

Key Takeaways:

Top Ohio Audit Findings

Ohio auditors have identified over \$9 billion in unsupported or fraudulent Medicaid spending since 2019, and audit activity is only increasing. The good news is the findings aren't random. The same five issues show up again and again, which means they're preventable.

EVV GAPS & MISMATCHES

Over half of Ohio's reviewed home health claims had no matching EVV record. Care that isn't verified electronically gets treated the same as care that never happened.

Takeaway: *Check for EVV gaps weekly and fix them the same day.*

DOCUMENTATION GAPS & DUPLICATE DOCUMENTATION

The single most common finding in Ohio audits. Missing notes, copied notes, and billed units that don't match the file have cost providers hundreds of thousands of dollars each.

Takeaway: *Every visit needs its own original, real-time note that matches what was billed.*

CREDENTIALING GAPS

Uncertified caregivers and lapsed provider licenses have led to some of the largest single findings in Ohio Medicaid history, including one case over \$2 million.

Takeaway: *Track certifications and licenses actively, with alerts before they expire, not after.*

SERVICES BILLED WITHOUT A VALID PLAN OF CARE

Billing before a plan of care is signed, after it's expired, or for a service it doesn't actually cover is a recurring, expensive mistake.

Takeaway: *If it's not signed and it's not in the plan of care, it's not billable yet.*

BILLING FOR INELIGIBLE RECIPIENTS

Over \$1 billion was paid statewide for recipients enrolled in more than one state's Medicaid program at the same time, plus millions more tied to deceased or incarcerated individuals.

Takeaway: *Verify eligibility at the start of every billing cycle, not just at intake.*

Bottom Line: Every finding above traces back to one habit: checking your own work before someone else does. Build these checks into your weekly and monthly routine, and you'll be setting your agency up for success



THANKS FOR READING!

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