Self-Audit Toolkit

Conducting a Self-Audit: A Guide for Physicians and Other Health Care Professionals

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Content Summary

This booklet describes the Federal guidance to physicians and other health care professionals for establishing a compliance program for an individual or small group practice and provides recommendations for how a practice or similar business can conduct a general Medicaid compliance self-audit. It describes a risk-assessment and self-audit process; how to examine financial and operational compliance; how to perform a claims audit; the characteristics of adequate and appropriate documentation; and how to document, measure, and monitor audit findings. The booklet concludes with discussions of the benefits and process of self-disclosure of compliance concerns and where to look for additional technical assistance.

What Is a Self-Audit?

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. Therefore, this booklet will not include information on audits and reviews conducted by outside entities.

Self-audit objectives can vary widely and may include: operational efficiency, economy, effectiveness, or clinical results and outcomes. The information in this booklet focuses on self-audits for compliance and control. The process described seeks to assess, correct, and maintain controls to promote compliance with applicable laws, rules, and regulations.

Federal Guidance

In its "Compliance Program Guidance for Individual and Small Group Physician Practices," the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) lays out seven key components of an effective compliance program, which are:

1. Conduct internal monitoring and auditing.
2. Implement compliance and practice standards.
3. Designate a compliance officer or contact.
4. Conduct appropriate training and education.
5. Respond appropriately to detected offenses and develop corrective action.
6. Develop open lines of communication.
7. Enforce disciplinary standards through well-publicized guidelines.

HHS-OIG advises "periodic audits."[1] Thus, regular monitoring is a foundation of effective compliance.

Reducing and preventing improper payments

Enhancing patient care

Minimizing billing mistakes

Why Should a Self-Audit Be Done?

While its guidance is not mandatory or all-inclusive, HHS-OIG states that implementation of its guidance can reduce and prevent improper conduct. The benefits of following the guidance include:

- Reducing and preventing improper payments;
- Ensuring that claims submitted are true and accurate;
- Enhancing patient care;
- Speeding up and optimizing proper claim payment;
- Minimizing billing mistakes;
- Reducing the chances of an external audit;
- Avoiding conflicts with self-referral and anti-kickback statutes;
- Showing a good faith and diligent commitment to a robust compliance effort; and
- Sending the message to staff that while mistakes will occur, employees have a duty to report errors and fraud so they may be corrected.[2]

In short, monitoring is just good "preventive medicine."

The General Process

The general steps in the self-audit process are:

- Identify the risks;
- Audit the risks;
- Document, document, document the audit; and
- Review and act on the results.

The next section of this booklet addresses each of these steps separately.

Identify the Risks—
What Is Risk Assessment?

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 are we most vulnerable to these risks?

Considering what is of "greatest concern" is easier by thinking in terms of:

- Existence—does a risk exist?
- Significance—does it matter?
- Materiality—how much does it matter?[3]

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—Who Should Do It?

A risk assessment is only as good as its inputs. So, choose the group of people participating in the risk assessment process thoughtfully. The functional areas that typically provide relevant input are:

- Medical and nursing services;
- Patient financial services (billing, chargemaster, accounting);
- Health information management (information technology); and
- Legal and compliance.

Some entities might have additional functional areas that would be relevant for the risk assessment, such as:

- Risk management;
- Administration;
- Human resources;
- Budget and finance;
- Pharmacy and other ancillaries;
- Laboratory; and
- Quality.

Identify the Risks—Scoring

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 identifying 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.[4]

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. Table 1. Basic Model illustrates an example for scoring a risk assessment using 3=High, 2=Medium, and 1=Low. Here, the scoring indicates monitoring is the prime concern.

Table 1. Basic Model

Control Area	Scorer 1	Scorer 2	Scorer 3	Average
Documentation	1	1	2	1.33
Policy	2	1	2	1.67
Training	2	3	1	2.00
Monitoring	3	2	2	2.33

Another common risk assessment method is the "Audit Risk Model."[5] This approach determines which risks to audit by prioritizing based on the nature of the risks identified. This model is described mathematically as:

AR (Audit Risk) = IR (Inherent Risk) x CR (Control Risk) x DR (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[6]

With this model, the assessment is more specific. Table 2. Audit Risk Model illustrates an example:

Table 2. Audit Risk Model

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

Using one of the methods discussed in this section can help you get started. Additional risk assessment focused on the legal, financial, operational, and reputational impact of each risk might further clarify audit priorities.

Audit the Risks—A Two-Part Process

HHS-OIG says that auditing and monitoring have two key components:

1. A standards and procedures review.
2. A claims submission audit.[7]

The next section of the booklet addresses each of these components separately.
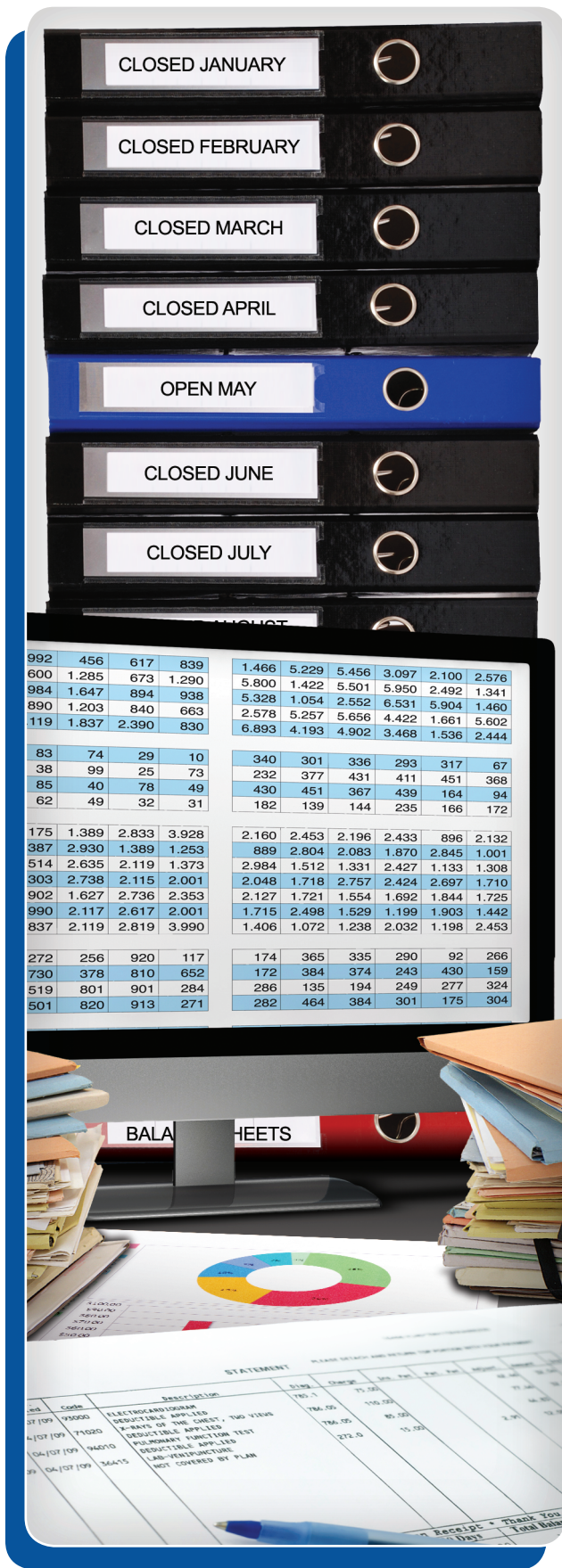
Standards and Procedures Review— Overview

Operational standards and procedures both manage internal control and compliance as well as create the boundaries that limit behavior and manage risk. HHS-OIG recommends that "an individual(s) in the physician 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"[8] (i.e., changes in Current Procedural Terminology (CPT) and ICD [International Classification of Diseases]CM codes). 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.
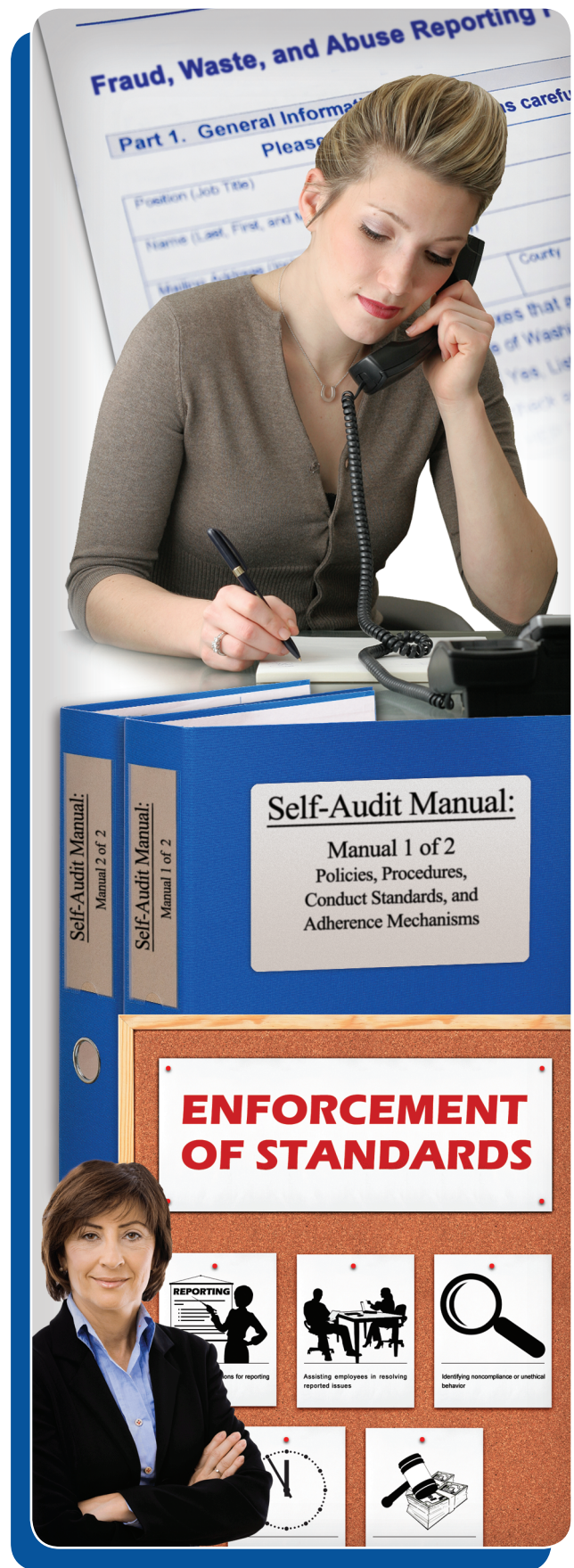
Standards and Procedures Review— General Method

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 books double-entry and based on accruals, rather than cash?
- 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;
- Limitations on use of subcontracts and middlemen;
- 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 suggest 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 Do I Test?

HHS-OIG says, "Although there is no set formula to how many medical records should be reviewed, a basic guide is five or more medical records per Federal pay[e]r (i.e., Medicare, Medicaid), or five to ten medical records per physician."[14] This recommendation is easily extended to support sampling at least five claims for each type of provider, procedure, time period, or other areas of analytical interest.

The AICPA suggests a minimum sample size of 11 per item type, assuming the expectation of no errors.[15] 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.[16]

Table 3. Control Testing Sample Size

Control Significance/Inherent Risk	Minimum Sample Size
Very significant/higher inherent risk	60
Very significant/limited inherent risk*	40
Moderately significant/limited inherent risk	25

* Also the sample size for a moderately significant risk and higher inherent risk.

These sample sizes are not hard criteria but show how risk can affect the scope of audit and monitoring work. Determining sample size should not be a barrier to starting the audit process. As HHS-OIG says, no criterion exists. The goal should be to make a good faith effort and get started.

Claims Submission Audit—Which Claims Do I Test?

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. Look where you have looked before, at least a little bit. This keeps fraudsters on their toes and helps find out if problems you thought you addressed are actually fixed.

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;
- Beneficiary geographic information—street address, city, state, ZIP CodeTM, and distance;
- Claim information—claim number, line number, first, actual, and last 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, credit card 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.[17]

Availability

Adequacy

Acceptability

Allowability

Appropriateness

Accuracy
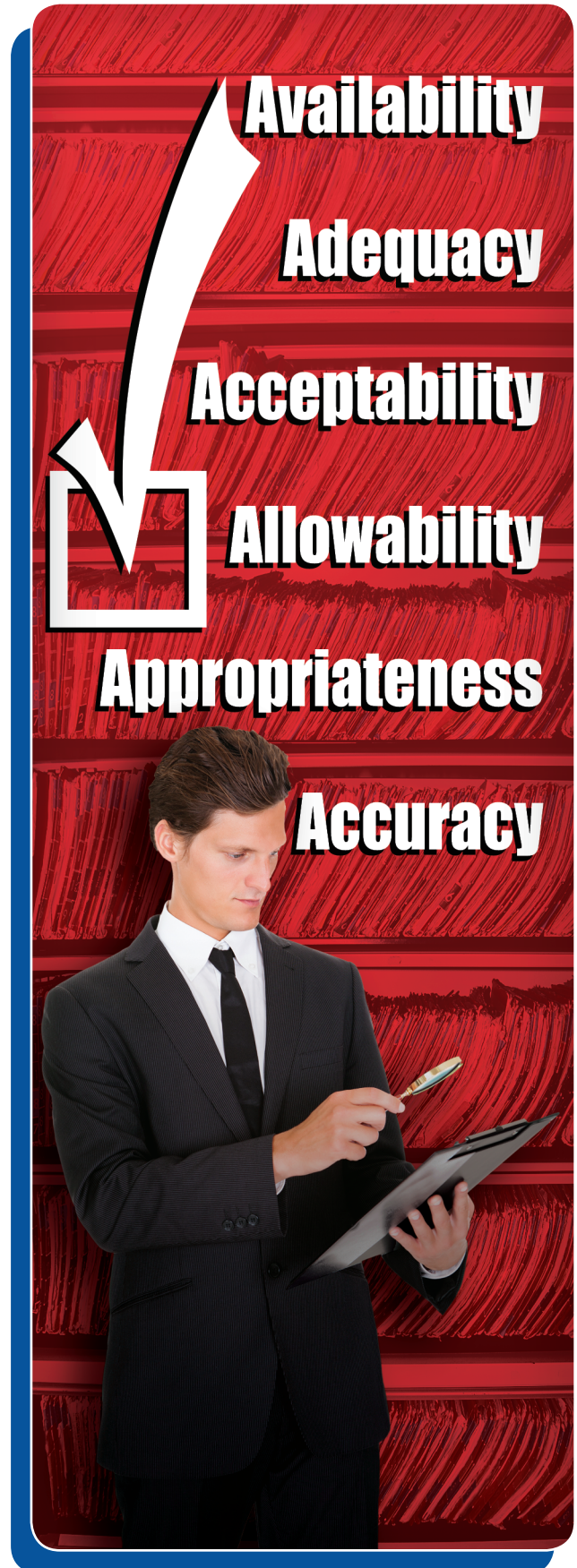
If a billing service is used, you are still responsible for errors, even if the biller made the mistake.[18] If possible, test the claim against the original records. Test against electronic data or reproductions only if no other option exists.

Claims Submission Audit— How Do I Test Them?

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.[19] 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 section of the booklet discusses 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 payments per beneficiary name and beneficiary number.

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.

You might also compare the claims in your practice to procedure-specific or area-specific norms via comparative billing reports and other data from the Centers for Medicare & Medicaid Services (CMS) and its contractors.[20] Similar reports might be available from your State Medicaid program.

Claims Submission Audit—Medical Record Contents

Compile attributes into a medical record testing checklist. Marking errors with a "1" and non-errors with a "0" makes tallying results fast and easy. Examples of attributes that may be appropriate for a medical record testing checklist are:

- Service dates, reason for each visit, and physician's orders for services, as required;
- Appropriate history, past and present diagnoses, risk factors, conditions limiting treatment, medications, and allergies with correct spelling and use of terminologies;
- Full information on labs, tests, exams, and X-rays with reasons, results, and good copies;
- Progress, treatment plans, response and changes, medication dosage, timing and usage, anesthesia, patient and family education, and any suspicious or "watch" areas;
- Patient communications and information on missed appointments; and
- Legible contents, dated and signed, with appropriate indication of valid credentials and the correct administration and initialing of any additions, erasures, deletions, or alterations.

It is vital that attributes test one and only one thing at a time and that their definitions do not include words like "if, and, or, but, nor," and so forth.

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;
- Same service not billed multiple times, to multiple carriers, or on multiple dates;
- Dates of service reasonably related;
- Multiple codes not used to describe a service where one code is sufficient;
- Third party and multi-carrier coverage sought, collected, and consistently used;
- No services deleted after billing insurance carriers;
- 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;
- Appointments documented, preferably electronically and tied to claims system;
- Non-client family members not billed for;
- Deceased beneficiaries checked for and not billed;
- Informed consent obtained and documented;
- Treatment not terminated too soon;
- Number of treatments at or just below maximum allowed;
- Treatments and surgeries medically necessary and appropriate;
- Number of hours claimed plausible;
- Generic drugs ordered but not paid at brand-name rates;
- Few resubmitted, re-dated, and recoded claims;
- Single-seat service not spread out over time or across plan years;
- Services billed on same day medically compatible;
- Appropriate number of "comprehensive," "initial," and "new-patient" evaluations;
- Correct timing and clinical sequence of hospice, hospital, rehab, and outpatient services;
- Medical transportation and location match billed services;
- Consultation procedures billed have referring provider information;
- Count and type of labs, drugs, and X-rays appropriate to treatment;
- Service dates match appointment dates and copayment receipt dates; and
- Services delivered are age, gender, and provider appropriate.

Claims Submission Audit—Explanation of Benefits

An Explanation of Benefits (EOB) is a written provider-customer or insurer-customer communication that verifies the nature, scope, timing, and billing of services. When conducting an audit, consider sending an EOB to some of the customers whose claims are in the sample to help determine whether a tested claim is correctly coded for services actually delivered to eligible beneficiaries. Questions that may be answered through this process include:

- How did you hear about us (this provider, practice, or business)?
- Were you out of town on the service date?
- Did you get the services claimed on the date indicated? If so, what do you recall about them?
- Did you get copies of claims, receipts, or bills?
- Were fees discussed?
- How much were any copayments collected for the date(s) of service in question?

CMS has developed models and a single integrated template for Medicare-Medicaid EOB data gathering. For details, search for "integrated EOB" at https:\\www.cms.gov on the CMS home page.

Claims Submission Audit—Interviews

Good interviews can corroborate evidence gathered during a claims review and may come from beneficiaries, medical professionals, claims administrators, and others as project and test objectives might dictate. Depending on the party being interviewed, best practices often include:

- Contact the interviewee soon after a service, preferably within 60 to 90 days;

- Address language and culture barriers;

- Explore any indication of doubt that some or any of the services were provided;

- Ask about anesthesia, medications, or equipment used as part of the service; and

- Ask about processes requiring multiple visits or procedures and how long they took.

Patients who realize they paid for something they did not get will often be eager to help.

Document, Document, 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).

Good interviews can **corporate** evidence gathered during a claims review and may come from **beneficiaries, medical professionals, claims administrators, and others...**

Documentation should provide "reasonable assurance that the evidence is sufficient and appropriate to support the auditors' findings and conclusions."[21, 22] 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.[23] 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.

Review and Act on the Results— General View

Follow these steps after audit work:

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.

Review and Act on the Results—Monitoring and Measurement

Tracking progress toward controlling business and overpayment risk is both an important and frequently ignored post-audit step. After all, if you do not monitor and measure such things as error counts, error rates, and dollars paid in error or placed at risk by inadequate compliance or control, you do not know whether post-audit changes have the desired effect.

A tracking matrix for either a single control area or the whole business operation might be like that shown in Table 4. Metrics for Monitoring. In this example, we assume that 40 claims that contained a total of 80 line-item details covering 20 beneficiaries and $1,000 worth of business were tested.

Table 4. Metrics for Monitoring

Variable	Number Sampled	Error Count	Error Rate
Claims	40	1	2.5%
Line Items	80	3	3.75%
Beneficiaries	20	1	5%
Dollars	$1,000	$250	25%

Note that the errors, whatever they might be, seem localized to one beneficiary. The errors are relatively insignificant from a control perspective but are rather material in dollar terms. Remember to consider both significance and materiality in the risk assessment and the related audits. When doing random sampling, extrapolate the results to get a good idea of what the overall risk looks like. While there are many ways to do this, a basic approach is:

$$\frac{\text{Items in Error X Items in the Population}}{\text{Items Sampled}}$$

Analyze results in terms of:

1. Error rates and error counts to determine the extent of sampling and testing, that is, to determine the error rate used to set future sample size.

2. Procedure codes in error to see which procedures are most error-prone.

3. Why codes are in error, that is, the actual and specific reasons a test fails, to increase chances of testing attributes most likely to generate errors.

Doing these three things helps determine if you are: (1) testing enough; (2) testing the right claims; and (3) testing the right attributes. If you stop finding errors, you may have addressed the issue and may be able to shift resources to look somewhere else!

Review and Act on the Results—Self-Disclosure

How should possible fraud or material noncompliance with Medicaid requirements be dealt with? An excellent option is using the OIG Self-Disclosure processes described at http://oig.hhs.gov/compliance/self-disclosure-info/index.asp on the HHS-OIG website. In general terms, self-disclosure provides an opportunity to demonstrate good faith and a robust, effective compliance program.

Self-disclosure to HHS-OIG has potential benefits, such as:

- Lower damages amounts than are sought in a government-initiated investigation;
- Less potential exposure under False Claims laws; and
- Possible release from permissive exclusion and corporate integrity measures.[24]

If improper claims for Federal health care dollars are disclosed to HHS-OIG, return any overpayments and conduct a review to estimate the improperly paid amount and prepare a report of findings that follows OIG requirements. The review may be based on either a census or a random sample of at least 100 of the claims. More information on HHS-OIG's process is in the April 2013 update of OIG's Provider Self-Disclosure Protocol.[25] Note that self-disclosure information can be submitted to HHS-OIG online, by mail, or by fax, but it should not be reported to the OIG Hotline.[26] No matter how you approach self-disclosure, remember you are required by law to return identified overpayments.[27]

Another option is to contact your State Medicaid agency or Medicaid Fraud Control Unit. For a link to the contact information, visit http://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforconsumers/report_fraud_and_suspected_fraud.html on the CMS website.

Where Can You Get Assistance?

Many resources exist to help design and execute an audit, such as:

- Generally Accepted Government Auditing Standards (Yellow Book) and other publications from the Government Accountability Office;
- State Office of Program Integrity/Inspector General or State Medicaid Fraud Control Unit; and
- State Medicaid agency.

You might also mine HHS-OIG work plans, U.S. Department of Justice cases, and OIG/CMS/Recovery Audit Contractor (RAC) reports to identify emerging risk areas.

Professional resources include:

- Other providers' compliance programs;
- An audit entity;
- Auditing, accounting, and legal firms with a health care specialty;
- State Board of Accountancy;
- Local chapter of AICPA or Institute of Internal Auditors (IIA); and
- Association of Certified Fraud Examiners.

You may also want to:

- Share information and detection methods, and check electronic mailing lists and blogs;
- Leverage and share best practices with other practitioners and health care professionals;
- Find out what your vendors are doing to control fraud, waste, and abuse and engage them;
- Get beneficiaries to be your eyes and ears;
- Use office staff to routinely scan risks to save time and make them better managers; and
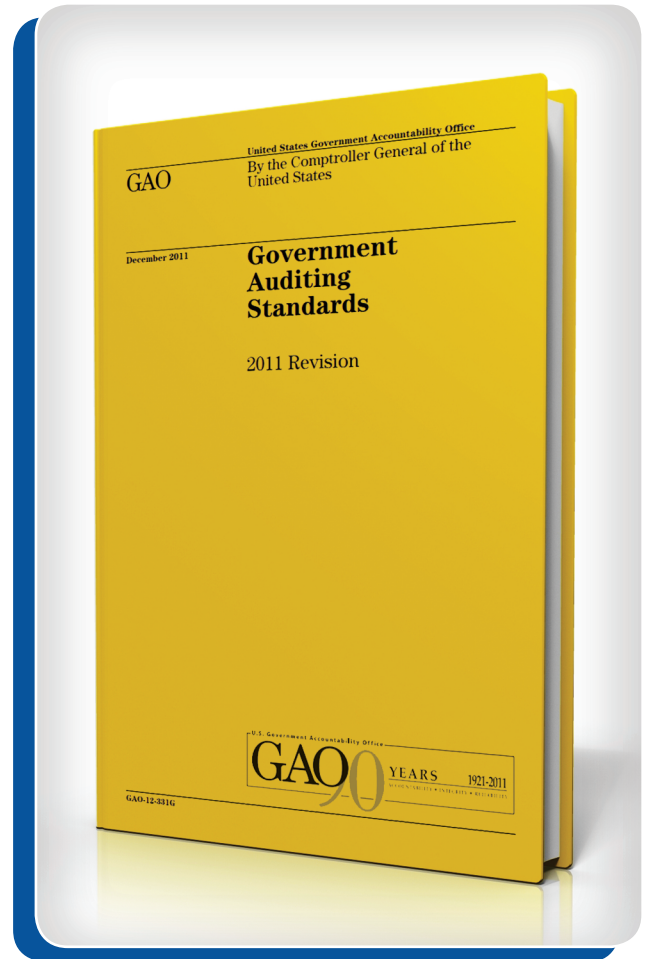- Stay current on regulatory and policy changes.

Assess and audit risks regularly and often and then use what you learn to improve your business and institutionalize a culture of compliance. The greater the effort now, the lower the cost later, for you, your business, the Medicare and Medicaid programs, and their customers and beneficiaries.

Questions?

Please direct questions or requests to: MedicaidProviderEducation@cms.hhs.gov

To see the electronic version of this booklet and the other products included in the "Audit" Toolkit, visit the Medicaid Program Integrity Education page at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

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