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

What Is a Self-Audit, and Why Does It Matter?

A self-audit is an audit, examination, review, or other inspection performed both by and within a given health care practice or 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) advises periodic internal monitoring and auditing among its list of the seven elements of a sound compliance program. Self-audits can help: (1) Reduce fraud and improper payments; (2) Improve patient care; (3) Lower the chances of an external audit; and (4) Help create a robust culture of compliance.[1]

Step One–Identify the Risks

Regardless of the method, a risk assessment seeks measureable answers to two key questions:

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

A risk assessment is only as good as its inputs. So, choose the group of people participating in the risk assessment thoughtfully from among such functions as:

- Medical and nursing services, including ancillaries (for example, pharmacy, laboratory);
- Patient financial services (for example, billing, chargemaster, accounting, budget, administration);
- Health information technology and quality management; and
- Legal, audit, and compliance services.

Risk assessments often use a scoring process to consider the relative significance and materiality of identified risks. There is flexibility to choose from the risk scoring system, as long as it is well-defined and consistently used. A basic scoring model like the following can be quite effective:

- High (3)–risks that repeat, are hard to detect, likely to occur, or of significant impact;
- Medium (2)–risks occurring less often but which are still difficult to detect; or
- Low (1)–risks that are unlikely or of small potential impact.[2]

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

Step Two–Audit the Risks: Review Standards and Procedures

The second step is to examine and assess the effectiveness and use of standards and procedures that define appropriate behavior, like policy manuals, financial procedures, compliance training, reporting mechanisms, vendor and staff screening, and coding practices.[3] Use direct observation and apply suitable criteria to "test" whether controls function as intended, focusing first on higher-scored risks and how well they have been addressed in the past. Weaknesses found in this step can give valuable direction when deciding which claims to audit.

Step Three–Audit the Risks: Review Claims

Claims audits involve reviewing bills and medical records "for compliance with applicable coding, billing, and documentation requirements … ideally [to] include the person in charge of billing … and a medically trained person (e.g., registered nurse or preferably a physician)."[4]

A basic guide for the number of claims to test is "five or more medical records per Federal payer (i.e., Medicare, Medicaid), or five to ten medical records per physician,"[5,6] or at least five claims per service type. The American Institute of Certified Public Accountants (AICPA) suggests at least 11 per item type (expecting no errors).[7] Higher risks may suggest using a larger sample.

Determining sample size should not be a barrier to starting the audit process. Even starting out small is a good control and can demonstrate a commitment to compliance. While claims can be chosen judgmentally, random sampling enables projecting error rates and improper payment amounts to the relevant population. Regardless of the sampling method, it is best if those involved in delivering or administering the sampled items not select them for audit. Also, usual and customary practices and processes are often best represented if neither the time period covered by the sampled claims nor the schedule of audit work is announced in advance.

Look at the claims with the greatest volume, value, or error likelihood first. Look where you have looked before, at least a little bit, to keep fraudsters on their toes. This also helps determine if problems you thought you addressed are actually fixed.

How Do I Test a Claim?

The general attributes to test for when examining claims 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

HHS-OIG has published practice-specific criteria for individual and small group physician practices.[8] Criteria are also available from professional associations. Tally the results of applying each criterion to individual records, claims, or details as a simple checklist. Marking errors with a "1" and non-errors with a "0" makes tallying results fast and easy. To ensure that attributes test one and only one thing at a time, do not use words like "if, and, or, but, nor" and so forth in their definitions.

More specific things to look for are:

- Evidence of good data integrity, like a general lack of blanks, zeroes, unreasonable values, edits, and duplicate entries;
- 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;
- Legible contents, dated and signed with appropriate indication of valid credentials, and the correct administration and initialing of any additions, erasures, deletions, or alterations; and
- Reasonable and appropriate patterns and relationships among vendor, provider, and beneficiary demographic and geographic characteristics.

Step □our–Do□ume□t □Do□ume□t □Do□ume□t the Audit

Good audit documentation will create an accurate, complete record of your efforts to collect risk data, address risks, and prevent and remedy improper payments. □ou want your documentation to include enough information to convince an interested but uninformed third party that the findings, conclusions, and assertions in the audit are reasonable and to demonstrate that the process used to reach them is reasonable.

Step □ive–Review□A□t o□□a□d Measure the Results

After the audit, review and prioritize audit results; revise your risk assessment, processes, policies, and controls, as needed; document your changes; and then train and educate those individuals whose work is affected by audit findings. Tracking progress toward controlling risk is an important, yet often overlooked, post-audit step. If you do not track corrective actions, you do not know whether new controls are working. □se both numbers and percentages to monitor error counts, error rates, and dollar amounts paid in error. If sampling randomly, results can (and should) be projected to the population. Many ways to do this exist, but a basic approach is:

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

Remember, if you stop finding errors, you may be able to shift resources to look somewhere else□

Sel□Dis□losure

If you find possible fraud or material noncompliance with Medicaid requirements, you should strongly consider self-disclosure. One option is the OIG self-disclosure process described at http:□oig.hhs.gov□compliance□self□disclosure□info□index.asp on the HHS-OIG website. Potential benefits of self-disclosure to OIG 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. □nder the OIG self□disclosure process, if improper claims for □ederal health care dollars are found, you must both return any overpayments and conduct either a census or a random sample of 100 claims, as detailed in the April 2013 update of OIG's Self-□isclosure Protocol.[□] □ote 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.[10] Regardless of the self-disclosure approach you use, the law requires you to return identified overpayments.[11]

□ou can also contact your State Medicaid agency or Medicaid Fraud Control □nit. A link to the contact information is available at https:□www.cms.gov□medicare□medicaid□coordination□fraud□prevention□fraudabuseforconsumers□report□fraud□and□suspected□fraud.html on the Centers for Medicare □ Medicaid Services (CMS) website.

Questions?

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

To see the electronic version of this fact sheet 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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