PDPM Audit Checklist 2026: What Auditors Actually Look For First

Most facilities prepare for an audit by reviewing their billed codes. That's not where auditors start.

Before a Medicare Administrative Contractor (MAC) requests a single chart, a specific sequence of questions gets asked internally: which contractor would even initiate the request, whether the request fits a known Additional Documentation Request (ADR) or Targeted Probe & Educate (TPE) pattern, and whether the eventual denial theory will rest on Local or National Coverage Determination (LCD/NCD) rules or straightforward medical necessity.

An experienced auditor doesn't start with the claim. They start with the certification. Then they work outward from there.

This checklist walks through that same sequence, so your facility can look at its own charts the way an auditor would — before a survey or ADR ever arrives.

1. Start With Certification, Not the Claim

The physician certification and recertification are the foundation everything else sits on. If the certification is missing, late, or doesn't clearly support the level of care being billed, everything downstream — MDS coding, HIPPS calculation, the claim itself — is vulnerable regardless of how well-documented the clinical notes are.

Checklist:

- Is the initial certification signed and dated within the required window?
- Do recertifications occur on schedule for the length of stay?
- Does the certifying physician's language support the level of care billed, or is it generic/boilerplate?

2. Identify Your ADR/TPE Exposure Pattern

Not every documentation gap is equally risky. What tends to trigger a pattern-based review (TPE) or a targeted request (ADR) is *repetition* — the same type of gap showing up across multiple stays or multiple months, not a single isolated error.

Checklist:

- Pull your last 90 days of ADR responses (if any). Do they cluster around a specific diagnosis category, therapy minute threshold, or HIPPS code?

- Are the same MDS coordinators or the same shift consistently associated with weaker documentation?
- If a MAC pulled 10 charts at random this week, would more than 1-2 show the same type of gap?

3. Know Your Denial Theory Before the Auditor Does

Denials generally fall into one of two buckets: a coverage issue (does an LCD/NCD say this service isn't covered under these circumstances) or a medical necessity issue (was the *level* of care justified by the clinical picture). These require different documentation fixes, so it matters which one your facility is exposed to.

Checklist:

- For your highest-acuity PDPM categories, do you have a current LCD/NCD reference on file for the relevant services?
- Does the clinical documentation independently support medical necessity, separate from the MDS coding itself?

4. Reconcile the Note, the MDS Lock, and the Claim — For the Same Stay

This is where most real exposure hides, and it's the single most useful audit-prep exercise a facility can run. Pull three things for the same resident stay:

1. The supporting clinical/nursing note
2. The locked MDS assessment
3. The claim that was billed

Then ask: do all three agree with each other? Contradictions between the clinical narrative and the billed codes — or missing documentation for the specific PDPM/HIPPS drivers that justified the reimbursement level — are exactly what raises methodology heat during a review.

Checklist:

- For each PDPM component (PT, OT, SLP, Nursing, NTA), is there a specific note that supports the coded level — not just a general assessment?
- Does the MDS lock date align logically with the clinical picture at that point in the stay?

- Would the billed HIPPS code make sense to someone who had only read the clinical notes, without seeing the MDS?

5. Use Industry Context as Backdrop, Not Proof

Labor pressure, occupancy trends, and PDPM policy headlines are useful for understanding the environment your facility operates in. There is no evidence of what's in any individual chart. A facility with strong industry tailwinds can still have significant chart-level exposure, and a facility in a difficult labor market can still have clean documentation. Audit readiness must be evaluated stay by stay, not inferred from sector-level trends.

A Simple Monthly Self-Audit Routine

You don't need to wait for a survey to run this checklist. A practical monthly routine:

1. Pull 5-10 stays at random each month (prioritize your highest-acuity HIPPS codes)
2. Run the certification check (Section 1)
3. Run the note/MDS lock/claim reconciliation (Section 4)
4. Log any gaps and assign a corrective action owner
5. Track whether the same gap type repeats month over month — repetition is what turns an isolated error into a pattern-based risk

The Bottom Line

Auditors don't discover risk by reading your billed codes in isolation — they build it from the certification outward, looking for contradictions and repetition. Running that same sequence internally, on a regular schedule, is the most reliable way to catch documentation exposure before a MAC, surveyor, or federal auditor does.

If you'd like a structured chart review that walks through this exact sequence — certification, ADR/TPE pattern risk, denial theory, and note/MDS/claim reconciliation — RevOptix1's free chart review is a no-cost starting point, and PDPM Audit Optimization Group provides the expert-led audit defense behind it.