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
(b) 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 the Inspector General/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.

Additionally, self audits conducted on a voluntary basis, upon acceptance by the Agency, shall be included in an amnesty program pursuant to Section 409.913(25)(e), F.S.

2. **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. Billing 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. Claims information (for the claims reviewed):
   (1) Date of Service;
   (2) Type of Service (e.g., procedure code; units of service);
   (3) Treating Provider;
   (4) Recipient Name and ID number
   (5) Internal control number (ICN);
   (6) Description of the non-compliance¹;
   (7) And any other information that would allow the Agency to verify the claim(s).

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.
Self Audit submissions shall be directed to:

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

3. **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.

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.

Provider shall maintain copies of all self-audit information and documentation for future reference.