Historical Records Validation Program

About the program

Kaiser Permanente Washington's Historical Records Validation Program (HRVP) allows providers to submit evidence of breast, cervical, and colorectal cancer screenings, diabetic retinal exams, and Patient Health Questionnaire 9 (PHQ-9) performed but not submitted through claims to Kaiser Permanente. Evidence can also be submitted to permanently exclude a patient from a screening population based on clinical history. This information is then used to suppress future patient reminders for care and to develop more accurate screening rates.

How to participate

Review patient care gaps

In addition to their own internal reporting, network primary care providers can review Kaiser Permanente's monthly Population Report to determine which of their assigned patients may be due or overdue for screening. If you have not received your organization's Population Report, contact the KP Network Quality Program Manager at KPWA.Quality@kp.org.

Review patient histories and store outside records

Patients sometimes tell their care team about, or provide record of, screenings and care performed elsewhere or covered by another health plan, or reasons they no longer need screenings. Providers who have outside records or document these conversations during an office visit can use this information as evidence of meeting screening measures.

Compare your records against the Population Report to determine if any care gaps can be closed by submitting documentation. Keep in mind that claims may take up to 90 days to be reflected in reporting.

Submit documentation

Email applicable records along with a copy of the HRVP Tab in your Population Report indicating which members you are sending documents on to HRVP@kp.org. The information may also be sent via fax to 1-800-826-8396.

Questions?

Contact KPWA.Quality@kp.org or Stefanie Gimse, Medical Record Reviewer at 206-305-4582 or Stefanie.S.Gimse@kp.org.

HRVP Measures

Breast Cancer Screening

- Results of mammogram performed in current or previous year

Note: Biopsies, ultrasounds, or MRI do not qualify

Surgical, pathology report, or office visit record* of:

- Bilateral Mastectomy
- Two unilateral mastectomies with laterality noted

Cervical Cancer Screening

- Cervical cytology results performed in the last 3 years *(age 21-64)*
- hrHPV (HPV) testing performed in the last 5 years *(age 30-64)*

Surgical, pathology report, or office visit record* of:

- Total abdominal hysterectomy or TAH
- Total hysterectomy
- Complete hysterectomy
- Total vaginal hysterectomy
- Vaginal hysterectomy
- Cervical agenesis
- Hysterectomy with cervix removed
- Hysterectomy with no residual cervix

*Office visit record: Patient history formally entered into chart notes as part of an office visit. Submit all pages of the visit.

Colorectal Cancer Screening

Procedure or office visit record indicating:

- Colonoscopy in current year or previous 9 years
- Sigmoidoscopy in current year or previous 4 years
- CT Colonography in current year or previous 4 years
- Stool DNA test in current year or previous 2 years

Surgical, pathology report, or office visit record* of:

- Total colectomy
- Complete colectomy
- Radical colectomy

Note: "Colectomy" alone does not qualify

DM Retinal Exams

No exclusions

Results of retinal or dilated eye exam performed by an eye care professional.

- If negative for retinopathy, exam in current year or previous year
- If positive for retinopathy, exam in current year

Utilization of the PHQ-9 to Monitor Depression Symptoms

No exclusions

A PHQ-9 score in the member's record between January 1 – April 30. **Documentation must be sent by September 30** and must include:

- Date
- The PHQ-9 Tool with all questions and answers
- The score

(Just a score of "9" documented in the chart is not sufficient)

Check service dates before sending as claims processing may take up to 90 days and documentation may be unnecessary. Records received may not be immediately reflected in reporting.