

Audit Date Range: 01/01/2012 to 02/28/2014

**Reviewer:** Auditor A  
**Provider:** Farwood MD, Elwood  
**Number of Reports Audited:** 9  
**Comments:**

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Records Accurately Coded	2	22.22%
Records Over Coded	3	33.33%
Records Under Coded	4	44.44%
Records Wrong Category(WC)	2	22.22%

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## Document and Coding Issues

**1 Encounter(s) had the Issues of:** *Documented Higher Level (I)*

The documentation substantiates a higher level of service than charged.

**1 Encounter(s) had the Issues of:** *Assessment (I)*

The assessment is not clearly stated for this encounter. Documentation Guidelines states 'The documentation for each patient encounter should include: . . . assessment, clinical impression or diagnosis . . .'

**1 Encounter(s) had the Issues of:** *25 Modifier (I)*

Misuse of the 25 modifier.

**1 Encounter(s) had the Issues of:** *Documented Lower Level (I)*

The documentation substantiates a lower level of service than charged.

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## Recommendations

### Documented Higher Level (R)

The documentation was thorough, and showed medical necessity. According to Documentation Requirements, there was enough documentation to substantiate the next higher level of service; and this would have increased revenue to the practice.

### Assessment (R)

The assessment should be clearly documented for each encounter. Since each note must 'stand alone', it is imperative to accurately document the most specific diagnosis in the assessment / impression section of the note.

### 25 Modifier (R)

Our recommendation of the misuse of the 25 modifier.