Perinatal Care CPG Medical Record Audit (MRA)

Document List

1 CPG MRA Report Process

2 Provider Audit (Form A)

3 Summarized MRA (Form B)

4 Quarterly Report (Form C)

5 Cumulative Medical Report Audit (MRA) Report (Form D)

6 Report Specification for Quarterly Report

7 Attestation

Perinatal Care Clinical Practice Guidelines (CPG) Medical Record Audit (MRA) Report

The CPG Medical Record Audit (MRA) process assesses whether the provider's medical practices conform to clinical standards of practice. The audit tool serves as an instrument to gather information on the use of evidence-based clinical practice guidelines in order to identify the effectiveness, or lack thereof, of the treatment provided in accordance with the guidelines. This audit tool incorporates the standards, established by the American College of Obstetricians and Gynecologists (ACOG), for Perinatal Care.

Guidelines for Perinatal Care 8th Edition https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx

What is a Clinical Practice Guideline?

The IOM in its newest definition describes CPGs as 'statements that include recommendations, intended to optimize patient care, that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.' (Consensus report, Institute of Medicine. Clinical practice guidelines we can trust. March 23, 2011)

Purpose of Clinical Practice Guidelines

The intent of clinical practice guidelines is to:

1. Improve the quality of patient care and health care outcomes
2. Summarize research findings and make clinical decisions more transparent
3. Reduce inappropriate variation in practice
4. Promote efficient use of resources
5. Identify gaps in knowledge and prioritize improvement activities
6. Provide guidance for consumers and inform and empower patients

Source: Davis D, Joanne G, Palda VA, Handbook on Clinical Practice Guidelines, Canadian Medical Association

The number of providers audited each quarter will reflect no less than 20% of the total allocated providers within the CMO who submitted a claim for Perinatal Care during the review period. The clinical reviewer will randomly select 3 - 5 medical records of the selected providers for the review of Perinatal Care according to the CPG. **If a selected provider has less than three (3) records, the reviewer should audit those records. However, the provider should be excluded from a reaudit if there are missed indicators.** The Georgia Families CMOs are required to collaborate to develop a process of equally dividing all providers and assigning each CMO the same group of providers on an annual rotation, or as a rotation as agreed between DCH and the CMOs. Individual CMO should create a review process that: 1) ensures at least 90% of total allocated providers are reviewed by the end of the review year and 2) avoids repeat reviews of any one provider, unless in the event of a reaudit for a previously identified deficit.

The provider's office manager or designee should be notified in advance of the pending MRA. The medical records should be pulled upon the arrival of the reviewer or may be submitted directly to the CMO (paper or electronic version) for review. Reviewers must utilize the DCH-approved forms (see attached) to conduct the audits. All individually identifiable health information must be kept confidential and private by the reviewer, in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and applicable Medicaid laws and regulations. Findings of audit must be shared with the provider within **seven (7) business days** of the MRA.

CPG MRA Process:

1. Provider Audit

The CPG Provider Audit Form (Form A) should be completed and submitted to DCH for each provider selected for review. Based on the identified indicators, the reviewer should thoroughly evaluate the medical record to determine whether the provider's medical practices conform to the clinical practice guidelines for the particular medical condition.

Interpreting the Audit

• ***Weighted Rate:*** The weighted rate (Column E) denotes the compliance rate at the record level and the total compliance rate for all records audited. Weights (Column D) have been assigned to each indicator based on the degree of its importance to the members' overall health outcomes. The weights are calculated to render a weighted rate. Each indicator should be represented with a 'Y' for Yes, if the documentation is found in the member's medical records; or an 'N' for No, if the documentation is not found in the medical records. *[NOTE: When an indicator is determined to be 'Not Applicable,' indicate 'N/A.' The assigned weight of that indicator will be credited in calculating total compliance rate DCH reserves the right to request justification for indicators deemed as 'N/A'].*

• ***Indicator Score:*** The indicator score (Column C) shows the number of records missing the same indicator(s). If a provider misses the same indicator in more than two (2) of the records reviewed, the provider should be re-audited within the second quarter of the initial audit, for the same indicator(s) that resulted in the re-audit (e.g. provider had a total of 5 audited records and more than 2 records scored an N for the same indicator in Q1, the reaudit should be completed in Q3). *[NOTE: The score is based on number of records with missed indicators and not a percentage. Providers with less than three (3) records should be included in the initial audit. If these providers have missed indicators, CMOs should notify them and provide education. DCH reserves the right to request confirmation that provider received notification and education. The provider should be included in audit for the following year].*

2. Summarized Medical Record Audit Form

The Summarized Medical Record Audit (Form B) must be submitted to DCH within 30 days from the end of each quarter. The Summarized MRA, a compilation of the CPG Provider Audits, provides the average compliance rate per indicator and the average overall compliance rate of the providers selected for review.

3. CPG Quarterly Report

The CPG Quarterly Report (Form C) must be submitted to DCH within 30 days from the end of each quarter. The Quarterly Report, which may be submitted as a Microsoft Word or Excel document, should be completed in accordance with the CPG MRA Specifications.

4. Cumulative Medical Record Audit Report

The Cumulative Medical Record Audit Report *(Form D)* must be submitted to DCH within 30 days from the end of each quarter. The Cumulative MRA Report is a compilation of the weighted rates calculated for each quarter. The purpose of this document is to inform DCH and the CMOs of the quarterly trends for compliance with this CPG.

Form A - Provider Audit (Perinatal Care) **CMO Name:** **Reporting Period: MM/DD/YYYY-MM/DD/YYYY**

INDICATORS	MEDICAL RECORDS					Numerator	Denominator	Indicator Score	Weights	Weighted Rate
						(A)	(B)	(C)	(D)	(E) = (A/B X D) X 100
Match Number to Patient in Confidential Manner	1	2	3	4	5	Total # of Records with Indicators	Total # of Records Audited	Total # of Records Missed		
Prenatal Assessment									***27%***	
Documentation of the Comprehensive Prenatal Visit to include vital signs, BP, weight, pregnancy and medical history, last menstrual period (LMP), or expected due date (EDD) or gestational age *(Note: All elements must be present to receive a 'Y')*									*8%*	
Documentation of Follow up Prenatal Visit(s): Documentation of any or all of the following (fetal movement, fetal heart auscultation, ultrasound, uterine & fundus size measurement) *(Note: These indicators do not exclude other treatment/screening/tests from being documented in the chart)*									*7%*	
Documentation of Mental/Behavioral Health Screening/History: (e.g. screening for anxiety, depression, mood disorders, tobacco and/or substance use disorder, pre-existing mental health issues, sleep disruption and fatigue)									*7%*	
Documentation of Risk Assessment: (e.g. UTI, preterm labor, edema, preeclampsia, cardiovascular related conditions, complications of past pregnancies, maternal age)									*5%*	
Prenatal Referral									***9%***	
Documentation of Referral with primary care or mental health, maternal fetal medicine, other specialists or high-risk case management *(if applicable, based on indicator #13)*									*9%*	
Prenatal Medications									***6%***	
Documentation of Current Medication and Adherence: All medications (prescription and over-the-counter, supplements, and herbal therapies) *(if applicable)*									*3%*	
Documentation of Aspirin: If history of preeclampsia is documented in the record									*3%*	
Prenatal Labs/Tests/Screenings									***15%***	
Documentation of Prenatal Panel Screening Test: CBC, Hepatitis B & C, tuberculosis (TB), urine culture/screen **or** urinalysis, Rubella status, blood type and RH factor, antibody screening, Group B Streptococcus Screening *(Note: All elements must be present to receive a "Y")*									*4%*	
Documentation of Glucose Screening									*4%*	
Documentation of STD Screening									*4%*	
Documentation of Genetic Risk Testing: If applicable [e.g. Chorionic Villus Sampling, Down Syndrome (Trisomy 21), Genetic amniocentesis]									*3%*	
Prenatal Member Education									***8%***	
Documentation of Education: [e.g. precautions for substance use, hot saunas, exposure to toxoplasmosis (cats/raw meats), environmental hazards, OTC and other non-prescribed/herbal medications]									*4%*	
Documentation of When to Seek Medical Care: [e.g. Contractions, leaking fluid or bleeding from the vagina, pressure in the pelvis (hip) area, abdominal cramps, sudden weight increase, headache, blurred vision, chest pain]									*4%*	
Postpartum Assessment (***NOTE:*** *For postpartum sections, select 'N/A' if member was pregnant at time of audit.)*									***27%***	
Documentation of Delivery Date									*3%*	
Documentation of Initial Contact (in person or by phone) within the first 3 weeks of postpartum									*5%*	
Documentation of a Comprehensive Postpartum Visit *(Note: Visit should occur no later than 12 weeks after birth)** Documentation of any or all of the following: Pelvic exam (vaginal delivery); full assessment of physical (e.g. vital signs, physical exam), social (e.g. family support/network, SDoH), and psychological (e.g. mood and emotional well-being)									*7%*	
Documentation of Follow up Postpartum Visit(s) for any of the following: Incision site (cesarean delivery), complications of pregnancy [e.g. gestational diabetes, Arteriosclerotic Cardiovascular Disease (ASCVD), cardiomyopathy, any other complications such as preterm delivery, gestational hypertension, preeclampsia, and eclampsia] *(Note: These indicators do not exclude other conditions from being documented in the chart)*									*6%*	
Documentation of Screening and Follow up for Postpartum Depression or any other Behavioral Health Condition *(if applicable)*									*6%*	
Postpartum Referral									***3%***	
Documentation of Referral for Follow up with primary care or mental health, cardiologists, and other specialists as needed *(if applicable)*									*3%*	
Postpartum Member Education									***5%***	
Documentation of Education on Postpartum Self-care: (e.g. care of c-section/episiotomy incision, prevention of mastitis, and/or when to contact the physician)									*5%*	
					TOTAL COMPLIANCE RATE				**100%**	

Note: Additional space has been provided in the event more than one medical record is selected for a provider.

*Source: American College of Obstetricians and Gynecologists

Guidelines for Perinatal Care 8th Edition https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx

* Optimizing Postpartum Care | ACOG

Prenatal Routine Tests (2024): https://www.acog.org/womens-health/faqs/routine-tests-during-pregnancy

Rev 9/2024

CPG Medical Record Audit Report- Perinatal Care

Report Submitted:

Form B: Summarized Medical Report Audit Report *(Due Quarterly)* CMO Name: Reporting Period: MM/DD/YYYY-MM/DD/YYYY

INDICATORS	Numerator	Denominator	Indicator Score	Weights	Weighted Rate
	(A)	(B)	(C)	(D)	(E) = (A/B X D) X 100
Match Number to Patient in Confidential Manner	Total # of Records with Indicators	Total # of Records Audited	Total # of Records Missed		
Prenatal Assessment				*27%*	
Documentation of the Comprehensive Prenatal Visit to include vital signs, BP, weight, pregnancy and medical history, last menstrual period (LMP), or expected due date (EDD) or gestational age *(Note: All elements must be present to receive a 'Y')*				*8%*	
Documentation of Follow up Prenatal Visit(s): Documentation of any or all of the following (fetal movement, fetal heart auscultation, ultrasound, uterine & fundus size measurement) *(Note: These indicators do not exclude other treatment/screening/tests from being documented in the chart)*				*7%*	
Documentation of Mental/Behavioral Health Screening/History: (e.g. screening for anxiety, depression, mood disorders, tobacco and/or substance use disorder, pre-existing mental health issues, sleep disruption and fatigue)				*7%*	
Documentation of Risk Assessment: (e.g. UTI, preterm labor, edema, preeclampsia, cardiovascular related conditions, complications of past pregnancies, maternal age)				*5%*	
Prenatal Referral				*9%*	
Documentation of Referral with primary care or mental health, maternal fetal medicine, other specialists or high-risk case management *(if applicable, based on indicator #13)*				*9%*	
Prenatal Medications				*6%*	
Documentation of Current Medication and Adherence: All medications (prescription and over-the-counter, supplements, and herbal therapies) *(if applicable)*				*3%*	
Documentation of Aspirin: If history of preeclampsia is documented in the record				*3%*	
Prenatal Labs/Tests/Screenings				*15%*	
Documentation of Prenatal Panel Screening Test: CBC, Hepatitis B & C, tuberculosis (TB), urine culture/screen or urinalysis, Rubella status, blood type and RH factor, antibody screening, Group B Streptococcus Screening *(Note: All elements must be present to receive a "Y")*				*4%*	
Documentation of Glucose Screening				*4%*	
Documentation of STD Screening				*4%*	
Documentation of Genetic Risk Testing: If applicable [e.g. Chorionic Villus Sampling, Down Syndrome (Trisomy 21), Genetic amniocentesis]				*3%*	
Prenatal Member Education				*8%*	
Documentation of Education: [e.g. precautions for substance use, hot saunas, exposure to toxoplasmosis (cats/raw meats), environmental hazards, OTC and other non-prescribed/herbal medications]				*4%*	
Documentation of When to Seek Medical Care: [e.g. Contractions, leaking fluid or bleeding from the vagina, pressure in the pelvis (hip) area, abdominal cramps, sudden weight increase, headache, blurred vision, chest pain]				*4%*	
Postpartum Assessment *(**NOTE:** For postpartum sections, select 'N/A' if member was pregnant at time of audit.)*				*27%*	
Documentation of Delivery Date				*3%*	
Documentation of Initial Contact (in person or by phone) within the first 3 weeks of postpartum				*5%*	
Documentation of a Comprehensive Postpartum Visit *(Note: Visit should occur no later than 12 weeks after birth)** Documentation of any or all of the following: Pelvic exam (vaginal delivery); full assessment of physical (e.g. vital signs, physical exam), social (e.g. family support/network, SDoH), and psychological (e.g. mood and emotional well-being)				*7%*	
Documentation of Follow up Postpartum Visit(s) for any of the following: Incision site (cesarean delivery), complications of pregnancy [e.g. gestational diabetes, Arteriosclerotic Cardiovascular Disease (ASCVD), cardiomyopathy, any other complications such as preterm delivery, gestational hypertension, preeclampsia, and eclampsia] *(Note: These indicators do not exclude other conditions from being documented in the chart)*				*6%*	
Documentation of Screening and Follow up for Postpartum Depression or any other Behavioral Health Condition *(if applicable)*				*6%*	
Postpartum Referral				*3%*	
Documentation of Referral for Follow up with primary care or mental health, cardiologists, and other specialists as needed *(if applicable)*				*3%*	
Postpartum Member Education				*5%*	
Documentation of Education on Postpartum Self-care: (e.g. care of c-section/episiotomy incision, prevention of mastitis, and/or when to contact the physician)				*5%*	
				100%	

Total # of Records Reviewed this Quarter

Total # of Providers Reviewed this Quarter

Note: Additional space has been provided in the event more than one medical record is selected for a provider.

*Source: American College of Obstetricians and Gynecologists

Guidelines for Perinatal Care 8th Edition https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx

Optimizing Postpartum Care | ACOG

Prenatal Routine Tests (2024): https://www.acog.org/womens-health/faqs/routine-tests-during-pregnancy

Rev 9/2024

CPG Medical Record Audit Report

Form C- Quarterly Report
CMO Name:____

Report Date: MM/DD/YYYY **Reporting Period:** MM/DD/YYYY- MM/DD/YYYY

Overview

Quarterly Medical Record Review Summary	
Total Number of Records Reviewed *(Transfer from Form B: Summarized MRA)*	
Total Number of Providers Reviewed *(Transfer from Form B: Summarized MRA)*	
Total Compliance Rate (%) (Transfer from Form B: Summarized MRA)	

Provider Summary Review

	Top 3 Indicators Missed this Audit Period *(List top 3 indicators in numbered cells below)*	**Total Number of Providers Missing the Top 3 Indicators**	**Provider Focus Review (Yes/No)**	**Tentative Re-audit Date**
1				
2				
3				

Re-audit Outcomes

Total Number of Providers Scheduled for Re-audits for the Past 12 Month Period	**Total Number of Re-audits Completed**	**Re-audit Outcome and Next Steps** (e.g. CEU, CAP, Peer Review)

Form B - Cumulative Medical Record Audit Report (Complete Quarterly) **CMO Name:** **Reporting Period: MM/DD/YYYY - MM/DD/YYYY**

Indicators	Weights	QUARTER 1 Weighted Rate	QUARTER 2 Weighted Rate	QUARTER 3 Weighted Rate	QUARTER 4 Weighted Rate
Prenatal Assessment	*27%*				
Documentation of the Comprehensive Prenatal Visit to include vital signs, BP, weight, pregnancy and medical history, last menstrual period (LMP), or expected due date (EDD) or gestational age *(Note: All elements must be present to receive a 'Y')*	*8%*				
Documentation of Follow up Prenatal Visit(s): Documentation of any or all of the following (fetal movement, fetal heart auscultation, ultrasound, uterine & fundus size measurement) *(Note: These indicators do not exclude other treatment/screening/tests from being documented in the chart)*	*7%*				
Documentation of Mental/Behavioral Health Screening/History: (e.g. screening for anxiety, depression, mood disorders, tobacco and/or substance use disorder, pre-existing mental health issues, sleep disruption and fatigue)	*7%*				
Documentation of Risk Assessment: (e.g. UTI, preterm labor, edema, preeclampsia, cardiovascular related conditions, complications of past pregnancies, maternal age)	*5%*				
Prenatal Referral	*9%*				
Documentation of Referral with primary care or mental health, maternal fetal medicine, other specialists or high-risk case management *(if applicable, based on indicator #13)*	*9%*				
Prenatal Medications	*6%*				
Documentation of Current Medication and Adherence: All medications (prescription and over-the-counter, supplements, and herbal therapies) *(if applicable)*	*3%*				
Documentation of Aspirin: If history of preeclampsia is documented in the record	*3%*				
Prenatal Labs/Tests/Screenings	*15%*				
Documentation of Prenatal Panel Screening Test: CBC, Hepatitis B & C, tuberculosis (TB), urine culture/screen or urinalysis, Rubella status, blood type and RH factor, antibody screening, Group B Streptococcus Screening *(Note: All elements must be present to receive a "Y")*	*4%*				
Documentation of Glucose Screening	*4%*				
Documentation of STD Screening	*4%*				
Documentation of Genetic Risk Testing: If applicable [e.g. Chorionic Villus Sampling, Down Syndrome (Trisomy 21), Genetic amniocentesis]	*3%*				
Prenatal Member Education	*8%*				
Documentation of Education: [e.g. precautions for substance use, hot saunas, exposure to toxoplasmosis (cats/raw meats), environmental hazards, OTC and other non-prescribed/herbal medications]	*4%*				
Documentation of When to Seek Medical Care: [e.g. Contractions, leaking fluid or bleeding from the vagina, pressure in the pelvis (hip) area, abdominal cramps, sudden weight increase, headache, blurred vision, chest pain]	*4%*				
Postpartum Assessment *(**NOTE:** For postpartum sections, select 'N/A' if member was pregnant at time of audit.)*	*27%*				
Documentation of Delivery Date	*3%*				
Documentation of Initial Contact (in person or by phone) within the first 3 weeks of postpartum	*5%*				
Documentation of a Comprehensive Postpartum Visit *(Note: Visit should occur no later than 12 weeks after birth)** Documentation of any or all of the following: Pelvic exam (vaginal delivery); full assessment of physical (e.g. vital signs, physical exam), social (e.g. family support/network, SDoH), and psychological (e.g. mood and emotional well-being)	*7%*				
Documentation of Follow up Postpartum Visit(s) for any of the following: Incision site (cesarean delivery), complications of pregnancy [e.g. gestational diabetes, Arteriosclerotic Cardiovascular Disease (ASCVD), cardiomyopathy, any other complications such as preterm delivery, gestational hypertension, preeclampsia, and eclampsia] *(Note: These indicators do not exclude other conditions from being documented in the chart)*	*6%*				
Documentation of Screening and Follow up for Postpartum Depression or any other Behavioral Health Condition *(if applicable)*	*6%*				
Postpartum Referral	*3%*				
Documentation of Referral for Follow up with primary care or mental health, cardiologists, and other specialists as needed *(if applicable)*	*3%*				
Postpartum Member Education	*5%*				
Documentation of Education on Postpartum Self-care: (e.g. care of c-section/episiotomy incision, prevention of mastitis, and/or when to contact the physician)	*5%*				
	100%				

Report Specification for Quarterly Report

Perinatal Care CPG Medical Record Audit
Report Specification for Quarterly Report

(may submit report as Microsoft Word or Excel document)

DO NOT MODIFY

Report Name	CPG Medical Record Audit (MRA) Quarterly Report		
CMO Name	Enter name of CMO		
Report Date	Enter report date as MM/DD/YYYY		
Frequency	Submit report quarterly		
Reporting Period	**CPG Claims**	**Date of Review**	**Report Due**
	Jan 1- Mar 31	Apr 1- Jun 30	July 31
	Apr 1- Jun 30	Jul 1- Sept 30	Oct 31
	Jul 1- Sept 30	Oct 1- Dec 31	Jan 31
	Oct 1- Dec 31	Jan 1- Mar 31	April 30

FIELD	FIELD DESCRIPTION
Total Number of Records Reviewed	**Conduct a random sample of records per providers who bill for services with diagnosis codes for the evidence-based clinical practice guideline (CPG) for Perinatal Care.** Enter total number of records reviewed this quarter *(Transfer number from Form B: Summarized MRA)*
Total Number of Providers Reviewed	Enter total number of providers reviewed this quarter. *(Transfer % rate from Form B: Summarized MRA)*
Overall Average Provider Compliance Rate (%)	Enter overall compliance percentage rate for this quarter. *(Transfer % rate from Form B: Summarized MRA)*
Top 3 Indicators Missed this Audit Period	Review missed indicators as indicated on Provider Audit (Form A). Enter the top 3 indicators missed this audit period in the numbered cells.
Total Number of Providers Missing the Top 3 Indicators	For each of the Top 3 indicators listed, enter the total number of providers for each of the missing indicators.
Provider Focus Review	**Select (Yes/No**) if a Provider Focus Review was initiated during the reporting period
Tentative Re-audit Date	Enter date of tentative re-audit
Deficits Outcome	**Provider Focused Review process:** •The CMOs must conduct a Provider Focused Review if a provider misses the same indicator in more than two (2) of the records reviewed. •Notify provider of the missed indicators and the need for a re-audit , •Provide education, and re-audit within the second quarter following the quarter when the deficit was identified (e.g. provider had a total of 5 audited records and more than 2 records scored an N for the same indicator in Q1, the reaudit should be completed in Q3). [Note: The score is based on number of records with missed indicators and not a percentage. Providers with less than three (3) records should be included in the initial audit, if these providers have missed indicators, CMOs should notify them and provide education]. • If deficits are identified at the first re-audit, CMOs are to provide mentoring and/or peer coaching on indicators targeted for a second re-audit. •If no deficits are identified at the first re-audit, no further action is needed. •If deficits persist after the second re-audit, the CMOs may choose to provide further education, refer the provider to the CMO's Peer Review Committee, or proceed with initiating a CAP. [Note: If the CMOs refer the provider to the CMO's Peer Review Committee or conducts a CAP, the outcomes should be reported to DCH via Quarterly Report (Form C)]. **NOTE:** If the providers have less than three records for a re-audit, CMOs should use any available number of records and if no records are available, the provider's name should remain on the list until the records are available to complete there-dit
Total Number of Providers Scheduled for Re-audits for the Past 12 Month Period	Enter total number of providers identified from previous audits for the past 12 month period.
Total Number of Re-audits Completed	Enter total number of completed re-audits
Re-Audit Outcome and Next Steps	Enter the outcome of re-audit and any necessary next steps *(e.g. Re-audit, CAP, peer-coaching /continuing education, Peer Review)*

ATTESTATION

This form must be reviewed, signed, and dated by the CMO's Chief Medical Officer and submitted with each Georgia Families Clinical Practice Guidelines quarterly reports, as specified, to DCH via the CMO report portal. Graphs, charts, and other documentation can be attached to this form.

I, ____, do hereby attest that the above information is true and correct to the best of my knowledge.

Date: ______________________________