SUBJECT: Quality Concerns Investigations

I. PURPOSE
   To investigate and correct significant systemic problems in the quality and safety of care and the quality of service provided to members by internal surveillance, received complaints or other mechanisms.

II. DEFINITIONS
   A. Clinical Performance Improvement Specialist (CPIS): - Registered Nurse in Quality Management
   B. Hospital Acquired Condition (HAC): An unintended event that occurred during an inpatient or outpatient encounter that was potentially adverse and or preventable. (Adverse describes a negative consequence of care that results in unintended injury or illness, which may or may not have been preventable. Preventable describes an event that could have been anticipated and prepared against, but occurs because of an error or other system failure.) See Appendix A.
   C. Peer Review: – Peer review is an evaluation, by clinicians, of the quality, safety, and efficiency of care ordered or performed by another practicing clinician. The results are collected and interpreted. The analysis of this data is for the purpose of bettering health care delivery; improve the quality of care, or to otherwise reduce patient morbidity and mortality. All peer review records used in peer review will be treated as confidential to the extent allowable under state and federal law.
   D. Practitioner – A physician, dentist, chiropractor, physician’s assistant, or nurse practitioner.
   E. Provider - A hospital, home health agency or vendor that interacts with Blue Cross of Idaho members.
   F. Quality Manager (QM): - Manager of the Quality Management Department
   G. Quality of Clinical Care Concerns (QOC) – Concerns regarding an identified action or incident that may result in significant risk to the health, welfare, or safety of the member (includes medical and dental).
   G. Quality of Service Concerns (QOS) - Dissatisfaction/concern with the quality of service provided to a member or related to a provider’s actions/demeanor during the provision of services (includes medical or dental providers). Service
concerns include, but are not limited to, poor communication, rudeness, excessive waiting time, and non-physical interpersonal conflict with staff.

H. Safety and Clinical Quality Committee- Standing Committee at Blue Cross of Idaho and external practitioners to review Safety and Clinical Quality. Refer to the annual Quality Improvement Program Description for the Committee charter.

I. Sentinel Event- Any unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injuries specifically include a loss of limb or function. The phrase “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. (The Joint Commission definition)

J. Serious Reportable Adverse Events (SRAE) – Defined by the Centers for Medicaid and Medicare (CMS). Currently includes:
   1) Wrong surgical or other invasive procedure performed on a patient;
   2) Surgical or other invasive procedure performed on the wrong body part;
   3) Surgical or other invasive procedure performed on the wrong patient;
   4) Surgery with post-operative death in a normal health person (ASA 1).

K. SIU- Special Investigations Unit

III. POLICY
A concern about an HAC, QOC, QOS, sentinel event, and or an SRAE will be reported to the QM in the Quality Management department for investigation. Concerns may be generated by internal or external sources. These include but are not limited to members, practitioners, providers, member representatives, medical necessity reviews, grievances, appeals, Medicare Part C reporting requirements, Denta Quest, and Blue Cross of Idaho employees.

IV. PROCEDURE
A. When a potential quality concern is identified (See Attachment A) the individual refers the concern to the Grievance and Appeals Specialist who forwards the information to the QM. Potential quality of care concerns may be identified through analysis of claims data, reporting, and CMS Part C reporting requirements.

   If the concern originates from a Medicare Advantage (MA) Grievance and Appeals Specialist, such as a member complaint, the Medical Director or the QM reviews the information. The QM or Medical Director accepts the QOC/QOS and forwards to the Quality Specialist.

   A QOC and QOS are entered in the tracking database by a Quality Specialist.

B. QOC Tracking Database Data Fields
   a) Case number - Each concern is assigned a unique number as follows: JULIAN DATE; then “GR” as grievance identifier; and SEQUENCE NUMBER.
Example: January 5, 2013, 111th concern = 130105 GR 111. This identifies the year; month and date referral is put into database, and the number of grievances for the year to date.

   i. Cases will be filed numerically by case number for confidentiality, by the year and then sequence number.

   b. Type of case- See Attachment A.
   c) Source
   d) Source name
   e) Received date
   f) Product (and ASC Group)
   g) Plan
   h) Member number
   i) Member last name
   j) Member first name
   k) Member date of birth
   l) Beginning date of service
   m) Classification of concern – See Attachment A
   n) Description of referral
   o) Provider identification
   p) Facility identification
   q) Date reviewed in Safety and Clinical Quality Committee
   r) Date reviewed in Credential’s Committee (if appropriate)
   s) Referral status (open/closed)
   t) Outcome

C. The QM or CPIS reviews the concern and identifies if medical records are needed for a comprehensive case review. If medical records are needed, quality staff will enter the information into the database, assign a tracking number, and request medical records.

D. In most instances, based upon clinical nursing judgment, the QM or CPIS will review the case with the Medical Director.

   a. For all quality of care and quality of service complaints from a member, a letter of inquiry regarding the potential concern will be sent to the practitioner and or provider.

   b. For all other quality of care concerns, a letter of inquiry regarding the potential concern may be sent to the practitioner and or provider at the discretion of the Medical Director.

   c. For HAC’s and SRAE’s a letter may be sent to the provider to confirm the presence of the HAC and SRAE. For all SRAE’s identified by Medicare Part C reporting requirements, medical records will be reviewed by the CPIS or clinician and presented as appropriate to the Safety and Clinical Quality Committee. For HAC and SRAE identified through monthly claims reporting,
the CPIS will review events in the claims adjudication system or the healthcare operations software platform to determine if the report correctly identifies an HAC or SRAE incident. The CPIS will review information with the Medical Director and a letter may be sent to the provider to confirm the presence of HAC or SRAE.

d. The practitioner or provider will have up to 30 working days to respond to all correspondence. Upon receipt of the practitioner or provider’s response, the QM or CPIS and Medical Director will review the response and determine if further review is necessary.

e. The Medical Director may at their discretion refer a dental case to the dentist consultant vendor.

f. The Medical Director and/or the CPIS may at their discretion request the case be referred to SIU for evaluation.

g. The Medical Director has the authority to categorize the case for tracking and trending (See Attachment A) and close the case at this point.

h. Blue Cross of Idaho receives QOS and or QOC regarding one of our credentialed practitioners and or providers within Idaho from other Blue Cross Blue Shield plans via a secure inter-plan communication system call Plan Connexion. The Quality Manager or CPIS receives an email that there is a concern in the system and retrieves it for processing as all other QOS or QOC. If Blue Cross of Idaho receives a QOS or QOC regarding an out of state provider or practitioner, the QM or CPIS submits the QOS or QOC to the appropriate Blue’s plan in the Plan Connexion system. No follow up is provided to other plans or from other plans within this system.

i. If the practitioner or provider fails to respond the case may be forwarded to Safety and Clinical Quality Committee for further review at the discretion of the Medical Director. Responses from providers may also be referred to Safety and Clinical Quality Committee at the discretion of the Medical Director. Once reviewed by Safety and Clinical Quality Committee the case may be referred to Credentials for further review or included in a summary during re-credentialing.

E. The CPIS will write up a brief summary of the QOC. The Quality Specialist will write up summaries regarding QOS. The QM will review the summaries. The outcome of Provider and Practitioner QOC and QOS will be forwarded monthly by the Quality Specialist to the Credentials Department for ongoing monitoring.

F. If in the opinion of the QM or CPIS, a significant, impending risk to the health, welfare or safety of members exists, such as an SRAE; the QM/CPIS will discuss the case with the Medical Director. The Medical Director will refer the case to the Chief Medical Officer or designee if unavailable on a
timely basis. The Chief Medical Officer may, in conjunction with the Vice President of Vice President Provider Partner and Payment Innovations, suspend the contract of the provider for a period not to exceed 29 days. Upon suspension, the case will be referred to an ad hoc meeting of the Credentials Committee for review and final determination.

G. External review may be utilized in certain situations. This is an impartial physician review by the same specialty physician, which critiques medical care delivered by another practitioner. The external review is used for QOC concerns in one of the following two ways:

1. The BCI Quality Manager or Medical Director may request a review from an impartial third party. The BCI Senior Medical Director or Chief Medical Officer must approve this review or designee before it is initiated.

2. At the request of a quality committee such as Safety and Clinical Quality Committee or at the Credentials Committee. The request for an external review is to assist the peer review participants in the assessment of care by utilizing the expertise of specialty board certified physicians.

ATTACHMENTS:

1. Attachment A - List of QOS/QOC
2. Attachment B – Example practitioner letter
3. Attachment C – Example provider letter

REVIEW/REVISIONS: This policy is reviewed and/or revised on an annual basis, or as otherwise appropriate.

Approval Signature: __________________________

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<th>Approval</th>
<th>Quality Manager</th>
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<tr>
<td>Original Approval Date</td>
<td>7/31/2000</td>
</tr>
<tr>
<td>Annual Review Date</td>
<td>5/23/01, 10/28/02, 4/18/03, 12/14/03, 1/10/05, 12/16/09, 8/30/16</td>
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<tr>
<td>Policy Owner</td>
<td>Chris Samuelson, RN, Quality Manager</td>
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Applicable to All Lines of Business: Yes ☑ No ☐ Applicable to Medicare Advantage Yes ☑ No ☐
Applicable to Dental: Yes ☑ No ☐ Applicable to Medicaid/MMP: Yes ☑ No ☐
Applicable to Group/ASC: Yes ☑ No ☐ Applicable to PPO: Yes ☑ No ☐
Applicable to Individual: Yes ☑ No ☐ Applicable to POS: Yes ☑ No ☐
Applicable to Exchange: Yes ☑ No ☐ Applicable to FEP: Yes ☑ No ☐

All information pertaining to this policy is considered confidential and proprietary and will be handled in a manner as prescribed by Blue Cross of Idaho policies and state and federal laws.
### Table One – Quality of Service Concerns

<table>
<thead>
<tr>
<th>Classification</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>S - 1</td>
<td>Behavior/service did not meet the member’s expectation for wait times, access to care, or an isolated incident of rude or inappropriate behavior.</td>
</tr>
<tr>
<td>S – 2</td>
<td>Repetition of S - 1</td>
</tr>
<tr>
<td>S – 3</td>
<td>Pattern of unacceptable behavior; potential for a negative effect on patient care.</td>
</tr>
<tr>
<td>S – 4</td>
<td>Physical violence, sexual harassment, drug or alcohol abuse.</td>
</tr>
</tbody>
</table>

### Table Two – Quality of Care Concerns

<table>
<thead>
<tr>
<th>Classification</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SRAE - 1</td>
<td>Surgery on wrong body part.</td>
</tr>
<tr>
<td>SRAE – 2</td>
<td>Surgery on wrong patient.</td>
</tr>
<tr>
<td>SRAE – 3</td>
<td>Wrong surgical procedure on a patient.</td>
</tr>
<tr>
<td>SRAE - 4</td>
<td>Surgery with a post-operative death in a normal healthy patient (ASA-1).</td>
</tr>
<tr>
<td>HAC – 1</td>
<td>Foreign object retained after surgery. (For example a sponge or instrument.)</td>
</tr>
<tr>
<td>HAC – 2</td>
<td>Air embolism (Causing death or serious disability. Could be from equipment or an intravenous line.)</td>
</tr>
<tr>
<td>HAC – 3</td>
<td>Blood Incompatibility (Transfusion reaction due to administration of ABO incompatible blood or blood products.)</td>
</tr>
<tr>
<td>HAC – 4</td>
<td>Stage III &amp; Stage IV Pressure Ulcers (Not present on admission.)</td>
</tr>
<tr>
<td>HAC – 5</td>
<td>Fall or trauma that caused injury or death. (Such as fractures, dislocation, intracranial injuries, crushing injuries or burns.)</td>
</tr>
<tr>
<td>HAC – 6</td>
<td>Catheter-associated urinary tract infection (UTI confirmed with positive C &amp; S with the catheter inserted at the facility.)</td>
</tr>
<tr>
<td>HAC – 7</td>
<td>Vascular catheter-associated infection (Catheter inserted at facility.)</td>
</tr>
<tr>
<td>HAC – 8</td>
<td>Surgical site infection- Mediastinitis after Coronary Bypass Graft (CABG)</td>
</tr>
<tr>
<td>HAC – 9</td>
<td>Manifestations of poor glycemic control (Diabetic ketoacidosis, nonketotic hyperosmolar coma, diabetic coma, hypoglycemic coma)</td>
</tr>
<tr>
<td>HAC – 10</td>
<td>Deep vein thrombosis or pulmonary embolism (ONLY after hip or knee replacement surgery)</td>
</tr>
<tr>
<td>HAC – 11</td>
<td>Surgical Site Infection – after Bariatric surgery</td>
</tr>
<tr>
<td>HAC – 12</td>
<td>Surgical Site Infection - Certain orthopedic procedures of spine, shoulder and elbow</td>
</tr>
<tr>
<td>HAC – 13</td>
<td>Surgical Site Infection – following Cardiac Implantable Electronic Device (CIED) procedures</td>
</tr>
<tr>
<td>HAC – 14</td>
<td>Iatrogenic Pneumothorax with Venous Catheterization</td>
</tr>
<tr>
<td>OTH</td>
<td>Any concern a clinician, member, or family member has related to the care provided.</td>
</tr>
</tbody>
</table>

Reference: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html
Attachment B - Practitioner Letter

Date

Name
Address
City/State/Zip

RE:  Enrollee:
    Enrollee#:
    DOB:
    Provider:
    Date(s) of Service

Dear XXX,

One facet of Blue Cross of Idaho’s effort to improve the quality of care provided to our beneficiaries is to periodically request process review when unexpected complications arise during the course of treatment. We would appreciate a quality of care review of the above noted member’s clinical episode(s). (Insert description)

We would like to understand your view of the event(s) in order to evaluate the case. Please provide a brief summary of the case in order to address these issues.

We understand how challenging some circumstances can be. The desire is that by bringing this case to your attention, any system-related errors may be identified and corrected. Any information provided to the Blue Cross of Idaho’s Quality Department is treated as confidential to the extent allowable under federal and state law.

Please direct your response by one of three options available the address listed below, to our confidential fax 208-387-6693 or by email at QualityConcernCase@bcidaho.com. Should we not receive a written response from you within 30 working days of receipt of this letter, we will make a determination as to whether a quality issue exists based solely upon the information submitted in the complaint/medical records received. If you have any questions, please contact the Quality Department at (208) 331-7651. We look forward to your response.

Sincerely,

Medical Director
Blue Cross of Idaho
Attachment C – Provider Letter

Date

Provider
Address
City/State/Zip

RE:  Enrollee:
     Enrollee#:
     DOB:
     Provider:
     Date(s) of Service

Dear Quality Assurance,

One facet of Blue Cross of Idaho’s effort to improve the quality of care provided to our beneficiaries is to periodically request process review when unexpected complications arise during the course of treatment. We would appreciate a quality of care review of the above noted member’s clinical episode(s). (Insert description)

We would like to understand your perception of this event(s), and, if significant in your opinion, whether it was potentially preventable. Please evaluate this case within your clinical quality review process and provide written notification to us that the services have been reviewed.

We understand how challenging some circumstances can be. The desire is that by bringing this case to your attention, any system-related errors may be identified and corrected. Any information provided to the Blue Cross of Idaho’s Quality Department is treated as confidential to the extent allowable under federal and state law.

Please direct your response by one of three options available the address listed below, to our confidential fax 208-387-6693 or by email at QualityConcernCase@bcidaho.com. Should we not receive a written response from you within 30 working days of receipt of this letter, we will make a determination as to whether a quality issue exists based solely upon the information submitted in the complaint/medical records received. If you have any questions, please contact the Quality Department at (208) 331-7651. We look forward to your response.

Sincerely,

Medical Director
Blue Cross of Idaho