Medicaid EHR Incentive Program
Auditing

Multi-Regional Meeting - Regions 5 & 7
July 28, 2014
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CMS Audit Resources

• Audit Toolkit
  – Contains six phases of information for states to leverage when planning and executing a state audit program for eligible professionals (EPs) and eligible hospitals (EHs) that are demonstrating Meaningful Use (MU).

• Audit Frequently Asked Questions (FAQs)
  – Audit specific FAQs that are gathered from states directly during the Auditing Communities of Practice (CoP) and/or other methods, and organized in a searchable format.

• Adverse Audit Findings
  – State de-identified audit documentation that illustrates adverse audit findings in different states. Located within the Audit Toolkit, documentation is organized into folders based on the adverse finding.

• Office of the National Coordinator for Health Information Technology (ONC) Certified Health IT Product List (CHPL)
  – Tool that allows for searches for certified complete Electronic Health Record (EHR) products or modules by entering a CMS certification number to conduct a search, or browse all products at once.
Audit Strategy Matrix

• CMS Audit Strategy Tracking Tool
• Specific criteria for review of state Audit Strategies
• Additional criteria added as of January 2014
  – primarily pre-payment review criteria
• States can use the criteria in the matrix when developing your next Audit Strategy Update
## Audit Strategy Matrix

### Evaluation Criteria

<table>
<thead>
<tr>
<th>Who conducts Eligible Hospital (EH) Meaningful Use (MU) audits?</th>
<th>Audit Document Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-payment Patient Volume (PV) Verification*</td>
<td>Field Audit Triggers</td>
</tr>
<tr>
<td>Pre-payment Certified EHR Technology (CEHRT) Verification*</td>
<td>How report audits to CMS</td>
</tr>
<tr>
<td>Pre-payment MU Verification*</td>
<td>Who conducts appeals?</td>
</tr>
<tr>
<td>Number of Staff Reviewing Pre-payment*</td>
<td>Does the SMA have an All-Payer Claims Database (APCD)?</td>
</tr>
<tr>
<td>Provider Letter Template*</td>
<td>Automated interfaces to Public Health Association (PHA)</td>
</tr>
<tr>
<td>Audit Checklist*</td>
<td>How you receive documentation from providers</td>
</tr>
<tr>
<td>How many risk categories?</td>
<td>How do you store audit documentation?</td>
</tr>
<tr>
<td>Audit selection % by risk category</td>
<td>Recoupment process</td>
</tr>
<tr>
<td>Audit All or Questionable</td>
<td>Risk factors or categories for MU</td>
</tr>
</tbody>
</table>

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Audit Strategy Matrix Findings

Audits Done by State Medicaid Agency (SMA) or Contractor

- In house (SMA) 35%
- Vendor 55%
- Combination 10%

Who Conducts EH Audits

- Dual - CMS; Medicaid Only - CMS 45%
- Dual - SMA; Medicaid Only - SMA 10%
- Dual - CMS; Medicaid Only - CMS 45%

Audit Strategy Findings

How Many Risk Categories
- None 6%
- 4 or more 42%
- 3 or less 52%

Audit Selection % by Risk Category
- Not Identified (3%)
- No (26%)
- Yes (71%)
Audit Strategy Matrix Findings

What Triggers a Field Audit

- Adverse Desk Audit: 77%
- All Audits: 7%
- Target: 16%

Reporting to CMS Research & Support (R&S) User Interface (UI) or E7

- Systematic: 39%
- Manual: 32%
- None: 29%
Medicare Meaningful Use Auditing
Overall

- **CEHRTs ability to produce adequate documentation?**
  - No improvement in CEHRTs capabilities; still remains difficult to get audit trails, and some CEHRTs are unable to produce detailed reporting (no experience with 2014 Edition CEHRTs).
  - However, there has been improvement in the number and quality of reports produced, largely due to providers’ increased understanding of the program.
Overall

• What does Medicare do when they cannot get sufficient documentation from the provider?
  – The EP/EH fails the audit.

• What does Medicare do when the provider cannot recreate the data submitted in their attestation?
  – If the documentation they are able to produce meets the threshold, the changes are noted in the audit and the provider meets the requirements. (The Medicare system does not facilitate a corrected attestation or re-attestation).

• How does Medicare verify the Clinical Quality Measures (CQMs)?
  – The Auditors do not verify the CQMs; the system’s front end edits do the verification.
EP Core Measures

- **EP Core Measure 2 - Drug Interaction Checks**
  - This measure is often difficult to verify; often see screen shots (beginning of reporting period and end of reporting period); audit trails showing the function is enabled would be best, but very few audit trails can be produced.

- **EP Core Measure 4 – e-RX**
  - While the ability to verify this measure has improved over the past year, this measure has been problematic. They usually get reports with the number of scripts. They have not seen exclusions based on the 10 mile radius exclusion.
EP Core Measures

- **EP Core Measure 11 - Clinical Decision Support Rules**
  - This measure is slightly difficult to verify, although generally not a big problem. Most of the verification is done via screen shots. The ideal verification tool would be an audit trail, but very few audit trails have been produced.

- **EP Core Measure 12 - Electronic Copy of Health Information**
  - It is difficult to verify the number of patients who have requested an e-copy. While EPs can usually generate a list of who has received e-copies, it is difficult to verify if they have received.
EP Core Measures

- EP Core Measure 13 - Clinical Summaries
  - This has been a problem to verify; very often an appointment log is needed to verify the number of office visits. Sometimes specialists (non-primary care EPs) claim an exclusion.

- EP Core Measure 14 - Electronic Exchange of Clinical Information
  - Generally this measure has not been a problem; it is usually verified with screen shots. Most EPs can generate a copy of what is sent. Sometimes it is difficult to verify if the data is sent to a separate CEHRT; mainly in establishing the CEHRT is a separate legal entity. Verifications are usually generated from CEHRTs fairly easily or the EPs can generate an ad hoc report.
  - This measure was discontinued beginning with program year 2013.
EP Core Measures

- **EP Core Measure 15 - Protect Electronic Health Information**
  
  - This has been the single most failed measure, and although it has improved over the past year, it is still the most problematic. EPs frequently do not understand what is required of the assessment. One of the biggest issues is that they need to implement corrections to any findings resulting from the assessment. They are supposed to implement during the reporting period; although Medicare accepts implementation by the time the audit is done.
EP Menu Measures

• EP Menu Measure 1 - Drug Formulary Checks
  – This measure is similar to Core Measure 2 and is difficult to verify; often see screen shots (beginning of reporting period and end of reporting period); audit trails showing the function is enabled would be best, but very few can be produced.

• EP Menu Measure 7 - Medication Reconciliation
  – This measure is not seen a lot; very few attest to this measure. Those that do attest usually produce sufficient documentation to verify the transitions. It is sometimes difficult to verify the exclusion.

• EP Menu Measure 8 - Transition of Care Summary
  – This measure is not seen a lot; very few attest to this measure. Those that do usually produce sufficient documentation from their CEHRT.
EP Menu Measures

• EP Menu Measure 10 - Syndromic Surveillance Data Submission
  – Not seeing as many of these as the Immunization Registry, but the numbers have been increasing over the last year. As with the Immunization Registry, most EPs either produce a transmission log from the CEHRT or a letter from the agency collecting the data.
STATE OF INDIANA
Partnering with Myers and Stauffer LC

Electronic Health Records
Incentive Payment Audit Strategies

DEDICATED TO GOVERNMENT HEALTH PROGRAMS
AUDIT STRATEGY TOPICS

I. Audit Strategies
II. Significant Findings
III. Lessons Learned
IV. Questions
I. AUDIT STRATEGIES

A. Prepayment Reviews:

All providers register and attest electronically using an interactive web application and are reviewed:

1. The web application performs various eligibility validation tests:
   a) Registered with CMS
   b) Enrolled Indiana Medicaid provider
   c) Status of Eligible Professional (EP) or Eligible Hospital (EH)
   d) Duplicate payment inquiry
I. AUDIT STRATEGIES
A. PREPAYMENT REVIEWS (CONT.)

2. Additional provider eligibility validations are performed

   a) Encounter Volume
      • 30% Patient threshold volume for EP
      • 20% Patient threshold volume for Pediatricians
      • 10% Patient threshold volume for EHs
      • 30% “Needy individuals” volume for Federally Qualified Health Centers (FQHCs) & Rural Health Clinics (RHCs)
I. AUDIT STRATEGIES
A. PREPAYMENT REVIEWS (CONT.)

b) Purchase or licensing of a Certified EHR Technology (CEHRT) for Adopt/Implement/Upgrade (AIU)

c) Review of Provider Licensure and Sanctions

d) Meaningful Use (MU) Measures
I. AUDIT STRATEGIES

B. Post-Payment Reviews:

1. Conducted on a risk-based approach for both EPs and EHs in which the population of providers is stratified into different risk groups.

2. The purpose of the stratification is to identify specific risk factors which are used to categorize each provider into one of the four risk groups for EP reviews (Low, Moderate-Low, Moderate-High and High Risk) and one of three risk groups for EH reviews (Low, Moderate, High).
I. AUDIT STRATEGIES
B. POST-PAYMENT REVIEWS (CONT.)

3. AIU Stratification and Audit Overview

a) EP Stratification:

- Providers are separated into individual and group proxy and are placed in a stratum based on the attested Medicaid encounter volume and by how closely this encounter volume can be correlated to the state Medicaid claims data.
I. AUDIT STRATEGIES

EP STRATIFICATION (CONT.)

• If a provider reported a high Medicaid utilization percentage but this percentage was not able to be verified through the state Medicaid claims data, they are placed in a separate category of “High – Verify” and are subjected to desk review processes.
## I. AUDIT STRATEGIES
### EP STRATIFICATION (CONT.)

<table>
<thead>
<tr>
<th>EP Attested Medicaid Encounter Volume</th>
<th>Provider's Attested Utilization Percentage</th>
<th>Variance of Attested Data to State Claims Data</th>
<th>Resulting Risk Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater than 50%</td>
<td></td>
<td></td>
<td>Low</td>
</tr>
<tr>
<td>41% to 50%</td>
<td></td>
<td></td>
<td>Moderate Low</td>
</tr>
<tr>
<td>35% to 40%</td>
<td>15% or Less</td>
<td></td>
<td>Moderate Low</td>
</tr>
<tr>
<td>35% to 40%</td>
<td>Greater than 15%</td>
<td></td>
<td>Moderate High</td>
</tr>
<tr>
<td>33% to 35%</td>
<td></td>
<td></td>
<td>Moderate High</td>
</tr>
<tr>
<td>30% to 32%</td>
<td>15% or Less</td>
<td></td>
<td>Moderate High</td>
</tr>
<tr>
<td>30%- to 32%</td>
<td>Greater than 15%</td>
<td></td>
<td>High</td>
</tr>
</tbody>
</table>
I. AUDIT STRATEGIES
   EP STRATIFICATION (CONT.)

   • Additional risk factors are used to refine the risk stratification process.
     
     – Providers needing out-of-state Medicaid encounters to meet the minimum threshold are elevated to a **High Risk** category.
     
     – Providers enrolling as a Medicaid provider after the beginning of the EHR program are elevated to a **High Risk** category.
     
     – Providers with a prior adverse audit outcome as determined by the state are elevated to a **High Risk** category.
I. AUDIT STRATEGIES
ADDITIONAL RISK FACTORS (CONT.)

– Pediatricians participating with a reduced encounter volume are elevated to a moderate **High Risk** category.

– Individual provider utilizing multiple locations are elevated to a moderate **High Risk** category.
I. AUDIT STRATEGIES
AIU STRATIFICATION AND AUDIT OVERVIEW (CONT.)

b) EH Stratification:

- Hospitals are stratified based on their reported discharges and acute Medicaid days and is further refined by how closely this patient volume can be correlated to the state Medicaid claims data and submitted cost reports.
  - Hospitals reporting discharges and acute Medicaid days within 4% of the Medicaid encounter claims data as reported by the State’s claims data and their submitted cost reports utilized to calculate the Aggregate EHR Incentive Amount are categorized as Low Risk.
I. Audit Strategies
EH Stratification (cont.)

– Hospitals reporting discharges and acute Medicaid days within 5% and 10% of the Medicaid encounter claims data as reported by the State’s claims data and their submitted cost reports utilized to calculate the Aggregate EHR Incentive Amount are categorized as **Moderate Risk**.

– Hospitals reporting discharges and acute Medicaid days greater than 10% of the Medicaid encounter claims data as reported by the State’s claims data and their submitted cost reports utilized to calculate the Aggregate EHR Incentive Amount are categorized as **High Risk**.

– Hospitals whose Medicare cost report could not be uploaded could not be incorporated into the calculation and are verified manually.
I. AUDIT STRATEGIES
EH STRATIFICATION (CONT.)

• In addition to the reported discharges and acute Medicaid days data, additional risk factors are used to refine the risk stratification process.
  – Providers using less than 4 years of data to calculate the growth factor of the incentive payments calculations are elevated to the high risk category.
  – Hospitals needing out-of-state Medicaid encounters to meet the minimum eligibility thresholds are elevated to the high risk category.
I. AUDIT STRATEGIES
EH STRATIFICATION (CONT.)

– Hospitals with a prior adverse audit outcome as determined by the state are elevated to a high risk category.
I. AUDIT STRATEGIES
   AIU STRATIFICATION AND AUDIT OVERVIEW (CONT.)

   c) Selection of providers for review

      - EP selection for review consists of 100% of the High risk providers. The remaining risk categories contain a sample selected on a random basis.

         - Low Risk: Lesser of 15 Providers or 5% of the strata population
         - Moderate Low: Lesser of 30 providers or 15% of the strata population
         - Moderate High: Lesser of 60 providers or 30% of the strata population
I. AUDIT STRATEGIES
SELECTION OF PROVIDERS FOR REVIEW (CONT.)

• EH selection for review consists of 100% of the High Risk providers. The remaining risk categories contain a sample selected on a random basis.
  – Low Risk: Lesser of 5 providers or 25% of the stratum
  – Moderate Risk: Lesser of 10 providers or 25% of the stratum
I. AUDIT STRATEGIES  
AIU STRATIFICATION AND AUDIT OVERVIEW (CONT.)

d) Desk review notification for AIU

• Sample population is notified and supporting documentation is requested.
  – EP documentation includes: Purchase or licensing agreement of CEHRT and detailed numerator and denominator for encounter volume.
  – EH documentation includes: Purchase or lease agreement of CEHRT and detailed Medicaid encounter and discharge data.
I. AUDIT STRATEGIES
AIU STRATIFICATION AND AUDIT OVERVIEW (CONT.)

e) Review procedures for AIU

- Upon receiving the requested documentation, the following reviews are performed.
  - Recalculation of Medicaid and total encounters
  - Review of the purchase or licensing agreement of the CEHRT
  - Review of Medicaid eligibility
I. AUDIT STRATEGIES
POST-PAYMENT REVIEWS (CONT.)

4. Meaningful Use (MU) Strata and audit overview for EP
   a) The providers are stratified into the four risk categories (Low, Moderate-Low, Moderate-High and High Risk) as they were for AIU with the following additional MU criteria.
I.  AUDIT STRATEGIES
ADDITIONAL MU RISK CRITERIA (CONT.)

• The following criteria would result in the provider being placed in the **High Risk** category.
  
  – 3 or more attempts to enter MU and CQMs to meet minimum thresholds.
  
  – Providers with the same payee identification numbers reporting on 3 or more different meaningful use measures and CQMs.
  
  – Providers with the same payee identification number reporting on more than two different MU measures and CQMs.
I. **AUDIT STRATEGIES**

**HIGH RISK CRITERIA (CONT.)**

– Reporting an exclusion for any meaningful use measure when another provider in the group did not elect the exclusion

– Providers with adverse audit outcomes as defined by the state

– Providers reporting different denominators for the following measures EPCMO3, EPCMO5, EPCMO6, EPCMO7, EPMMUO5, EPMMUO6.

– Any combination of 10 or more Core or Menu measures reported within 3% of the minimum threshold for those measures.

– Reporting zero denominators for all three Core and alternate core CQMs
b) MU Stratification Hierarchy

- A hierarchy of all of the risk factors should be created in order to identify the providers with the highest risk.
  
  - If a hierarchy is not created, the audit population may not be stratified properly and you will find an unreasonable number of providers in the High Risk category. When this happens you will not be able to focus on the truly high risk factors.
  
  - It is important to understand the reasons why providers are meeting certain criteria and if a change in the criteria is necessary.
I. AUDIT STRATEGIES

MU STRATA AND AUDIT OVERVIEW (CONT.)

c) Selection of providers and review type for MU audits.

- Based on the risk stratification, providers are subjected to one of three audit types (On-Site Audit, Desk Review Audit or High Verify Audit).
- On-Site Audits are performed on 100% of the High Risk providers.
I. AUDIT STRATEGIES
SELECTION OF PROVIDERS AND REVIEW TYPE (CONT.)

• Desk Review Audits are selected on a random basis from the risk categories in the following manner.
  – Low Risk: Lesser of 10 Providers or 5% of the strata population
  – Moderate Low: Lesser of 30 providers or 15% of the strata population
  – Moderate High: Lesser of 50 providers or 30% of the strata population
I. AUDIT STRATEGIES
SELECTION OF PROVIDERS AND REVIEW TYPE (CONT.)

• If a provider is in the Low or Moderate-Low category and reported a high Medicaid utilization percentage which could not be verified through the state Medicaid claims data, a High-Verify review is performed.

• Any provider not placed into a category will be defaulted into high risk.
I. AUDIT STRATEGIES
MU STRATA AND AUDIT OVERVIEW (CONT.)

d) Document request

- On-Site and Desk audits: The following is a sample of the items requested for the On-Site and Desk review audits.
  - Detailed encounter listing for the entire practice to support the numerator and denominator utilized in the Medicaid patient volume eligibility attestation.
  - Documentation to support the professional’s affiliation with the locations for which patient encounter volume was reported.
I. AUDIT STRATEGIES ON-SITE AND DESK AUDITS (CONT.)

- A report detailing all encounters occurring at locations where certified EHR technology is being utilized for the 90-day meaningful use period.
- EHR system-generated reports that support all attested responses made for Meaningful Use Core measures, Menu measures, and Clinical Quality measures for the 90-day Meaningful Use period.
- Documentation supporting all reported measures attested to which do not require a numerator and denominator.
- Completed provider questionnaire (Desk Reviews)
I. AUDIT STRATEGIES
DOCUMENT REQUEST (CONT.)

• High-Verify audit: The following is a sample of the items requested for the High-Verify audits.
  – Detailed encounter listing for the entire practice to support the numerator and denominator utilized in the Medicaid patient volume eligibility attestation.
  – Documentation to support the professional’s affiliation with the locations for which patient encounter volume was reported.
I. AUDIT STRATEGIES
MU STRATA AND AUDIT OVERVIEW (CONT.)

e) Audit processes

- Recalculate the patient encounter volume. (On-Site Audit, Desk Review Audit or High-Verify Audit)
- Recalculate the 50% and 80% utilization percentage. (On-Site Audit or Desk Review Audit)
- Verify the MU Core, Menu and CQM results submitted during attestation to the detailed documentation provided in your request. (On-Site Audit or Desk Review Audit)
I. AUDIT STRATEGIES
AUDIT PROCESS (CONT.)

- Provider interview. (On-Site Audit)
- Review responses to Questionnaire. (Desk Review Audit)
- Use the MU stratification to identify areas of detailed testing. (On-Site Audit or Desk Review Audit)
- Perform detailed testing. (On-Site Audit or Desk Review Audit)
- Determine if standard procedures are sufficient. (On-Site Audit, Desk Review Audit or High-Verify Audit)
II. SIGNIFICANT FINDINGS

A. Medicaid Encounter Volume Calculation

1. Unadjusted billing reports
2. Using reports detailing Relative Value Units (RVU)
II. SIGNIFICANT FINDINGS

B. Failure to Maintain Documentation

1. Documentation does not exist
2. No access to detailed documentation
3. Reports have to be run at a subsequent date
II. SIGNIFICANT FINDINGS

C. Reporting Incorrect Patient Volumes on the MU Measures

1. Reporting group MU measure volumes instead of individual EP
III. LESSONS LEARNED

A. Issues unique to an individual state will occur (such as provider billing).

B. A strong prepayment review will reduce post-payment issues.

C. Most providers understand their CEHRT only to the extent that they use it.

D. Difficulties of calculating encounters for Obstetrics and Gynecology (OB/GYN) providers using global delivery codes.

E. The value of interacting with the CEHRT firsthand (including gaining remote access, if possible).
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CMS Regional Office Meeting

Wisconsin Prepayment Validation and Audit Procedures
July 28, 2014
# Overview

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<th>Reference</th>
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<td>Wisconsin Prepayment Validation Process</td>
<td>Slides 3 - 6</td>
</tr>
<tr>
<td>Wisconsin Post-Payment Audit</td>
<td>Slides 7 - 11</td>
</tr>
<tr>
<td>Wisconsin Lessons Learned &amp; Strategies to Address</td>
<td>Slides 12 - 13</td>
</tr>
</tbody>
</table>
WISCONSIN PREPAYMENT VALIDATION
Prepayment Validation Principles

- Establish consistent processes based on the Final Rules and CMS guidance.
- To the extent practicable, automate validation using industry leading practices. Supplement automation gaps with standardized tools.
- Collaborate with providers and application preparers to obtain additional information.
- Minimize audit findings by applying lessons learned.
- Validate applications in a timely manner.
Prepayment Validation Review

Eligible Hospitals

Automated Validation:
- Wisconsin Medicaid enrolled
- Current or pending sanctions
- CMS Electronic Health Reporting (EHR) Certification ID
- Meaningful Use Measures (Dually Eligible Hospitals)
- Duplicate payments

Manual Validation:
- Patient Volume
- Cost Report Data
- Meaningful Use Measures (Medicaid Only Hospitals)

Eligible Professionals

Automated Validation:
- Wisconsin Medicaid enrolled
- Current or pending sanctions
- CMS EHR Certification ID
- Duplicate payments

Manual Validation:
- Patient Volume
- Meaningful Use Measures
Wisconsin developed procedures and tools to increase the efficiency, consistency, quality, and timeliness of manual prepayment validation activities.
WISCONSIN POST-PAYMENT AUDIT
Overview of Profiling Activities

• Purpose
  – Systematically identify high risk providers

• Process
  – Identify providers meeting criteria for each risk factor
  – Calculate a risk score and ranking
  – Audit providers with high risk scores

• Data Sources
  – Medicaid Management Information System (MMIS) fee-for-service claims data
  – MMIS HMO encounters
  – MMIS provider data
  – MMIS financial data
  – Adjusted clinical grouper morbidity score
  – Medical Assistance Provider Incentive Repository (MAPIR) data
  – CaseTracker audit data
Risk Profiler Tool

- Risk Profiler report run quarterly
- Incorporates data from several other sources:
  - MAPIR
  - Department of Social Services (DSS)
  - MMIS
  - Case Management Software
- Fifteen risk factor categories are assigned weights and evaluated
- Total score identifies relative risk of potential overpayment
- Detailed information relevant to each flagged risk factor is displayed on the report
EHR Meaningful Use (MU) Risk Profiler

Dr. John Doe
123 Main Street
Madison, WI 53711

Score: 21.00

<table>
<thead>
<tr>
<th>NPI</th>
<th>Provider ID / Group ID</th>
<th>Payee Name</th>
<th>PT/SPC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0123456789</td>
<td>0123456789/9876543210</td>
<td>General Clinic</td>
<td>31/311</td>
</tr>
</tbody>
</table>

Rank: 1

Patient Volume Period: 01/03/2012 - 04/01/2012
Payment Date: 08/02/2013
Program Year: 2013
Audit Operations

• Use Risk Profiler to identify Eligible Professionals and Hospitals for audit
• Audit documentation collection process
• Desk review
• Field review
• Audit findings
• Lessons learned
WISCONSIN LESSONS LEARNED & STRATEGIES TO ADDRESS
**Lessons Learned & Strategies to Address**

<table>
<thead>
<tr>
<th>Lessons Learned</th>
<th>Strategies to Address</th>
</tr>
</thead>
</table>
| Patient Volume is a complex eligibility requirement for new and returning Eligible Professionals. | • Prepayment validation review  
  • Patient Volume tools, webinars                                           |
| Medicare cost report data for Eligible Hospitals can change between Program Years. | • Prepayment validation review  
  • Frequently asked questions tipsheet                                       |
QUESTIONS?