Medical Record Documentation Standards Audit Tool Sample

Provider Name

Provider ID#: Provider Specialty:

Reviewer Name: Review Date: Score:

Member Name/Initials: Member ID#:

Confidentiality & Record Organization & Office Procedures	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
1. The office has a policy regarding medical record confidentiality that addresses office staff training on confidentiality; release of information; record retention; and availability of medical records housed in a different office. location (as applicable).									
2. Staff is trained in medical record confidentiality.									
3. The office uses a Release of Information form that requires member signature.									
4. There is a policy for timely transfer of medical records to other locations/ care providers.									
5. There is an identified order to the chart assembly.									
6. Pages are fastened in the medical record.									
7. Each member has a separate medical record.									
8. Medical records are stored in an organized fashion for easy retrieval.									
9. Medical records are available to the treating practitioner where the member generally receives care.									
10. Medical records are released to entities as designated consistent with federal regulations.									
11. Records are stored in a secure location only accessible by authorized personnel.									
12. There is a mechanism to monitor and handle missed appointments.									

History	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
1. Medical and surgical history is present.									
2. The family history includes pertinent history of parents and/or siblings.									
3. The social history minimally includes pertinent information such as occupation, living situation, etc.									

Preventive Services	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
1. Evidence of current age appropriate immunizations.									
2. Annual comprehensive physical (or more often for newborns).									
3. Documentation of mental & physical development for children and/or cognitive functioning for adults.									
4. Evidence of depression screening.									
5. Evidence of screening for high-risk behaviors such as drug, alcohol and tobacco use, sexual activity, exercise and nutrition .counseling									
6. Evidence that Medicare members are screened for functional status and pain.									
7. Evidence of tracking and referral of age and gender appropriate preventive health services.									
8. Use of flow sheets or tools to promote adherence to clinical practice guidelines/preventive screenings.									

Problem Evaluation and Management	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
Documentation for each visit includes:									
1. Appropriate vital signs (i.e., weight, height, BMI measurement annually).									
2. Chief complaint.									
3. Physical assessment.									

Problem Evaluation and Management	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
4. Diagnosis.									
5. Treatment plan.									
6. Treatment plans are consistent with evidence-based care and with findings/diagnosis.									
7. Appropriate use of referrals/consults, studies, tests.									
8. X-rays, labs, consultation reports are included in the medical record with evidence of practitioner review.									
9. Timeframe for follow-up visit as appropriate.									
10. Follow-up of all abnormal diagnostic tests, procedures, X-rays, consultation reports.									
11. Unresolved issues from the first visit are followed-up on the subsequent visit.									
12. There is evidence of coordination of care with behavioral health.									
13. Education, including counseling, is documented.									
14. Member input and/or understanding of treatment plan and options is documented.									
15. Copies of hospital discharge summaries, home health care reports, emergency room care, physical or other therapies as ordered by the practitioner are documented.									

_____	+	_____	=	_____	_____	+	_____	=	_____
(Questions)		(# N/A)		(Adjusted # of Questions)	(# Yes)		(Adjusted # of Questions)		(Score)

If a care provider scores less than 85%, review five more charts. Only review those elements the care provider received a “NO” on in the initial phase of the review. Upon secondary review, if a data element scores at 85% or above, that data element is recalculated as a “YES” in the initial scoring. If upon secondary review, a data element scores below 85%, the original calculation remains.

***Items are MUST PASS**