

FLORIDA MEDICAID PROVIDER SELF AUDIT PROTOCOL

1. Introduction.

The purpose of this Protocol is to provide guidance to providers regarding self audits. Self audits may be performed either:

- (a) voluntarily by a provider, unsolicited by the Agency for Health Care Administration (Agency), or
- (c) in response to a request by the Agency pursuant to an amnesty program under Section 409.913(25)(e), Florida Statutes (F.S.).

The Agency's process for validating a self audit shall be consistent regardless of the means by which the self audit was initiated. Self audits will be forwarded to the Office of Inspector General, Bureau of Medicaid Program Integrity (OIG/MPI) for analysis, validation, and acceptance.

- a. **Voluntary self audits.** A provider has an obligation to ensure that claims submitted to the Medicaid program are proper. 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 state. Providers should return the improper amounts to the Agency along with supporting information that will allow OIG/MPI to validate the overpayment amount. Examples and an explanation of the necessary supporting information are set forth in this protocol.
- b. **Amnesty programs.** The Agency recognizes that by conducting a self-audit, a Medicaid provider has more control over the parameters of the audit; also, the process is generally more educational for the provider, which results in a greater likelihood of future compliance, and less opportunity for future overpayments and sanctions; the expense of the audit process is generally less for the provider who conducts a self-audit, as opposed to when the Agency conducts the audit and investigative costs are recovered.

Furthermore, Section 409.913, F.S., obligates the Agency to impose a sanction on providers when the Agency has discovered certain specified violations of Medicaid laws, including the laws governing the provider's profession. These sanctions are imposed in accordance with Rule 59G-9.070, F.A. C. (Administrative Sanctions of Providers, Entities and Persons). Section 409.913, F.S., however, also authorizes the Agency to institute amnesty programs, wherein Medicaid providers may repay an overpayment without sanctions being imposed.

Therefore, pursuant to Section 409.913(25)(e), F.S., the Agency may provide opportunities for providers to conduct self audits. Providers will receive notice from the Agency of a specific matter to be addressed via the self audit, along with

other pertinent audit parameters (time period for review, specific claims to review, etc.) and will be afforded a specified period of time in which to conduct the self audit. Providers who avail themselves of this opportunity within the timeframe afforded by the Agency will benefit from the amnesty provisions. Providers who do not avail themselves of this opportunity will be subject to audit by the Agency, and will be subject to sanctions that may follow as a result of violations discovered during the audit.

2. Notice of Intent to Conduct a Self Audit.

To assist the Agency in expediting its review and verification of a self audit providers are requested to first advise the Agency of the intent to conduct a self audit. Providers who are voluntarily conducting a self audit should first contact MPI to advise the Agency of the intent to conduct a self audit; all others should follow the instructions in the notice from the Agency. Unless otherwise agreed upon, submissions to OIG/MPI should be directed to:

Agency for Health Care Administration
Bureau of Medicaid Program Integrity
Attention: Special Audit Coordinator
2727 Mahan Drive, MS 6
Tallahassee, Florida 32308

3. Self Audit Work Plan.

Following the notice of intent to conduct a self audit, a provider should submit an audit work plan for review by the Agency. An audit work plan advises the Agency regarding whether the provider intends to conduct a review of particular issues or all aspects of the provider's practice. The work plan specifies the methodology by which the provider will conduct the audit and the timeframe within which the provider expects to complete the audit. By submitting the work plan prior to conducting the audit, the provider can coordinate with the Agency to develop an acceptable methodology prior to expending the time and resources to conduct the audit.

Self audits should consist of either a 100 percent claim review (a census review) or a review utilizing sampling.

- a. **Option 1 (100 Percent Claim Review, a Census Review):** A provider may identify actual inappropriate payments by performing a 100 percent review of claims.
- b. **Option 2 (Sampling):** A provider may identify and project inappropriate payments pursuant to a detailed work plan submitted to the Agency for approval. The review may consist of a statistically valid random sample of the claims that can be projected to a population of claims affected by the audit findings for the relevant period. The provider may use simple random sampling, cluster sampling,

or two-stage cluster sampling, as appropriate. If the provider generates the data, it must be consistent with the criteria utilized by the Agency in conducting audits, must be presented in a fashion that is readily reviewable by the Agency and must be compatible with Agency systems. Further explanation regarding sampling can be obtained by contacting the OIG/MPI Special Audit Coordinator. *A confidence level of 95 percent must be used.* Additionally, the provider may coordinate with OIG/MPI to use OIG/MPI programs to generate the sample.

The work plan should identify:

- a. The subject of the review (e.g., audit period and claims/procedure codes under review);
- b. The population of claims or recipients that will be reviewed with an explanation of the methodology used to develop the population and the basis for this determination;
- c. The point of contact (including contact information) for questions by the Agency regarding statistics (if utilized) and clinical/medical issues.

If the review will be based upon a sample, the work plan should also include the sampling plan as follows:

- d. Sample Size: Include a description of the sample, indicating the number of recipients and number of claims in the sample, and the total amount of the payments received for all claims in the sample. The minimum sample size is as follows and should only be deviated from in consultation with OIG/MPI:
 - i. Cluster samples: 40 or greater, with at least 150 claims in the clusters.
 - ii. Two-stage cluster samples: 30 or greater, with at least 250 claims in the clusters.
 - iii. Simple random samples: at least 150 claims.
- e. Sample Design: The work plan should describe the method of sampling (simple random sample, cluster, two-stage cluster), with a brief statement indicating why that method was selected.
- f. Characteristics Measured in the Sample: Identify the characteristics to be measured for each sample item. In a sample drawn to estimate the value of overpayments due to duplicate payments, the characteristic to be measured is the overpayment resulting from a duplicate payment. Criteria must be established to form the basis for determining when an overpayment exists. If a duplicate payment exists, the amount of the duplicate payment is the amount of the overpayment. The plan must contain decision rules to be used in determining whether the sample element meets the criteria wholly, in part or not at all.

The final overpayment calculation may not use apparent underpayments to reduce or offset overpayments owed to the Agency.

4. Self Audit Submission.

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, the Agency needs the following information:

a. Provider information:

- (1) Name;
- (2) Address;
- (3) Provider type;
- (4) Provider identification number(s);
- (5) Tax identification number(s);
- (6) Name, address, and telephone number of the designated contact for the provider regarding the self audit.

b. Claim information (for the claims reviewed; either all claims in a 100 percent review or the claims in the sample):

- (1) Date of Service;
- (2) Type of Service (e.g., procedure code);
- (3) Treating Provider;
- (4) Pay-to-provider;
- (5) Date the claim was paid;
- (6) Internal control number (ICN);
- (7) Description of the non-compliance¹;
- (8) and, any other information that would allow the Agency to verify the claim(s).

c. Audit methodology:

The provider should submit a detailed description regarding the audit methodology that was actually used. [Note: the work plan detailed the *intended* methodology; the audit submission should detail the *actual* methodology] If the review was based upon a sample, the report should also include the following:

- (1) Sample Size: (see above for further details);
- (2) Random Numbers: The sample must be selected through random numbers and include a description of how the random numbers were generated;
- (3) Sample Design: (see above for further details);

¹ Descriptions may included such issues as "services not rendered", "up-coding", "brand drugs for generics", "unqualified staff performing service", "incorrect dates of service", "incorrect recipient", "duplicate services", "unbundling", "services not documented", etc.

(4) Characteristics Measured in the Sample: (see above for further details);

(5) Missing Sample Items: Where documentation for a sample item (claim) is not available, the claim can not be substituted and should be recorded as an overpayment.

d. Overpayment calculation:

The provider should submit a final overpayment amount that is due to the Agency along with a detailed explanation regarding how that amount was calculated. The final overpayment calculation may not use apparent underpayments to reduce or offset overpayments owed to the Agency. A self audit completed using sampling must include an overpayment extended to the population using generally accepted statistical methods. OIG/MPI will assist the provider in calculating the overpayment using the method of extending to the population used by OIG/MPI.

e. Certification:

Upon completion of the self-audit, the provider must submit to the Agency, a statement indicating that the report contains truthful information and is based on a good faith effort to assist the Agency in making a final overpayment determination.

5. Agency Verification:

The extent of the Agency's 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; the Agency will work closely with providers to answer any questions that they may have. Providers or their representatives that have questions regarding this protocol may contact the provider self-audit coordinator, whose name and contact information is included in the letter that initiated the self-audit or was identified following the provider's notice of intent to submit a self audit.

Upon completion of the Agency's review of the self-audit, the audit will either be accepted or declined. Accepted audits will result in the issuance of a final agency action letter stating the amount of money to be repaid and providing repayment instructions.

Audits that are not accepted will be returned to the provider for corrections, with an explanation regarding why the audit could not be accepted. Audits that are declined more than once may result in the Agency conducting an independent comprehensive audit that may also result in the imposition of sanctions.

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