Documentation Red Flag Self-Audit: what's your audit risk score?

These are the patterns auditors and payers look for first. Score each one honestly for your own practice, add up the total, and see where you land.

HOW TO SCORE

- 0 Never, or not applicable
- 1 Sometimes or inconsistently
- 2 Often, or **I'm not sure**

If you can't confirm it, score it 2. An auditor won't give you the benefit of the doubt either.

	RED FLAG	0	1	2
CLINICAL DOCUMENTATION				/ 8
01	**Cloned or copy-forward notes** History, exam or plan text carried over from earlier visits without being updated for today's encounter.	0	1	2
02	**Template defaults left in place** Pre-populated "normal" findings or review-of-systems entries that weren't actually examined or asked.	0	**1**	2
03	**Missing or vague time statements** Time-based E/M or other timed services billed without total time and the activities that time covered.	0	1	2
04	**Signature problems** Unsigned, late-signed or stamped notes, missing credentials, or no attestation for scribes and students.	0	1	2
CODING & MODIFIERS				/ 8
05	**Routine modifier 25** Added to E/M on procedure days without a significant, separately identifiable service documented.	0	**1**	2
06	**Modifier 59 / X{EPSU} to clear edits** Used to get past NCCI edits when the note doesn't show a distinct site, session or encounter.	0	1	2
07	**Diagnosis doesn't support the service** Medical necessity isn't clearly tied to the codes, orders or level of service billed.	0	1	2
08	**Top-heavy E/M levels** Most visits coded 99214/99215, or a level mix well above specialty benchmarks.	0	1	2
ENROLLMENT & OVERSIGHT				/ 8
09	**Enrollment gaps** Providers seeing patients before payer effective dates, or billing under another provider's NPI in the meantime.	0	1	2
10	**Incident-to / split-shared gaps** Billed without documented supervision, or without showing who performed the substantive portion.	0	1	2
11	**Lapsed credentials or revalidation** Expired licenses or DEA, missed CAQH attestations, or overdue Medicare revalidation.	0	1	2
12	**No recent internal audit** No documentation or coding review in the last 12 months, or findings that were never followed up.	0	1	2

YOUR TOTAL

2 / 24

2 of 12 answered



Low risk 0–6
Good habits are in place. Keep them up with routine internal reviews.

Moderate 7–14
Gaps are starting to show. Pick your 2s and fix those first, before a payer finds them.

High risk 15–24
An external audit is likely to find problems. A focused documentation review is the next step.

Practice / specialty _____ Date _____