CHART AUDITING WORKSHEET

RECOMMENDATIONS

RECOMMENDATIONS		YES	NO	NOT APPLICABLE	AUDITORS RECOMMENDATION
1. The medical record should be complete and legible					
2. The documentation of each patient encounter should include: the date; reason for the encounter; appropriate history and physical exam; review of lab, X-ray data and other ancillary services and, when appropriate, assessment; and a plan of care (including discharge plan, if appropriate)					
DATE					
REASON FOR THE ENCOUNTER					
APPROPRIATE HX AND EXAM					
REVIEW OF LABS					
REVIEW OF XRAY					
DOCUMENTED ANCILLARY SERVICES					
ASSESSMENT/DIAGNOSIS					
PLAN OF CARE					
3. Past and present diagnoses should be accessible to the treating and/or consulting physician					
4. The reasons for and results of X-rays, lab tests and other ancillary services should be documented or included in the medical record. In many records, the order and/or intent for the service to be performed is missing.					
5. Relevant health risk factors should be identified					

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GENERAL DOCUMENTATION STANDARD		PRESENT	NOT PRESENT	NOT APPLICABLE	NOTE
6. The patient's progress, including response to treatment, change in treatment, change in diagnosis and patient non-compliance should be documented.					
7. The written plan of care should include, when appropriate: treatments and medications, specifying frequency and dosage; any referrals; patient/family education; and specific instructions for follow-up					
9. The documentation should support the medical necessity of the patient evaluation and/or treatment, including thought processes and the complexity of medical decision-making					
8. All entries to the medical record should be dated and authenticated by physician/provider signature. Medical documentation with missing or invalid signatures fails to meet the CMS signature requirements and may result in claim denial.					
10. The CPT/HCPCS/ICD-10-CM codes reported on the Medicare claim should reflect the documentation in the medical record					