Optometry Coding & Billing Alert

Reader Questions: Provide Copies to an Outside Auditor

Question: When our outside auditor gets copies of chart notes to perform an audit, the patient's name is usually the only identifying information on the paper. I think the patient's date of birth and the medical record number should also be on every piece of paper in the chart - this would help the auditor distinguish more easily between records. Are there any official requirements that describe which identifying information should be on the medical record for audits?

Washington Subscriber

Answer: First of all, remember that you should send only copies of medical records to an outside auditor (such as a consultant) - never the originals. And you should black out the patient's name to ensure confidentiality. But there really are no standard rules dictating what identifying information you must put on records headed for audit. To ensure an efficient and accurate audit, each record should include:

1. a copy of the medical record documentation for the given date of service, and
2. a copy of the superbill with the reported ICD-9 and CPT codes for the date of service, or ICD-9 codes and CPT codes written on a copy of the record for the date of service.

Information such as the patient's date of birth or medical record number may help the auditor but are not necessary. Your office may want to assign a special audit number to each record for clarity.

Experts warn: If the auditor is acting on behalf of a carrier, the auditor doesn't have the right to look at records of patients not covered by that carrier's plan. The auditor can see the carrier's patients and no more.