Guidelines for Acupuncture 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 some pages of the file.
0	The patient's name is not noted on any of the pages 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 some pages of the file.
0	The patient's DOB or unique ID # is not noted on any of the pages in the file.

	Provider Name
2	The provider's name is on every page of the file.
1	The provider's name is on some of the pages of the file but not on all.
0	The provider's name is not noted on any of the pages in the file.

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

	Provider Phone
2	The provider's phone number is on every page of the file.
1	The provider's phone number is on some pages in the file.
0	The provider's phone number is not noted on any of the pages in the file.

	Date of Visit
2	The date is noted every time there is an entry in the chart.
0	Any entry in the chart is not dated.

	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

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	Height/Weight
1	Exercise Status

Patient Chief Complaint(s)

	Current Chief Complaint(s)
2	The patient's chief complaint(s) are noted on every chart note and there is specific information about how the patient feels that day.
1	The patient's chief complaint(s) are noted but not on every chart note or provider only notes "same as above" or something similar.
0	There are no patient reported chief complaint(s) or comments on any chart notes.

	Location
2	The body part(s) that is/are being treated is specifically identified.
1	The body part(s) that is/are being treated is generally identified.
0	The body part(s) is/are not identified or is not specific.

	Quality
1	The quality of the chief complaint(s) is noted.
0	The quality of the chief complaint(s) is not noted.

	Duration
1	The provider notes how long the chief complaint(s) lasts (e.g., when the chief complaint(s) comes on, it generally lasts for a few moments, or for several hours, or until the next day).
0	The duration of the chief complaint(s) is not noted.

	Intensity
1	The intensity of the chief complaint(s) is noted.
0	The intensity of the chief complaint(s) is not noted.

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

	Onset
1	The provider notes how the chief complaint(s) began.
0	There is no note regarding the onset of the chief complaint(s).

	Radiation
1	The radiation of the chief complaint(s) is noted.
0	The radiation of the chief complaint(s) is not noted.

	Associated Symptoms
1	Symptoms associated with the chief complaint(s) are included in the initial note.
0	Associated symptoms are not noted.

	Timing
1	The timing of the chief complaint(s) is noted (e.g., wakes with it, it is worse at night, end of workday).
0	The timing of the chief complaint(s) is not noted.

	Provoking/Palliating Factors
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.

Objective Findings

	Blood Pressure
1	Blood Pressure

	Palpatory Findings
3	The provider notes all significant palpatory findings on the initial examination.
2	The provider notes some palpatory findings on the initial examination.
1	The provider notes few palpatory findings on the initial examination.
0	The provider does not note any palpatory findings on the initial examination.

Diagnosis

	Initial Diagnosis (Bian Bing)
3	There is an initial diagnosis (Bian Bing) listed.
0	There is no initial diagnosis (Bian Bing) listed.

	Syndrome Differentiation (Dian Zheng)
3	There is a syndrome differentiation (Bian Zheng) listed.
0	There is no syndrome differentiation (Bian Zheng) listed.

Plan: Treatment, Modalities & Procedures

	Treatment, modalities & procedures
4	Treatment modalities and procedures are listed.
2	Acupuncture points are listed with no reference to modality employed.
0	Treatment modalities and procedures are not listed.

	Patient 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 any kind of home care instructions.

	Informed Consent (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
0	The provider does not note that PARQ has been done.

PART III: DAILY VISIT NOTES

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.

	Patient chief complaint(s) and comments
4	The patient's chief complaint(s) are noted on every chart note and there is specific information about how the patient feels that day.
2	The patient's chief complaint(s) are noted but not on every chart note or provider only notes "same as above" or something similar.
0	There are no patient chief complaint(s) or comments on any chart notes.

	Interval changes
4	The provider has noted changes in the patient's condition since the last visit on every chart note entry.
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 part(s)
3	The body part is specifically listed in the chief complaint(s) or is marked clearly in a pain drawing or diagram.
2	The body part is specifically listed, but not at every visit.
1	The body part is generally identified.
0	The body part is not listed or identified.

	Findings
4	There are detailed findings of the patient's condition listed in most chart notes.
3	There are detailed findings of the patient's condition listed in some chart notes.

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 from visit to visit until a re-examination is performed.
1	There are few findings of the patient's condition in the chart notes.
0	There are no findings listed.

	Provider Assessment
5	The provider notes an updated clinical assessment on every chart note. The assessment indicates the Provider'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.
0	There is no patient assessment information.

	Treatment, modalities & procedures
5	Acupuncture points, modalities and procedures are listed on every chart note.
4	Acupuncture points are listed with no reference to modalities or procedures on every chart note.
3	Treatment, modalities and procedures are listed on some chart notes – others signifying "same as (date)" or "repeat treatment of (date)".
2	Acupuncture points are listed on some chart notes with no reference to modalities or procedures.
1	There are few treatments, modalities, or procedures listed.
0	There are no treatments, modalities or procedures listed.

	Patient 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 any kind of home care instructions.

PART IV: OVERALL EVALUATION OF FILE

Clerical

	Legibility
4	The chart 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
1	The provider uses standard abbreviations that are understood.
0	The provider does not use standard abbreviations.

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

	Copy quality
1	The copies are clear enough to read without difficulty and no significant elements are cut off.
0	The copies are too dark or washed out or significant elements of the chart are cut off.

	S.O.A.P. format used
6	S.O.A.P. format is used. There is good content and things are listed in the appropriate sections.
5	There is good content and most of it is listed in the appropriate sections.
4	There is some content and it is listed appropriately.
3	SOAP format is used but the content is vague or incomplete.
2	The content is consistent and appropriate but is not in SOAP format.
1	SOAP format is not used and the content is inadequate.
0	There is minimal content.

Clinical

Does the treatment given seem reasonable or is it usual and customary for the diagnosis given? Does the treatment make sense for the condition being treated?

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

Are all the components in the treatment plan (**i.e., 1. therapeutic goals and 2. treatment modalities at a 3. particular frequency over a 4. particular timeframe**) complete and consistent with the patient's response and updated at appropriate intervals?

	Treatment plan is complete and follow-up is appropriate
8	All components are in place.
6	Most components are in place.
4	Some components are in place.
2	Few components are in place.
0	No components are in place.