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Best Practices for Handling Medicaid Audits

2026 OPRA Business Operations Committee |
July 15, 2026

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Agenda

- Introduction to Medicaid Payor Audits
- Auditor of State Audit Process
- Recent Trends in Ohio Auditor of State Audits
- Frequently Asked Questions
- Best Practices

Introduction to Payor Audits

What are they and who conducts them?

What is a Payor Audit?

- A systematic review of healthcare claims, medical records, and billing practices to review:
  - Accuracy of claim coding
  - Medical necessity of services rendered
  - Proper documentation standards
  - Appropriate reimbursement
- The goal is to identify patterns of non-compliance to determine overpayments as well as potential fraud

What Triggers an Audit?

- A provider can be audited **at any time** and **for any reason.**
- Common triggers include:
  - Outlier statistics based on billing practices compared to peers
  - High volume of billing of specific codes or procedures
  - Previous issues or patterns of concern
  - Data analytics that identify anomalies
  - Whistleblower complaints
  - Random statistical sampling

Types of Payor Audits

Prepayment Audits

- Review before claim payment
- Delays cash flow

Post-Payment Audits

- Review after claim payment
- Results in recoupment
- Targeted or random
  - Focus on services, codes, or diagnoses
  - Random sampling

Who Conducts an Audit?

- DODD and County Board Compliance Reviews - *New* State claims reviews to coincide with Compliance Reviews starting August 1, 2026
- Ohio Department of Medicaid – Bureau of Program Integrity
- The Ohio Auditor of State
- Medicaid Fraud Control Unit (Ohio Attorney General's Office)

Who Conducts an Audit
Ohio Auditor of State

- The Auditor of State works in conjunction with ODM to conduct compliance examinations within the Ohio Medicaid Program
- The Auditor of State generally tests service documentation, service authorization, and personnel qualifications for compliance with state and federal statutes and rules as well as for compliance with the regulations and polices established by ODM
- The Auditor of State's goal is to identify whether any improper Medicaid payments exist

Audit Process

What does an audit look like in practice?

Audit Process and Timeline

- Depends on the type of audit and who is conducting the audit
- Generally, includes the following steps:
  - Notification
  - Documentation Request
  - Documentation Submission
  - Auditor's Initial Findings
  - Auditor's Final Determination
  - Chapter 119 Hearing

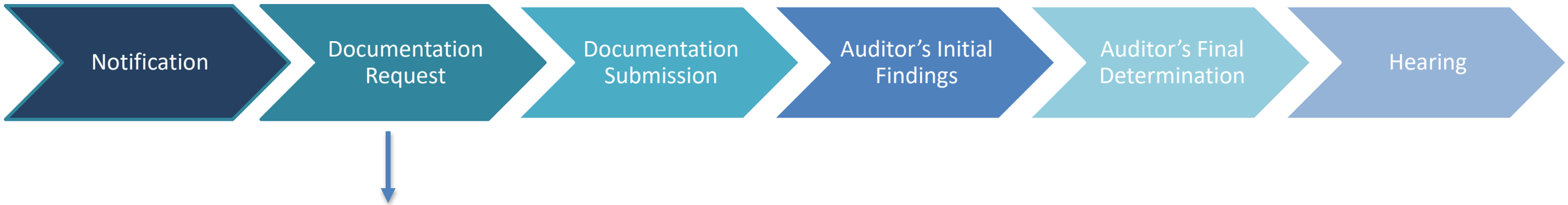
Audit Process

- Medicaid audits are commonly conducted by the Auditor of State (generally referred to throughout this presentation as the “Auditor”)
- The goal is to audit provider documentation and billing practices to ensure that funds are spent in a lawful and appropriate manner

Notification

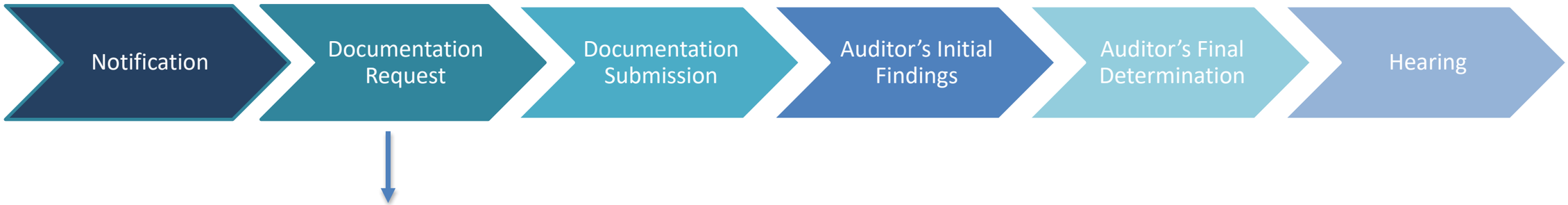
- Auditor notifies provider of selection for audit.
- What to do?
  - Do not panic
  - Review the notification for deadlines and specific records being requested
  - Engage counsel for assistance
  - Respond in a timely and professional manner

Documentation Request



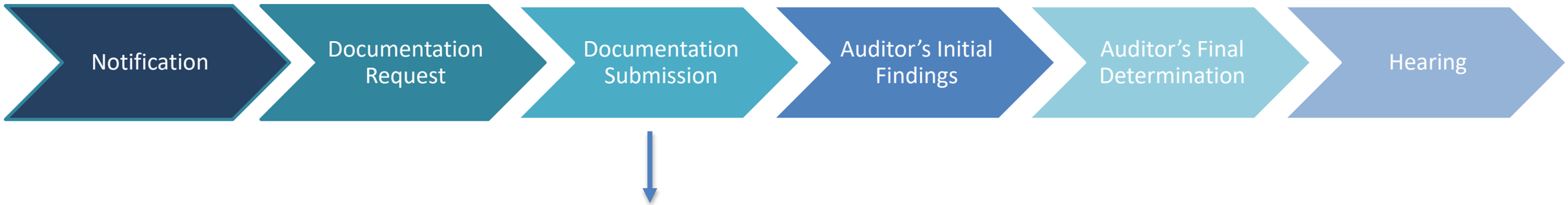
- The number of records requested can be voluminous
- Provider is given a deadline to gather and produce records
  - The Ohio Auditor of State generally afford providers 30 days to produce records
  - While providers can request extensions, these are not always granted

Documentation Request



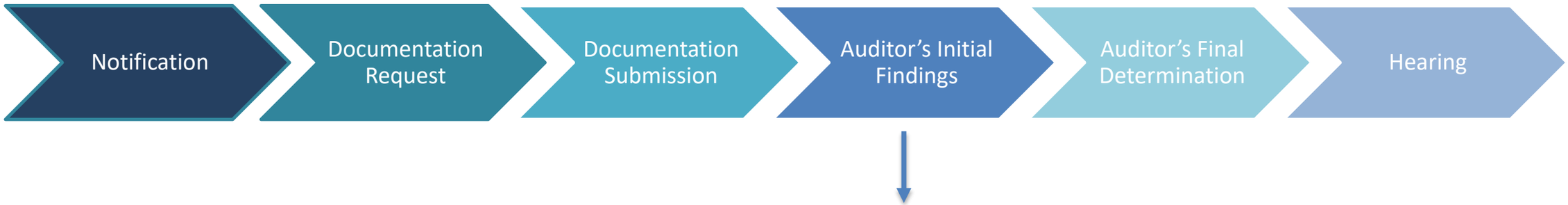
- Review documentation to preemptively determine whether there are compliance gaps
- Produce documents in accordance with the Auditor's specifications
- Organization is key
- What should Provider's goal be when complying with the Auditor's request for records?

Documentation Submission / Investigation



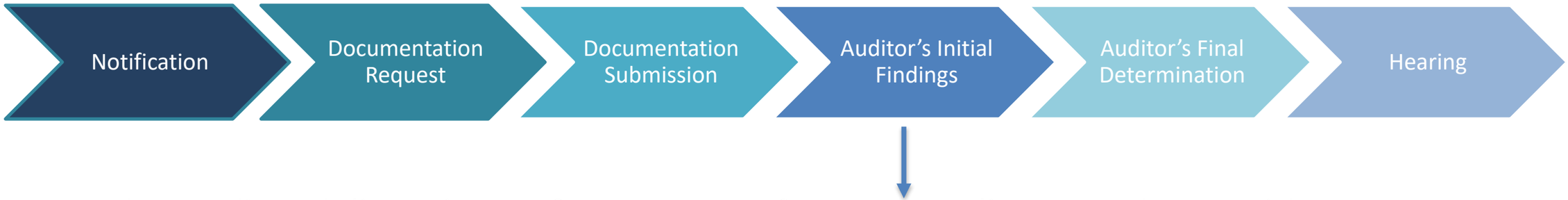
- Waiting for the Auditor to finish reviewing documents
  - This can be a long process
- Address any pre-emptive compliance gaps
- Begin crafting arguments to defend any compliance gaps
  - Be creative

Auditor’s Initial Findings



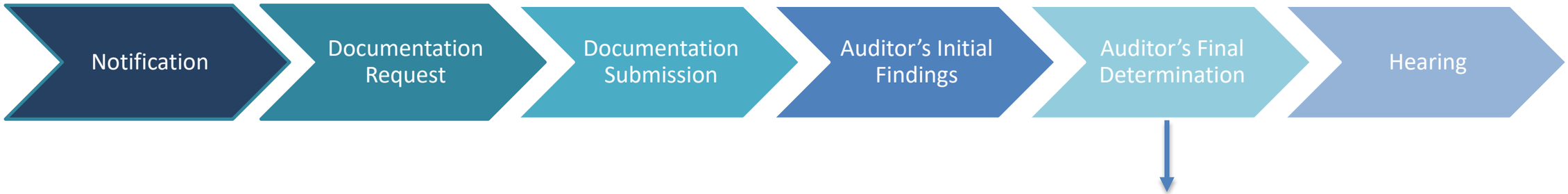
- Work with counsel
- Review findings and documentation
- Craft arguments to challenge findings
- Draft response to findings

Auditor's Initial Findings



- The Auditor delivers its Draft Summary of Non-Compliance to the provider
- Provider is granted five business days to submit additional relevant information that would address any areas of non-compliance
- This is Provider's:
  - Final opportunity to submit new documentation; and
  - First opportunity to make legal arguments.
- What should Provider's goal be when responding to the Auditor's draft summary of non-compliance?

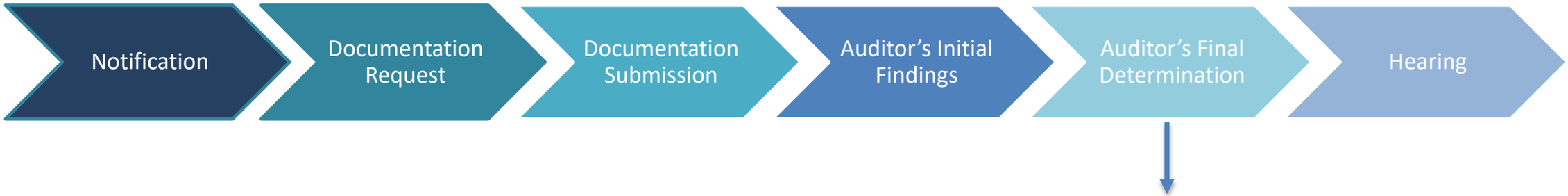
Auditor's Final Determination



Draft Compliance Examination Report

- Overview of the Auditor's findings
- Identification of improper payments
  - Direct v. extrapolated overpayment
- Testing results and legal analysis

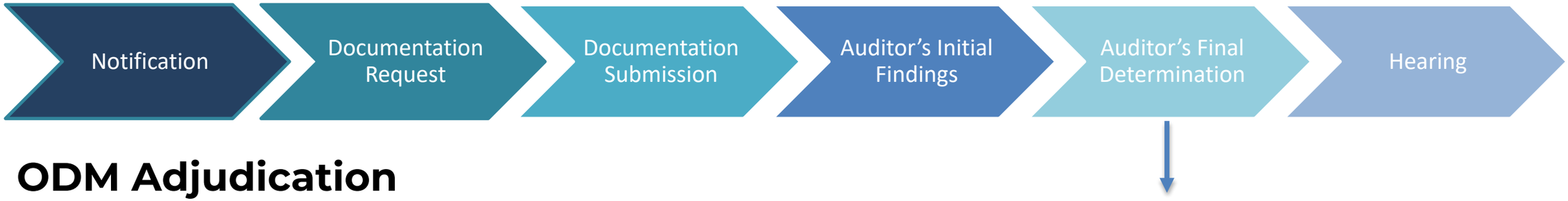
Auditor's Final Determination



Final Compliance Examination Report

- The Auditor may revise its findings in the draft compliance examination report based on discussions at the exit conference or the content included in the provider's response to the draft compliance examination report.
- Similar to the draft report, the final report will provide an overview of the Auditor's findings, identify any improper Medicaid payments, and provide its testing results and legal analysis.
- Within a few weeks of delivery of the final report to the provider, the Auditor publishes the final compliance examination report and the provider's response on its website.

Auditor's Final Determination



ODM Adjudication

- ODM has the authority to pursue collection of an overpayment identified in the Auditor's final compliance examination report.
- Historically, it can take months to years for ODM to pursue an overpayment collection. This is likely to change.
- For ODM to recover an overpayment, it must notify Provider of the overpayment during the five-year period immediately following the end of the state fiscal year in which the overpayment was made.
    - E.g., If the compliance examination analyzed claims for service between 1/1/21, and 12/31/23, ODM would be required to notify Provider by the end of 2026 if it intends to adjudicate and collect the entirety of the Auditor's overpayment findings. However, ODM could wait until as late as 2028 to notify Provider of its intention to adjudicate the portion of the overpayment findings for the services that were paid in 2023.

Recent Trends

What are we seeing today?

Recent Trends in the Auditor's Findings

Ohio Auditor of State

- Medicaid compliance examinations are public record
  - Final Medicaid compliance reports are published on the Ohio Auditor of State's website
  - Provider responses are not published if they contain PHI
- Press release if the findings are significant.

Recent Trends in the Auditor's Findings

Ohio Auditor of State

- CY 2025: The Auditor conducted 47 Medicaid Provider compliance examinations
- There have been a handful of waiver-service provider audits in the past few years
- The focus on provider type has shifted
  - Impact of recent events

Recent Trends in the Auditor's Findings

Ohio Auditor of State

- Direct care worker qualifications – background check, CPR
- Documentation of time – enough? Overlapping?
- Missing documentation – make sure you have it and it is accurate
- Phantom billing – billing for a service when it was not provided

FAQ

- Q: What precautions can a provider take to avoid being subject to an audit?

- A: Unfortunately, none. Providers must comply with all the necessary laws and rules surrounding Medicaid reimbursement, and the Auditor of State is permitted at any time to audit a provider's records to monitor for fraud, waste, and abuse. Nevertheless, providers can adhere to certain best practices to limit overpayment findings when audits arise.

Best Practices

Documentation Best Practices

- Documentation of services should be:
  - Complete – All elements present
  - Accurate – Reflects care rendered
  - Timely – Documented concurrent with provision of service
  - Specific – Detailed, not template-driven
  - Authenticated – Signed and dated by provider
  - Legible – Clear and readable

Documentation Best Practices

- Team members should be trained on best practices. This includes:
  - Protocol when receiving an audit request
  - Designate a point of contact

Billing Best Practices

- Utilize team members that are billing experts
  - Maintain regular and continuing education
- Conduct regular compliance and internal audits
  - Sample 10-15 charts on a quarterly basis
  - Be aware of outliers or trends
- Keep up to date with regulatory updates and payor policy changes
- For *new* DODD claims reviews, use the OPRA Great Provider Playbook section on service documentation as a guidepost

Audit Preparedness Best Practices

- Establish a process for responding to audits and records:
  - Notify all internal stakeholders
  - Engage with counsel
  - Assign persons responsible for responding to the audit
  - Never ignore the request, miss a deadline, or alter medical records
  - Prepare a professional, organized response to the audit (e.g., documents and formal responses)
  - Make the Auditor's job as easy as possible
  - Be professional to the Auditor and respond promptly

Audit Defense Best Practices

- An audit will almost always result in findings
- The following methods can be used as a defense:
  - Affirmative defenses: Statute of limitations, improper notice, etc.
  - Challenge findings related to the failure to produce records
  - Challenge whether noted requirement is also required for reimbursement under the law
  - Challenge the calculation methodology
  - Challenge the statistical method for extrapolation
- Know your rights!

Questions?

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