AUDIT-READY RESOURCE CENTER

If It Is Not Documented

A documentation-integrity framework connecting the medical record to coding support, claim defensibility, and audit readiness.

The Documentation Support Test

Before validating a code or claim element, review the record through four documentation-integrity lenses.

Step	Review Lens	Audit Question
1	**Presence**	Is the required information actually documented in the record?
2	**Clarity**	Is the documentation specific, internally consistent, and understandable?
3	**Linkage**	Does the record connect the condition, service, site, laterality, time, or clinical rationale when required?
4	**Support**	Does the documented evidence justify the reported code, service level, modifier, or diagnosis?

Common Documentation Gaps

Missing Detail

The record lacks specificity needed to support the selected code or service.

Conflicting Statements

Different sections of the record describe the condition, service, or findings inconsistently.

Unsupported Linkage

The relationship between diagnoses, symptoms, treatment, time, or medical necessity is not established.

Copied-Forward Content

Repeated language may not reflect the current encounter or the work actually performed.

Incomplete Time Support

Time-based reporting lacks qualifying total time, start/stop time, or required activity details.

Unclear Clinical Rationale

The record does not explain why the service, test, treatment, or level of care was reasonable and necessary.

Document the Finding - Not the Assumption

A defensible finding explains the documentation condition, the applicable requirement, and the resulting risk without assigning intent that the evidence does not establish.

Condition	What is present, missing, conflicting, or unsupported in the record?
Criteria	What authoritative guideline, payer policy, edit, or internal standard applies?
Impact	What coding, compliance, reimbursement, quality, or operational risk results?
Recommendation	What correction, education, clarification, or monitoring is appropriate?

Use Objective Audit Language

Instead of	Use
The provider upcoded the service.	The documented elements do not support the reported level of service.
This was fraudulent.	The variance creates a compliance risk and requires further review.
The coder should have known.	The finding indicates a potential education or process gap.
The diagnosis is wrong.	The record does not support the reported diagnosis as documented.

Three Questions Before Finalizing

QUESTION 1

Can another reviewer identify the same documentation gap from the same record?

QUESTION 2

Did I cite the requirement that supports the finding?

QUESTION 3

Did I separate the documentation issue from assumptions about intent?

Think Like an Auditor. Code With Defensibility.

If it is not documented, it is not supported.