Chiropractic Clinical Records Scoring Tool

INITIAL _____ CRQIP _____ MONTHLY AUDIT _____

Name of Chiropractor			
Date of Review			
Dates Reviewed			
Reviewer Name			
SCORED ELEMENTS	**AVAILABLE POINTS**	**POINTS GRANTED**	**SCORING COMMENTS**
PART I: IDENTIFICATION PARAMETERS (excludes non-clinical forms)			
Patient Name	2		
Patient DOB or Unique ID #	2		
Provider Name	2		
Provider Address	2		
Provider Phone	2		
Date of Visit	2		
Signed/Initials	3		
Subtotal	**15**	**0**	
PART II: INITIAL EVALUATION			
Patient Chief Complaint(s)/Comments/Subjective			
Past History	2		
Review of Systems	2		
Prior imaging and/or lab documented	2		
Chief Complaint(s)			
Location	2		
Frequency	1		
Onset	2		
Provoking/Palliating	1		
Quality	1		
Radiation	1		
Severity	1		
Timing	1		
Subtotal	**16**	**0**	
Preventative Health			
Smoking Status	1		
Exercise Status	1		
Subtotal	**2**	**0**	
Objective Findings			
Height/Weight	1		
Blood Pressure	1		
Inspection/Posture	2		
Palpation	3		
Range of Motion	3		
Any orthopedic/neurologic tests	2		
Appropriate for condition	2		
Adequately qualified & quantified	2		
Subtotal	**16**	**0**	
Diagnosis			
Initial diagnosis	3		
Diagnosis consistent with subjective & objective data	2		
Indications for x-ray and/or lab, if applies	2		
Subtotal	**7**	**0**	

Treatment, Modalities & Procedures			
Location	1		
Duration	1		
Intensity of modalities	1		
CMT Listing, Level	2		
CMT Listing, Side	2		
Subtotal	**7**	**0**	
Treatment Plan Documentation			
Frequency	1		
Duration	1		
Informed Consent (PARQ)	4		
Subtotal	**6**	**0**	
PART III: DAILY VISIT NOTES			
S.O.A.P.			
Subjective:			
Patient Chief Complaint(s)/Comments	5		
Interval	4		
Body Part(s)	3		
Objective: Findings	5		
Assessment:	5		
Plan: Treatment, modalities & procedures			
Location	1		
Duration	1		
Intensity of modalities	1		
CMT Listing, Level	2		
CMT Listing, Side	2		
Subtotal	**29**	**0**	
Patient Instructions			
Homecare instructions	2		
Exercises/Stretches	2		
Subtotal	**4**	**0**	
Are notes visit specific?*			
PART IV: OVERALL EVALUATION OF FILE			
Clerical			
Legibility	4		
Abbreviations understandable	1		
Sufficient space available on notes	1		
If there are referrals, is there evidence of a report	1		
Subtotal	**7**	**0**	
Clinical			
Treatment consistent with diagnosis	6		
Treatment plan follow up is appropriate	6		
Subtotal	**12**	**0**	

	Available Points	**Granted Points**
FINAL SCORE	**121**	**0**
FINAL PERCENTAGE: A passing score is at or above 70% unless notes do not meet visit specific criteria	**0%**	

*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 process.

REVIEWER COMMENTS: