

Scaling Chart Review for the Modern Clinical Workforce

*Chart review maturity, operational risk, and 50-state
requirements for NP and PA teams*

OCTOBER 2026

FIRST EDITION





Inside This Report



What is chart review? | 02

The purpose of chart review and where it sits within compliance and quality.



How chart review breaks down at scale | 03

Common challenges that organizations face while scaling chart review.



What a well-run process looks like | 05

Five essential traits of a good chart review and quality program.



Where your organization sits on the maturity curve | 07

See where your organization falls within the four stages of chart review maturity.



What the law requires, state by state, for NPs and PAs | 10

A state-by-state breakdown of essential chart review rules across the US.

About This Report

Clinical chart review is a standard quality assurance practice across healthcare, used to measure clinical quality and clinician performance. Chart review has become one of the largest operational bottlenecks a clinical operations team manages.

The result is a workflow that consumes scarce physician and administrative time, offers little to no centralized view of what has been reviewed or what the findings show, and grows more fragile with every new clinician, state, and specialty added.

For organizations employing NPs and PAs, chart review is also a regulatory obligation. Each state sets its own chart review rules, the requirements shift as clinicians gain experience, and most organizations still run the whole process by hand, through spreadsheets, email threads, and manual follow-up.

This report is written for the leaders who see what that fragility costs and treat chart review as an active operational variable rather than a back-office task.

When managed well, chart review enables an organization to move faster and scale with less risk than peers of the same size. It produces both a defensible compliance record and a live read on clinical quality and how the workforce is practicing.

APP Clinical Oversight Landscape



+33%

Workforce Growth

NP and PA roles are projected to undergo a combined growth of 33% by 2034.



**41
states**

Required Chart Review

41 states require either chart review or a formal evaluation method for NPs or PAs in collaborative relationships.



**1K+
rules**

Chart Review Rules

Across the US, chart review rules can range from 5% to 100% mandatory review, with different rules for timing, prescribing, experience, and practice setting.

What Is Chart Review?

Chart review, known also as chart auditing, is an ongoing quality assurance process for measuring clinical quality, clinician performance, adverse events, and compliance. A reviewer evaluates a sample of a clinician's documented encounters against a defined standard, and the findings show how care is actually being delivered.

For APPs specifically, compliance includes a state-driven oversight activity. In states where physician oversight is a condition of practice, chart review must be maintained and recorded on a recurring basis. And in most states, chart review sits inside a broader collaboration-compliance program that also includes scheduled physician-APP meetings, quality-assurance plans, physician-to-APP ratio limits, board filings and documentation retention.

For a workforce operating across multiple states, each provider can fall under a different cadence and a different sampling rule, and those rules shift as states revise their practice laws.

Chart review for APP workforces serves two important purposes

1. Regulatory Requirement

In many states, a collaborating physician must review a sample of charts and document it.

2. Clinical Quality Signal

The same review is one of the most direct reads an organization has on the quality of its care.

A program that treats chart review as a box to check produces a review record while missing the clinical quality signal the same review generates.

A program that treats it as an operational asset keeps both, turning a monthly obligation into a steady, actionable view of workforce and care delivery quality.

Spotlight: Adverse Events

An adverse event is harm to a patient that stems from the care delivered rather than the underlying illness, from a medication error or missed diagnosis to a documentation gap.

Chart review is one of the few routine mechanisms an organization has to catch adverse events, document them, and connect a single occurrence to a wider pattern across providers, sites, and states.

Nearly
1 in 4

Nearly one in four inpatient admissions involves at least one adverse event.

3
states

Three states require collaborating physicians to review 100% of all adverse events for NPs or PAs.

Why Chart Review Breaks at Scale

Chart review processes break down through a handful of related pressures that each get worse as the workforce grows.

Manual processes.



Despite that complexity, most organizations still manage chart review manually. A compliance manager pulls each state's sampling rule from a spreadsheet, exports charts and identifiers into a separate program, selects the required sample, and routes it to the physicians. Each physician reviews in whatever tool they use and returns findings, which get keyed back into a database. The work spans clinical, credentialing, operations, and compliance functions, and it is usually held together by one person. A cycle that works cleanly for a handful of clinicians turns into a monthly scramble across teams and states.

No one has a single source of truth.



Because the work lives across spreadsheets, PDFs, email, shared drives, and EHR exports, no one can see at a glance what has been reviewed, what is overdue, or which findings keep recurring. Status becomes something a person assembles by hand at the end of every cycle, and gaps stay invisible until someone goes looking.

Every state is a different program.



Requirements vary widely in cadence, sampling, and documentation, and they calibrate to collaboration type, physician involvement, and recurring oversight tasks. The clock can reset when an APP moves states, changes specialties, or adds prescribing authority. An organization operating in a dozen states is effectively running a dozen chart review programs at once.

“What really determines how well an organization can track, stay compliant, and stay on top of [chart review] is having some kind of tool — especially when you start talking about larger organizations. If you don’t have a tool that gives you a window into this information, they are going to struggle.”

- Pam Reid, Senior Director of Compliance, CRH Healthcare

The clinical signal is generated and lost.

Chart review exists in part to catch the highest-stakes issues, like adverse events. Yet in a manual process a flagged chart reaches the right person weeks after the encounter, and nothing connects it to a pattern across the workforce. Feedback works best close to the event that triggered it, and manual oversight ignores that by design.

The hidden costs compound.

Coordination burns the scarcest resources in the model — supervising-physician and compliance-admin hours — on pulling rules, chasing signatures, and re-keying findings rather than care. Audit exposure builds quietly with every new hire and state, invisible until an audit, payor review, or state inquiry forces a multi-week scramble to assemble proof. Meanwhile the clinicians being reviewed grow slowly on procedural, delayed feedback, which makes turnover both more likely and more expensive. None of these scale linearly. They compound and surface exactly when an organization is expanding fastest and can least afford a failure.

The Confidence Gap in Chart Review

63% 63% of collaborating physicians said the purpose of chart reviews is to both meet state requirements and evaluate performance



39% Only 39% called their chart review process “very effective”



24% Only 24% were “very confident” reviews meaningfully improve performance



What Good Looks Like

A well-run chart review program comes down to structure. The same pressures that break the manual model become manageable when a few things are true.

The process runs on rails.



Chart selection, routing, due dates, and reminders are systematized, so a cycle no longer depends on one person holding it together. Ownership is explicit every period, and the monthly scramble gives way to a repeatable operation.

There is a scalable source of truth.



Assigned, completed, overdue, and flagged reviews are visible in real time. Status becomes something leaders can see rather than assemble by hand, and gaps surface as they happen instead of at month-end.

Reviews are standardized, and the data becomes intelligence.



A shared set of criteria means every chart is assessed the same way, and AI-assisted review applies that standard consistently at scale. Each finding is captured as structured data rather than a static score, so results are comparable across the workforce, states, and specialties, and the review record becomes clinical quality intelligence rather than an archive of completed forms.

One framework absorbs the state variation.



A written policy sets a clear purpose for each review, and a single core framework with state-specific overlays adjusts cadence and sampling automatically. Adding a state becomes a configuration change rather than a new program to build from scratch.

The loop closes.



Findings feed coaching, targeted education, and trend analysis instead of a folder. The same activity that satisfies a regulator becomes a live instrument for clinical quality: performance visible by provider, state, and specialty, recurring issues caught before they become audit findings, and a real answer to whether feedback improves how APPs practice over time.



The Chart Review Maturity Index

The maturity of a chart review program shows up in two places: how reliably it runs and how much value its findings create. As organizations move from manual processes toward standardized workflows, real-time visibility, and continuous quality improvement, operational risk falls while the clinical signal grows stronger.

The Chart Review Maturity Index provides a practical framework for assessing where your organization stands today across four stages, and what separates a process that can keep pace with growth from one that becomes more effective as the workforce scales.

[CONTACT US](#)



[ZIVIANHEALTH.COM](https://zivianhealth.com)

The Chart Review Maturity Index

Leaders can gauge where they stand with a short diagnostic. A process built to scale can answer yes to each of these:

- Can an administrator see progress across the entire workforce in real time?
- Can every reviewer complete work in a consistent, structured format?
- Can we turn review findings into feedback, coaching, and trend analysis?
- Can we produce a complete audit trail on demand?
- Can we enforce different chart review rules by state, automatically?
- Would this process still hold if our provider count doubled?

Where several answers are no, the process may be working today but won't scale as the organization and workforce grow.

Most organizations fall somewhere between the two ends of the spectrum. The following maturity index marks four different stages, evaluating operational risk and clinical-quality signal along the curve.

Four Stages of APP Oversight Maturity

	01 Manual & Reactive	02 Standardized	03 Centralized & Visible	04 Continuous & Intelligent
Reviews	Per-state spreadsheets, email threads, and manual follow-up, usually held together by one compliance manager. Intent is box-checking.	A written policy defines sampling, review templates, a core framework with state overlays, monthly ownership, and an audit trail. Still tracked by hand.	One source of truth. Completion and exceptions track in real time across physicians, APPs, and admins.	Findings drive action. Trends analyzed by provider, state, and specialty; feedback returns close to the encounter.
Cost & risk	Coordination consumes physician and admin hours. Audit exposure rises with every new hire and state. Breaks first under growth.	Consistent and defensible, but tracking effort scales linearly with the workforce. Status is known only when someone assembles it.	Coordination cost drops. Overdue reviews and flags surface as they happen rather than at month-end. Audit-ready by default.	Lowest risk and cost. Oversight shifts from proving work happened to improving the work itself.
Quality signal	Effectively none. Findings sit in static files and never aggregate.	Comparable reviews exist, yet analysis is manual and infrequent.	Workforce-level visibility into activity, scores, and outliers.	The organization can answer whether feedback improves performance over time.

The Chart Review Maturity Index (Cont.)

The maturity of a chart review and quality program is anchored to how reliably the program produces the same result every cycle. The right reviewer knows what is expected, exceptions have a clear path for escalation, and every step leaves a record that can be reconstructed later. For APP teams, the right charts are selected under the right rules. When these elements depend on individual memory or manual coordination, consistency erodes as volume grows.

A strong program also separates completion from quality. Knowing that 100% of required reviews were finished answers an important compliance question, but doesn't tell leaders what those reviews found, whether the same issue is appearing across multiple clinicians, or whether feedback changed practice. That requires structured review criteria, comparable findings, and a defined path from an observation to feedback, follow-up, and, when warranted, broader quality improvement.

At the highest level of maturity, chart review becomes a continuous management discipline. Leaders can see whether the program is operating as designed in real time, while also using the accumulated findings to understand variation across providers, specialties, and markets. It is a process rigorous enough to satisfy regulatory obligations and useful enough to improve the care those obligations are meant to protect.

The Shift from Operational Risk to Clinical Insight

Illustrative relationship across stages of chart review maturity

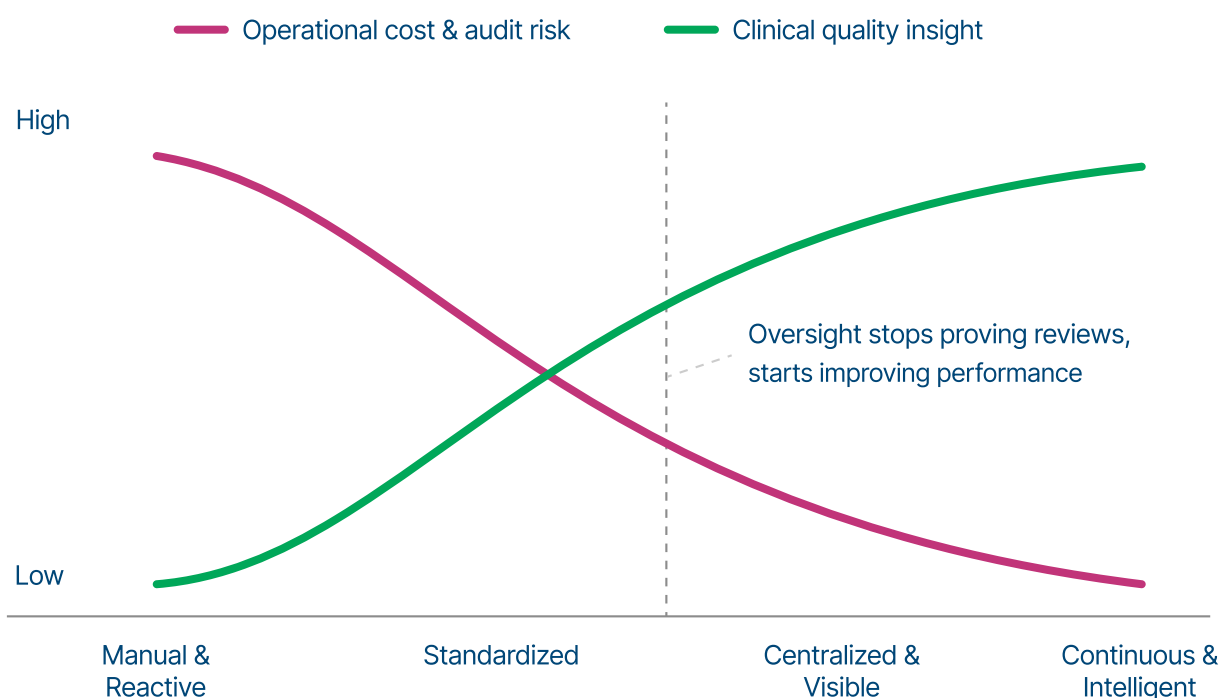




Chart Review Rules: 50-State Analysis

Chart review requirements for APPs vary widely across the country. State rules differ by provider type, prescribing authority, experience, practice setting, review cadence, and documentation requirements, while some states embed chart review within broader quality-assurance obligations rather than mandate it directly.

The following 50-state analysis provides a practical reference for how these requirements apply to NPs and PAs, helping organizations understand the variation they need to account for when building a consistent, multi-state oversight program.

[CONTACT US](#)



[ZIVIANHEALTH.COM](https://zivianhealth.com)

Chart Review Rules for NPs and PAs: 50-State Analysis

Chart review requirements do not follow a clean national pattern. State rules illustrate how wide this variation can be: requirements may call for a “meaningful sample” of records, incorporate all adverse outcomes, or tie additional review obligations to the structure of the physician-APP relationship. Rules also differ between NPs and PAs in the same state or change based on clinical experience and practice setting.

Other states require a broader quality-assurance process without naming chart review as the method. In these cases, chart review is often how organizations satisfy those obligations because it provides a structured, asynchronous way for physicians and APPs to evaluate care. Alabama NPs, for example, participate in quarterly quality assurance that includes review of a “meaningful sample” of records and adverse outcomes, even though the rule does not mandate a fixed chart-review percentage.

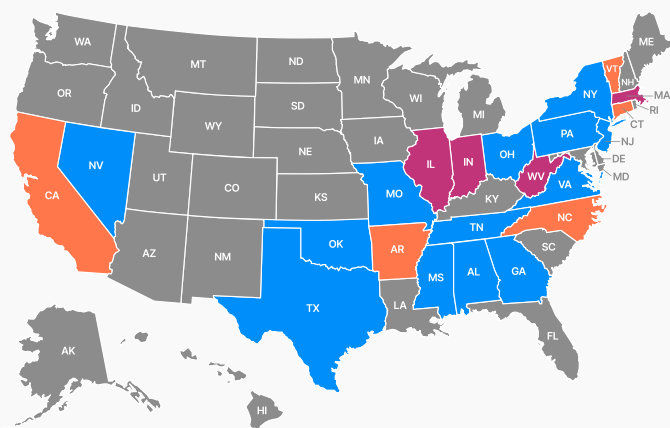
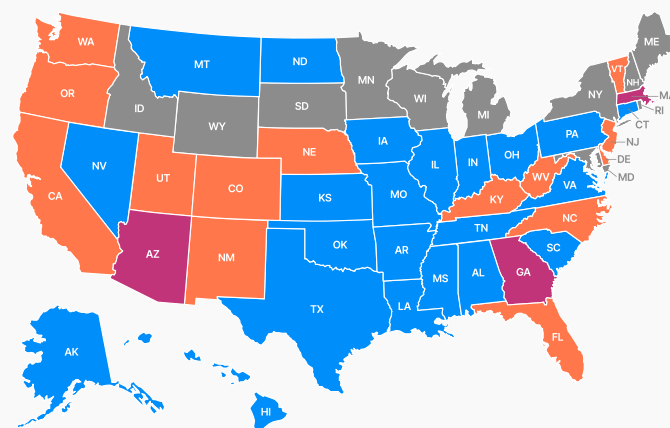
Therefore, an organization may operate in a state without an explicit chart review mandate and still need a recurring process for clinical quality assurance, physician oversight, documentation, or performance evaluation that ultimately leads to chart review.

For multi-state organizations, the challenge is maintaining one oversight program while honoring these differences. The strongest programs build differing state rules into a common operating framework, providing a clearer baseline for building a consistent multi-state program. The tables that follow provide a reference across all 50 states for both NPs and PAs.

Spotlight: Chart Review Landscape for Collaborating NPs & PAs

Nurse Practitioners

Physician Assistants



Required

Not required

Prescribing only

Recommended
(evaluation method required)

Chart Review Rules for Nurse Practitioners

	Required?	How many	How often	Controlled Substances	Co-signing?
AL	Yes	No set amount; 100% of all adverse events	Quarterly	No added requirement	No
AR	Recommended; Evaluation method req.	×	×	Schedule II stimulants: physician must see patient every 6 mos.	×
CA	Recommended; Evaluation method req.	×	×	Schedule II & III: physician-approved patient-specific protocol	×
CT	Recommended; Evaluation method req.	×	×	×	×
GA	Yes	10% of charts for prescribing; No set amount for non- prescribing	Annually	100% of controlled- substance records, reviewed and signed, quarterly	No
IL	Prescribing only	No set amount	Not specified	Schedule II: monthly case review; Physician approval to continue past 30-day supply	No
IN	Prescribing only	5% of prescribing charts	Every 7 days	No added requirement	No
MA	Prescribing only	No set amount	No set frequency	Schedule II: initial prescription reviewed within 96 hours	No
MO	Yes	10% of charts	Every 14 days	20% of controlled substance charts	Yes, for certain conditions
MS	Yes	10% or 20 charts, whichever is less	Monthly	No added requirement	No
NC	Recommended; Evaluation method req.	×	×	Certain controlled substances: physician consult before starting and every 90 days	×
NJ	Yes	No set amount	No set frequency	No added requirement	No

Note: All information reflects pre-transition to independence requirements.

	Required?	How many	How often	Controlled Substances	Co-signing?
NV	Yes	No set amount	No set frequency	No added requirement	Yes; Initialing of selected charts required
NY	Yes	No set amount	Quarterly	No added requirement	No
OH	Yes	No set amount	Annually	No added requirement	No
OK	Yes	No set amount	No set frequency	No added requirement	No
PA	Yes	No set amount	No set frequency	No added requirement	No
TN	Yes	20% of charts and 100% of adverse events	Every 30 days	100% of charts, reviewed and signed every 10 business days	No
TX	Yes	No set amount	No set frequency	No added requirement	No
VA	Yes	No set amount	No set frequency	No added requirement	No
VT	Recommended; Evaluation method req.	×	×	×	×
WV	Prescribing only	No set amount	Annually	None required; Board recommends flagging high-oversight meds	No

Chart Review Rules for Physician Assistants

	Required?	How many	How often	Controlled Substances	Co-signing?
AL	Yes	No set amount	Quarterly	No added requirement	No
AK	Yes	No set amount	Quarterly	No added requirement	No
AZ	Prescribing only	No set amount	No set frequency	100% of Schedule II & III	No
AR	Yes	10% of charts	Monthly	100% of Schedule II	✗
CA	Recommended; Evaluation method req.	✗	✗	✗	✗
CO	Recommended; Evaluation method req.	✗	✗	✗	✗
CT	Yes	No set amount	No set frequency	Physician documents Schedule II & III approval in chart	Yes; Schedule II & III only
DC	Recommended; Evaluation method req.	✗	✗	✗	No; PA notes physician name in chart
DE	Recommended; Evaluation method req.	✗	✗	✗	✗
FL	Recommended; Evaluation method req.	✗	✗	✗	✗
GA	Prescribing only	No set amount	No set frequency	100% of CS charts, quarterly	No
HI	Yes	100% of charts	Within 7 business days	No added requirement	No

Note: All information reflects pre-transition to independence requirements.

	Required?	How many	How often	Controlled Substances	Co-signing?
IL	Yes	No set amount	No set frequency	Discussed monthly; Schedule II >30 days requires approval	No
IN	Yes	10% of charts (first year)	Within 10 business days	No added requirement	No
IA	Yes	No set amount	No set frequency	No added requirement	No
KS	Yes	100% in first 30 days, then no set amount	Within 7 days in first 30 days, then no set frequency	No added requirement	No
KY	Recommended; Evaluation method req.	✗	✗	✗	Yes; “sufficient number”
LA	Yes	50% for new graduates and offsite PAs, then no set amount	Monthly	A “representative sample” of the PAs prescriptions	✗
MA	Prescribing only	✗	Quarterly	Schedule II charts reviewed within 96 hours	✗
MO	Yes	10% of charts	Every 14 days	20% of CS charts every 14 days	✗
MS	Yes	10% or 20 charts, whichever is less	Monthly	No added requirement	No
MT	Yes	No set amount	No set frequency	No added requirement	No
NC	Recommended; Evaluation method req.	✗	✗	✗	✗
ND	Yes, for PAs at non- approved sites; no req. for PAs at approved facilities	✗	✗	✗	✗
NE	Recommended; Evaluation method req.	✗	✗	✗	✗

	Required?	How many	How often	Controlled Substances	Co-signing?
NJ	Recommended; Evaluation method req.	×	×	Prior consultation with physician req. to adjust or initiate a CS	×
NM	Recommended; Evaluation method req.	×	×	×	×
NV	Yes	No set amount (10% for collaborating DO)	No set frequency (Quarterly for DOs)	No added requirement	No
OH	Yes	No set amount	No set frequency	No added requirement	No
OK	Yes	No set amount	No set frequency	Schedule II requires physician approval	No
OR	Recommended; Evaluation method req.	×	×	×	×
SC	Yes, for offsite PAs	No set amount	No set frequency	Schedule II requires physician approval	Yes, for offsite PAs; Requires initial and date
TN	Yes	20% of charts; 100% of adverse events	Every 30 days; For set cases, 100% charts within 10 business days	100% of CS charts within 10 business days	×
TX	Yes	No set amount	No set frequency	No added requirement	No
UT	Recommended; Evaluation method req.	×	×	×	×
VA	Yes	No set amount	No set frequency	No added requirement	No
VT	Recommended; Evaluation method req.	×	×	×	×
WA	Recommended; Evaluation method req.	×	×	×	×

	Required?	How many	How often	Controlled Substances	Co-signing?
WV	Recommended; Evaluation method req.	×	×	×	×





A Note from Griffin Mulcahey, Zivian CEO

For most organizations, chart review is a passive, painful problem. I know this firsthand, having lived it as an operator for over a decade. It's a cost center that consumes scarce physician and administrative time, produces not much more than a compliance record, and gives almost nothing back. Nearly everyone I talk to describes their chart review process the same way while also assuming the status quo is the only option.

But it doesn't. The same review that satisfies a regulator is also the most direct signal an organization has about the quality of its care. Done well, it can speed up the quality work you are already doing and get feedback to your clinicians fast enough to matter. The reason that rarely happens isn't for lack of effort, but because the process was never built to be more than a box to check.

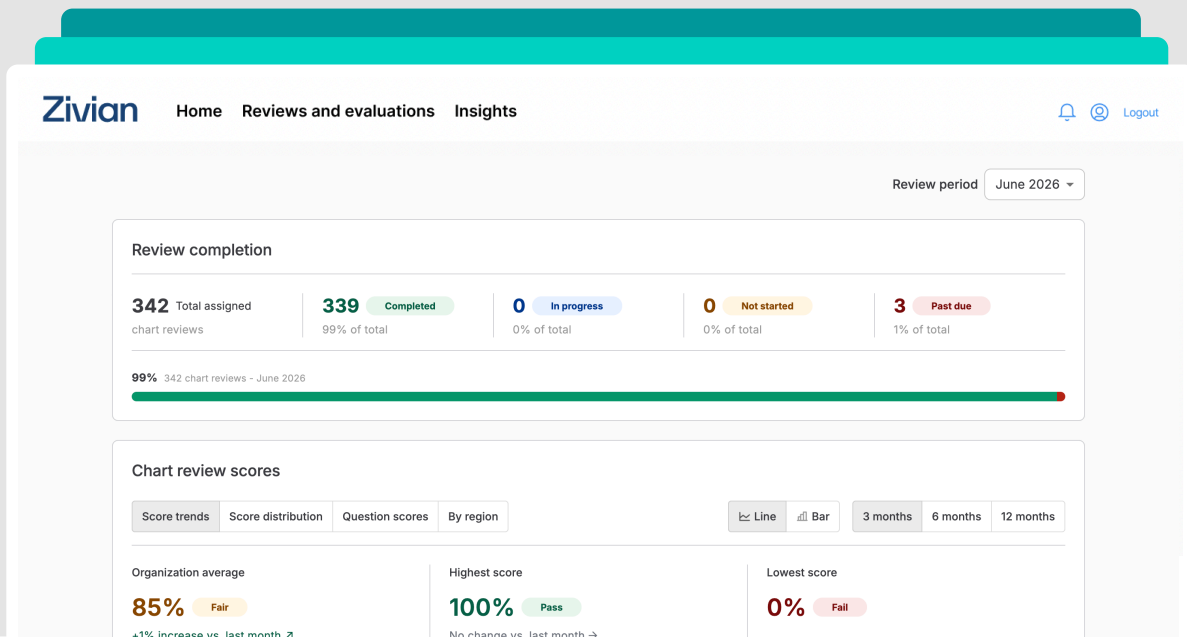
Part of why it stays that way is structural. NPs and PAs were introduced to help close a physician shortage, and the regulatory frameworks around them were assembled incrementally, over decades, with no operator in mind. The result is the landscape this report documents: fragmented, state-specific, and demanding in ways that compound as an organization grows.

What we're building at Zivian, and what this report reflects, is a belief that the chart review cost center can become an advantage. Treat chart review as an operational variable rather than back-office overhead, and the organizations that do carry less risk and scale faster than peers of the same size.

We hope this report is useful, and our team is here if you want to go deeper.

— Griffin Mulcahey, CEO, Zivian Health

One System for NP & PA Compliance



About Zivian Health

Zivian is the compliance infrastructure for organizations managing Advanced Practice Provider (NP/PA) workforces across multiple states.

The regulatory environment governing APP-integrated care models is one of the most operationally underestimated constraints on healthcare growth, and the complexity only compounds as organizations scale. Zivian is how organizations deploy providers faster, expand into new markets, and build a compliance program that grows with the business.

To learn more, visit zivianhealth.com or [schedule a demo here](#).