



No. 4 QUALITY OF CARE

The quality of care and peer review programs described in this policy memo may apply to providers delivering services to Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) members.

I. QUALITY IMPROVEMENT PROGRAM

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 quality improvement department. Once a problem or pattern of problems is identified, a Quality Improvement Plan (QIP) may be developed as an educational effort to correct a specific problem relating to the care rendered by contracting providers. All cases in which the quality of care is either questionable or substandard 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.

A QIP is developed for all providers identified as having a pattern of quality issues. Problem codes assigned to these cases are reviewed to tailor the QIP according to specified problems identified during the initial review process. Therefore, QIPs may be developed for facility, physician, or ancillary providers depending upon the problem focus.

Evaluation of the effectiveness of the QIP will be performed at intervals appropriate to the identified problem or deficiencies, but not to exceed one (1) year.

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, the provider will be notified of the appeal rights set forth herein. No action will be taken until the provider either exhausts his/her appeal 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 BCBSKS Chief Medical Officer within 30 days of the initial notification of the QIP requesting an appeal. The request should outline why he/she disagrees with the QIP and supply additional information or highlight specific points for reconsideration.

Upon receipt of the outcome of the appeal from the BCBSKS Chief Medical Officer, a letter shall be sent to the appealing provider relaying the final 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 has exhausted the appeal process.

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

II. 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.

III. CARE MANAGEMENT

BCBSKS has care management initiatives available for our members with diabetes, coronary artery disease, asthma, congestive heart failure, and other chronic medical conditions. 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 and offer tools and resources to assist members in managing their chronic health condition.

Members will be contacted by phone or letter and invited 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.

IV. 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 (Healthcare Effectiveness 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.