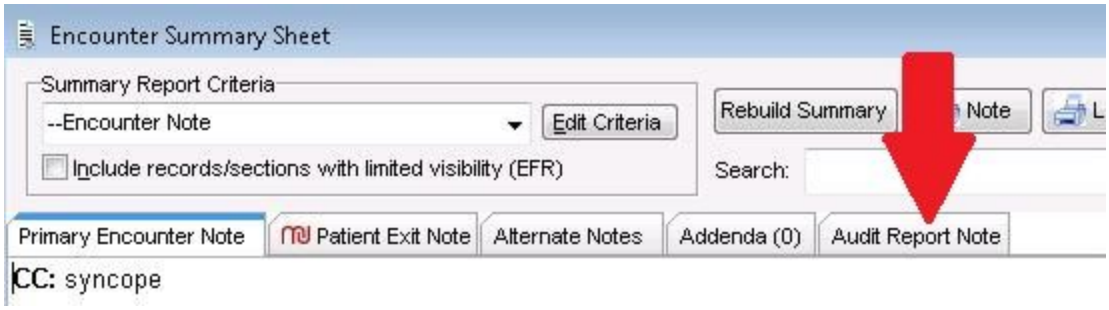
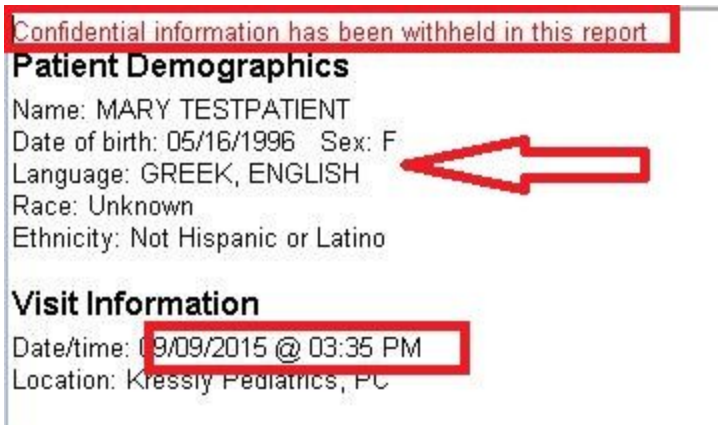
Understanding the Audit Report Note

What is an audit report note?
The audit note was added to more recent versions of OP to assist practices who were being subject to payer audits. The audit note is ***not*** customizable by end users and reflects a compilation of information that often is asked for by auditors/reviewers. OP allows users to edit the contents of the standard primary encounter note which for some audited practices did not contain specific enough information to support CMS coding guidelines.

Where do I find the audit report note?
After your note has been finalized the Audit Report Note tab will be visible when you click on the Encounter Note:
Chart→ Encounters→ Double click on finalized note
On the Encounter Summary Sheet, to the far right you will see a tab labeled "Audit Report Note":



What information is in the audit report note?

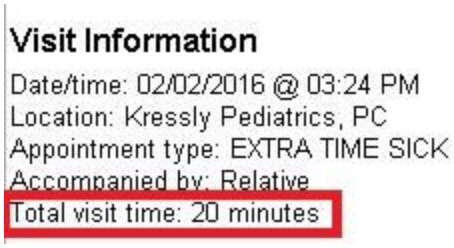


1. ALL audit report notes contain a disclaimer that the note may not include confidential information. This is because some reviewers may not be entitled to confidential information. If they request additional information that may be in the primary encounter

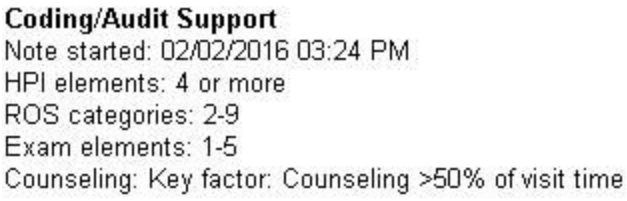
note, it is up to the user/provider to determine if they would like to add the encounter note including confidential information as an adjunct report for a payer reviewer.

2. Meaningful Use information is provided as some payer (especially Medicaid) reviewers are looking for this information.
3. Visit Information includes the date and start time.
4. If there is a appointment type associated with the appointment in the schedule, that will be displayed in the audit report note along with the start time. If the user decides to choose a coding level based on time, **and** they enter the total time of the visit in the coding decision support tab on the bottom right...

The audit note will also reveal the visit length in the Visit Information:



5. The audit report note also contains a summary of the information that was presented on the coding decision support.



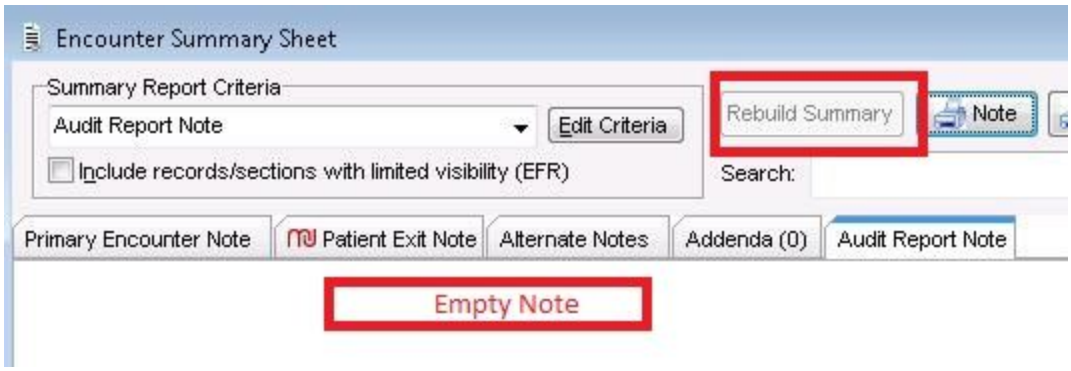
6. If you override the coding decision support manually, for any reason, including you entered information on the Medical Decision Making (MDM) section, override wording is

included in the Coding/Audit Support Documentation.

Coding/Audit Support
Note started: 02/02/2016 02:24 PM
HPI elements: 4 or more
ROS categories: 2-9
Exam elements: 12 or more
MDM differential diagnoses: Limited
MDM data reviewed: Minimal or none
MDM risk of complications: Moderate
Counseling: Time not a key factor
*Manual coding overrides were applied to this encounter.

How do I generate this audit report note?
OP automatically generates and saves an audit report note at the same time the user finalizes the primary encounter note. Simply open the note as you normally would and toggle from the tab for primary encounter note, to the audit report note tab to the far right.

What about old notes that existed prior to this Audit Report Note feature?
If you go to an old encounter note that was finalized prior this feature was added, you will notice that the Audit Note Report is empty and the “rebuild summary” button is inactivated:



If you toggle to the tab that says “Alternate Notes” and you Select Audit Report Note in the Summary Report Criteria then select “Rebuild Summary” you will get a recreation of the Audit Report Note. Best practices are to include the reason in the comment/purpose field:

Important information about old encounter notes: very old notes may not be supported by this function based on how the note was stored in the database. In addition, the audit report note may not contain all of the fields that you expect based on how the note was originally compiled. Please review the information before submitting for review.

Under what circumstances should I use this Audit Report Note?
If you receive a payer coding review or audit, Office Practicum recommends that you first start by generating and printing out the audit report note. Prior to submitting to the payer/reviewer, best practices including having someone with coding expertise (within your organization or an external consultant) review these notes for comments/completeness. You may want to include additional information such as survey details, diagnostic test results, or other materials which are supportive of the work completed for the visit and coding level chosen.