HIDING IN PLAIN SIGHT

TAKING BACK CONTROL IN COMMERCIAL PAYOR AUDITS

Presented by

HILL
Health Law Group
EST 2015

WINDHAM BRANNON
offering more

July 15, 2026

Amanda Hill
Founder & CEO

Denise Gaulin
Principal Healthcare
Consulting Leader

Lori Baker
Director
Healthcare Consulting

WHY ARE WE DOING THIS?

The audit didn't read your chart. It read your fields.

- **Targeting & scoring have industrialized** AI analytics, contingency vendors, and checklist-driven scoring before anyone reads the chart
- **The new failure mode:** Clinically complete, well-documented care that fails on a technical issue
- **The stakes are high:** A 30-chart sample, extrapolated, is still a six- or seven-figure demand

HOW THEY TARGET YOU

Two scoring passes, narrative only matters in the second, if it happens at all

- **Selection:** Payors mine structured claims data: E/M curves, modifier frequency, utilization patterns, units per patient, template-level patterns
- **First-pass scoring:** Checklist review against the payor's policy element grid
- **Second-Pass Review:** Narrative review usually happens only on appeal, and only if the provider forces it
- **Vendor Economics:** A blank field is faster and more defensible to flag than a clinical judgment call
- **Key Implication:** Documentation is being scored for both substance and structure

COMMON THEMES IN AUDITS

Seven findings, four traits: binary, high-volume, 100% denials, extrapolation-ready

Tier 1 & 2 (binary/systemic; code vs. documentation), medical record-based:

1. Incident-to, supervision & signature failures: broken workflow fails every claim
2. Missing orders/op-note elements: “no document, no payment”
3. E/M levels unsupported, amplified by cloned notes
4. Modifier 25/59 misuse: a failed modifier is a 100% denial
5. Time-based services with no documented time

Tier 3, medical necessity & argumentation-based:

6. Medical necessity per the payor’s written policy
7. **Discrete-field denials (flagship):** a behavioral health note fully documents spiritual concerns in narrative, but the structured field is blank. Scored “absent.” Denied. Extrapolated.

The tell: This is the only finding where the substance IS in the chart, which makes it the most appealable denial on the list

HILL Health Law Group EST 2015

WINDHAM BRANNON offering more

AUDIT DEFENSE: PROACTIVE & REACTIVE

What to do before the vendor audits you, and the moment their letter arrives

Proactive: Before the Letter

- **Build payor policy crosswalks** by top payor and code; map each element to where it lives in your EHR
- **Run field-completeness analytics** on yourself before their algorithm does
- **Fix the template, not the clinician**; structure lasts, training decays
- **Keep the cadence:** internal audits every 6–12 months, weighted to the seven findings; loop in counsel early

Proof it works*: one clinic cut upcoding from 15% to ~2% by rebuilding its template*

Reactive: When the Letter Arrives

- **Calendar the deadline** immediately
- **Identify the plan type first:** self-funded ERISA vs. fully insured
- **Reserve rights** in the cover letter; pre-audit against the policy grid before producing records
- **Follow addendum protocols only**, never late or informal edits

Call counsel on extrapolation, SIU language, prepayment review, offset, or termination threats

HILL Health Law Group EST 2015

WINDHAM BRANNON offering more

YOUR LEVERAGE: CONTRACT, STATUTE & ERISA

Their case was hiding in your fields. Yours is hiding in your contract.

The contract is the battlefield:

- Audit-rights provisions define the fight: lookback periods, notice, appeal timelines
- Policies become contract terms only if the contract actually incorporates them
- Version control as a defense: was the policy in effect and noticed on the date of service?

Condition of payment vs. standard of documentation:

- Is the element truly a condition of payment, or a quality standard repurposed as one?

State law (Texas):

- TX Insurance Code limits recoupment, notice and contest rights apply
- TDI complaints are a real pressure point for fully insured business

The ERISA divide:

- Self-funded plans fall outside state insurance protections: different rules, different remedies
- Identify plan type on day one; segment mixed books of business by plan type

HILL Health Law Group EST 2015

WINDHAM BRANNON offering more

ATTACK THE MATH & BUILD THE REBUTTAL

Make them prove it.

1. **Clinical Care Was Documented:** Use an element map to pair the policy requirement with narrative language and page cite
2. **Provider Manual or Policies:** Challenge incorporation, notice, effective date or applicability
3. **The Remedy Is Disproportionate:** Challenge full denial of a documented encounter over one blank field
4. **Extrapolation Is Attackable:** Question sample design, universe definition, partial vs. full denials and methodology
5. **Demand the Methodology in Writing**
6. **Credibility of the Reviewers**
7. **Catch-all**

WORKING UNDER PRIVILEGE

The same audit can become protected analysis, or the payor's Exhibit A.

- **The same audit, two outcomes:** Done under counsel, it's protected analysis; done without, it can become the payor's Exhibit A
- **Attorney-client privilege & work product:** What each protects and when each applies
- **Route consultants through counsel** engagement letter so the coding review itself is protected
- **What privilege does NOT cover:** The underlying medical records and claims are always discoverable; privilege protects analysis, not facts
- **Timing matters:** Privilege can't be applied retroactively, so involve counsel before the deep dive

WORKING UNDER PRIVILEGE

The same audit can become protected analysis, or the payor's Exhibit A.

Putting Privilege Into Practice

1. **Privilege Protects Analysis:** Attorney-client privilege and work product protect analysis, not the underlying records
2. **Route Through Counsel:** Consultants can be routed through counsel, so the review is structured as protected work
3. **Timing Matters:** Privilege generally cannot be applied retroactively
4. **Involve Counsel Early:** Bring counsel in before the deep dive when findings may be significant
5. **How We Did It Before**

SETTLEMENT TERMS & PROCESS

The number matters, but the terms may matter more.

When Settlement Makes Sense

- Defense costs outweigh continued fighting
- Cash-flow pressure
- Relationship considerations with the payor

Terms That Matter

- Repayment structure and timing
- Scope of release
- No-admission language
- Protection against re-audit of the same claims
- Prospective agreement on the disputed documentation standard, where possible
- Removal from prepayment review
- Get it all in writing

HILL Health Law Group EST 2015

WINDHAM BRANNON offering more

TAKING BACK CONTROL

- ✓ Audit yourself against the seven lucrative findings, before a payor does
- ✓ Build policy-element crosswalks for your top payors and codes; align your templates so required fields can't be skipped
- ✓ Read your contracts' audit, recoupment, and policy-incorporation provisions now, not after the letter
- ✓ Identify the plan type (ERISA vs. fully insured) the day a request arrives, and reserve rights in your production letter
- ✓ Never produce records without a pre-audit; involve counsel early enough to preserve privilege
- ✓ Never accept an extrapolated demand, or a form-over-substance denial, at face value

Q&A

HILL
Health Law Group
EST 2015

WINDHAM BRANNON
offering more

THANK YOU

Amanda Hill
Founder & CEO

Denise Gaulin
Principal Healthcare
Consulting Leader

Lori Baker
Director
Healthcare Consulting

HILL
Health Law Group
EST 2015

WINDHAM BRANNON
offering more