Clinical Record Review Internal Auditing Best Practice

Purpose: Internal auditing of clinical records is a continuous quality improvement (QI) process. Reviewing clinical records for correct coding and supporting documentation is essential to ensure compliance with the National Correct Coding Initiative, which requires accurate coding to reduce the incidence of under and overpayments by Medicare and Medicaid (Centers for Medicare and Medicaid Services, n.d.). Ensuring correct coding also reduces the incidence of third-party payment audits, recoupments, and overbilling of self-pay patients.

Internal Auditing: Clinical record coding, billing, and supporting documentation should be part of each agency's internal auditing process and policy. Clinical records should be reviewed quarterly to ensure compliance with the national coding standards.

Audit Team: The audit team should be multidisciplinary and include clinical and non-clinical staff from the agency. The audit team should include the provider(s) of clinical services as reviewers and subject matter experts.

Audit Sampling: The audit sample should include a minimum of three records per provider across all evaluation and management services defined by agency policy. If the clinical record review reveals that further review is necessary to determine the adherence to correct coding guidelines, two more records should be pulled into the sample for review

Audit Findings:

- If the clinical record audit reveals over or under coding in one third of the clinical records, an improvement plan should be developed with the provider and the providers records reviewed in sixty days for correct coding as defined in agency policy.
- At the sixty day follow up if the audit again reveals over or under coding in one third of the records reviewed the improvement plan should be extended for an additional sixty day follow up.
- Audit findings should be communicated with the provider by the appropriate representative detailed in the agency policy.
- Audit records and reports should be maintained by the agency as defined in agency policy.

Audit Tools: The audit tools, instructions, and training for clinical record auditing can be found on the NCDPH For Local Health Department website

Additional Resources: For support, training, and technical assistance, please contact your Regional Nurse Consultant in the Office of the Chief Public Health Nurse.

Centers for Medicare and Medicaid Services. (n.d.). *The National Correct Coding Initiative in Medicaid*, https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.html