

Documentation Dialog

A monthly flyer highlighting Coventry Health Care's medical record standards and preventive health guideline documentation requirements for Primary Care Providers.

NEW YEAR•NEW PROCESS •REVISED STANDARDS•



WHAT IS HEDIS?

The **Healthcare Effectiveness Data and Information Set (HEDIS)** is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA).

HEDIS was designed to allow consumers to compare health plan performance to other plans and to national or regional benchmarks. Although not originally intended for trending, HEDIS results are increasingly used to track year-to-year performance. HEDIS is one component of NCQA's accreditation process, although some plans submit HEDIS data without seeking accreditation. An incentive for many health plans to collect HEDIS data is a Centers for Medicare and Medicaid Services (CMS) requirement that Health maintenance organizations (HMOs) submit Medicare HEDIS data in order to provide HMO services for Medicare enrollees under a program called Medicare Advantage.

Coventry Health Plan participates in the annual HEDIS data collection project. Data collected supports our Quality Improvement projects for both of our Commercial and Medicare populations.

HEDIS season is very near. The project begins in March and ends in May. You can expect Coventry's Quality Improvement team to be contacting your office soon to schedule visits.

For more information on HEDIS visit the NCQA website at the web address listed below.

<http://www.ncqa.org/>

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As promised in our flyer in December, a new process for assessing medical record documentation has been developed and approved by the Plan's Quality Improvement Committees. The number of standards that medical records are measured against have been reduced from 20 to 8. Standards that were retired include: preventive health and standards that consistently received high compliance scores and were not core to ensuring quality of care to members. The table below represents the standards for the 2010 measurement year.

Standards	
1	Patient demographic data is present in chart and name or ID # is on each document.
2	Medication allergies and adverse reactions are prominently noted/displayed in the record. If the member does not have allergies, this should also be noted.
3	Advanced Directives such as Living Will for members 21 years and over has been discussed and documented with a date.
4	A current medication list is present in patient record. (For best practice: dosage, date medication was initiated, and dates of refills are present)
5	A current problem list that includes significant illnesses, medical conditions, and psychological conditions is present.
6	Past medical history is present and includes serious accidents, operations, substance abuse, and illnesses.
7	A history of immunizations is present in the medical record for adults.
8	Documentation for each visit supports presenting complaints, clinical findings, evaluation, treatment plan, and follow-up recommendations. The treatment plan is appropriate to findings and patient is not at risk by diagnostic or therapeutic problem.

In addition to the revised standards our process has changed regarding scoring, time of audit, and member selection criteria. Listed below are the key changes to our process.

- Audit will be performed at same time as the HEDIS (see article to left) project performed in the spring of each measurement year. This will reduce the number of times the Quality Improvement staff need to visit physician offices.
- Audits will be performed on members who are age 19 and over only as pediatric audits have had consistently high compliance scores.
- Eliminated Pass/Fail scoring of Providers. Results of audits will be reported to Providers at aggregate level with a list of areas needing improvement. Weighted scores will continue to be calculated for each individual clinic into compliance percentages, however, only if the clinic receives an overall score of less than 80% and/or are identified as having a quality of care issue will there be an intervention implemented by the Plan. Scores are defined as optimal at 90% or higher and acceptable at 80-89%.

Coventry Health Care hopes these changes will provide a more efficient and effective process in measuring the quality of documentation our Providers use to improve member health. To obtain more detail on how our auditors will apply the above standards visit the DirectProvider.com website. The auditors guide is located in the site's resource library under the letter M.