and thoroughness of the internal investigative and self-audit reports. During the self-audit process, providers may have questions and concerns; DPI will work closely with providers to answer any questions that they may have. Providers or their representatives that have questions regarding this process may contact DPI.

When a provider determines that payments made to the provider were in excess of the amount due from the Medicaid program, the provider is obligated to return the improper amounts to the District of Columbia. Providers should return the improper amounts to DHCF along with supporting information that will allow OIG/MPI to validate the overpayment amount.

In order to ensure that the Agency can validate the audit findings and properly document the overpayment as well as the provider's correction of the overpayment, DHCF, DPI needs the following information:

1. Billing Provider information:
    a. Name;
    b. Address;
    c. Provider type;

      d.   Provider identification number(s);

      e.   Tax identification number(s);

      f.   Name, address, and telephone number of the designated contact for the provider regarding the self-audit.

2.   Claims information (for the claims reviewed):

      a.   Date of Service;

      b.   Type of Service (e.g., procedure code; units of service);

      c.   Treating Provider;

      d.   Recipient Name and ID number

      e.   Internal control number (ICN);

      f.   Description of the non-compliance1 ;

      g.   And any other information that would allow the Agency to verify the claim(s).

Self-Audit submissions shall be directed to:

> **Department of Health Care Finance**
> **Division of Program Integrity**
> **Attention: Provider Self-Audit Coordinator**
> **441 4th Street, NW**
> **Washington, DC, 20001**

Upon completion of the DPI's review of the self-audit, the audit will either be accepted or declined. Accepted audits will result in the issuance of a final DHCF action letter, including stating the amount of money to be repaid and providing repayment instructions, if appropriate. Audits that are not accepted will be returned to the provider for corrections, with an explanation regarding why the audit could not be accepted.

Participation in a self- audit does not eliminate the possibility of further review by DHCF and does not affect in any manner the DHCF or other regulatory or law enforcement agencies ability to pursue criminal, civil, or administrative remedies.

Provider shall maintain copies of all self-audit information and documentation for future reference.

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