



Checklist: Medical Chart Review Standards

The following managed care plan audit guidelines, developed by the National Committee for Quality Assurance to review medical records, are used by numerous plans.

- If paper records, are all documents properly secured to chart?
- Do all pages contain the correct patient ID?
- Is documentation legible? If not, take the time to dictate. Auditors can only audit that which they can read.
- Is the physician identified with their signature on each date of service?
- Are all entries dated, including the year?
- Is all clinical staff assisting identified in each chart entry?
- Are the entries written in a consistent, organized format? There should be no subjective or personal remarks about the patient, family or other caregivers noted in the chart.
- Are all record entries legible?
- Are errors made in documentation clearly labeled as an error with the standard of policy utilized? There should be no omissions, erasures, white-out or missing pages.
- Are allergies and adverse reactions to medications prominently displayed on all medical charts?
- Are lab and other studies ordered and documented as appropriate? Is there a physician order and test results (interpretation and report) documented?
- Are any prescriptions and refills documented?
- How do you differentiate patients with the same name?
- Are reported diagnoses consistent with findings?
- Are plans of action or treatment consistent with the diagnosis or diagnoses?
- Is the surgical consent form signed, witnessed and dated (if applicable) with the correct eye(s) noted?
- Is there a date noted for a return visit or other follow-up plan for each encounter?
- Are problems from previous visits addressed?
- Do consultant summaries, lab and imaging study results reflect the physician's review?
- Are all telephone calls regarding patient care documented?
- Check to ensure only approved abbreviation(s) are used in documentation.
- Is the physician signature legible or is the EHR signature secure?