Documentation Integrity Checklist

A practical review of specificity, clarity, consistency, authentication, and support for reported services.

Review purpose: Confirm that documentation is complete, specific, internally consistent, authenticated, clinically relevant, and sufficient to support reported diagnoses, procedures, modifiers, units, and medical necessity.

Patient, Encounter & Author Verification

- ■ Correct patient and date of service are identified.
- ■ The author, rendering provider, and applicable credentials are clear.
- ■ The note is signed, dated, and authenticated according to organizational requirements.
- ■ The documented setting and encounter type match the service reported.
- ■ Required orders, referrals, certifications, or authorizations are present when applicable.

Reason for the Encounter

- ■ The chief complaint or reason for the encounter is clearly documented.
- ■ The record reflects the patient's current clinical needs.
- ■ The documented purpose of the visit is consistent with the assessment and plan.
- ■ Preventive, screening, follow-up, aftercare, and problem-oriented services are clearly distinguished.
- ■ The record does not rely solely on a diagnosis list to explain why the service occurred.

Clinical Specificity

- ■ Diagnoses are documented with the highest clinically supported specificity.
- ■ Laterality, site, acuity, severity, stage, type, and episode of care are documented when relevant.
- ■ Acute, chronic, active, resolved, historical, and status conditions are clearly distinguished.
- ■ Cause-and-effect relationships are documented when required for accurate code assignment.
- ■ Unspecified terminology is used only when greater specificity is not clinically known.

Assessment & Plan Support

- ■ Each reported diagnosis is addressed in the assessment and plan.
- ■ The record shows evaluation, treatment, monitoring, or management of credited conditions.
- ■ The plan is consistent with the documented clinical findings.
- ■ Medication, testing, referral, procedure, follow-up, and monitoring decisions are clearly stated.
- ■ Conditions listed without current evaluation or management are not presented as actively addressed.

Procedure & Service Documentation

- ■ The service or procedure performed is clearly identified.
- ■ The indication and medical necessity for the service are documented.
- ■ Anatomic site, laterality, technique, findings, and outcome are documented when applicable.
- ■ Units, dosage, route, time, supplies, devices, or medications are recorded when relevant.
- ■ Documentation supports separately reported services and applicable modifiers.

Clarity & Internal Consistency

- ■ The history, examination, assessment, plan, orders, and results are internally consistent.
- ■ Conflicting diagnoses, dates, sites, laterality, or treatment details are resolved.
- ■ Abbreviations and terminology are clear and not misleading.
- ■ The record does not contain unexplained discrepancies between structured fields and narrative text.
- ■ Documentation supports a consistent clinical story from presentation through disposition.

Templates, Copy-Forward & Imported Data

- ■ Templated content is individualized to the current encounter.
- ■ Copied or carried-forward information remains accurate and clinically relevant.
- ■ Outdated, duplicated, or contradictory information is removed or corrected.
- ■ Imported test results, medication lists, and problem lists are reviewed and incorporated appropriately.
- ■ The volume of templated text does not overstate the work performed.

Queries, Clarifications & Amendments

- ■ Documentation gaps are clarified through a compliant query process when appropriate.
- ■ Queries are non-leading, clinically supported, and retained according to policy.
- ■ Amendments, corrections, addenda, and late entries are clearly identified and dated.
- ■ The original documentation remains traceable after correction.
- ■ Changes are not made solely to increase reimbursement or bypass an edit.

Medical Necessity & Defensibility

- ■ The documentation supports why the service was reasonable and necessary.
- ■ The intensity, frequency, and duration of services are clinically supported.
- ■ Reported diagnoses support the services, tests, procedures, and level of care.
- ■ The record supports applicable coverage, payer, and organizational requirements.
- ■ Every reported code can be traced to clear documentation in the medical record.

Final Integrity Review

- ■ All required documentation components are present.
- ■ No unsupported diagnosis, procedure, modifier, or unit remains.
- ■ The record is complete enough for another qualified reviewer to understand the care provided.
- ■ Identified deficiencies are documented and routed for correction, education, or escalation.
- ■ The final record is accurate, complete, consistent, authenticated, and defensible.

Documentation Finding Classification

■ Complete and supported	■ Specificity deficiency	■ Authentication deficiency
■ Internal inconsistency	■ Query or clarification needed	■ Education or escalation recommended

Integrity reminder: The medical record should clearly show what was evaluated, what was performed, why it was necessary, and how the documented information supports the reported service.

Educational Disclaimer