NEWS&NOTES

EmblemHealth

The Newsletter for EmblemHealth, GHI and HIP Providers

Winter 2012

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Upcoming Medical Record Audits for 2012

Adequate and proper medical documentation is essential for quality medical care. We conduct audits to review practitioner documentation and ensure compliance with Centers for Medicare and Medicaid Services (CMS) and New York State Department of Health (NYSDOH) regulatory requirements and to meet National Committee for Quality Assurance (NCQA) standards of patient care.

We work with our practitioners to review medical records and identify concerns, as well as offer tips for correct medical documentation when needed. We also provide appropriate preventive health guidelines to discuss with members.

Here are some of the audits you can expect in 2012:

HEDIS

Our Quality Management Department will soon begin its annual Healthcare Effectiveness Data and Information Set (HEDIS®) audit. HEDIS results are an integral part of the NCQA accreditation process. HEDIS measures allow consumers to readily compare the performance of health care plans.

HEDIS packets will be mailed to network providers in February 2012, requesting a total of approximately 40,000 medical records for standards of care measures such as well-child visits and preventive breast cancer screenings, and for chronic illnesses including diabetes and hypertension. Strict procedures are followed during all phases of data collection, and the data is audited by NCQA-certified auditors to ensure that data requirements are followed.

If you are asked to submit medical records, please make sure that you follow the standards set by NCQA and NYSDOH and submit the records within the requested timeframes. Please refer to the EmblemHealth Provider Manual for medical record documentation requirements.

Higher HEDIS scores are usually the result of members receiving recommended health services and preventive health screenings. We ask you to remind your patients to schedule yearly exams and follow-up visits.

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Prenatal Care Assistance Program Audit

NYSDOH requires all Medicaid Managed Care plans to provide all pregnant members with comprehensive prenatal care services through their participating practitioners. To meet this requirement, we annually review a sampling of medical records for our pregnant Medicaid members. This year's audit, covering service year 2011, will begin in March 2012.

For medical records reviewed in 2011, covering service year 2010, we found an overall improvement in the number of practitioners meeting the benchmark score of 90 percent or greater. Thank you for your efforts.

Our practitioners did not fare so well in assessing high-risk factors and documenting them in patient medical records. This warrants further improvement. Assessments must include a notation of discussion and counseling with the pregnant member on the following:

and counseling with the pregnant member on the following:

- Dental Care
- Medication side effects and symptoms
- Sexual abuse
- Safe sex practices
- Parenting skills

Additional PCAP information and resources, as well as many other topics, may be found on the New York State Department of Health Web site.

Primary Care Physician Audit

The Primary Care Physician audit will occur in September 2012. To comply with NYSDOH regulations, as well as NCQA accreditation requirements, we perform an annual review of the medical records of a sample of network practitioners specializing in internal medicine, pediatrics and obstetrics/gynecology.

To meet the NCQA standards and fulfill audit requirements, a practitioner must obtain a score greater than 90 percent. For the 2011 audit, covering service year 2010, 72.54 percent of our network practitioners met the benchmark for standards of care.

The largest observed improvement in documentation for adult records was in the Preventive Health Guideline category for practitioners who measure a member's BMI. Documentation increased 38.52 percent from 2009 to 2010. An area that still requires improvement is documenting appropriate immunization history and making sure immunizations stay current.

Additional information and resources on medical record documentation standards can be found in our Provider Manual.

Communicable Disease Reporting

Practitioners are mandated by both New York State and City health law to report suspected or confirmed cases of communicable diseases to the patient's local health department. Practitioners in New York City may submit reports to the New York City Department of Health and Mental Hygiene.

All diseases that require submission must be reported within 24 hours of diagnosis.

To ensure practitioner compliance with these regulations, we conduct a monthly Communicable Disease Audit. Practitioners are chosen randomly by analysis of the reportable diagnoses outlined by the New York City Department of Health. In 2010, 100 percent of the reportable diseases were reported.

The New York State Department of Health has published communicable disease reporting guidelines with a list of specific communicable diseases and additional instructions. Please post this document for your staff.

CMS Medical Record Documentation Requirements

The Centers for Medicare & Medicaid Services (CMS) requires that patient medical records are accurate and complete. Complete medical records must be legible and include the patient name and date of service, information supporting the diagnosis, documentation of the treatment plan, outcomes, etc. An acceptable practitioner signature and credentials must accompany each patient encounter in the medical record.