

What Type Of Audit Is Performed Internally After Claims Are Submitted?A. Accreditation AuditB. Routine

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When healthcare providers submit claims to insurance companies or government programs, the process doesn't end there. To ensure accuracy, compliance, and quality assurance, internal audits are conducted to review and verify claims after submission. Among the various types of audits performed internally, two primary categories stand out: Accreditation Audits and Routine Audits. Understanding the differences between these audits, their purposes, and how they are conducted is vital for healthcare organizations aiming to maintain high standards, ensure compliance, and optimize their reimbursement processes.

In this article, we will explore the characteristics, objectives, and procedures associated with Accreditation Audits and Routine Audits conducted internally after claims are submitted. We will also discuss their significance in the healthcare revenue cycle and how organizations can prepare for and benefit from these audits.

Understanding Internal Audits in Healthcare

Internal audits in healthcare are systematic reviews conducted by an organization's own staff or designated auditors to evaluate various aspects of clinical and administrative operations. These audits aim to ensure compliance with regulatory requirements, improve operational efficiency, and verify the accuracy of claims and billing processes. When it comes to post-claims submission reviews, internal audits help identify errors, prevent fraud, and facilitate proper reimbursement.

Types of Internal Audits After Claims Submission

Broadly, the main types of internal audits performed after claims are submitted include:

- Accreditation Audits: Focused on meeting specific standards set by

accrediting bodies.

- Routine Audits: Ongoing, scheduled or unscheduled reviews aimed at overall compliance and process improvement.

Let's delve deeper into each type to understand their purpose, scope, and methodology.

What Is an Accreditation Audit?

Definition and Purpose

An Accreditation Audit is an evaluation conducted internally to assess whether a healthcare organization meets the standards established by recognized accrediting bodies such as The Joint Commission (TJC), the National Committee for Quality Assurance (NCQA), or other relevant organizations. These standards typically encompass clinical quality, patient safety, administrative processes, staff qualifications, and compliance with industry best practices.

The primary purpose of an Accreditation Audit is to ensure that the organization maintains the necessary standards to achieve accreditation, which in turn signals to payers, patients, and regulators that the organization provides high-quality care and adheres to legal and ethical requirements.

Scope of Accreditation Audits

Accreditation audits are comprehensive and cover multiple facets of the organization, including:

- Clinical documentation and patient records
- Billing and coding accuracy
- Staff credentials and training
- Infection control protocols
- Patient safety measures
- Policies and procedures compliance

While accreditation audits are broad, they also include a review of financial and administrative aspects, such as claims submission processes, to verify compliance with standards related to billing practices.

How Accreditation Audits Are Conducted Internally

Internal accreditation audits typically involve:

- Reviewing documentation to ensure standards are met
- Conducting interviews with staff to assess understanding and adherence
- Observing clinical and administrative processes

- Cross-checking claims data against clinical records for accuracy and completeness
- Identifying areas of non-compliance or improvement opportunities

These audits are often scheduled periodically (e.g., annually) and may be prepared for in anticipation of external accreditation surveys.

Importance of Accreditation Audits

- Ensures ongoing compliance with accreditation standards
- Enhances patient safety and quality of care
- Improves operational efficiency
- Reduces risk of non-compliance penalties
- Supports successful external accreditation surveys
- Validates the credibility of claims submitted for reimbursement

What Is a Routine Audit?

Definition and Purpose

Routine audits are regular, systematic reviews performed internally to monitor ongoing compliance, accuracy, and efficiency within the organization. These audits are not necessarily tied to accreditation standards but are part of an organization's internal quality assurance and risk management processes.

The main goal of routine audits is to detect errors, prevent fraud, ensure proper coding and billing, and optimize revenue cycle management.

Scope of Routine Audits

Routine audits often focus on:

- Claims submitted over a specific period
- Billing and coding accuracy
- Compliance with payer policies and regulations
- Documentation completeness
- Payment and reimbursement accuracy

They can be targeted (focused on specific departments or types of claims) or comprehensive (covering multiple departments or services).

How Routine Audits Are Conducted Internally

Typically, routine audits involve:

- Selecting a sample of claims for review

- Comparing clinical documentation with submitted claims
- Verifying correct coding (ICD, CPT, HCPCS codes)
- Ensuring claims adhere to payer guidelines
- Identifying patterns of errors or discrepancies
- Providing feedback and training to staff

Routine audits can be scheduled periodically (monthly, quarterly, annually) or conducted as needed when issues arise.

Significance of Routine Audits

- Maintains billing accuracy and compliance
- Reduces claim denials and rework
- Enhances revenue cycle efficiency
- Identifies training needs for staff
- Supports ongoing quality improvement initiatives
- Helps organizations stay compliant with changing regulations

Key Differences Between Accreditation and Routine Audits

Aspect	Accreditation Audit	Routine Audit
Primary Focus	Meeting accreditation standards	Ensuring ongoing compliance and accuracy
Frequency	Periodic (e.g., annually) or pre-accreditation	Ongoing, scheduled regularly or as needed
Scope	Broad, covering clinical, administrative, and billing	Specific to claims, coding, or billing practices
Conducted By	Internal staff or external auditors (preparation)	Internal staff or designated auditors
Outcome	Accreditation readiness, quality improvement	Error detection, process optimization

Why Both Audits Are Essential

Having both Accreditation and Routine audits is crucial for a healthcare organization’s success. Accreditation audits ensure the organization meets external standards, which can influence reputation, payer contracts, and patient trust. Routine audits, on the other hand, maintain day-to-day operational integrity, reduce financial risk, and ensure compliance with payer requirements.

Together, these audits create a comprehensive quality assurance framework that supports sustainable growth and high-quality patient care.

Best Practices for Internal Audits Post-Claims Submission

To maximize the benefits of internal audits, healthcare organizations should consider the following best practices:

- Develop clear audit protocols and checklists
- Train staff involved in audits on current standards and coding practices
- Use data analytics to identify high-risk areas
- Document findings thoroughly and implement corrective actions
- Monitor progress and re-audit to ensure improvements
- Stay updated with regulatory changes and industry standards

Conclusion

In summary, the internal audit performed after claims are submitted typically falls into two categories: Accreditation Audit and Routine Audit. Accreditation audits are comprehensive evaluations aimed at maintaining certification standards and demonstrating quality to external bodies. Routine audits are ongoing reviews focused on accuracy, compliance, and process improvement within the organization's revenue cycle.

Both types of audits play vital roles in ensuring healthcare providers operate efficiently, maintain compliance, and optimize reimbursements. By understanding their differences and implementing best practices, healthcare organizations can effectively manage their internal audit processes, minimize errors, and uphold high standards of patient care and operational excellence.

Keywords: internal audit, accreditation audit, routine audit, claims review, healthcare compliance, billing accuracy, revenue cycle management, quality assurance, healthcare standards

Frequently Asked Questions

What is the primary purpose of an internal audit performed after claims are submitted?

The primary purpose is to ensure the accuracy and compliance of claims with organizational policies and regulations, identifying errors or discrepancies for correction.

How does a Routine internal audit differ from an

Accreditation audit in the claims process?

A Routine internal audit focuses on standard procedural checks and internal compliance, whereas an Accreditation audit assesses adherence to external standards required for accreditation purposes.

When should an internal audit be conducted after claims submission?

Internal audits are typically conducted periodically, often after claims are submitted, to verify accuracy, detect fraud, and improve processes, with specific timing depending on organizational policies.

What are common areas reviewed during an internal audit after claims submission?

Common areas include claim accuracy, documentation completeness, adherence to policies, coding correctness, and compliance with regulatory requirements.

Is an internal audit considered a routine process or part of accreditation procedures?

An internal audit after claims submission is generally considered a routine process aimed at internal quality control, though some aspects may relate to accreditation standards.

What are the benefits of performing internal audits on submitted claims regularly?

Benefits include early detection of errors or fraud, improved claim processing accuracy, compliance with regulations, and enhanced overall organizational performance.

Can an internal audit after claims submission impact accreditation status?

Yes, consistent internal audits help ensure compliance with accreditation standards, which can positively influence accreditation status by demonstrating ongoing quality assurance.

What tools or methods are commonly used in conducting an internal audit after claims are submitted?

Tools include audit checklists, data analytics software, claim management systems, and manual review processes to evaluate accuracy and compliance.

Additional Resources

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In the complex landscape of healthcare administration and insurance claims processing, audits serve as essential tools to ensure compliance, accuracy, and integrity of the claims submitted by providers. When a healthcare provider or insurer submits claims for reimbursement, an internal review often follows to verify that the claims are accurate, compliant with regulatory standards, and properly documented. This internal review process, typically known as an internal audit, is crucial for maintaining operational integrity, preventing fraud, and ensuring optimal reimbursement. Among the various types of internal audits performed post-claims submission, the most relevant are often categorized into Accreditation Audits and Routine Audits. Understanding the distinctions, purposes, and methodologies of these audits provides valuable insight into the ongoing quality control mechanisms within healthcare and insurance environments.

Understanding Internal Audits in Healthcare and Insurance

An internal audit refers to an organizational process where internal personnel review and evaluate the accuracy, compliance, and efficiency of operations—specifically here, the claims submitted by healthcare providers. These audits are proactive measures designed to identify issues before external regulators or payers do, thereby reducing the risk of denials, penalties, or legal repercussions.

Key objectives of internal audits include:

- Verifying the accuracy of submitted claims
- Ensuring compliance with federal, state, and payer-specific regulations
- Detecting and preventing fraudulent or erroneous claims
- Improving documentation practices
- Enhancing overall operational efficiency

Within this scope, different types of audits can be performed, each with distinct objectives and methodologies. The two primary categories relevant to post-claims internal review are Accreditation Audits and Routine Audits.

Accreditation Audit: Definition, Purpose, and Role

What Is an Accreditation Audit?

An Accreditation Audit is a formal, comprehensive review conducted by an independent accreditation body to assess whether a healthcare organization complies with established standards of quality, safety, and operational excellence. These standards are often set by national or regional accreditation agencies such as The Joint Commission (TJC), the National Committee for Quality Assurance (NCQA), or the Commission on Accreditation of Rehabilitation Facilities (CARF).

In the context of claims submission, an accreditation audit may include:

- Reviewing how claims are prepared and documented
- Ensuring policies and procedures align with accreditation standards
- Validating that staff training and competency requirements are met
- Confirming that quality improvement initiatives are in place regarding claims processing

While accreditation audits are primarily focused on overall organizational compliance, they inevitably include a review of submitted claims as part of their broader assessment.

Purpose of Accreditation Audits

The core purpose of an accreditation audit is to:

- Certify that the organization meets nationally recognized quality standards
- Improve patient care outcomes and safety
- Enhance organizational accountability
- Maintain or achieve accreditation status, which can influence reimbursement rates and payer relationships

In relation to claims, accreditation audits indirectly influence billing practices by ensuring the organization's operational systems are aligned with best practices, thereby reducing errors and denials.

When Are Accreditation Audits Performed?

Accreditation audits are typically scheduled at regular intervals—often annually or biennially—and are comprehensive, covering all aspects of the organization's operations, including claims processing. These audits are not exclusively focused on claims but encompass policies, procedures, documentation, staff training, and patient care processes.

Key points:

- Usually conducted by external accrediting bodies
- Require thorough preparation and self-assessment
- Can lead to accreditation renewal or improvement plans

Impact on Claims Processing

Though not solely dedicated to claims, accreditation audits influence claims accuracy by:

- Ensuring documentation standards are met
- Promoting adherence to coding and billing guidelines
- Encouraging continuous quality improvement initiatives that reduce billing errors

In essence, accreditation audits serve as a comprehensive quality assurance mechanism that encompasses claims review as part of organizational compliance.

Routine Audit: Definition, Purpose, and Role

What Is a Routine Audit?

A Routine Audit is an ongoing, systematic review conducted internally by an organization to monitor, evaluate, and improve the accuracy and compliance of claims submitted after the fact. These audits are typically scheduled at regular intervals—monthly, quarterly, or annually—and are designed to identify discrepancies, errors, or patterns of non-compliance at an operational level.

Features of routine audits include:

- Focused on specific departments or types of claims
- Conducted by internal staff or designated compliance teams
- Targeted at detecting and correcting issues proactively

Types of routine audits can include:

- Random sampling of claims
- Focused reviews on high-risk or high-volume claim categories
- Follow-up audits after prior identified issues

Purpose of Routine Audits

The primary goals of routine audits are to:

- Detect billing errors, coding inaccuracies, or documentation deficiencies
- Ensure adherence to payer policies, coding guidelines, and regulatory requirements
- Prevent fraud and abuse
- Improve revenue cycle management
- Maintain compliance with federal and state laws

Routine audits serve as a critical quality control process, allowing organizations to identify weaknesses in their claims process and implement corrective actions promptly.

When Are Routine Audits Performed?

Routine audits are typically embedded into an organization’s regular compliance and quality assurance programs. They may be scheduled quarterly or monthly and often involve:

- Reviewing a representative sample of claims
- Cross-checking documentation against billed services
- Analyzing denial patterns for process improvement

They are flexible, adaptable, and tailored to organizational needs, often evolving based on prior findings or changing regulatory landscapes.

Impact on Claims Processing

Routine audits directly impact the accuracy and reliability of claims submission by:

- Identifying common errors such as incorrect coding or incomplete documentation
- Providing feedback and training to billing staff
- Updating policies and procedures to prevent recurring issues
- Reducing claim denials and improving reimbursement rates

By establishing a continuous feedback loop, routine audits help organizations maintain high standards of compliance and operational efficiency.

Comparative Analysis: Accreditation Audit vs. Routine Audit

Aspect	Accreditation Audit	Routine Audit
Frequency	Annual	Quarterly or Monthly
Scope	Comprehensive	Targeted
Focus	Systemic	Operational
Outcome	Certification	Improvement

| Scope | Broad, organizational standards including claims, quality, safety |
Focused, operational, often claims-specific |
| Frequency | Scheduled periodically (annually/biennially) | Regularly
scheduled (monthly/quarterly) |
| Conducted by | External accreditation bodies | Internal staff or compliance
teams |
| Objectives | Achieve or maintain accreditation, overall quality improvement
| Detect errors, ensure compliance, improve billing accuracy |
| Focus on Claims | Indirect; part of overall organizational compliance |
Direct; specific review of claims and documentation |
| Outcome | Accreditation status, quality certification | Error reduction,
compliance, operational efficiency |

Conclusion: Which Audit Is Performed Internally After Claims Are Submitted?

Considering the definitions, purposes, and operational characteristics, Routine audits are the primary type of internal audit performed after claims are submitted. These audits are proactive, ongoing efforts aimed at reviewing claims to identify and rectify errors, ensure compliance, and optimize revenue cycle management. Routine audits are integral to internal control systems, fostering continuous improvement and minimizing the risk of denials and regulatory penalties.

Accreditation audits, on the other hand, are periodic, comprehensive assessments conducted by external entities to evaluate overall organizational compliance with established standards. While accreditation audits include an assessment of claims processes, they are not primarily internal or conducted immediately after claims submission but serve as a broader certification of quality.

In summary:

- Routine audits are the main internal mechanism performed after claims are submitted to verify accuracy and compliance.
- Accreditation audits are external, comprehensive evaluations that include claims review among many other organizational aspects.

Through diligent routine audits, healthcare organizations can maintain high standards of accuracy, compliance, and operational efficiency, ultimately leading to better patient care, optimized reimbursements, and reduced legal or financial risks.

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