



Audit Survival 101

How to get through a Medicaid Audit

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OMPP – Program Integrity
2026 IHCP Works Annual Seminar

Agenda



- Program Integrity Overview
- What is an audit? Why do we have them?
- Medicaid is conducting an audit, what do you do?
- Ding Dong, Medicaid Calling! – Onsite visits
- Survival Tips
- Common Issues
- Questions



Program Integrity Mission

The mission of the Indiana Office of Medicaid Policy and Planning (OMPP) Program Integrity (PI) staff is to guard against fraud, waste and abuse of Medicaid program benefits and resources.

PI Toolbox

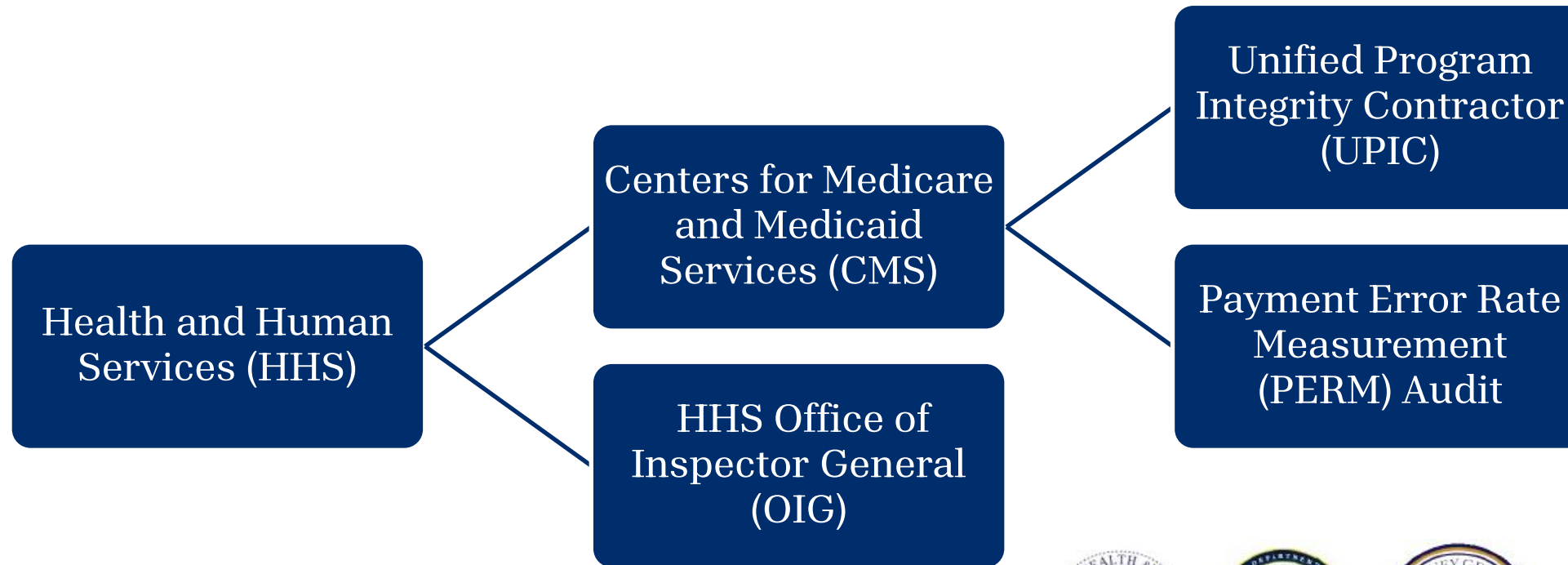


PI State Partners

- Managed Care Organization (MCO) Special Investigation Units (SIU)
- Indiana Attorney General Medicaid Fraud Control Unit (MFCU)
- FSSA Divisions
- OMPP Fraud and Abuse Detection System (FADS) Vendor, Deloitte

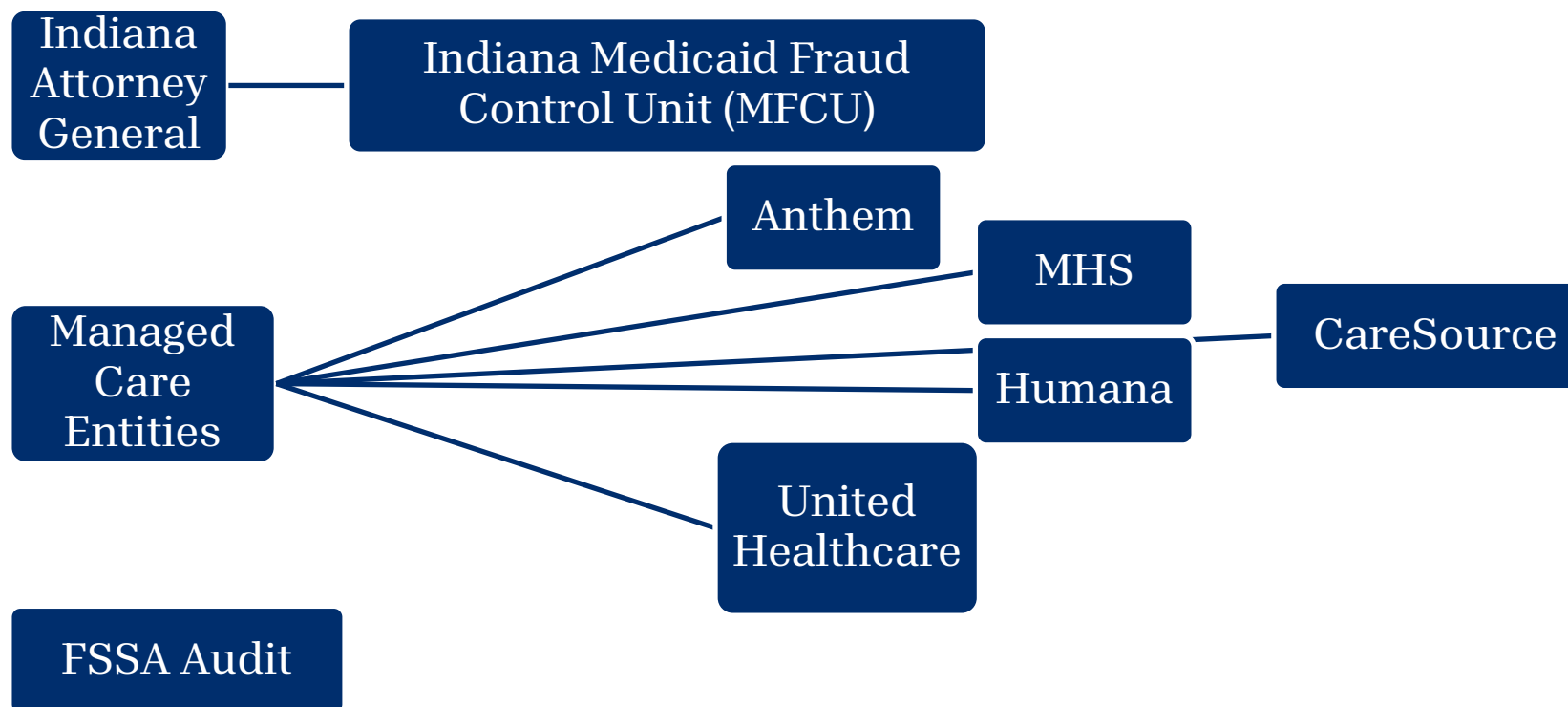


Federal Auditing Partners





State Auditing Partners



What Are Audits?





Why Do Audits Matter

- Required by participating program providers
- Ensure that payments made are accurate, appropriate, and supported by documentation.
- Stops Fraud, Waste, and Abuse
- Ensures that taxpayer dollars are available to help members.

How are providers selected?

- Data Mining: focuses on a specific issue that is reflected in all our data
- Peer Provider Comparison: comparing providers amongst themselves
- Outside referrals received from Provider and Member concern line
- Referrals from other FSSA divisions



Entities Who Will Ask to Audit

Federal Entities

- Office of Inspector General
- Department of Health and Human Services
- Center for Medicare and Medicaid Services.

State Entities

- Office of Medicaid Planning & Policy (OMPP)
- Family & Social Services Administration Audit
- Office of the Attorney General

These entities utilize contractors for auditing purposes, and you may be contacted by these third parties



Types of Audits

- Self Audit/Desk Audit: provider is requested to review their records and provide information as to incorrect coding and/or billing
- Medical Record Review: records are requested from the provider and are reviewed for incorrect coding and/or billing or documentation issues
- On-Site Audit: announced or unannounced visits where documentation is reviewed and/or gathered at the provider's place of business





Audit Process Steps

Notification and Records Request

- Request can happen via letter or retrieved onsite. Providers will receive audit scope, claims under review, and required documentation

Documentation Submission

- Provider submits documentation per instructions from the requesting entity

Initial Review

- Claims and documentation are reviewed against applicable requirements

Additional Records Request

- Further, supplemental, documentation could be requested

Draft Findings

- Preliminary findings give providers an opportunity to respond

Reconsideration

- Providers can request reconsideration of the draft findings within specified timeframes

Final Findings

- Auditor issues final findings with overpayment calculations

Audit Rights

- Providers retain all appeal rights as outlined in their IHCP provider agreement and applicable MCO contracts



OMPP PI Calls

What do you do?



You Got an Audit Notification



Providers are required by contract to comply with federal and state audits



Providers may not charge IHCP, MCOs or other business partners for audit records



For quick and smooth experiences, submit all requested documentation within identified deadlines in the audit notice



Ensure that you are familiar with the documentation requirements for your specialty

Documentation Requirements Example



GENERAL REQUIREMENTS

- Clinical, administrative, or financial records that substantiate medical necessity, appropriateness, billing, delivery, or monitoring of the service provided
- Physician/provider notes and Medication Administration Records (MAR), when applicable
- Physician orders; history and physical; progress notes; nursing and consult notes
- Discharge summaries, operative reports, and diagnostic test results
- Ancillary services, including radiology, ultrasound, CT scans, OT/PT, EKGs, etc.
- Prior authorization documentation and concurrent review records
- Medical staff credentials and signatures
- Provider background check documentation
- Care plans and individualized service plans
- Correspondence between ordering provider, rendering provider, subcontractor, and the Plan concerning the service

More Documentation Requirement Examples



PATHWAYS WAIVER PROVIDERS

- Comprehensive Assessments
- Signed Plans of Care
- Notice of Action (NOA) LTSS
- Authorization Documents
- PASRR Results
- Interdisciplinary Team Notes

HOME HEALTH

- Attendant Time sheets
- Visit/Verbal Logs
- Home-Visit Summaries
- Electronic Visit Verification (EVV) Documentation

DME

- Invoices
- Delivery Tickets
- Proof-of-Delivery Receipts
- Equipment Serial Numbers
- Maintenance Logs
- Vendor Invoices
- Itemized Charge Sheets and Related Financial Documentation supporting the billed claim



No altering of documents.

Reviewing Documentation





Documentation Review



Documentation is evaluated for medical necessity, appropriateness of care, billing accuracy, and documentation completeness



Documentation that is missing, illegible, or insufficient to support services billed will be deemed as a finding in the overpayment determination



Applicable Standards

Indiana Medicaid Program Requirements
OMPP Provider Modules
MCO Policies
State and Federal Laws and Regulation



HCBS Waiver Provider Responsibilities

- Ensure services match approved Prior Authorization (PA)
- Document individualized supports delivered
- Maintain Electronic Visit Verification (EVV)-compliant records for applicable services



Common PI Findings

- Missing documentation for billed units
- Service logs inconsistent with IHCP requirements
- Billing exceeds documented time
- Applicable signatures are not present
- Complete background checks not performed or timely



EVV Compliance Findings

- In/out times that are not accurate
- Mismatched or missing GPS information
- Impossible Commutes



Staff Ratios & Training Documentation

- Maintain ratio logs per IHCP guidelines
- Ensure staff training meets waiver and provider manual requirements



Self Disclosure



Before an audit providers should:

Disclose any overpayments

Disclose any billing errors



Once an audit is initiated, providers are no longer eligible to self-disclose the claims under review



Identified issues must be addressed through the audit process

Surviving an Audit



Key factors to surviving an Audit

- Don't Panic!!
- Read the medical record documentation request or additional documentation request thoroughly
- Identify where to return the records to
- Identify the due date
- Identify the documents that are being requested
- Collect all the requested documentation including all records necessary to support the services for the dates requested
- Make sure the medical records collected are complete and legible and are for all the dates of service on the claims requested



Surviving an Audit, cont.

- If you are copying the records, make sure they are legible, and that both sides of a double-sided document are included
- Verify all documentation requested is included in your submission
- Include the name and telephone number of the contact person for the request
- Return all requested documents to previously identified place
- Comply by the deadline
- It is the billing provider's responsibility to obtain any necessary information required for the record review, regardless of the location of the documentation.



Questions



Contact Information

Program Integrity:

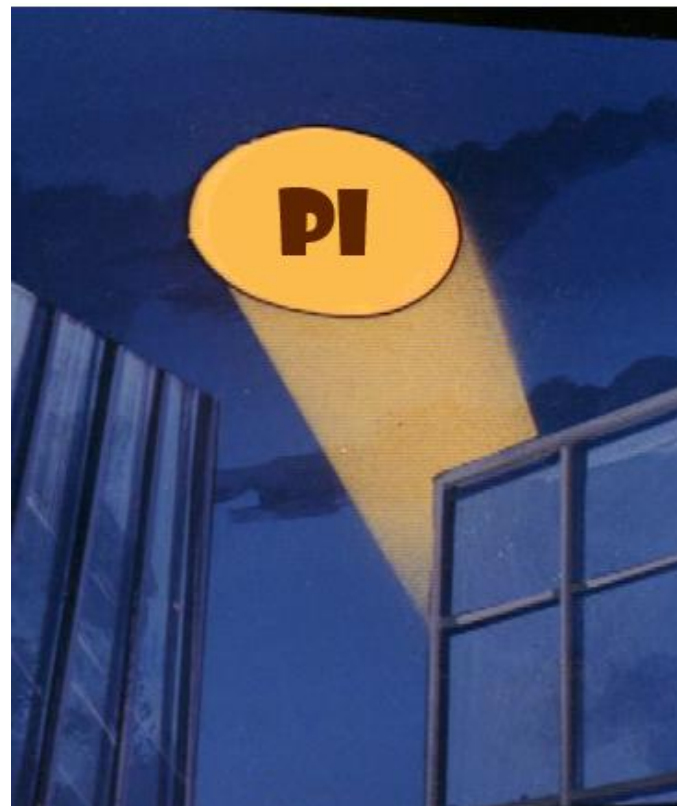
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Thank You!



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