Survey Ready Medical Records

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Participants will:

- Identify required RHC medical record documentation elements
- Apply effective audit and collaborative record review processes
- Use practical tools to support compliance

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Administrative Chart Audits

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Conditions for Certification

- 491.10 Patient health records.
  - Records system.
    - The clinic or center maintains a clinical record system in accordance with written policies and procedures.
    - A designated member of the professional staff is responsible for maintaining the records and for insuring that they are completely and accurately documented, readily accessible, and systematically organized.
    - For each patient receiving health care services, the clinic or center maintains a record that includes, as applicable:

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Conditions for Certification

- 491.10 Patient health records.
  - Records system.
    - Identification and social data, evidence of consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient;
    - Reports of physical examinations, diagnostic and laboratory test results, and consultative findings;
    - All physician's orders, reports of treatments and medications, and other pertinent information necessary to monitor the patient's progress;
    - Signatures of the physician or other health care professional.

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Conditions for Certification

- 491.10 Patient health records.
  - Protection of record information.
    - The clinic or center maintains the confidentiality of record information and provides safeguards against loss, destruction or unauthorized use.
    - Written policies and procedures govern the use and removal of records from the clinic or center and the conditions for release of information.
    - The patient's written consent is required for release of information not authorized to be released without such consent.
  - Retention of records. The records are retained for at least 6 years from date of last entry, and longer if required by State statute.

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Administrative Chart Audit	Collaborative Chart Audit
50 or 5%, whichever is less OR policy	Number and frequency based on your State OR policy
Determination if required elements are being captured	Medical review between MD/DO and NP/PA
Covers all providers	Covers all APPs
Includes closed record(s) and feeds into program evaluation	Maintain documentation as proof of compliance

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Chart Audit Process

- The evaluation must include a review of a representative sample of both active and closed clinical records of RHC patients. The sample must also include at least 5 percent of the RHC's current patients or 50 records, whichever is less. The purpose of the review is to determine whether utilization of the RHC's services was appropriate, i.e., whether practitioners adhere to accepted standards of practice and adhere to the RHC's guidelines for medical management when diagnosing or treating patients. The review also must evaluate whether all personnel providing direct patient care adhere to the RHC's patient care policies. The evaluation of whether the RHC's patient care policies were followed may be conducted by an MD/DO, a non-physician practitioner, an RN, or other personnel who meet the RHC's qualifications criteria.

- Appendix G Pg. 87

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Patient Chart Audit
Name of Clinic:
Date Reviewed:

Prepared by:
Reviewer:

	Practitioner	Date of Service	Account Number	Chief Complaint	Consent	Social Data	H&P	Provider Signature	Labs Signed	Treatment Reports	Instructions to Patients	Evidence of Follow-up	Med. List	Allergies	Comments
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															

1
2
3
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5
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If the policy is silent
and documentation is absent,
it is cited.

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Identify the Record:

- Practitioner name
- Date of service
- Account number
- Ability to relocate the record after the audit and discuss findings with relevant team members

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Elements:

- Chief Complaint/History of Present Illness (HPI)
  - Intention is to answer the question – Why did the patient present to the clinic?
  - What they tell scheduler may be different than what they tell the care team

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Elements:

- Consent:
  - Common area of deficiency
    - Incomplete forms
    - Missing forms
    - Timeline doesn't match policy
    - Relationship to patient is not defined (minors)
  - Base requirement – Upon initial visit or if information changes OR based on written policy – whichever is stricter

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Elements:

- Social data:
  - Common information: alcohol use, tobacco cessation, car safety, home environment, etc.
  - Screening tools (ie. food insecurity)
- Appendix G pg. 82
  - "Social data" may include the patient's address, work information, insurance information, names of family members, designated representative (if any), etc.

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Elements:

- History and Physical (H&P)
  - Includes chief complaint, history of present illness (HPI), past medical history, past surgical history, family history, social history and a review of systems
  - Defers to the provider to determine what areas need to be reviewed based on what the patient presents with
    - Overall record vs. pulled into that specific note

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Elements:

- Provider signature
  - Timeline
    - Based on policy
    - Reminder – If policy is silent, and documentation is missing, then it will be cited
  - Provider is final authority over the record
  - Defining a closed record:
    - 491.10 - Provider signing off on record "closes" the record
    - 491.11 - The "closed" record relative to the program evaluation is qualified as:
      - Deceased, transferred out care, inactive (based on policy ie. 3 years), or aged out

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Elements:

- Gaps in Care
  - Laboratory services
  - Consultative services
  - Imaging
  - No-Show appointments
  - Return visits

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Laboratory Services

- Provider order
- Labs drawn
- Results received
- Provider review
- Results to patient

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Laboratory Services (cont.)

- Results must be reviewed by the ordering provider (or designee per policy)
- Clinics must have a defined timeframe for result review and patient notification
- Abnormal results require documented follow-up action

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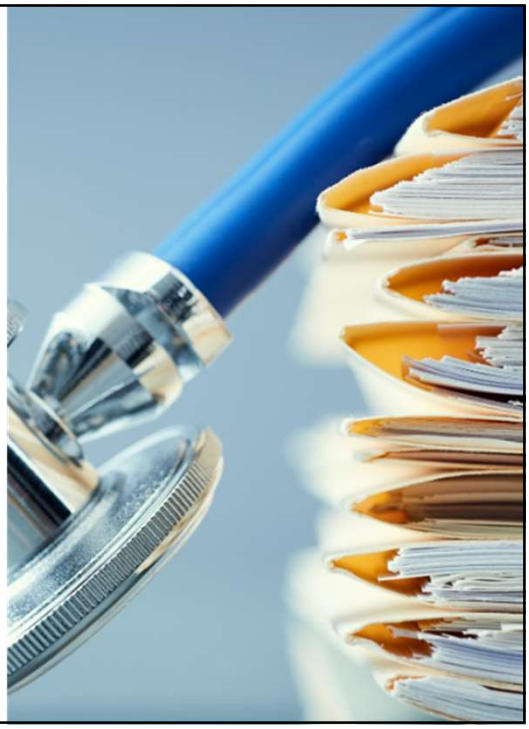
Consultative Services

- Provider order
- Pre-authorization
- Scheduled with specialist
- Consultative note brought back into patient record



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Consultative Services (cont.)

- Referral tracking is the clinic's responsibility, not the patient's
- Documentation must show the referral outcome (completed, declined, no-show)
- Consult notes must be reviewed and incorporated into the plan of care

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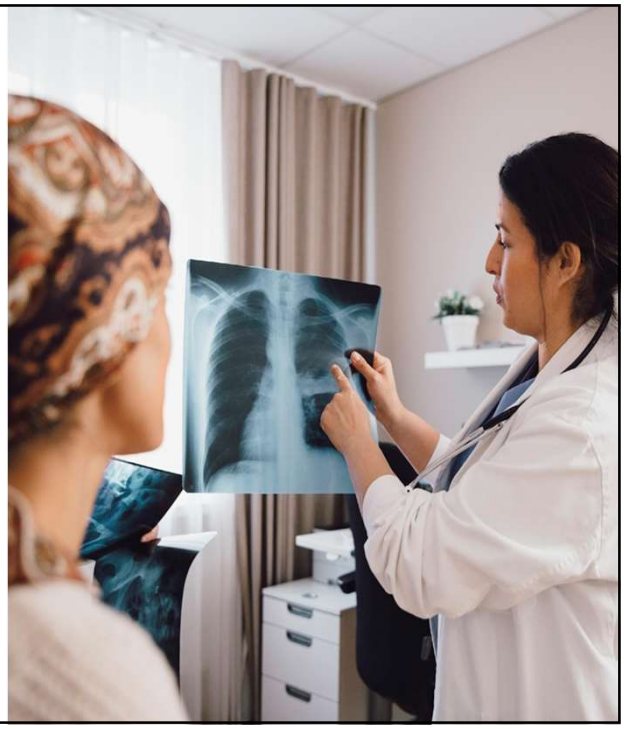
Imaging

- Provider order
- Image taken
- Interpretation
- Results received by clinic
- Results reviewed by provider
- Results to patient



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No-Show Appointments

- Documentation in record of actions taken
- Policy should define follow-up steps after missed appointments

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No-Show Appointments (cont.)

- Documentation should reflect patient outreach attempts
- Repeat no-shows may require escalation or care plan adjustment

Surveyors look for consistency between policy and what is documented in the chart.

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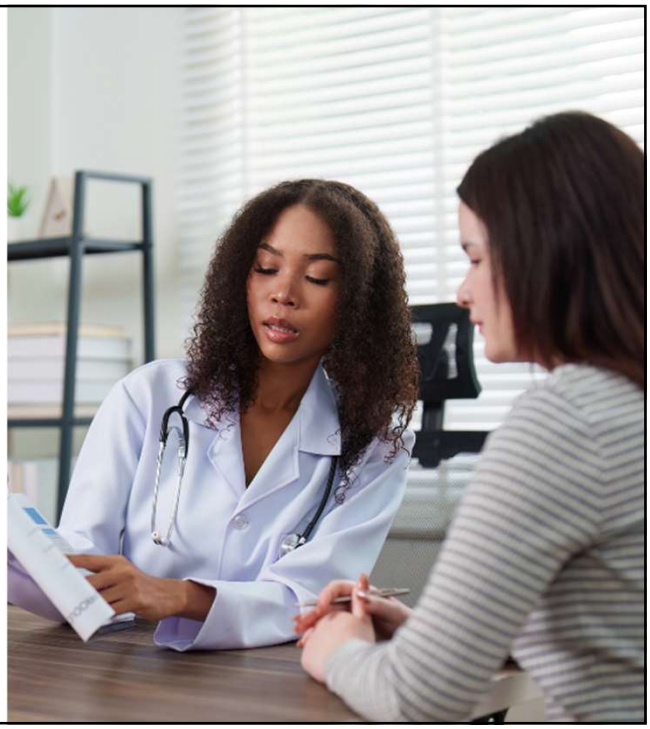
Return Visits

- Follow-up expectations should be clear in the provider's plan of care
- Chronic and preventative visits should align with evidence-based guidelines



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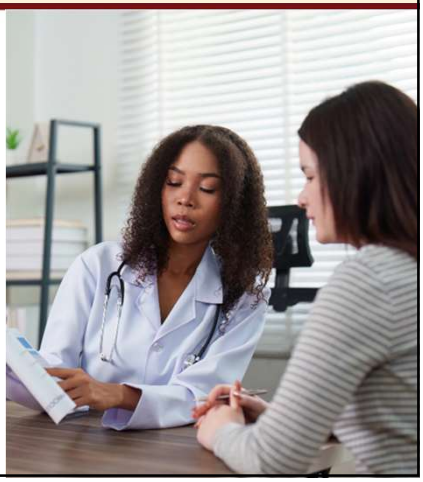
Return Visits (cont.)

- Missed or delayed return visits should be tracked when clinically significant
- Considerations:
  - Chronic vs. acute
  - PRN (as needed)
  - Timeline
  - Future orders



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Common Findings

- Results not sent to patient
- Follow-up appointment not scheduled
- Tracking system not established

These findings frequently lead to deficiency if systemic.

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Helpful Tips

- Administrative chart audits
- Spreadsheets
- Referral coordinator
- Chronic Care Management (CCM)
- Standardized follow-up documentation templates

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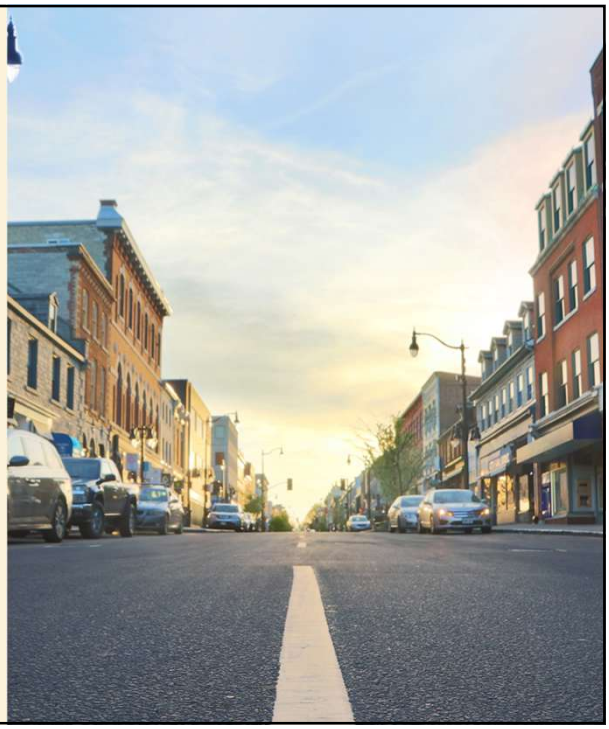
Documentation

- Notes in record of all communication
- Patient portals do not replace provider documentation
- Patient summaries



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If it's ordered, it must be tracked.
If it's received, it must be reviewed.
If action is needed, it must be documented.

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Elements:

- Instructions to patient
  - The patient should leave knowing their next step in care
- Medications
  - Reconcile at visit
  - Administered/distributed
- Allergies
  - In the overall record
  - Allergy/reaction
  - No known allergies is common

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Workflow:

- Establish a written policy defining chart audit process
  - Include number and frequency
- Train staff on expectations for their relevant areas
- Develop a tool to document ongoing audits
  - Don't forget to clearly identify closed records (ie. Closed – Deceased)
- Review the outcome with your staff to drive improvement
- Keep the completed audits for future program evaluations

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Recent NPP Update

Notice of Privacy Practices (NPP) should have been updated no later than February 16, 2026.

Substance Use Disorder (SUD) records are protected by a federal confidentiality law (42 CFR Part 2), which provides greater privacy protections than HIPAA.

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Collaborative Chart Audits

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Chart Audit Process

- A physician must review periodically the RHC's patient clinical records. In States where State law requires a collaborating physician to review medical records, co-sign medical records, or both for outpatients whose care is managed by a non-physician practitioner, an RHC physician must review and sign all such records. If there is more than one physician on the RHC's staff, it is permissible for staff physicians other than/in addition to the medical director to review and co-sign the records.
- The RHC's NP(s) and/or PA(s) must participate in the physician's review of the clinical records. Participation may be face-to-face or via telecommunications. If there is more than one NP or PA in the clinic, the NP or PA would participate only in the review of records of those patients for which the NP or PA provided care.
  - Appendix G Pg. 60

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Chart Audit Process

- Where co-signature is not required, the regulation still requires periodic physician review of the clinical records of patients cared for by non-physician practitioners. If the RHC has more than one physician on its staff, it is permissible for physicians other than/in addition to the medical director to conduct the periodic review of clinical records, so that this task might be divided or shared among the physicians.
- If the RHC has more than one physician, its policies and procedures must specify who is authorized (i.e. whether it is the medical director alone, or may include other staff physicians) to review and, if required under State law, co-sign clinical records of patients cared for by a non-physician practitioner.

• Appendix G Pg. 60

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Chart Audit Process

- The regulation does not specify a particular timeframe to satisfy the requirement for "periodic" review of clinical records, but the RHC must specify a maximum interval between record reviews in its policies and procedures. The RHC is expected to take into account the volume and types of services it offers in developing its policy. For example, an RHC that has office hours only one day per week would likely establish a different requirement for record review than an RHC that is open 6 days per week/ 10 hours per day. Further, there is no regulatory requirement for the review of records to be performed on site and in person. Thus, if the RHC has electronic clinical records that can be accessed and digitally signed remotely by the physician, this method of review is acceptable. Therefore, RHCs with and without the capability for electronic record review and signature might also develop different policies for the maximum interval between reviews.

• Appendix G Pg. 60

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Medical Record Review Tool
For the Month of _____ Year_____
Physician:_____ Advanced Practice Provider:_____

If there is a concern place N and respond in Notes.

Pt ID	DOS	H & P	ROS	Meds	Plan/Treatment	Education	Tests Ordered	Notes:

Physician Signature:_____ Date:_____

Advanced Practice Provider is required to respond to EACH notation from Physician.

Pt ID	DOS	Notes/Feedback & Response:

Advanced Practice Provider Signature:_____ Date:_____

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Workflow:

- Establish a written policy defining collaborative chart audit process
  - Include number and frequency (must meet State requirement if applicable)
- Train staff on expectations for their relevant areas
- Develop a tool to document ongoing audits
- Review the outcome with your staff to drive improvement

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Workflow:

- Documentation Methods:
  - EMR system
    - Caution – Can you pull a report
    - Caution – Co-signature not recommended unless required by State
  - Recommend
    - Track all cases discussed between physician and APP
      - On developed form, in a spreadsheet, through email, through EMR messaging
      - MUST BE ABLE TO PULL EVIDENCE
    - At the end of the defined timeline, confirm the number required has been met
    - Review additional charts as needed to meet policy
    - Have both providers sign-off on participation
      - 491.8 defines the collaborative review under BOTH physician and APP responsibilities

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