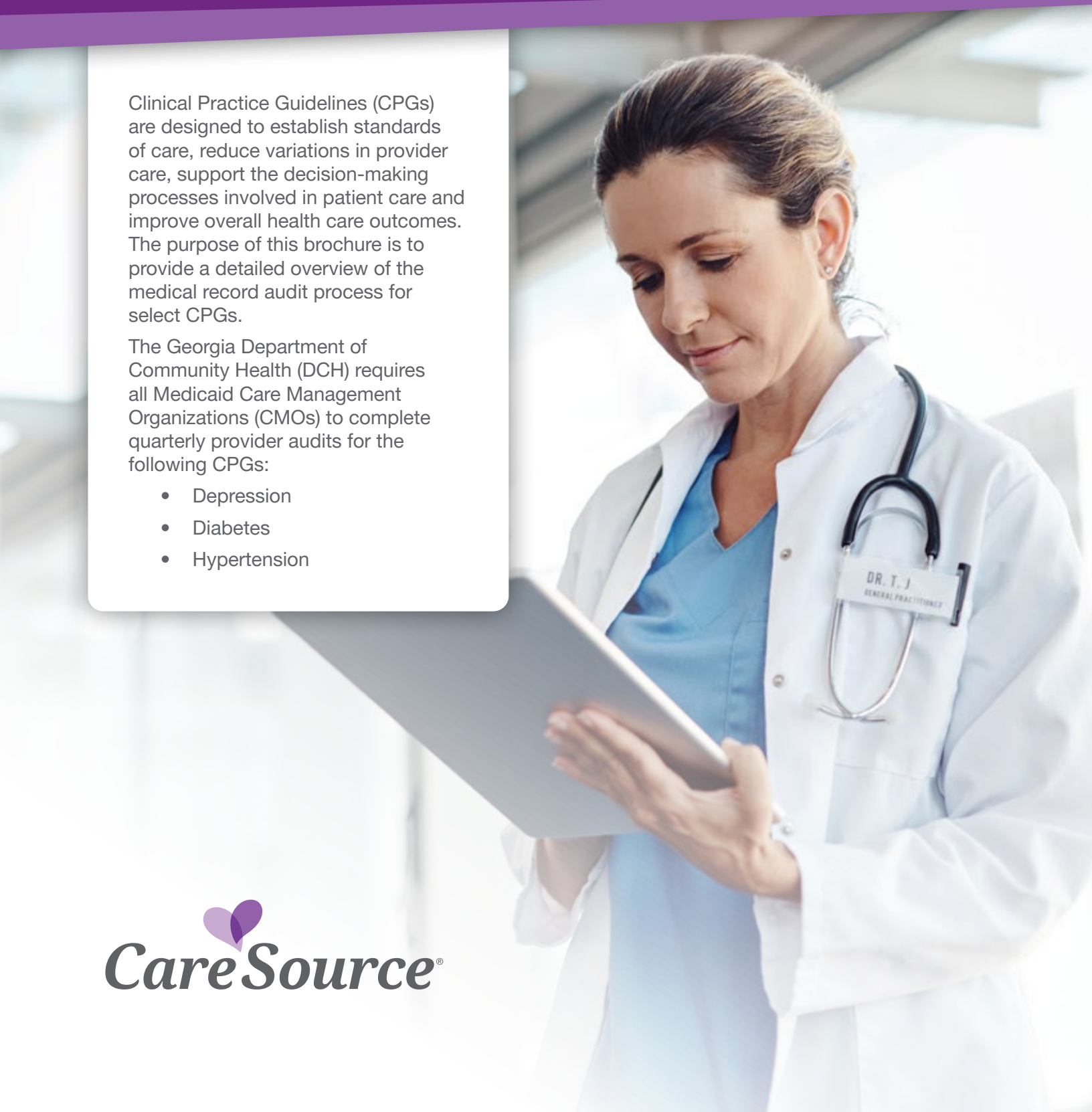
Clinical Practice Guidelines

Clinical Practice Guidelines (CPGs) are designed to establish standards of care, reduce variations in provider care, support the decision-making processes involved in patient care and improve overall health care outcomes. The purpose of this brochure is to provide a detailed overview of the medical record audit process for select CPGs.

The Georgia Department of Community Health (DCH) requires all Medicaid Care Management Organizations (CMOs) to complete quarterly provider audits for the following CPGs:

- Depression
- Diabetes
- Hypertension



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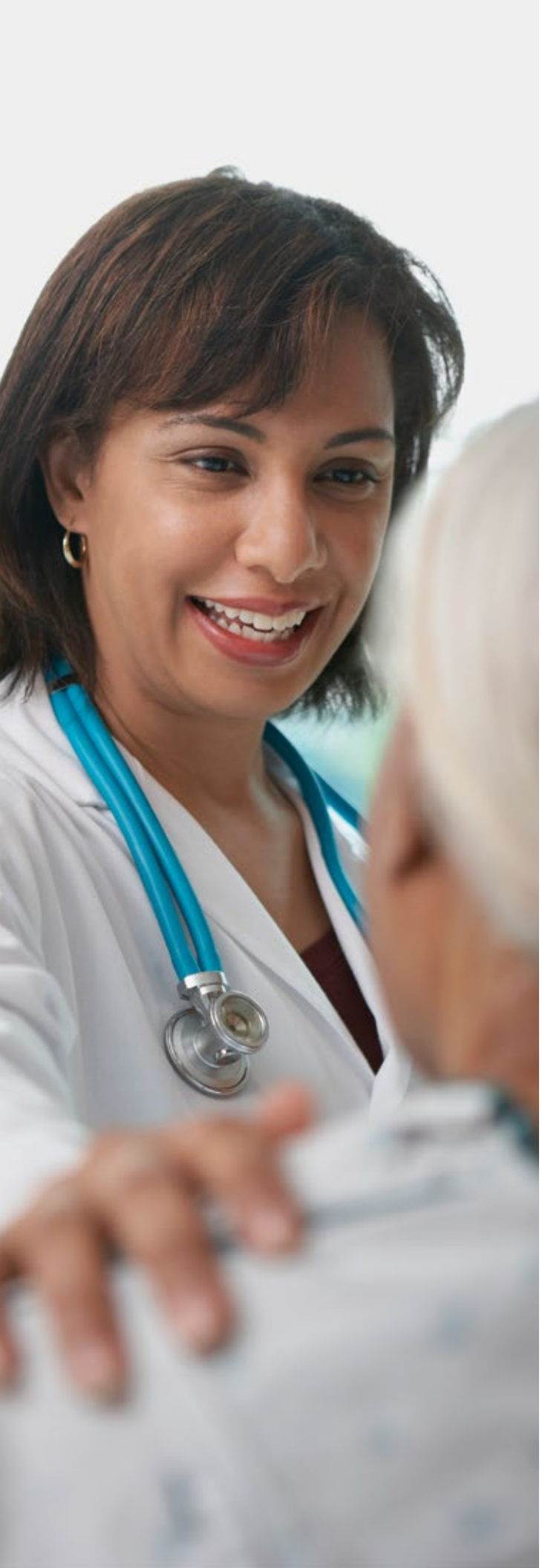

Provider Selection and Audit Frequency

CareSource will select a random sample of medical records to review each quarter. All providers who submit claims with a primary diagnosis of depression, diabetes or hypertension are subject to a CPG audit. To help reduce potential abrasion, providers will only be audited by one Medicaid CMO per year except in the case of required reaudits. Additionally, providers who submit primary claims for more than one applicable diagnosis will only be audited on **one** of those diagnoses per year.

Audit Process

To assess compliance with CPG standards and identify opportunities for improvement, the CMOs will utilize audit tools developed by DCH. The audit tools incorporate guidelines or standards established and published by applicable professional organizations such as the American Psychological Association (APA), American Diabetes Association (ADA) and American College of Cardiology (ACC). The audit tools include relevant indicators (i.e., required documentation) that CMO auditors will look for in the medical records.

Per DCH, the compliance goal for providers is to achieve both an overall audit score of 80% or higher and a minimum score of 80% on the individual indicators. Upon initial review of medical records, providers who score less than 80% on any individual indicator will receive feedback from the auditor to facilitate future compliance. These providers will be reaudited on the noncompliant indicators during a subsequent quarter.

If the first reaudit for the noncompliant indicators does not meet the minimum 80% score requirement, the provider will receive guidance from CareSource's medical leadership team (e.g., Chief Medical Officer or designee). After receiving this guidance, the provider will be reaudited again on the noncompliant indicators during a subsequent quarter.

If the second reaudit does not meet the minimum 80% score requirement, CareSource's medical leadership team will collaborate with the provider to develop a Corrective Action Plan (CAP) to improve compliance. Once the CAP has been implemented, a final reaudit will be completed to reassess compliance. If the applicable indicators are still noncompliant, the provider will be referred to the CareSource Peer Review Committee to determine next steps.

Depression Medical Record Indicators

The following documentation is required (as clinically appropriate) for patients with depression:

	Weight
Assessment (Physical and Mental)	**9%**
Documentation of the following elements: • Allergies and vital signs • Height, weight and BMI • Growth/pubertal development in children and adolescents (e.g., signs of malnutrition) • Last menstrual period (LMP), if applicable, depending on age of patient and prescribed medications	4%
Mental/behavioral health screening including, but not limited to, depression, anxiety and substance use disorder	5%
History	**37%**
Complete history of presenting behavioral symptoms (e.g., depression, suicidal ideation, suicide attempts) from patient and all sources (e.g., caregivers)	4%
Family history of mental and social health (e.g., depression, suicidal ideation, suicide attempts)	4%
History of prior treatment and response	3%
Comorbid conditions (e.g., comorbid psychiatric disorders such as anxiety, schizophrenia, bipolar disorder)	3%
Documentation of status/changes in medical/family history since last visit	2%
Assessment of risk of harm to self or others	7%
Mental status examination	7%
Established diagnosis according to current diagnostic criteria	7%
Behavioral Factors	**5%**
Documentation of physical activity and sleep behaviors	2%
Documentation of tobacco, alcohol and substance use	3%
Social Life Assessment	**5%**
Identification of existing social supports	2%
Identification of surrogate decision maker	1%
Identification of social determinants of health (e.g., food security, housing stability and homelessness, transportation access, financial security, community safety)	2%

Depression Medical Record Indicators (continued)

	Weight
Treatment/Therapy	**28%**
Presence of an up-to-date treatment plan in the chart (i.e., updated within a 3-6 month period of initial treatment plan)	9%
Treatment plan contains details about treatment setting, medications and treatment modalities to be used	9%
Documentation of medication monitoring and management (if patient is prescribed medication)	5%
Documentation of psychotherapy sessions or consultation with therapy provider	5%
Medications and Vaccinations	**11%**
Documentation of current medication regimen (age-appropriate medications and dosage)	4%
Documentation of medication intolerance or side effects	3%
Documentation of medication reconciliation, if applicable (e.g., if medication prescribed, validate there are no outdated medications, drug interactions, contraindications)	2%
Documentation of complementary and alternative medicine use	2%
Psychoeducation	**5%**
Assessment of patient and caregiver (for minors and adults requiring caretakers) knowledge and understanding of illness	2%
Evidence of education about diagnosis and symptoms	1%
Evidence of education about treatment options	1%
Documentation of a safety plan in the chart and evidence that it has been reviewed with the patient (and caregivers, as indicated)	1%

REFERENCES:

National Center for Biotechnology Information - National Library of Medicine Indian Journal of Psychiatry: Clinical Practice Guidelines for the Management of Depression

American Psychological Association (APA) Clinical Practice Guideline APA Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts

Mayo Clinic Mayo Clinic: Antidepressants for Children and Teens

Diabetes Medical Record Indicators

The following documentation is required (as clinically appropriate) for patients with diabetes:

RELEVANT VISIT TYPES	Initial Visit	Follow-Up Visit	Annual Visit	Weights
Assessment (Physical, Mental and Oral)				**28%**
Documentation of the following elements: • Allergies and vital signs • Height, weight and BMI • Growth/pubertal development in children and adolescents (e.g., signs of malnutrition) • Last menstrual period (LMP), if applicable, depending on age of patient and prescribed medications	✓	✓	✓	8%
Mental/behavioral health screening including, but not limited to, depression, anxiety, and substance use disorder	✓	✓	✓	5%
Documentation of last dilated or retinal eye exam	✓		✓	5%
Documentation of oral health status (include oral exam)	✓		✓	5%
Documentation of comprehensive foot exam including evaluation of sensation and vascular status (e.g., monofilament test, pin prick test, tuning fork, capillary refill) and assessment of nails, skin and ulcers (indicate stages of ulcers when applicable)	✓	✓	✓	5%
Medical History				**10%**
Diabetes history: • Documentation of family history • Type of diabetes for the patient and characteristics at onset (e.g., age, symptoms) • Review of previous treatment regimens and responses • Frequency/cause/severity of past hospitalizations	✓			5%
Personal history: • Comorbid conditions • Celiac disease screening in children with type 1 diabetes • High blood pressure or abnormal lipids • Presence of hemoglobinopathies or anemias • Macrovascular and microvascular complications	✓			5%
Medications and Vaccinations				**20%**
Assessment of current medication regimen and adherence (e.g., medication-taking behavior, medication intolerance or side effects, complementary and alternative medication use)	✓	✓	✓	10%
Documentation of medication reconciliation, if applicable	✓		✓	5%
Vaccination history and needs (e.g., influenza vaccine, if applicable)	✓		✓	5%

Diabetes Medical Record Indicators (continued)

RELEVANT VISIT TYPES	Initial Visit	Follow-Up Visit	Annual Visit	Weights
Education and Referrals				**10%**
Education on self-management, lifestyle changes (e.g., tobacco cessation, alcohol use, eating disorders) and other education as needed	✓		✓	5%
Referrals to specialists (e.g., podiatrist, endocrinologist, nutritionist, ophthalmologist, nephrologist, neurologist, dentist), if applicable	✓	✓	✓	5%
Social Life Assessment				**4%**
Documentation of social network (e.g., existing social supports, identification of surrogate decision maker, advance care plan, identification of social determinants of health)	✓	✓	✓	4%
Laboratory Evaluation				**28%**
Testing for glucose control: • Fasting blood sugar (FBS) • Estimated average glucose (eAG) • Hemoglobin A1c testing (results within the past three months or as ordered)	✓	✓	✓	4%
Kidney function testing (if applicable based on previous findings): • Serum creatinine • Blood urea nitrogen (BUN) • Estimated glomerular filtration rate (eGFR)	✓	✓	✓	4%
Thyroid-stimulating hormone test for patients with type 1 diabetes (if applicable, based on previous findings)	✓	✓	✓	4%
Vitamin B12 test if patient is on metformin (when indicated)	✓	✓	✓	4%
Serum potassium level for patients on angiotensin-converting enzyme (ACE) inhibitors, angiotensin II receptor blockers (ARBs) or diuretics (if applicable, based on previous findings)	✓	✓	✓	4%
Lipid profile including LDL, HDL, total cholesterol and triglycerides (if applicable, based on previous findings)	✓	✓	✓	4%
Liver function tests including ALT, AST, ALP, albumin and bilirubin (if applicable, based on previous findings)	✓	✓	✓	4%

REFERENCES:

American Diabetes Association (ADA) Practice Guidelines

Clinical Diabetes Journals.org

- Standards of Medical Care in Diabetes - 2020 Abridged for Primary Care Providers
- Children and Adolescents: Standards of Medical Care in Diabetes 2019
- Children and Adolescents: Standards of Medical Care in Diabetes 2020

Hypertension Medical Record Indicators

The following documentation is required (as clinically appropriate) for patients with hypertension:

RELEVANT VISIT TYPES	Initial Visit	Follow-Up Visit	Annual Visit	Weights
Assessment (Physical and Mental)				**18%**
Documentation of the following elements: • Allergies and vital signs • Height, weight and BMI • Growth/pubertal development in children and adolescents (e.g., signs of malnutrition) • Last menstrual period (LMP) if applicable, depending on age of patient and prescribed medications	✓	✓	✓	7%
Mental/behavioral health screening including, but not limited to, depression, anxiety, and substance use disorder	✓		✓	6%
History of comorbid conditions (e.g., obesity, diabetes), if applicable	✓	✓		5%
Medical History				**10%**
Hypertension history: • Documentation of family history • Characteristics for patient at onset (e.g., age, symptoms) • Abnormal labs or diagnostics • Review of previous treatment regimens and responses • Frequency/cause/severity of past hospitalizations	✓			5%
Personal history: • Nutritional history • Activity level • Medication/treatment • Psychosocial factors • If child, documentation of perinatal history	✓	✓	✓	5%
Medications and Vaccinations				**30%**
Documentation of treatment or medication(s)	✓	✓	✓	10%
Documentation of evaluated response to treatment/medication therapy regimen and adherence (e.g., medication-taking behavior, medication intolerance or side effects) Note: If no pharmacological treatment, documentation of response to lifestyle changes/alternative therapy	✓	✓	✓	10%
Documentation of medication reconciliation, if applicable	✓		✓	5%
Documentation of vaccination history and needs (e.g., influenza vaccine, if applicable)	✓		✓	5%

RELEVANT VISIT TYPES	Initial Visit	Follow-Up Visit	Annual Visit	Weights
Education and Referrals				**11%**
Education on blood pressure monitoring, self-management, lifestyle changes (e.g., nutrition/diet/weight management such as DASH eating plan, dietary sodium reduction, etc.) and/or other education, if applicable	✓	✓	✓	6%
Referrals to specialists (e.g., cardiologist, nephrologist, nutritionist, etc.), if applicable	✓	✓	✓	5%
Social Life Assessment				**3%**
Documentation of social network (e.g., existing social supports, identification of surrogate decision maker, advance care plan, identification of social determinants of health)	✓	✓	✓	3%
Laboratory Evaluation				**28%**
Kidney function testing (if applicable based on previous findings): • Glucose • Urinalysis • Sodium and potassium • Serum creatinine • Estimated glomerular filtration rate (eGFR) or other renal panel tests not listed here	✓	✓	✓	7%
Serum potassium level for patients on angiotensin-converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARBs) or diuretics (if applicable, based on previous findings)	✓	✓	✓	7%
Lipid profile including LDL, HDL, total cholesterol and triglycerides (if applicable, based on previous findings)	✓	✓	✓	7%
Liver function tests including ALT, AST, ALP, albumin and bilirubin (if applicable, based on previous findings)	✓	✓	✓	7%

REFERENCES:

Joint National Committee (JNC) 8 Hypertension Guideline Algorithm

American Academy of Family Physicians (AAFP) AAFP Clinical Preventive Service Recommendation: Hypertension

American Heart Association (AHA) Journals 2020 International Society of Hypertension Global Hypertension Practice Guidelines

American Academy of Pediatrics (AAP) Clinical Practice Guideline AAP Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents

American College of Cardiology ACC 2017 Guideline for High Blood Pressure in Adults