Five Documentation Tips That Reduce Audit Risk

By Teri Romano, RN, MBA, CPC, CMDP
1. Don't use the EHR to auto-populate information from the patient's last visit — unless there is a clinical rationale for using it in the patient's current visit.
EHRs have a lot of fine features, but one that is a risk management concern is the automatic "pulling forward" of notes from a previous visit. Although it may be a time saver, it can also make it a little too easy to finish a patient encounter without changing the auto-populated note to reflect the unique reason for the visit.

What do to? When working from auto-populated notes from a previous visit, modify them to reflect the unique reason for the current visit. Even better — if relevant — add notes in "comments" that express any specifics that were addressed in that visit.
2. Don't base the E/M code level on the volume of information the EHR produces.

Just because the note contains a lot of words and phrases doesn't necessarily mean it supports a certain E/M level. The correct E/M code is based on what was clinically relevant (i.e., medically necessary) for the patient's visit. And that varies depending on the history, examination, and medical decision making — not how many pages of notes get printed from the EHR.
3. Evaluate your utilization of level 4 and 5 E/M codes.

Simply put: if providers use too many level 4 and 5 codes compared to peers in their specialty and state, they are automatically on CMS' and other payers' radar for potential audit.
How do you know whether utilization of levels 4 and 5 are high in your practice? Generate a CPT frequency report from the computer and compare annual usage patterns for each provider against Medicare's usage pattern data. CMS sells this raw data by specialty and state so you can run your own analysis. You can also skip the need to parse raw data and set up data models and use a product that does it for you, such as the E/M Profile Analyzer. You enter each provider's E/M usage and the product graphs it against CMS usage patterns in your state and specialty.
"But we use more level 4 and 5 codes because our patients have more complex issues and comorbidities, and take more time to counsel and treat."

Fair enough. But if that is indeed the case, take a sampling of each provider's notes for visits billed as level 4 and 5, and review them to ensure they meet CPT criteria for the billed code.
4. Evaluate your EHR template use.

If every patient's exam documentation looks the same — often referred to as "cloning" — your documentation may be suspect. This often occurs when providers lean on the EHR templates a little too heavily and don't modify the template to match the unique exam for the patient. The result is exam documentation that looks strikingly similar, visit after visit and patient after patient.

The fix? Train providers how to customize their exam templates so the note accurately describes the exam. If necessary, create more granular visit templates or ideally, a unique template for the top 20 most common conditions or diagnoses the provider treats.
5. Using a scribe for any or all of your documentation? Document this fact correctly.

A scribe does not act independently. He simply documents the activities of the visit on the provider's behalf. Payers expect that the provider they reimburse for those services is the clinician delivering them, and creating the record.

To substantiate this, in any provider documentation for which a scribe was used, do the following: enter the name of the person "acting as a scribe for Dr. X" in the note; direct the scribe to sign the note (because everyone must authenticate his or her own entry); and be sure the provider signs the note indicating that it is an accurate record of all discussion and actions taken during that visit.
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