Self-Audit Worksheet Explanation

A provider has an obligation to ensure that claims submitted to the Medicaid program are proper. 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 the Agency with all of the information that is necessary to validate and accept your self-disclosure. The chart below is an explanation of the items requested on the worksheet.

If a provider determines that payments made to it 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. In fact, the provider can be sanctioned for failure to do so.

<table>
<tr><td>PROVIDER NAME – the name of the provider who received payment from DHCF</td><td>DATE – the date the worksheet was prepared</td></tr>
<tr><td>MEDICAID PROVIDER NUMBER – the nine (9) digit provider number to which DHCF made payment</td><td>CONTACT PERSON – name of the person to contact about the self-audit</td></tr>
<tr><td>PROVIDER TYPE – enter the type of provider you are enrolled as (for this provider number)</td><td>TELEPHONE NUMBER – telephone number for contact person</td></tr>
<tr><td>TAX I.D. – the federal tax identification number for the provider conducting the self-audit</td><td>PROVIDER ADDRESS – the address for written correspondence regarding the self-audit</td></tr>
<tr><td>NPI NUMBER – the national provider identifier for the provider conducting the self-audit</td><td>AUDIT PERIOD – the time period covered by the audit (start date to end date)</td></tr>
<tr><td colspan="2">AUDIT TYPE – a comprehensive audit is a review of all claims (or a sample of all claims for a given time period); a focus review is an audit of a subset of the provider’s claims, such as specified services</td></tr>
<tr><td>STATISTICS USED – indicate whether the audit involved the use of statistical sampling for purposes of reviewing claims</td><td>SAMPLE FROM DHCF – if statistical sampling was used, indicate whether DHCF assisted with obtaining the sample</td></tr>
<tr><td colspan="2">AUDIT METHODOLOGY – provide a written explanation about how the audit was conducted; be as detailed as possible</td></tr>
<tr><td colspan="2">AUDIT FINDINGS -- identify the claims that were reviewed and the findings of the review (whether the claim should be allowed or denied, and reasons for the denial)* see examples below
• Service not rendered
• Up-coding
• Unqualified staff performing services
• Incorrect dates of service
• Incorrect recipient
• Duplicate services
• Unbundling
• Service not documented
• Not covered
• Not medically necessary
• Accompanied by inappropriate (or absent) modifier(s)
• Double-billed
• Misrepresented (incorrect location, date, time, sequence, frequency, quantity, description, staff, licensure, etc.)
• Under(over)utilized
• Billed as a consultation rather than an office visit</td></tr>
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