Guidelines for Chiropractic Clinical Records Scoring Tool

PART I: IDENTIFICATION PARAMETERS (excludes non-clinical forms)

Points	Patient Name
2	The patient's name is on every page of the file.
1	The patient's name is on most of the pages of the file.
0	The patient's name is not or rarely noted in the file.

	Patient DOB or Unique ID #
2	The patient's DOB or unique ID # is on every page of the file.
1	The patient's DOB or unique ID # is on most pages of the file.
0	The patient's DOB or unique ID # is not or rarely noted in the file.

	Provider Name
2	The provider's name (not clinic name) is on every page of the file.
1	The provider's name (not clinic name) is on most pages of the file.
0	The provider's name (not clinic name) is not or rarely noted in the file.

	Provider Address
2	The provider's address is on every page of the file.
1	The provider's address is on most pages of the file.
0	The provider's address is not or rarely noted in the file.

	Provider Phone Number
2	The provider's phone number is on every page of the file.
1	The provider's phone number is on most pages of the file.
0	The provider's phone number is not or rarely noted in the file.

	Date of Visit
2	The date of visit is on every page of the file.
1	The date of visit is on most pages of the file.
0	The date of visit is not or rarely noted in the file.

	Signed/Initials
3	The author of record is legibly identified, and the chart note is signed by hand or digitally or initialed at the end of each date of service.
2	The author of record is legibly identified, and the chart note is signed by hand or digitally or initialed at the end of every page.
1	The author of record is not legibly identified, and the chart note is signed or initialed at the end of each date of service or page.
0	The author of records does not sign their chart notes.

PART II: INITIAL EVALUATION

Patient Chief Complaint(s)/Comments/Subjective

Past History
Significant past history is defined as past medical history that is significant to presenting chief complaint(s) but may not necessarily be directly related to the chief complaint(s). For instance, history of kidney stones and kidney infection is significant past history in relation to chief complaint(s) of lower back pain. Significant past history usually comes up as response to doctor's line of questioning.

2	The provider notes the patient's significant past history and history specific to current condition.
1	The provider notes the patient's significant past history OR the patient's history specific to current condition, but not both.
0	The provider does not note the patient's past history.

Review of Systems
Review of systems is a brief review of past or current health issues by body system (for instance: genitourinary, gastrointestinal, cardiorespiratory, etc.). This may be done with a check off list or by direct questioning, i.e., Have you ever had or are you now having problems related to your digestive system, urinary tract, etc.?

2	There is a thorough review of systems.
1	There is a minimal review of systems.
0	The doctor does not note that a review of systems was done.

	Prior imaging and/or lab documented
2	Prior x-ray and/or lab tests were done and findings noted or requested.
1	Prior x-ray and/or lab tests were noted on intake but not followed up.
0	No indication of whether prior testing was done when warranted.

Chief Complaint(s)
Chief complaint(s) means current chief complaint(s), not historical or "suffering for years from…".

	Location
2	The location of the chief complaint(s) is specifically noted. (e.g., right lumbosacral or distal third of left lateral forearm)
1	The location of the chief complaint(s) is generally noted either in narrative form or with a pain drawing (e.g., low back or left arm).
0	The location of the chief complaint(s) is not listed.

	Frequency
1	The frequency of the chief complaint(s) is noted.
0	The frequency of the chief complaint(s) is not noted.

	Onset
2	The provider notes how and when the chief complaint(s) began.
1	The provider notes how or when the chief complaint(s) began.
0	There is no note regarding the onset of the chief complaint(s).
	Provoking/Palliating
1	Provoking and/or palliative conditions associated with the chief complaint(s) are noted.
0	Provoking and/or palliative conditions associated with the chief complaint(s) are not noted.
	Quality
1	The quality of the chief complaint(s) is noted.
0	The quality of the chief complaint(s) is not noted.
	Radiation
1	The radiation of the chief complaint(s) is noted if chief complaint(s) is in the cervical or lumbar regions.
0	The radiation of the chief complaint(s) is not noted.
	Severity
1	The intensity of the chief complaint(s) is noted.
0	The intensity of the chief complaint(s) is not noted.
	Timing / Time of Day
1	The timing of the chief compliant(s) is noted, (i.e., wakes with it, it is worse at night, end of work day or it is stated that chief complaint(s) is independent of timing).
0	The timing of the chief complaint(s) is not noted.

Preventative Health

The chart documents for preventive health (PH) factors in the patient-completed forms, the clinical history, and examination or in some other way. One point for each.

1	Smoking Status
1	Exercise Status

Objective Findings

	Vitals
1	Height/Weight
1	Blood Pressure

	Inspection/Posture
2	The provider notes the patient's posture and references inspection of the patient.
1	The provider notes the patient's posture, but it is not fully qualified and quantified.
0	The provider does not note the patient's posture on the intake exam.

	Palpation
3	The provider notes all significant palpatory findings on the initial exam.
2	The provider notes some palpatory findings on the initial exam.
1	The provider notes few palpatory findings on the initial exam.
0	The provider does not note palpatory findings on the initial exam.

	Range of Motion (ROM)
3	The provider lists ranges of motion in degrees with specific detail including if it caused pain and where.
2	Both elements of range of motion and pain are included, but only one component is detailed (e.g., degrees are listed but there is no indication of pain or pain-free or where).
1	The provider lists ranges of motion qualitatively (% of normal, mildly, or moderately restricted, etc.).
0	The provider does not list ranges of motion on the initial exam.

	Orthopedic/Neurological testing: Any testing done?
2	Provider performed provocative orthopedic or neurological testing.
1	Testing was done but is incomplete or missing important tests.
0	No testing was performed.

	Orthopedic/Neurological testing: Appropriate for condition?
2	Testing was appropriate for patient's condition.
1	Testing done was appropriate, but some important tests were not done.
0	The testing was not appropriate for the patient's condition.

	Orthopedic/Neurological testing: Adequately qualified and quantified?
2	All documented ortho/neuro testing was adequately qualified and quantified.
1	Some of the tests are adequately qualified and quantified
0	The testing was not adequately qualified and quantified.

Diagnosis

	Initial Diagnosis
3	There is an initial diagnosis documented.
0	There is no initial diagnosis documented.

	Diagnosis consistent with subjective and objective data
2	The diagnosis is consistent with the subjective and objective findings.
0	The diagnosis is inconsistent with regards to the subjective and objective findings.

	Indications for x-ray and/or lab
2	Subjective and objective findings support x-rays and/or lab tests done with appropriate reporting.
1	Subjective and objective findings support x-rays and/or lab tests done without appropriate reporting.
0	Subjective and objective findings do not support x-ray and/or lab tests done.

Treatment, Modalities & Procedures

	Location
1	The provider specifically identifies the anatomical location of the therapy.
0	The provider does not specifically identify the location or the location is vague.

	Duration
1	The provider specifically lists the duration of the therapy.
0	The provider does not identify the duration of the therapy.

	Intensity of Modalities
1	The provider specifically lists the intensity of the therapy.
0	The provider does not identify the intensity of the therapy.

	CMT Listings, Level
2	It is clear which vertebral level/joint was adjusted/treated.
1	There is an objective finding of a listing, but it is unclear that this listing was also treated/adjusted.
0	The provider does not list the level being adjusted.

	CMT Listings, Side
2	It is clear which side of the joint was adjusted/treated.
1	There is an objective finding of the side of the joint restriction/subluxation, but it is unclear what was adjusted/treated, or some listings include side but not all.
0	The provider does not list the side being adjusted.

Treatment Plan Documentation

	Frequency/Duration
2	There is a treatment plan that indicates frequency (# of visits) and duration. One point for each.
1	There is a treatment plan that includes frequency (# of visits) or duration.
0	The treatment plan does not include frequency (# of visits) or duration. Note: “return in 1 week” or PRN is not a sufficient treatment plan.

	PARQ
4	Informed consent. The elements of informed consent are present (PARQ). One point for each. “PARQ” is acceptable. PARQ consent form with all 4 elements is preferred. P=Procedures, A=Alternatives, R=Risks, Q=Questions

PART III: DAILY VISIT NOTES

Daily visit notes need to be encounter specific for each date of service and contain both qualitative and quantitative elements evident for the subjective and objective portions of the documentation. EMR generated documentation is commonly identical to the letter, comma, and space, with only minor word changes; therefore, it does not reflect medical necessity. Daily visit notes submitted with repetitive entries lacking encounter specific information will cause the entire clinical record to fail this review process.

S.O.A.P.

	Subjective: Patient Chief Complaint(s)/Comments
5	The patient's chief complaint(s) are noted on every chart note and there is specific information about how the patient feels that day since their last visit.
4	The patient's chief complaint(s) are noted and well documented in most of the chart notes.
3	The patient's chief complaint(s) are noted and well documented in some of the chart notes.
2	There are very few patient chief complaint(s) and they are not very substantive.
1	The provider only repeats or references presenting chief complaint(s) from the initial visit (i.e., same as above). Comments are not visit specific.
0	There are no patient chief complaint(s) or comments on any chart notes.

	Interval
4	The provider has noted changes in the patient's condition since the last visit on every chart note.
2	The provider has only sporadically noted interval changes or uses single words like "improved" or "better".
0	There is no indication of interval changes in the chart notes.

	Body Parts
3	The body part is specifically listed in the chief complaint(s) or is marked clearly in a pain drawing or diagram at each visit
2	The body part is specifically listed on most visits.
1	The body part is specifically listed on some visits.
0	The body part is not identified.

	Objective: Findings
5	There are adequate and detailed findings of the patient's condition listed in every chart note. These findings might include muscle findings, subluxation levels, and changes in ROM or provocative testing, for example. There should be some findings referencing the patient's condition at each visit but not necessary to do full examination at each visit.
4	There are adequate and detailed findings of the patient's condition listed in most chart notes.
3	The only findings noted are specific listings.
2	There are findings of the patient's condition on some chart notes, but they are not very detailed OR the findings are exactly the same.
1	There are few findings of the patient's condition in the patient's chart notes or are not visit specific.
0	There are no findings listed.

	Assessment:
5	The provider notes an updated clinical assessment on every chart note. The assessment indicates the doctor's clinical thought process concerning subjective and objective data and/or the patient's response to care.
4	There is a clear and descriptive assessment on most visits or there is a periodic update of the diagnosis.
3	There is an assessment periodically that is adequate to ascertain patient response to treatment.
2	The diagnosis is listed at each visit, but it has not been updated since the initial visit.
1	There are few notes with a patient assessment noted or do not correlate with subject complaints or objective findings.
0	There is no patient assessment information.

Plan: Treatment, Modalities & Procedures

	Location
1	The provider specifically identifies the anatomical location of the therapy.
0	The provider does not specifically identify the location or the location is vague.

	Duration
1	The provider specifically lists the duration of the therapy.
0	The provider does not identify the duration of the therapy.

	Intensity of Modalities
1	The provider specifically lists the intensity of the therapy.
0	The provider does not identify the intensity of the therapy.

	CMT Listings, Level
2	It is clear which vertebral level/joint was adjusted/treated.
1	There is an objective finding of a listing, but it is unclear that this listing was also treated/adjusted.
0	The provider does not list the level being adjusted.

	CMT Listings, Side
2	It is clear which side of the joint was adjusted/treated.
1	There is an objective finding of the side of the joint restriction/subluxation, but it is unclear what was adjusted/treated.
0	The provider does not list the side being adjusted.

Patient Instructions

	Home Care Instructions
2	The provider has given the patient specific home care instructions.
1	The provider has given the patient some sort of home care instructions.
0	The provider has not given the patient home care instructions.

	Exercises/Stretches (Not applicable if exercises given on initial visit.)
2	The provider has given the patient specific exercises and/or stretches and has documented that they have instructed the patient how to complete them properly and has followed up with the patient on subsequent visit(s).
1	The provider has given the patient general exercises and/or stretches.
0	The provider has not given the patient exercises and/or stretches.

PART IV: OVERALL EVALUATION OF FILE

Clerical

	Legibility
4	Notes are typed.
3	Can read the whole file without difficulty.
2	Can read most of the file without difficulty.
1	Can read a small portion of the file but not much of it.
0	Can't read the file at all.

	Abbreviations understandable
1	The provider uses standard abbreviations that I can understand.
0	The provider does not use standard abbreviations.

	Sufficient space available on notes
1	There is enough space on the note to write additional information without having to condense the writing so much as to render it illegible.
0	There is not enough space for additional notes.

	If there is evidence of a referral to a specialist or PCP, is there indication of a report or other follow up?
1	There is evidence of a referral in the chart.

Clinical

	Treatment consistent with diagnosis?
6	Treatment is consistent with diagnosis.
3	Treatment consistency with diagnosis is unclear or incomplete.
0	Treatment is inconsistent with diagnosis or there is no diagnosis present.

	Treatment plan follow-up is appropriate?
6	Treatment plan follow-up is appropriate.
3	Treatment plan follow-up is unclear or incomplete.
0	There is no treatment plan.