SANCTIONS FOR PROVIDER MISCONDUCT FACT SHEET

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A self-audit is an audit, examination, review, or other inspection performed by and within a physician's or other health care professional's business. Self-audits generally focus on assessing, correcting, and maintaining controls to promote compliance with applicable laws, rules, and regulations. The U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG), includes periodic internal monitoring and auditing in its list of the seven elements of an effective compliance program.[1]

States may require provider self-audits as a way to identify additional overpayments. For example, New Mexico uses provider self-audits to capture more improper payments than program integrity staff could do through State-initiated audits and investigations.[2] A self-audit is a useful tool for providers in reducing noncompliance. Self-audits can help:

- Reduce fraud and improper payments;
- Improve patient care;
- Lower the chances of an external audit; and
- Create a robust culture of compliance.

HHS-OIG recommends providers start with a baseline audit of the claims development and submission process.[3] The audit should cover a period of at least 3 months and include a random sample selection of between 5 and 10 Medicaid records per professional who bills Medicaid services.[4] Helpful details on how to collect a statistically valid random sample are set forth in HHS-OIG's Provider Self-Disclosure Protocol.[5] A designated staff member who understands documentation and coding principles should then review the sample claims and medical records "for compliance with applicable coding, billing and documentation requirements." The professional who rendered the care should not review his or her own records. Providers should use the results of the baseline audit to identify the areas that should be the subject of ongoing monitoring and periodic self-audits.[6]

In the course of a self-audit, if a provider uncovers possible fraud or material noncompliance with Medicaid requirements, they should self-disclose the information. Many States offer provider self-disclosure protocols.[7, 8] Another option is the OIG self-disclosure process posted to https://oig.hhs.gov/compliance/ self-disclosure-info/ on the HHS-OIG website. Potential benefits of self-disclosure may include lower damage amounts than are sought in government-initiated investigations, less potential exposure under False Claims laws, and possible release from exclusions and corporate integrity measures.[9] Under the OIG self-disclosure process, if providers find improper claims for Federal health care dollars, they must return any overpayments within 60 days of identification and conduct either a census or a random sample of 100 claims.[10] Providers can submit self-disclosure information to HHS-OIG online, by mail, or by fax, but they should not report it to the OIG Hotline.[11]

For More Information

For more information on self-audits, see the "Self-Audit" document posted to https://www.cms.gov/MedicareMedicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website. The electronic version of this and other documents and additional program integrity information can also be found there.

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