Depression 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

Depression 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 and published by the American Psychological Association (APA), for the management and treatment of Depression.

https://www.apa.org/depression-guideline/guideline.pdf

What is a Clinical Practice Guideline?
Clinical practice guidelines are systematically developed statements to assist practitioners and patient decisions about appropriate health care for specific circumstances. —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 Depression during the review period. The actual number of providers audited each quarter will reflect no less than 20% of the total allocated providers within the CMO. The clinical reviewer will randomly select 4 -5 medical records of the selected providers for the review of Depression care according to the CPG. 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 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. Weights 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). Please note: DCH reserves the right to request justification for indicators deemed as 'N/A'. If a provider scores less than the 80% compliance threshold for any individual indicator (see Indicator Rate column in Form A), 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 only 3 records scored a 'Y' or 'N/A' for the individual indicator, this would be equal to a compliance rate of 60%; if deficit is identified in Q1, the reaudit should be completed in Q3).

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 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.

Rev. 7/2023

Form A - Provider Audit (Depression) **CMO Name:** _____

Reporting Period: MM/DD/YYYY-MM/DD/YYYY _____

INDICATORS	MEDICAL RECORDS					Numerator	Denominator	Indicator Rate	Weights	Weighted Rate
						(A)	(B)	(A/B)	(C)	(A/B X C) X 100
Match Number to Patient in Confidential Manner	**1**	**2**	**3**	**4**	**5**	**Total # of charts compliant with indicators**	**Total # of charts audited**			
Assessment									***9%***	
^ Documentation of Allergies and Weight									*2%*	
^ Documentation of Last Menstrual Period (LMP): *(Note: If applicable, depending on age of member and prescribed medications, elements must be documented in the medical records to receive the weighted rate)*									*2%*	
# Documentation of Mental/Behavioral Health Screening: any behavioral condition									*5%*	
History									***16%***	
# Complete history taken of presenting behavioral symptoms from patient and all sources (i.e. caregivers, etc.)									*4%*	
# History taken includes family history of mental and social health									*4%*	
# History taken includes history of prior treatment and response									*3%*	
# History taken of comorbid conditions (e.g. comorbid psychiatric disorders such as anxiety, schziophrenia, and bipolar)									*3%*	
# Documentation of status/changes in medical/family history since last visit									*2%*	
Diagnostic Assessment									***21%***	
# 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 screening and/or history									*3%*	
Social Network Assessment									***5%***	
# Identified existing social supports									*2%*	
# Identified surrogate decision maker									*1%*	
# Identified social determinants of health (e.g. food security, housing stability and homeless, transportation access, financial security, community safety									*2%*	
Treatment/Therapy									***29%***	
# Presence of an up-to-date treatment plan in the chart (i.e. updated within a 3-6 month period of initial treatment plan)									*8%*	
^ Treatment plan contains details about treatment setting, medications and treatment modalities to be used									*8%*	
^ Documentation of medication monitoring and management (if member prescribed medication)									*5%*	
# Documentation of psychotherapy sessions or consultation with therapy provider									*5%*	
# Referral for presciber consult/involvement									*3%*	
Medications and Vaccinations									***10%***	
^ Documentation of current medication regimen (age appropriate medications and dosage)**									*4%*	
^ Documentation of medication intolerance or side effects									*3%*	
^ Documentation of medication reconciliation (e.g. if medication prescribed, validate there are no out-dated medications, drug interactions, contraindications)									*2%*	
^ Documentation of complementary and alternative medicine use									*1%*	
Psychoeducation									***5%***	
# Assessment of member 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 member and caregivers (if a safety plan is indicated) *(Note: A copy of the patient safety plan must be retained in the member records and updated as indicated)*									*1%*	
						TOTAL COMPLIANCE RATE			**100%**	

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

 # - Indicator to be completed by all providers

^ - Indicator to be completed by prescribers

References

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5310101/

https://www.apa.org/depression-guideline/guideline.pdf

Antidepressants for children and teens - Mayo Clinic

****Commonly prescribed FDA approved antidepressants for children and teenagers**

Medication*	Age (in years)	Diagnosis
*Many of these drugs are also available in generic form. Recommended initial dose and maximum dose vary by age.		
Clomipramine (Anafranil)	10 and older	Obsessive-compulsive disorder (OCD)
Duloxetine (Cymbalta, Drizalma Sprinkle)	7 and older	Generalized anxiety disorder
Escitalopram (Lexapro)	12 and older	Major depressive disorder
Fluoxetine (Prozac)	8 and older	Major depressive disorder
	7 and older	OCD
Fluvoxamine	8 and older	OCD
Lurasidone (Latuda)	10 and older	Bipolar depression
Olanzapine and fluoxetine, combination drug (Symbyax)	10 and older	Bipolar depression
Sertraline (Zoloft)	6 and older	OCD

CPG Medical Recod Audit Report- Depression

Report Submitted: _____

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

INDICATORS	Numerator	Denominator	Indicator Rate	Weights	Weighted Rate	Total # of Records Reviewed this Quarter
	(A)	(B)	(A/B)	(C)	(A/B X C) X 100	
Match Number to Patient in Confidential Manner	Total # of charts compliant with indicators	Total # of charts audited				
Assessment (Physical and Mental)				***9%***		
^ Documentation of Allergies and Weight				*2%*		
^ Documentation of Last Menstrual Period (LMP): *(*Note: If applicable, depending on age of member and prescribed medications, elements must be documented in the medical records to receive the weighted rate)*				*2%*		
# Documentation of Mental/Behavioral Health Screening: any behavioral condition				*5%*		**Total # of Providers Reviewed this Quarter**
History				***16%***		
# Complete history taken of presenting behavioral symptoms from patient and all sources (i.e. caregivers, etc.)				*4%*		
# History taken includes family history of mental and social health				*4%*		
# History taken includes history of prior treatment and response				*3%*		
# History taken of comorbid conditions (e.g. comorbid psychiatric disorders such as anxiety, schziophrenia, and bipolar)				*3%*		
# Documentation of status/changes in medical/family history since last visit				*2%*		
Diagnostic Assessment				***21%***		
# 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 screening and/or history				*3%*		
Social Network Assessment				***5%***		
# Identified existing social supports				*2%*		
# Identified surrogate decision maker				*1%*		
# Identified social determinants of health (e.g. food security, housing stability and homeless, transportation access, financial security, community safety				*2%*		
Treatment/Therapy				***29%***		
# Presence of an up-to-date treatment plan in the chart (i.e. updated within a 3-6 month period of initial treatment plan)				*8%*		
^ Treatment plan contains details about treatment setting, medications -and treatment modalities to be used				*8%*		
^ Documentation of medication monitoring and management (if member prescribed medication)				*5%*		
^ Documentation of psychotherapy sessions or consultation with therapy provider				*5%*		
# Referral for presciber consult/involvement				*3%*		
Medications and Vaccinations				***10%***		
^ Documentation of current medication regimen (age appropriate medications and dosage)**				*4%*		
^ Documentation of medication intolerance or side effects				*3%*		
^ Documentation of medication reconciliation (e.g. if medication prescribed, validate there are no out-dated medications, drug interactions, contraindications)				*2%*		
^ Documentation of complementary and alternative medicine use				*1%*		
Pscyhoeducation				***5%***		
# Assessment of member 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 member and caregivers (if a safety plan is indicated) *(Note: A copy of the patient safety plan must be retained in the member records and updated as indicated)*				*1%*		
				100%		

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

 # - Indicator to be completed by all providers
^ - Indicator to be completed by prescribers

References
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5310101/
https://www.apa.org/depression-guideline/guideline.pdf
Antidepressants for children and teens - Mayo Clinic

****Commonly prescribed FDA approved antidepressants for children and teenagers**

Medication*	Age (in years)	Diagnosis
*Many of these drugs are also available in generic form. Recommended initial dose and maximum dose vary by age.		
Clomipramine (Anafranil)	10 and older	Obsessive-compulsive disorder (OCD)
Duloxetine (Cymbalta, Drizalma Sprinkle)	7 and older	Generalized anxiety disorder
Escitalopram (Lexapro)	12 and older	Major depressive disorder
Fluoxetine (Prozac)	8 and older	Major depressive disorder
	7 and older	OCD
Fluvoxamine	8 and older	OCD
Lurasidone (Latuda)	10 and older	Bipolar depression
Olanzapine and fluoxetine, combination drug (Symbyax)	10 and older	Bipolar depression
Sertraline (Zoloft)	6 and older	OCD

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

	Quarterly Summary of Top 3 Indicators with an 'N' (Place top 3 areas in numbered cells.)	Total Number of Providers with this Deficit	Provider Focus Review (Yes/No)	Tentative Re-audit Date
1				
2				
3				

Re-audit Outcomes

Total Number of Providers Previously Scheduled for Re-audit	Total Number of Re-audits Completed	Re-audit Outcome and Next Steps (e.g. CEU, CAP, Peer Review)

Rev. 3/2024

Form D - 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
Assessment (Physical and Mental)	***9%***				
Documentation of Allergies and Weight	*2%*				
Documentation of Last Menstrual Period (LMP): *(*Note: If applicable, depending on age of member and prescribed medications, elements must be documented in the medical records to receive the weighted rate)*	*2%*				
Documentation of Mental/Behavioral Health Screening: any behavioral condition	*5%*				
History	***16%***				
Complete history taken of presenting behavioral symptoms	*4%*				
History taken includes family history of physical, mental and social health	*4%*				
History taken includes history of prior treatment and response	*3%*				
History taken of comorbid conditions (e.g. comorbid psychiatric disorders such as anxiety, schziophrenia, and bipolar)	*3%*				
Assessment of changes in medical/ family history since last visit	*2%*				
Diagnostic Assessement	***21%***				
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 abuse screening and/or history	*3%*				
Social Network Assessment	***5%***				
Identified existing social supports	*2%*				
Identified surrogate decision maker	*1%*				
Identified social determinants of health (e.g. food security, housing stability and homeless, transportation access, financial security, community safety	*2%*				
Treatment/Therapy	***29%***				
Presence of an up-to-date treatment plan in the chart (i.e. updated within a 3-6 month period of initial treatment plan)	*8%*				
Treatment plan contains details about treatment setting, medications and treatment modalities to be used	*8%*				
Documentation of medication monitoring and management (if member prescribed medication)	*5%*				
Documentation of psychotherapy sessions or consultation with therapy provider	*5%*				
Referral for presciber consult/involvement	*3%*				
Medications and Vaccinations	***10%***				
Documentation of current medication regimen (age appropriate medications and dosage)**	*4%*				
Documentation of medication intolerance or side effects	*3%*				
Documentation of medication reconciliation (e.g. if medication prescribed, validate there are no out-dated medications, drug interactions, contraindications)	*2%*				
Documentation of complementary and alternative medicine use	*1%*				
Psychoeducation	***5%***				
Assessment of member 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 member and caregivers (if a safety plan is indicated) *(Note: A copy of the patient safety plan must be retained in the member records and updated as indicated)*	*1%*				
	100%				

[Report Specification for Quarterly Report]

Depression 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 Depression.** 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)*
Quarterly Summary of Top 3 Indicators with an 'N'	Review office deficits as indicated on Form A: Provider Audit. Enter the top 3 indicators with an 'N' score in the numbered cells
Total Number of Providers with this Deficit	For each of the Top 3 deficiencies listed, enter the total number of providers for each deficiency.
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 scores less than the 80% compliance threshold for any **individual** indicator (see Indicator Rate column in Form A), [e.g. provider had a total of 5 audited records and only 3 records scored a 'Y' or 'N/A' for the individual indicator, this would be equal to a compliance rate of 60%]. •Notify provider of the need to re-audit and provide education and/or peer coaching on indicators targeted for re-audit. •***Note:*** *If less than* ***three (3)*** *additional records are available by the re-audit period, the CMO will delay the re-audit until there are at least* ***three (3)*** *records available.* •Re-audit in the second quarter following the quarter when the deficit was identified (e.g. deficit is identified in Q1, the reaudit should be completed in Q3). •If no deficits are identified at re-audit, no further action is needed. For deficits beyond re-audit, CMOs will complete a Corrective Action Plan (CAP). •If deficiency persists following completion of a CAP, CMOs will be required to refer the provider to the CMO's Peer Review Committee for determination of next steps and the outcomes should be reported to DCH via Quarterly Report (Form C).
Total Number of Providers Previously Scheduled for Re-audit	Enter total number of providers identified from previous audits to be re-audited

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)

Rev. 7/2023

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: _____