

Behind the Scenes: How Claim Audits Work



Large employers that self-fund their benefits plans, particularly for medical and prescription coverage, typically outsource claims processing to specialized vendors. To ensure these administrators are performing as promised, companies routinely engage **medical claim auditors**. When an audit reviews 100 percent of claims, the report provides a highly accurate, objective view of the plan's cash outflows. While recoverable errors are often the immediate focus, the long-term value lies in identifying systemic issues. Addressing root causes helps prevent future mistakes, keeping benefit plans efficient.

Audit software is often designed by professionals with direct experience in large claim processing organizations, ensuring a deep understanding of industry complexities. In contrast, generalist audit firms—those focused mainly on tax or bookkeeping—may lack the specialized expertise required for medical claims, potentially missing nuances. After the initial technological review, expert analysts carefully examine the electronic findings. This stage can involve re-running portions of the audit to clarify anomalies, ensuring that every detail is understood and any patterns of error are fully explored.

A claims audit is best seen as the beginning of a continuous improvement process. Audits identify and document errors, but their greater value is in guiding claims administrators to enhance their systems. Since most third-party processors are major health plans, they occasionally dispute audit findings by presenting their own data. However, experienced audit firms are well-equipped to handle these discussions and advocate for the plan sponsor's interests. Even though the error rate in processing is low, the volume of claims in large plans means that even a small percentage can be significant.

By running audit software in the background, organizations can detect and address errors in real time without disrupting regular administrative workflows. This proactive approach is especially valuable during unexpected events. Detailed monthly reporting provides plan managers with actionable insights, simplifying oversight and supporting responsible financial management. With growing expectations for financial stewardship in both the corporate and nonprofit sectors, regular, more frequent medical claims audits are becoming a best practice for organizations committed to operational excellence.