AUDIT-READY RESOURCE CENTER

Documentation Decision Trees

Visual frameworks for evaluating documentation completeness, specificity, linkage, consistency, and coding support.

1	**Review the Complete Record** Identify the encounter purpose, documented conditions, services, findings, and relevant supporting details.
2	**Define the Documentation Question** Determine whether the issue involves completeness, specificity, linkage, consistency, time, or clinical support.
3	**Follow the Official Guidance** Apply the appropriate official coding guidelines, payer policy, or organizational standard before reaching a conclusion.
4	**Determine Documentation Support** Decide whether the record is supported, incomplete, conflicting, unclear, or requires clarification.
5	**Document the Next Action** Record the finding, supporting evidence, impact, and whether correction, education, query, or escalation is appropriate.

Core principle: Documentation must clearly support the reported diagnosis, service, code, and level of care. Do not infer facts that are absent, unclear, or conflicting.

Think Like an Auditor. Code with Intent. Defend with Confidence.

Review the record. Identify the gap. Document the rationale.

Core Documentation Decision Pathways

Use these pathways as a structured starting point for documentation review.

Completeness	**Decision question:** Are all required elements present for the reported diagnosis or service?	**YES:** Continue to specificity, linkage, and consistency review. **NO:** Identify the missing element and determine whether clarification or education is needed.
Specificity	**Decision question:** Does the record include the detail needed for the most specific supported code?	**YES:** Assign or validate the supported level of specificity. **NO:** Use a permitted less-specific code or query when additional detail is required.
Linkage	**Decision question:** Does the record clearly connect the condition, manifestation, complication, or treatment relationship?	**YES:** Apply the documented relationship and official guidance. **NO:** Do not assume linkage; seek clarification when the relationship is required.
Consistency	**Decision question:** Are the history, assessment, plan, orders, and results internally consistent?	**YES:** Proceed with the supported conclusion. **NO:** Resolve or escalate material conflicts before final coding or audit disposition.
Time Support	**Decision question:** Does the record contain the time detail required for the reported service?	**YES:** Validate the time-based service using the applicable rule. **NO:** Do not infer time; identify the documentation gap or query when permitted.
Clinical Support	**Decision question:** Does the documentation support the reported condition, service, risk, or level of care?	**YES:** Document the supported conclusion and rationale. **NO:** Identify the unsupported element and determine the appropriate corrective action.

Documentation Review Safeguards

These safeguards help keep documentation findings objective, consistent, and defensible.

Use the Complete Medical Record

Do not make a final decision from one note section, copied-forward statement, or isolated data element.

Follow the Official Guidance

Apply the appropriate official coding guidelines, payer policy, or organizational standard before reaching a conclusion.

Do Not Infer Missing Facts

Document only what the record establishes; seek clarification when required information is absent or ambiguous.

Separate Documentation From Intent

A documentation gap does not automatically establish improper intent, fraud, or abuse.

Describe the Finding Objectively

State what is present, missing, conflicting, or unsupported without overstating the evidence.

Preserve the Audit Trail

Retain the reviewed evidence, applicable guidance, rationale, disposition, and follow-up action.

Three Questions Before Finalizing

QUESTION 1

Does the medical record support my decision?

QUESTION 2

Did I follow the applicable official guidelines, payer policy, or organizational standard?

QUESTION 3

Could another coder or auditor reproduce the same conclusion from the same record?