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?