

# CNC Self Assessment Health Record Audit Form

The following CNC Health Record Audit Form is used by CNC's Quality Improvement Committee when reviewing patient records for compliance to CNC and payor policies.

This audit tool includes some criteria used by managed care organizations when auditing physician health records for compliance. CNC is providing this form to our network providers to be used as a self-assessment tool. We strongly encourage you and your staff to perform your own health record audits to help protect your practice.

**Provider Name:** \_\_\_\_\_

**Audit Date:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

## Initial Visit Documentation Checklist

- Signature of rendering provider and/or reviewing provider with professional designation (DC)
- Patient name on each page of the record
- Date history taken is documented
- Past history documented
- Family history documented
- Social history: occupation, recreational interests and hobbies documented
- Past and present medical/chiropractic TX for this condition and TX outcomes documented
- Chief complaint documented
- Timing and intensity of complaints documented
- Causation: accident, injury, and etiology documented
- Details of complaint documented
- Clinical exam findings documented (including vitals and locations of subluxations specified)
- Written radiographic findings documented
- Diagnostic impression documented
- Is there a diagnosis in the record associated with each service provided on the day of service?
- Is the diagnosis reasonable given the results of the diagnostic tests and other information available?
- Is the diagnosis related to a neuromusculoskeletal condition?
- Is there a treatment plan for this condition?
- Does the treatment plan include the expected duration and frequency of visits?
- Does the treatment plan include specific treatment goals?
- Does the treatment plan include objective measured outcomes?
- Treatment/services rendered documented
- If E/M Consultation billed, records clearly show letter from physician or attorney specifically requesting my advice or opinion.
- If E/M Consultation billed, records clearly show letter back to referring entity, outlining your advice, opinion and treatment plan.
- CPT(s), modifier(s), and ICD-9(s) reported on health insurance claims are APPROPRIATE and SUPPORTED by documentation in the health record**
- Health record is complete and legible

- Informed Consent Form signed by patient and filed in patient record

### Subsequent Visit Documentation Checklist

- Date of service documented.
- Signature of provider rendering services, including profession.
- Patient name on each page of the health record.
- Treatment/service rendered documented.
- Only billed for manipulation to the area involved in the chief complaint.
- Significant changes in subjective complaints; such as, frequency and intensity of pain.
- Is there a diagnosis in the record associated with each service provided on the day of service?
- Is the diagnosis related to a neuromusculoskeletal condition?
- Changes in measurable outcomes documented.
- Medical record indicates patient's progress as it relates to treatment.
- Are all modalities and therapies documented?
- If applicable, are times of therapies properly documented?
- Is there a decrease in number of therapies as patient improves?
- Do all subsequent visits include S.O.A.P. notes?
- Is there a written, signed radiology report for any repeat or subsequent x-rays?
- Are specific segments or regions manipulated documented?
- Are patient education/instructions documented?
- If applicable, is DME included in documentation (including signed waiver in non-covered service)?
- Prognosis documented?
- Is patient progress clearly documented?
- Was each service performed adequately supported by documentation available in the record?
- Were patient education/home recommendations documented?
- Final diagnosis and patient status upon discharge documented?
- CPT(s), modifier(s), and ICD-9(s) reported on health insurance claims are APPROPRIATE and SUPPORTED by documentation in the health record.**
- Health record is complete and legible.

### Radiology Checklist

- Area(s) initially x-rayed are area(s) of major initial complaint.
- Is the name of the person who performed the x-ray documented?
- Did the diagnostic tests or patient histories reveal any contraindications warranting x-rays prior to treatment?
- Did initial clinical findings support the need for initial x-ray?
- Clinical findings and documentation support need for repeat x-ray
- All x-ray reports signed and dated by treating physician
- Did not report the professional component (indicated by the modifier 26) for any radiographs billed.

Routine repetitive x-rays within 90 day period document the following:

- New injury reported for same area as initial area
- Initially identified pathology or biomechanical aberration required further investigation
- New symptom in that same area appeared which was not present initially

## Office Visit Frequency Checklist

- More than one visit per day without supportive documentation
- One visit per day for more than one week without supportive documentation
- Three visits per week exceed four weeks without supportive documentation
- Visits exceed fifteen visits in the first month without supportive documentation
- If any non-covered services were provided, the appropriate waiver was obtained and is filed in the patient record.
- Does your treatment follow the NC BOE Practice Guides (these are available on the NC BOE website)?

## Modality Checklist

- Need for each service is clearly indicated in the medical record
- Frequency and duration of treatment documented and consistent with diagnosis
- If time-based code reported, does your documentation include the actual times service provided (ex: 30 minutes if 2 units reported) AND the specific muscle group(s), if applicable?
- Does the record clearly show the location of therapy performed?
- If time based codes reported and service provided for less than 15 minutes, was the code appended with modifier 52 to indicate reduced service?
- Was there a reduction in the use of therapies as patient's condition improved?

## Financial Records Checklist

- Have not billed INSURANCE for any non-covered service.
- If dry hydrotherapy, the service was reported using only 97124.
- No co-pays have been waived or reduced (records clearly reflect that all co-pays/deductibles have been collected OR there is a signed and dated financial arrangement plan clearly detailing how patient will pay for co-pays/deductibles, etc...)
- No free services were provided.
- No advertising of free or discounted services.
- Claims filed to insurance for each and every covered service provided.
- No discounts were given for case fees or prepayment plans.
- Patient financial records reflect that the patient was ONLY charged for co-pays, deductibles, co-insurance and/or non-covered services (for which a signed waiver was first obtained).

## **Areas of Non - Compliance/Actions Needed to Improve**

### Initial Visit Documentation

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### Subsequent Visit Documentation

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### Radiology

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### Office Visit Frequency

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### Modalities

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Financial Records

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Recommendations/Actions Needed

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Signed: \_\_\_\_\_

Provider: \_\_\_\_\_