Aetna Better Health of West Virginia

2023 Medical Record Documentation Audit

Aetna Better Health of West Virginia performs an annual, statewide medical record documentation audit to ensure compliance with current standards recognized by agencies that accredit and regulate Aetna Better Health of West Virginia. The purpose of this audit is to evaluate participating practitioner compliance with Aetna Better Health of West Virginia's established medical record and documentation standards.

Based on the results of the 2023 Medical Record Documentation Audit, Aetna Better Health of West Virginia would like to pass on the following reminders to participating providers:

- Practitioners should discuss **Advance Directives** with members age 18 and over and document the discussion, including the presence or absence of an Advance Directive, in the member's medical record.
- A **Follow-up Plan/Return Visit** should be noted for each encounter.
- For members 15-44 years of age, there should be discussion regarding **Family Planning** which may include assessments of sexual activity, contraception, STD screening, and/or counseling OR documentation that the member saw a family planning practitioner.
- Assessment of use of **Alcohol/Substance Abuse/Smoking** should be documented for members age 12 and over. It is important to include all 3 in the documentation.
- **EPSDT Visits** (up to age 21) should be documented using an EPSDT assessment tool (HealthCheck or Bright Futures)
- The medical record should be complete and **legible** to someone other than the writer
- Practitioner office staff should receive periodic training in member information **confidentiality**.

Audit Methodology
Member medical records were chosen by random sample. Primary care sites included general practice, internal medicine, family practice, and pediatrics. The medical records were reviewed using the 2023 Medical Record Audit Tool, which includes 20 medical record standards. In addition to the standards for medical record documentation, all offices are expected to have medical records stored in a secure manner and train staff periodically in member information confidentiality. A total of 60 charts from 12 unique offices were reviewed. Offices who participated in the review received a letter with their individual results.

Note that the annual Medical Record Review was put on hold during the COVID Pandemic. 2023 was the first year since 2019 that the audit was performed.

Performance Standards
Overall Goal for each Standard = 85%
Individual Office Performance Score = 85%

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Results

The following standards scored below 100% on the Medical Record Documentation Audit. The Overall Goal was not met for two of the standards.

Standard	Score	Goal Met?
Medical record is legible	92%	Yes
Alcohol/ Substance Abuse/ Smoking (For members 12 or over, seen three or more times)	97%	Yes
Advanced Directives present if 18 or older	49%	NO
Follow-up Plan/ Return Visit for each Encounter	88%	Yes
EPSDT Documentation using an EPSDT Assessment Tool	80%	NO
Family Planning/Reproductive Health (members 15-44 years old, seen 3 or more times)	89%	Yes

Two measures reviewed in the audit were not included in the office scoring documentation: EPSDT Documentation using an EPSDT Assessment Tool and Family planning/reproductive health discussions. Family planning discussions show an increasing trend in this measure over the last three audit cycles, with the 2023 result of 89% being the highest result received on this standard and the first time the goal was met. The goal for EPSDT documentation was not met, however 2023 was the first time this standard was included in the Medical Record Audit, so it will serve as a baseline.

Advanced Directives remains the lowest scoring standard and has remained steady for 3 reporting cycles. Of the charts that did not meet the measure, 42% of the members were over age 50.

Additional findings for the audited practices include:

- Fourteen standards received a 100% score in 2023, versus 11 standards in 2019 and 9 standards in 2018.
- All offices met or exceeded the Individual Office Performance goal of 85%.
- The Individual Office Performance Scores for the 12 offices ranged from 86.75% to 100% with four offices scoring 100%
- All offices audited had secure storage of medical records
- All but one office (92%) provided periodic training in member information confidentiality
- 83% (10/12) of the offices audited exclusively use electronic medical records. This is an increase from the number of offices using electronic records in 2019 (72%).

For a copy of our Medical Record Standards visit the provider section of our website and click on document library, or click this link to get your copy: Medical Record Standards for Physicians