Claims Audit Snapshot

Health care insurers, including Medicaid, process more than 5 billion claims for payment each year.[1] The volume of claims and expenditures requires that Medicaid protect itself from fraud, waste, and abuse.[2] The Centers for Medicare & Medicaid Services (CMS) and States have developed a variety of approaches to audit Medicaid claims to protect the integrity of Medicaid.[3]

Section 1936 of the Social Security Act[4] requires CMS to enter into contracts to review Medicaid provider actions, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues.[5] CMS contracts with Medicaid Integrity Contractors to perform these tasks.[6] Section 1902(a)(42) of the Social Security Act[7] requires States to contract with Medicaid Recovery Audit Contractors to audit providers and identify overpayments and underpayments. Additionally, the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG), conducts audits as part of its Medicaid program integrity oversight responsibilities.[8]

Providers are selected for audits in many ways, such as data analysis by CMS contractors and collaborative efforts between States and CMS.[9] States often supplement their in-house audit and investigation capabilities by contracting with companies that specialize in Medicaid claims and utilization reviews.[10]

A claims audit should determine if the services or items claimed for payment were the same as what the beneficiary received. A claims audit might follow these steps:

1. Identifying a sample of claims billed to one insurance carrier (for example, Medicaid, Medicare, commercial plan), involving the same provider type (for example, obstetrics, well-child, gynecological surgery in an obstetrics/gynecology practice), or the same diagnosis.
2. Retrieving the documentation for each record included in the sample.
3. Comparing the medical record to the billing documentation.
4. Documenting and analyzing the results, in the form of a report.

After receiving the final report, the provider's audit response team should meet to discuss items they need to address and to correct any weaknesses identified in the report. Any overpayment identified by the audit should receive immediate attention. The law requires "if a person has received an overpayment, the person shall report and return the overpayment" to Federal health care programs within 60 days of identification. Failure to do so may make the overpayment a false claim,[11] which could subject the provider to serious consequences under the civil False Claims Act, including exclusion from the Medicaid program. The provider should take corrective action to prevent future overpayments and any other identified errors. These actions may include changes to policies or procedures, including procedures for internal monitoring and auditing and staff training. The provider should assign a specific person in the office who is responsible for tracking corrective action and reporting on progress.

For More Information

To see the electronic version of this E-Bulletin and other E-Bulletins posted to the Medicaid Program Integrity Education page, visit https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

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