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**	**0**
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: