

Acupuncture Clinical Records Scoring Tool

INITIAL _____

CRQIP _____

MONTHLY AUDIT _____

Name of Acupuncturist			
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			
Preventative Health			
Smoking Status	1		
Height/Weight	1		
Exercise Status	1		
Subtotal	3	0	
Patient Chief Complaint(s)			
Current chief complaint(s)	2		
Location	2		
Quality	1		
Duration	1		
Intensity	1		
Frequency	1		
Onset	1		
Radiation	1		
Associated Symptoms	1		
Timing	1		
Provoking/Palliating Factors	1		
Subtotal	13	0	
Objective Findings			
Blood Pressure	1		
Palpatory Findings	3		
Subtotal	4	0	
Diagnosis			
Initial diagnosis/diagnoses (Bian Bing)	3		
Syndrome Differentiation (Bian Zheng)	3		
Subtotal	6	0	
Plan: Treatment, Modalities & Procedures			
Treatment, modalities & procedures	4		
Patient Instructions	2		
Informed Consent (PARQ)	4		
Subtotal	10	0	

PART III: DAILY VISIT NOTES

Daily Visit Notes

Patient chief complaint(s) and comments	4		
Interval changes	4		
Body part(s)	3		
Findings	4		
Provider Assessment	5		
Treatment, modalities & procedures	5		
Patient instructions	2		
Subtotal	27	0	

Are notes visit specific?*

PART IV: OVERALL EVALUATION OF FILE

Clerical

Legibility	4		
Abbreviations	1		
Sufficient space	1		
Copy quality	1		
S.O.A.P. format used	6		
Subtotal	13	0	

Clinical

Treatment consistent with diagnosis	3		
Treatment plan follow-up is appropriate	8		
Subtotal	11	0	

Available Points	Granted Points
FINAL SCORE	102
FINAL PERCENTAGE: A passing score is at or above 80% 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: