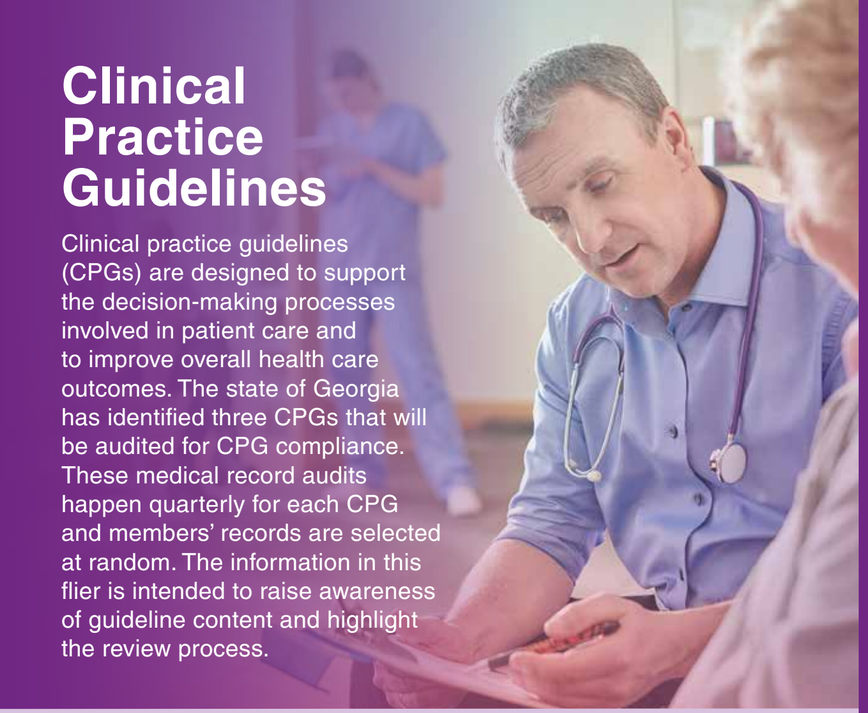
Clinical Practice Guidelines



Clinical practice guidelines (CPGs) are designed to support the decision-making processes involved in patient care and to improve overall health care outcomes. The state of Georgia has identified three CPGs that will be audited for CPG compliance. These medical record audits happen quarterly for each CPG and members' records are selected at random. The information in this flier is intended to raise awareness of guideline content and highlight the review process.

HOW OFTEN WILL I BE AUDITED?

Each care management organization (CMO) in Georgia is required to audit a random fifty (50) members' medical records per evidence-based clinical practice guideline (CPG) every quarter. This practice requires 150 member records every three months. As a provider, you are only allowed to be audited by one CMO each quarter, but you could be audited by a CMO every quarter. Your office will be notified in advance of the audit. Preliminary result of the audit will be shared with you, and formal review findings will be given to your office within seven days of the medical record audit completion.

WHAT IS A CORRECTIVE ACTION PLAN?

If less than 80 percent of your records fail to comply with any one of the listed components of the CPG, a corrective action plan (CAP) form must be submitted to DCH. The CAP form must be completed by your office and submitted by the CMO to DCH within 30 days from the end of the quarter. The CAP form should provide a plan for improvement and detail intended collaboration between you and the CMO to increase compliance.

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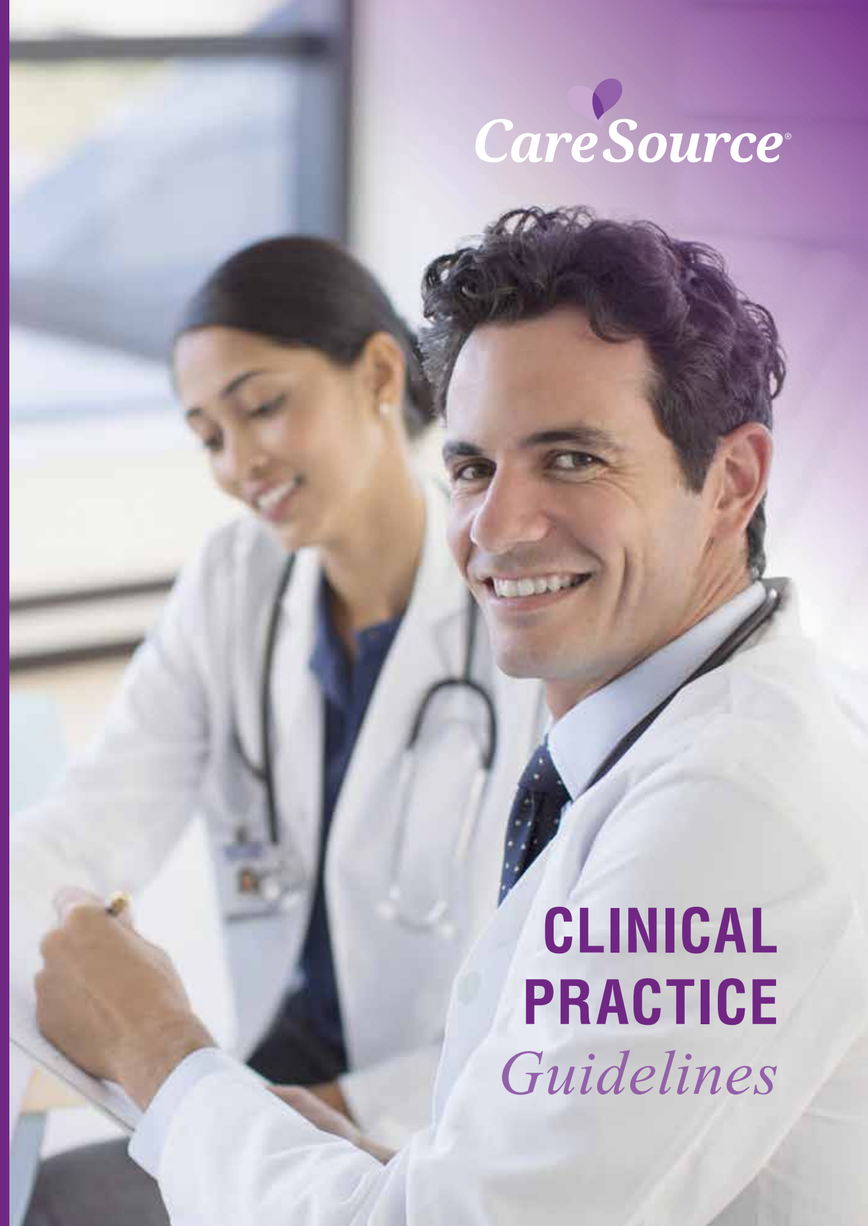


CLINICAL PRACTICE *Guidelines*

CLINICAL PRACTICE GUIDELINE MEDICAL RECORD REVIEW

To ensure a compliant medical record review, consider the following components:

Attention-deficit/hyperactivity disorder (ADHD)

Nine medical record components

Appropriate diagnosis/assessment

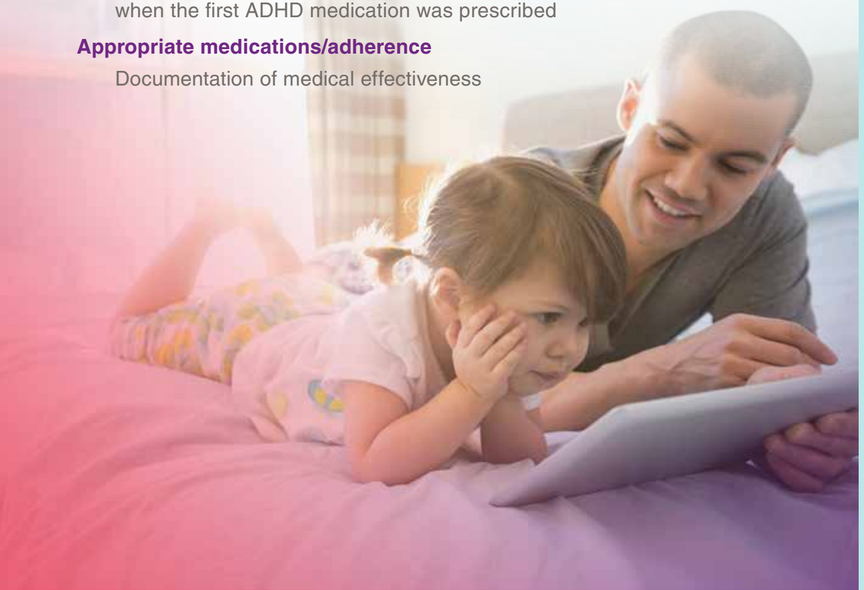
1. Developmental history completed (must be documented at a minimum of normal or abnormal)
2. History/physical completed (must have a minimum of vitals, height and weight)
3. Rating scale reviewed and used to confirm diagnosis (if the diagnosis was made within the prior year)
4. Co-existing emotional and behavioral conditions assessed

Parent/patient education & risk factor assessment

1. Developed management plan with the parent/member
2. Parent educated on how to recognize the trigger for inattention, impulsivity & hypersensitivity
3. Parent educated on how to implement behavior management strategies
4. Parent educated on the importance of follow up visit within 30 days of when the first ADHD medication was prescribed

Appropriate medications/adherence

Documentation of medical effectiveness



Asthma

Ten medical record components

Appropriate diagnosis/assessment

1. History & physical completed (must include documented vitals & cardiopulmonary exam)
2. Spirometry & peak flow measures used to confirm diagnosis in members ≥ 5 years of age
3. Severity of asthma assessed and episodic sighs/symptoms identified

Patient education/risk factor assessment

1. Evidence of an asthma management plan developed with member/parent (must include documentation of understanding and that plan was provided)
2. Comorbid conditions assessed and discussed
3. Educated member/parent on recognizing triggers and reducing exposure to environmental risk factors
4. Educated member/parent on taking prescribed medications correctly

Appropriate medications/adherence

1. Prescribed the appropriate long-term medications
2. Evaluated response to medication and control of asthma assessed
3. Prescribed rescue inhaler

Diabetes

Twelve medical record components

History/physical/assessment

1. History/physical exam (must include documentation of weight/height/blood pressure/body mass index [BMI])
2. Annual neuropathy screening (must include documentation of assessment for numbness and/or tingling in hands or feet, balance, dizziness and erectile dysfunction in males)
3. Annual diabetes kidney disease screening (must include documentation that creatinine was ordered)
4. Annual retinal eye exam (must include documentation of referral to ophthalmologist for annual retinal eye exam or documentation that exam was declined by member)
5. Annual foot exam (must include documentation of assessment of skin & nails, check for foot ulcers and/or recent podiatry visit)

Labs/immunizations

1. Documentation that an HbA1c was ordered at a minimum of twice per year
2. Documentation that an annual fasting lipid profile was ordered, noting: if results are available, whether they align with CPG guidelines
3. Documentation that an annual urine microalbumin screening was ordered
4. Documentation that annual influenza vaccine was offered

Appropriate medication/adherence/education

1. Educated member on self-monitoring glucose levels
2. Educated member on nutrition/diet/weight management
3. Educated member on the use of aspirin (antiplatelet therapy)