Best Practices for Responding to Documentation Requests/Audits

TYPES OF DOCUMENTATION REQUESTS

Commercial Insurance

Every payor has its own policies on claim audits. All include pre and post payment reviews to ensure payment accuracy.

Innovation | Payment Integrity: Employer overview (uhc.com)

https://lp.aetna.com/rs/595-CON-228/images/DemandGenEmployer-04-2024-webinar_one_pager.pdf?version=0

https://providernewsroom.com/medicare-network-insider/zelis-to-assist-with-payment-integrity-claim-reviews-for-cigna-healthcare-medicare-advantage/

MEDICARE

Target, Probe and Educate (TPE) Audits

Targeted Probe and Educate | CMS

These requests are sent to providers that CMS Medicare Administrative Contractors (MACs) find have high denial rates or unusual billing. The MAC will request documentation for 20-40 claims. If errors are found, the MAC will provide feedback and request another audit in 45 days.

Recovery Audit Contractor (RAC) Audits

Medicare Fee for Service Recovery Audit Program | CMS

RAC review topics vary and can be found on the CMS website. If chosen for a RAC audit, an Additional Documentation Request (ADR) will be sent to the provider.

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Office of the Inspector General (OIG)

The OIG launches investigations when utilization increases sharply or concerns are raised by whistleblowers and CMS fraud investigations. The OIG publishes their workplan on their website.

Work Plan | Office of Inspector General | U.S. Department of Health and Human Services (hhs.gov)

Best Practices When a Documentation Request/Audit Is Received

Read the request. Depending on the type of audit, consider obtaining legal counsel to determine the best course of action and respond promptly.

Send in the specific information being requested. Include all documents that help determine medical necessity or justify the service billed.

Clearly separate and label different patients/dates of service. Always include a copy of the request/ADR.

Send the documents back in a secure format to protect PHI.

Be sure to keep a copy of all submitted materials.

Do a full review of the medical record to determine any issues with other dates of service. Prepare corrected claims/refunds as stipulated by your contract with the payer.

Pay attention to the reasons for any denials and educate all providers and staff on proper billing practices.