



## No. 4 QUALITY OF CARE

The quality of care and peer review programs described in this policy memo apply to providers delivering services to Blue Select members. In addition, Section II., MEDICAL RECORD REVIEW, and Section III., ADVERSE QUALITY OF CARE DETERMINATION AND QUALITY IMPROVEMENT PLAN (QIP) APPEAL PROCESS also apply to all Competitive Allowance Program (CAP) contracting providers.

### I. CREDENTIALING - Only applicable to primary care physicians (PCP).

This process consists of two parts: credentialing and re-credentialing.

#### A. Credentialing

This process consists of an initial full review of the provider's credentials at the time of application.

1. If a provider desires to apply for participation in a primary care program, he/she may obtain a credentials packet (contract, application and credentials data sheet) from the appropriate professional relations field representative.
2. The packet is completed by the applicant and submitted to Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) for review.
3. Upon receipt of the completed packet, correspondence is initiated with the appropriate licensing board(s), the Health Care Stabilization Fund, National Practitioners Data Bank, and all hospitals/health care facilities and specialty practice boards with which the provider is affiliated.
4. The Quality Improvement staff will review the credentials packet to ascertain compliance with the following credentials criteria:

M.D.s and D.O.s

- a. Graduation with a D.O. or M.D. degree from an osteopathic or medical school in the United States or Canada, accredited

- by the Liaison Committee on Medical Education of the American Medical Association, or a medical school approved by the American Osteopathic Association, or medical school approved by the Education Council for Foreign Medical Graduates, or a medical school approved by the Royal College of Physicians and Surgeons of Canada. In order to participate in Blue Select in our plan area, a provider must participate in the Competitive Allowance Program (CAP) of BCBSKS.
- b. PCPs must supply documentation of successful completion of three years postgraduate training or board certification in primary specialty of family practice, general internal medicine, general practice, or general pediatrics. In lieu of educational requirements, equivalent experience may be considered based on work history, interview, and recommendations. Board certification is strongly recommended.
  - c. Current and unrestricted license to practice medicine in Kansas. The credentials committee has the authority to make exceptions for a “restricted license” where the restriction does not interfere with providing quality care to our membership.
  - d. Current and unrestricted Drug Enforcement Agency (DEA) number, as appropriate, for practice. The credentials committee has the authority to make exceptions to a restriction on a DEA when the restriction does not interfere with providing quality care to our membership.
  - e. Agreement to complete regular credentialing forms.
  - f. Agreement to participate in quality of care and utilization review programs of BCBSKS.
  - g. Agreement to maintain a comprehensive medical record on each BCBSKS member/patient.
  - h. Current unrestricted hospital staff clinical and admitting privileges for the declared primary specialty and no restrictions due to a disciplinary action based on professional competence, adherence to appropriate standards of medical care, health status or other parameters agreed upon by the medical staff for any other privileges granted by a BCBSKS contracting/participating hospital within the service area. Physicians without admitting privileges may be approved, if there is evidence of an established referral process to assure access of inpatient care, or if the physician can provide coverage for required hospital care, twenty-four (24) hours per day, seven (7) days per week. This exception DOES

NOT apply to those physicians who have lost admitting or clinical privileges, due to disciplinary measures, or who have voluntarily resigned privileges to avoid loss of privileges or other disciplinary measures.

- i. Specialty appropriate coverage/timely access is arranged by the physician 24 hours per day, 7 days per week. Exceptions may be given, based on geographic location and at the sole discretion of BCBSKS.
- j. Current professional liability coverage, which meets or exceeds minimum limits as established by the State of Kansas.
- k. Absence of a history of involvement in a malpractice suit(s), arbitration, or settlement. In the case of an applicant with such history, evidence that this history does not demonstrate probable future professional performance.
- l. Utilization review pattern consistent with peers in designated primary specialty and congruent with needs of managed care.
- m. Absence of patterns of behavior to suggest quality of care concerns.
- n. No sanctions placed upon him/her by Medicaid, Medicare, or disbarred by Federal Employee Health Benefit Program. If applicant has such history, applicant will be denied credentialing if applicant: (1) is currently excluded, suspended, debarred, or otherwise ineligible to participate in any state or federal healthcare programs, including but not limited to Medicare, Medicaid or Federal Employee Health Benefit Program or (2) has been convicted of a criminal offense related to the provision of health care items or services and has not been reinstated in a state or federal health care program, after a period of exclusion, suspension, debarment, or ineligibility.
- o. Absence of a history of disciplinary actions affecting applicant's professional license, DEA, or other required certification. For applicants with such history, evidence that this history does not currently affect applicant's ability to perform professional duties, for which the applicant is contracted, or does not demonstrate probable future performance.
- p. No felony or misdemeanor convictions to include repeated DUI or drug related arrests, which could affect applicant's current ability to perform the professional duties for which the

applicant is contracted and does not demonstrate probable future substandard care.

- q. No current drug or alcohol abuse. Absence of a history of chemical dependency/substance abuse. For those applicants who have such history, evidence that the applicant is participating in, or has completed a prescribed, monitored treatment program, and that no further current chemical dependency or substance abuse exists.
- r. If a physician provider is not in full-time practice, participation will be at the sole discretion of BCBSKS.

All providers who participate with BCBSKS must maintain the above criteria on an ongoing basis.

**B. Re-credentialing**

After a provider has completed the initial credentialing process, he/she will undergo re-credentialing every three years thereafter.

The re-credentialing process will be conducted in the same fashion as outlined in the credentialing process.

**C. Ongoing Monitoring of Sanctions and Complaints**

Ongoing monthly monitoring of providers is performed in order to ensure quality and safety of care between recredentialing cycles. The monitoring is achieved via the Web site of the Kansas State Board of Healing Arts (KSBHA), the Web site of the Office of Inspector General (OIG), and review of member complaints data. When appropriate, intervention on important quality or safety issues will be referred to the credentials committee in a timely manner.

**D. Provider's Rights**

Provider's rights to review their credentialing file: A provider may request to review the information submitted in support of their credentialing application. Only the provider will be granted access, during regular business hours, on an agreed appointment time, to review their credentialing information in the presence of the credentialing manager/nurse coordinator.

- The practitioner will not be allowed to copy or remove any documentation from their credentialing information.
- This review will not include references or recommendations or other information that is peer review protected.

**E. Erroneous/Inaccurate Information**

A provider will have the opportunity to clarify information in his/her application that is inconsistent with information obtained via primary source verification during the credentialing or recredentialing process. The credentialing manager/credentialing nurse coordinator will notify the provider, in writing, of such findings and will return with the letter, a copy of the application submitted, highlighting the inconsistent information. The notice to the provider will not include copies such as information collected from the National Practitioner Data Bank, Health Care Integrity and Protection Data Bank, licensure documentation obtained from the Kansas State Board of Healing Arts, or hospital(s) queried. The provider has the right to correct erroneous information received from the verification sources directly with the verifying source. The provider will be asked to respond in writing to any conflicting information provided on the application and return a formal response to the credentialing manager within 30 days. The credentialing manager/credentialing nurse coordinator will review the information obtained against the information collected, from the primary source once again, within 30 days, to verify that there is no longer a discrepancy. The response will then be evaluated against the Blue Select credentialing policy/procedure and requires credentialing committee review.

**F. Appeals**

If the determination of BCBSKS results in ineligibility, limitation or provisional approval as a contracting provider, he/she will be notified of the appeal rights set forth herein. No action will be taken (other than in cases of refusing to accept the provider's initial application) until the applicant/provider exhausts his/her appeal rights or voluntarily waives the appeal rights, unless imminent risk of member's health is at stake. If this risk exists, temporary action will be implemented awaiting completion of the appeal process.

Appeal rights do not exist where there is no dispute of fact as to whether the provider satisfies all eligibility criteria.

Prior to institution of any legal proceedings or suit against BCBSKS the following appeal process will be utilized by applicants/providers who disagree with the denial of, limitation of practice, or provisional approval as a contracting provider.

**1. First Level of Appeal**

If the applicant/provider is dissatisfied with the determination by the Credentials Committee of ineligibility, limitation of practice, or provisional approval as a contracting provider with BCBSKS managed care programs, he/she may request the first level of the credentials appeal process.

The written request should be sent to the Manager, Quality Improvement/Credentialing and must be received within 30 days of the initial determination letter. The request should outline why he/she is dissatisfied with the determination and supply additional information or highlight specific points for reconsideration.

Upon receipt of this appeal, it should be date stamped, logged in and referred to the Manager, Quality Improvement/Credentialing to initiate the appeal process. Upon review of the appeal, the Manager, Quality Improvement/Credentialing shall review the request and notify the applicant of either the date when the appeal will be presented to the BCBSKS Board of Directors, or that the original decision has been modified/rescinded.

The appeal will be developed by the Manager, Quality Improvement/Credentialing to include all supportive documentation and presented to the BCBSKS Board of Directors during its next scheduled quarterly meeting.

Upon receipt of the determination made by the BCBSKS Board of Directors, a letter shall be sent to the applicant/provider relaying the determination. If the determination of the BCBSKS Board is to grant contracting status, or allow unrestricted privileges, the application will be processed in accordance with BCBSKS procedure. If the determination results in continued ineligibility, limitation of practice or provisional approval of contracting status, the applicant/provider will be notified of the determination and informed that he/she may request the final level of the appeal process within 30 days. The applicant/provider will also be notified of the effective date the ineligibility, limitation of practice or provisional approval will occur in the absence of such appeal.

## 2. Final Level of Appeal

If the applicant/provider chooses to request the final level of appeal, he/she must again submit a letter to the Manager, Quality Improvement/Credentialing within 30 days of the initial appeal determination. The request should outline why he/she remains dissatisfied with the determination and the applicant/provider must supply additional information or highlight points for reconsideration.

Within 30 days of receipt of the applicant's/provider's appeal, a review panel consisting of two members from the BCBSKS Board of Directors, the Vice President of Medical Affairs, and two physicians will be convened to review the appeal. One of the physicians will be from the same primary specialty and both will be currently participating in Blue Cross and Blue Shield Programs. The physicians selected will not be in direct competition with the provider. The

appealing applicant/provider will be notified, in writing, at least 30 days in advance of the time, place and date of the hearing and of any witnesses BCBSKS intends to present. The appealing applicant/provider will be informed that he/she will have the right to representation, to have a record made of the proceedings with copies available at his/her expense, to call his/her own witnesses, to present relevant evidence, and to submit a written statement at the conclusion of the review.

Upon receipt of the review panel's determination, a letter shall be sent to the appealing applicant/provider relaying the determination. If the determination is to grant contracting status or allow unrestricted privileges, the application will be processed in accordance with Blue Cross and Blue Shield's procedure. If the determination results in continued denial/restriction of contracting status, the applicant/provider will be notified of the determination, and that this is the final decision, and that all avenues of appeal have been exhausted.

If the applicant/provider remains dissatisfied with the determination, he/she may proceed with normal remedies of law, if any.

### 3. Credentialing of Office Personnel

Providers are responsible for assuring that office personnel who claim to be licensed, certified or registered maintain such in accordance with state law requirements.

## **II. MEDICAL RECORD REVIEW**

An integral component of the quality improvement program is the evaluation of the health care rendered to members by contracting providers through medical record review.

The initial step in improving health care is identification of areas for improvement. Medical record documentation merits special consideration in evaluating the appropriateness and effectiveness of health care.

Pertinent data collected from the medical record is analyzed according to established criteria and implicit medical knowledge by quality improvement staff and peer reviewers. Providers are encouraged to take an active role in the review process, providing additional information and clarification when appropriate.

The second step is to work cooperatively with providers in the development of solutions to the identified problems.

The third step requires recommendations be evaluated to ensure provider's performance meets established standards.

The final step in quality improvement through medical record review is to revise or enhance recommendations which are not improving or maintaining the quality of care as planned.

Emerging patterns of confirmed inappropriate or inadequate care provided by contracting providers are monitored within the QI Department. Once a problem or pattern of problems is identified, a Quality Improvement Plan (QIP) may be developed as an educational effort to

### **III. ADVERSE QUALITY OF CARE DETERMINATION AND QUALITY IMPROVEMENT PLAN (QIP) APPEAL PROCESS**

An integral component of the Quality Improvement Program is the evaluation of health care rendered to members through medical record review.

Pertinent data is collected from the medical record and analyzed by staff according to established and implicit criteria. If quality of care concerns are identified, written or oral comments are obtained from the provider under review. All cases in which the quality of care is either questionable or are referred to a physician advisor for evaluation and implementation of a QIP if necessary. If the QIP limits the provider's practice/privileges and the provider does not agree with the determination, the provider may appeal.

If as a result of an adverse quality of care determination by BCBSKS a QIP is assigned which restricts or suspends a provider's clinical privileges for greater than 30 days, or requests dismissal of a provider, the provider will be notified of the appeal rights set forth herein. No action will be taken until the provider either exhausts his/her appeals rights or voluntarily waives his/her appeal rights, unless imminent risk of member's health is at stake. If this risk is present, then a temporary action will be implemented awaiting completion of the appeals process.

Prior to institution of any legal proceedings or suit, the appealing provider will utilize the appeal process as outlined.

The appealing provider must submit a letter to the Vice President of Medical Affairs within 30 days of the initial notification of the QIP requesting a direct appeal to the BCBSKS Board of Directors. The request should outline why he/she disagrees with the QIP and supply additional information or highlight specific points for reconsideration.

The provider's appeal will be developed by staff to include all supportive documentation and be presented to the BCBSKS Board of Directors during the next scheduled quarterly meeting.

Upon receipt of the outcome of the appeal from the appropriate board of directors, a letter shall be sent to the appealing provider relaying the determination. If the determination does not concur with the initial QIP, the plan will be modified or canceled and the provider so notified. If the determination results in continued

upholding of the QIP, the appealing provider will be notified of the decision and informed that he/she may request the final level of the appeal within 30 days.

The provider will also be notified of the date the QIP will be implemented in absence of such appeal.

If the provider requests the final level of appeal, he/she must submit a letter to the Vice President of Medical Affairs within 30 days of notification of the first level appeal determination. The request should outline why he/she continues to disagree with the QIP. The appealing provider must supply additional information or highlight specific points for reconsideration.

Within 30 days of receipt of the provider's appeal, a review panel consisting of two members from the appropriate board of directors, the Corporate Medical Director, Vice President of Medical Affairs, and two physicians will be convened to review the appeal. One of the physicians will be from the same primary specialty and both will be currently participating in Blue Select. The physicians selected will not be in direct competition with the provider. The appealing provider will be notified, in writing, at least 30 days in advance of the time, place, and date of the hearing and of any witnesses who will be present. The appealing provider will be informed that he/she will have the right to representation, to have a record made of the proceedings with copies available at his/her expense, to call his/her own witnesses, to present relevant evidence, and to submit a written statement at the conclusion of the review. Upon receipt of the review panel's decision, a letter shall be sent to the appealing provider relaying the determination. If the determination does not concur with previous decisions, the QIP will be modified or canceled. If the recommendation results in continued upholding of the QIP, the appealing provider will be notified that this is the final decision and that all avenues of appeal have been exhausted.

If the provider continues to disagree with the corrective action plan, he/she may pursue normal remedies of law, if any.

#### **IV. HEALTH PLAN EMPLOYER DATA AND INFORMATION SET (HEDIS)**

BCBSKS utilizes HEDIS (Health Plan Employer Data and Information Set) to report information about its managed care products. As part of its ongoing quality improvement (QI) activities, HEDIS has been developed by the National Committee for Quality Assurance (NCQA) as a report card for employees and consumers to use to compare managed care plans to one another.

The HEDIS data set is an extensive compilation of information about a managed care plan. The data set includes sections on effectiveness of care, utilization of services, access to care, member satisfaction and financial measures.

Several of the measures, particularly in the effectiveness of care section, require a review of member's medical records to determine if a particular service, such as a mammogram or pap smear, has been provided to a member within a given time period. These reviews are done of randomly selected members' charts in accordance

with HEDIS guidelines. There are two ways that this review may occur. This chart may be reviewed by one of our nurse reviewers at your office or you may be asked to send a copy of the patient's chart in for our review.

Due to the extensive number of charts that must be reviewed and the short timeline that BCBSKS has to compile this information, your timely response and cooperation with these medical review requests is critical. Copies of records requested are submitted at the provider's expense.

## **V. MEMBER SATISFACTION SURVEY**

Members' perceptions are an essential source of information for BCBSKS. A satisfaction survey is not only a good management tool, but also a key indicator of the quality of care being provided. Surveys may be conducted to comply with performance standards and/or to gain insight into specific issues. BCBSKS is committed to continuous quality improvement and survey results are analyzed to determine areas of strength and areas of concern. Root causes are identified and action plans implemented so improvements can be achieved.

## **VI. MEMBER CONCERN AND COMPLAINT**

BCBSKS recognizes that from time to time members may encounter situations where the performance of BCBSKS or their PCP does not meet their expectations. When this occurs, the member has the right to direct an inquiry to the attention of BCBSKS management. An inquiry must be received in writing. It is the policy of BCBSKS to promptly and fairly consider all inquiries of its members. BCBSKS monitors the number and type of complaints made by members, and monitors trends and patterns.

Complaints are reviewed on an ongoing basis. The insured's PCP may be contacted by their professional relations representative for additional information, such as medical records, to assist in resolving the matter. Following receipt of all the necessary information, a thorough review is conducted and a determination made. When the outcome of the case affects the PCP, a representative will contact the PCP to apprise him/her of the determination.

If a member requests information on filing an inquiry, it should be forwarded to the respective customer service area: Blue Cross and Blue Shield of Kansas, Customer Service Center, 1133 SW Topeka Boulevard, Topeka, Kansas, 66629-1622. Phone: 785-232-4054 or 1-800-521-0117

## **VII. PATIENT DISMISSAL/EDUCATION - APPLICABLE TO PCPS ONLY**

The Intercept Committee serves as the responsible party for handling requests for member education and dismissal notifications within managed care products. The objectives of the Intercept Committee are:

- Provide a forum for primary care physicians (PCPs) to request assistance with a member

- Insure members access to their benefits
- Assure members are not being dismissed due to:
  - Type of insurance, or
  - Medical diagnoses/conditions

A. Member Education

The Intercept Committee views formal education as a valuable tool. Written education is an effective method of advising a member of specific detailed information and placing responsibility for compliance directly on the member. The Committee expects the PCP or his/her office to perform and document verbal or written education whenever a clear set of instructions needs to be conveyed. The consequences, if there are any, for not following instructions should always be included.

Members may need to be reminded of how the managed care process works and what the role of the PCP is in the provision of managed care. Other issues requiring education may include referrals, eligible providers, etc. The Intercept Committee is available to assist PCPs with this education at their request. The PCP shall provide their professional representative with documentation detailing the situation; such as pertinent dates (missed appointments), documentation of conversations (verbal abuse), documentation of previous attempts to educate, and any other information that would aid the committee in clearly understanding the circumstances involved. Following receipt of the PCP's request and documentation, BCBSKS staff will correspond with the member on the issue and reinforce the PCP's comments.

B. Member Dismissal

The Intercept Committee regards the dismissal of a member by the PCP as a serious matter and provides assistance when requested to support the maintenance of a solid, productive physician/patient relationship. Nonetheless, problems such as non-payment of an outstanding debt, non-compliance with the PCP's medical recommendations/office practices, or conflict/abuse toward the PCP or the PCP's staff may result in the need for member dismissal.

When a PCP dismisses a member or members from the practice, the Intercept Committee requires that a copy of the dismissal letter being sent to the member, be simultaneously sent to the attention of the Intercept Committee at cc: 466L1. The purpose of this is so BCBSKS can conduct timely correspondence with the member and coordinate the selection of a new PCP.

The following are important steps to follow when dismissing a managed care member:

- Always send a copy of the member dismissal letter concurrently to the Intercept Committee when you notify the member.
  
- DO include the following information in the letter:
  - Member's ID Number
  - Names of all the members being dismissed.
  - A statement of dismissal to the member including the specific circumstances precipitating the dismissal.
  - A statement that the removal is not based on the member's medical needs or type of insurance.
  - A statement indicating you or a covering provider will be available to manage the member's care until the effective date of the new PCP.
  - If your office policy dictates that a member dismissed from your practice cannot choose another physician in your group, please indicate this as well.
  - Indicate that BCBSKS has been copied on the letter.
  
- DO NOT include the following information in the letter:
  - A specific time during which you will continue to see the member (such as 30 days).
  - A statement to the member that he/she should present payment in full for services in order to be seen during the transition. You will continue to receive reimbursement from BCBSKS for covered services until the member selects a new PCP. You may collect applicable deductibles and co-insurance at the time of service.

Following the Intercept Committee's receipt of the dismissal letter, BCBSKS will:

- Write the member, notifying them that we have received notification of their dismissal and will advise them to select a new PCP. We will copy the PCP on this letter.
  
- Assure the member selects a new PCP with an effective date that will be no later than the first of the month following 30 days of the Intercept Committee's receipt of the PCP's dismissal letter.

If the PCP would like assistance from the Intercept Committee before proceeding with the dismissal, the PCP should contact their professional relations representative. When a PCP accepts a previously dismissed managed care patient back into their practice, they must first notify their professional relations representative or the chair of the Intercept Committee. This allows the Intercept Committee to track and remove any PCP selection limitations, as needed. The PCP must inform the member to contact BCBSKS and re-select them as their PCP. Upon the member's request, the change in PCP will take effect the first of the following month.

**VIII. MEMBER'S RIGHTS AND RESPONSIBILITIES**

The following is the Member's Rights & Responsibilities document provided to members and providers. The document seeks to convey to members their rights and responsibilities when seeking health care and service.

It is the responsibility of BCBSKS and its contracting providers to treat you and/or members of your family in a manner that acknowledges and supports your basic human rights. BCBSKS assumes the role of resolving organizational problems that interfere with exercising your stated rights and responsibilities. The extent to which these rights and responsibilities are enforceable by the member or BCBSKS is governed solely by the BCBSKS contract. These rights and responsibilities are detailed below:

- A. You have the right to considerate and courteous care, with respect for personal privacy and dignity.

You have the responsibility to treat all BCBSKS personnel respectfully and courteously as partners in good health care.

- B. You have the right to select your own personal PCP from the list of contracting PCPs of BCBSKS. However, if your selection is not satisfactory, you have the right to select a different PCP.

You have the responsibility to select a PCP and to communicate openly with that PCP. You have the responsibility to develop a physician-patient relationship based on trust and cooperation. You are expected to coordinate all your care with your PCP. This continuity strengthens the positive relationship between you and your physician and enables your PCP to develop a better understanding of your needs.

- C. You have the right to expect your PCP to provide or arrange for all medically necessary care, except for care not requiring PCP authorization.

You have the responsibility to seek and obtain referrals, from your PCP, for services received only from BCBSKS contracting professionals. Exceptions apply only to medical emergencies or the initial treatment of an out-of-area accidental injury.

- D. You have the right to participate in the health care process with the professionals who can help you to take charge of your health.

You have the primary responsibility to maintain your health and prevent illness. By using the information BCBSKS provides, making positive health choices, and seeking appropriate care when it is needed, you will be taking charge of your health.

- E. You have the right to receive enough information to enable you to make a thoughtful decision before you receive any recommended treatment.
- You have the responsibility to ask questions and make certain that you understand the explanations and instructions you are given.
- F. You have the right to refuse to participate in experimental research.
- You have the responsibility to advise your PCP and/or BCBSKS when any experimental treatment is being recommended.
- G. You have the right to be informed of your diagnosis and treatment plan in terms that you understand and to participate in decisions involving your medical care.
- You have the responsibility to consider the potential consequences if you refuse to comply with treatment plans or recommendations.
- H. You have the right to reasonable access to appropriate medical services.
- You have the responsibility to keep scheduled appointments or to give adequate notice of delay or cancellation and to notify BCBSKS if you are unable to access appropriate medical services.
- I. You have the right to a candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage. You have the right to receive the benefits of your BCBSKS contract and to be informed of available services, as well as where, when, and how you can obtain these services.
- You have the responsibility to read all BCBSKS materials carefully and immediately upon your enrollment, and to ask questions when necessary. You have the responsibility to follow the rules of your BCBSKS contract.
- J. You have the right to receive assistance when language barriers exist between you or a member of your family and a provider of approved services.
- You have the responsibility to advise your PCP and/or BCBSKS when you require assistance, to allow for adequate communication between you or your family member and a provider. BCBSKS will assist in making the appropriate arrangements.
- K. You have the right for your medical records to be kept confidential except when disclosure is required by law or by BCBSKS. With adequate notice, you have the right to review your medical record with your PCP.

You have the responsibility to help maintain accurate and current medical records by being honest and complete when providing information to health care professionals.

- L. You have the right to express a complaint and to receive an answer to the complaint within a reasonable period of time.

You have the responsibility to express your opinions, concerns, or complaints in a constructive manner to the appropriate people at BCBSKS.

## **IX. PROVIDER ACCESS**

BCBSKS may develop standards so providers and members are aware of the expectations in the area of provider accessibility and availability. A number of avenues may be utilized to monitor compliance with these standards, such as complaints and appeals, member satisfaction, and after-hours accessibility audits.

## **X. PROVIDER SATISFACTION**

Providers' perceptions are an essential source of information for BCBSKS. A provider satisfaction survey is not only a good management tool, but also a key indicator of the quality of care and service being provided. Surveys may be developed to monitor satisfaction of providers. Feedback received provides an opportunity to implement process improvements aimed at achieving high-quality care, service, and retention of providers.

## **XI. DISEASE MANAGEMENT (CARE MANAGEMENT)**

BCBSKS has care management initiatives available for our members with diabetes, coronary artery disease, asthma, and congestive heart failure. The intent of these initiatives is to improve the overall health of our members with chronic health conditions by providing the education, tools, and one-on-one support that may assist members in having a positive impact on their health.

This HIPAA compliant program is physician directed and nurse managed via telephone. Through periodic telephone calls, the nurse case managers can assist in identifying risk factors.

Members will be contacted via phone or letter for their agreement to participate in the program. Education material is free of charge, and mailed on an individual basis.

Members will be selected for these initiatives by utilizing the health conditions risk identification tool.

**XII. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

According to the HIPAA Privacy Rule, health care providers can disclose protected health information (PHI) to health plans pertaining to credentialing, retrospective review, office record reviews, and HEDIS (Health Plan Employer Data and Information Set) data collection for the following types of health care operations:

- A. Quality assurance and quality improvement activities
- B. Accreditation activities (e.g., HEDIS data collection)
- C. Case management, care coordination, and related functions
- D. Disease management
- E. Protocol development
- F. Credentialing Provider or health plan performance evaluation
- G. Training
- H. Certification
- I. Licensing

Providers are permitted by HIPAA to disclose PHI to health plans for the above purposes without authorization from the patient when both the provider and health plan have or had a relationship with the patient and the information relates to that relationship.