Naturopathic Clinical Records Scoring Tool

INITIAL _____ **CRQIP** _____ **MONTHLY AUDIT** ____

Name of Naturopathic Physician			
Date of Review			
Dates Reviewed			
Reviewer Name			
SCORED ELEMENTS	**AVAILABLE POINTS**	**POINTS GRANTED**	**SCORING COMMENTS**
PART I: IDENTIFICATION PARAMETERS			
Identification Parameters			
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 Complaint(s)			
Problems	2		
Onset	2		
History of chief complaint(s)	2		
Symptoms experienced	4		
Associated symptoms	2		
Severity and degree of debilitation	2		
Review of systems	4		
Relevant family history	2		
Current medications/supplements	2		
Relevant Past Medical History	2		
Secondary complaints with history, modalities	4		
Subtotal	**28**	**0**	
Preventative Health			
Smoking Status	1		
Exercise Status	1		
Subtotal	**2**	**0**	
Objective Findings			
Vitals	3		
Subtotal	**3**	**0**	
Pertinent Physical Exam Performed			
Appropriate to chief complaint	4		
Appropriate to secondary complaints	2		
Documentation of findings	2		
Mental/Emotional assessment	2		
Relevant labs and diagnostic evaluation	2		
Subtotal	**12**	**0**	
Diagnosis			
Initial diagnosis (diagnoses) and assessment	3		
Indications for lab and/or x-ray (if applicable)	2		
Subtotal	**5**	**0**	

Treatment, Modalities & Procedures (done in house day of visit, if applicable)			
Treatment appropriate to subjective and objective findings	2		
Modalities and procedures appropriately documented	2		
Subtotal	**4**	**0**	
Treatment Plan Documentation			
Medicines: type, dosage and frequency prescribed	2		
Exercise, PT and diet recommendations	2		
Patient "Homework" prescribed	2		
Counseling performed	2		
Patient instructions	2		
Informed Consent (PARQ)	4		
Subtotal	**14**	**0**	
PART III: DAILY VISIT NOTES			
S: Patient Complaints			
Interim History	2		
Response to treatment and compliance with therapy	2		
O: Exam/Evaluation findings, if appropriate	4		
Mental/Emotional Assessment	2		
A: Assessment of response to treatment	4		
New diagnosis (diagnoses), if appropriate	2		
P: Treatment Plan modifications/additions/ dosage/frequency of medicines	2		
Dietary modifications	2		
Patient instructions	2		
Subtotal	**22**	**0**	
Are notes visit specific?*			
PART IV: OVERALL EVALUATION OF FILE			
Clerical			
Legibility	4		
Abbreviations understandable	1		
Sufficient space available on notes	1		
Copy quality	1		
If there are referrals, is there evidence of a report	1		
Subtotal	**8**	**0**	
Clinical			
Treatment consistent with diagnosis	6		
Treatment plan follow up is appropriate	6		
Subtotal	**12**	**0**	
	Available Points	**Points Granted**	
FINAL SCORE	**125**	**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: