# Chiropractic Care of Minnesota, Inc.
# Chart Review Checklist

| | | | |
|---|---|---|---|
| **Patient Name:** | _____ | **Provider Name:** | _____ |
| **Clinic Address:** | _____ | **Clinic Name:** | _____ |
| | _____ | **Clinic Phone:** | _____ |

| | | | |
|---|---|---|---|
| ***Reviewer:*** | _____ | ***Date of Review:*** | _____ |

## Required Documentation in Patient Record

1. Contains date of birth, marital status, occupation, employer name, home / cell / work phone numbers:
   ☐ **Pass** ☐ **Fail** (*noted in summary*) ☐ **Notice Given:** _____
2. Each *page* of record contains either the patient name or assigned ID number:
   ☐ **Pass** ☐ **Fail** (*noted in summary*) ☐ **Notice Given:** _____
3. Entries are dated and contain author identification (can be stamped, electronically added or hand written):
   ☐ **Pass** ☐ **Fail** (*noted in summary*) ☐ **Notice Given:** _____
4. Description of past conditions and trauma, past treatment received, current treatment being received from other health care providers, description of the patient's current conditions including onset and description of trauma (if trauma occurred), vital signs including blood pressure, height, weight, and/or BMI.
   ☐ **Pass** ☐ **Fail** (*noted in summary*) ☐ **Notice Given:** _____
5. Must contain examination(s) performed – a preliminary diagnosis based on indicated diagnostic tests, with an indication of all findings of each test performed:
   ☐ **Pass** ☐ **Fail** (*noted in summary*) ☐ **Notice Given:** _____
6. Results of re-examinations that are performed to evaluate significant changes in a patient's condition, including tests that were positive or deviated from results used to indicate normal findings:
   ☐ **Pass** ☐ **Fail** (*noted in summary*) ☐ **Notice Given:** _____
7. A diagnosis supported by documented subjective and objective findings or clearly qualified as an opinion must be recorded in the patient file:
   ☐ **Pass** ☐ **Fail** (*noted in summary*) ☐ **Notice Given:** _____
8. Contains a treatment plan that meets minimum standards:
   ☐ **Pass** ☐ **Fail** (*noted in summary*) ☐ **Notice Given:** _____

9. Adverse reactions, history of adverse reactions and / or contraindications to care must be prominently noted in the file, i.e. pregnancy, strokes, history of clots, use of blood thinners, etc.:

☐ **Pass** ☐ **Fail** (*noted in summary*) ☐ **N/A** ☐ **Notice Given:** _____

10. Description by the chiropractor or written description by the patient each time an incident occurs that results in an aggravation of the patient's condition or a new developing condition:

☐ **Pass** ☐ **Fail** (*noted in summary*) ☐ **N/A** ☐ **Notice Given:** _____

11. X-rays taken by the chiropractor / resultant findings

☐ **Pass** ☐ **Fail** (*noted in summary*) ☐ **N/A** ☐ **Notice Given:** _____

12. Consultant reports must be in the file and initialed by the treating chiropractor to signify review:

☐ **Pass** ☐ **Fail** (*noted in summary*) ☐ **N/A** ☐ **Notice Given:** _____

13. Patient file must be organized and legible. If symbols or abbreviations are used, a key must accompany the file:

☐ **Pass** ☐ **Fail** (*noted in summary*) ☐ **Notice Given:** _____

14. The patient record is kept in chronological order and written in permanent ink:

☐ **Pass** ☐ **Fail** (*noted in summary*) ☐ **Notice Given:** _____

15. Amended / corrected record entries should be crossed out yet readable, contain a date and a signature:

☐ **Pass** ☐ **Fail** (*noted in summary*) ☐ **N/A** ☐ **Notice Given:** _____

16. Daily notes documenting current subjective complaints as described by the patient, any change in objective findings if noted during that visit, a listing of all procedures provided during that visit and information that is exchanged and will affect that patient's treatment must be recorded in the patient file. The daily notes should be SOAP type format and shall contain date for return visits or a follow-up plan. An expected time for a return visit or a follow-up plan for each encounter should be in the record. This can be noted by a return visit date following each entry in the daily record or a treatment plan initiated with the onset of care. No-show and recall efforts should be documented in the file.

☐ **Pass** ☐ **Fail** (*noted in summary*) ☐ **Notice Given:** _____

17. Contains a discharge record that includes the reason for discharge with the patient health status noted:

☐ **Pass** ☐ **Fail** (*noted in summary*) ☐ **N/A** ☐ **Notice Given:** _____

18. Contains documentation that family history has been evaluated:

☐ **Pass** ☐ **Fail** (*noted in summary*) ☐ **Notice Given:** _____

19. External Documentation Requirement – Documentation to and from external sources is maintained in the patient's record (i.e. correspondence to another physician, general correspondence to payers, attorneys, etc.)

☐ **Pass** ☐ **Fail** (*noted in summary*) ☐ **N/A** ☐ **Notice Given:** _____

**Patient Name**: _____

20. Provider incorporates differential diagnosis as necessary (*includes the process of ruling out non-NMS and non-mechanical conditions / diseases that require medical referral or concurrent care*).

    ☐ **Pass** ☐ **Fail** (*noted in summary*) ☐ **N/A** ☐ **Notice Given:** _____

21. Provider demonstrates referrals for patients as appropriate and when requested to other health care professionals for the evaluation and treatment of non-NMS conditions, NMS conditions that are not amenable or responsive to chiropractic care or for significant complicating factors or co-morbidities that have not been recently evaluated by the patient's Primary Care Physician.

    ☐ **Pass** ☐ **Fail** (*noted in summary*) ☐ **N/A** ☐ **Notice Given:** _____

22. All billed services are supported by documentation in the patient file, including appropriate support for the level of manipulation or examination that was billed.

    ☐ **Pass** ☐ **Fail** (*noted in summary*) ☐ **N/A** ☐ **Notice Given:** _____

****** If any items above were marked as "Fail", the Summary on the following page must also be completed.******

**Summary of Failed Requirements** - All "Failed" items must be marked below and fully documented.
*These items will be listed as deficiencies in the report back to the provider.*

**Required Documentation in Patient Record:**

| | | | | |
|---|---|---|---|---|
| ☐ 1. | ☐ 2. | ☐ 3. | ☐ 4. | ☐ 5. |
| ☐ 6. | ☐ 7. | ☐ 8. | ☐ 9. | ☐ 10. |
| ☐ 11. | ☐ 12. | ☐ 13. | ☐ 14. | ☐ 15. |
| ☐ 16. | ☐ 17. | ☐ 18. | ☐ 19. | ☐ 20. |
| ☐ 21. | ☐ 22. | | | |

**Notes:** _____