Quality of Care Risk Investigations Policy

Purpose

Blue Cross and Blue Shield of Vermont (Blue Cross VT or the Plan) aims to evaluate clinical quality-related issues and concerns, as well as complaints across all lines of business.

Policy Scope

This policy affects all network practitioners, facilities, durable medical equipment providers, community agencies and clinics that contract with Blue Cross VT. The policy is a thorough framework crafted to meet quality-of-care standards set by regulatory and accreditation guidelines, placing the highest emphasis on member care and safety. It highlights the Plan's dedication to enhancing the member experience, with a focus on preventing harm and fostering continuous improvement in healthcare quality. This policy outlines the Plan's network requirement to participate with all quality-of-care investigations, including complying with any requests for documentation, policy, procedure, and/or collaborations. Participation in performance improvement activities resulting from quality-of-care investigations is also a contractual obligation for the Plan's network.

Regulatory/Accreditation Links

2024 NCQA HPA Standards and Guidelines: ME 1, ME 7A, ME 7C-F, CR 5, NET 1-3
Vermont Rule H-2009-03: 1.5A, 6.3B8
American with Disabilities Act (ADA)

Related Policies

Complaints Policy
Credentialing Policy
Facility Credentialing Policy
Professional Credentialling Policy
Site Visit and Medical Record Keeping Policy
Accessibility of Service and Provider Administration Service Standards Policy
Provider Contract Termination Policy
Clinical Practice Guidelines Policy
Records Retention and Management Policy
Never Events and Hospital Acquired Conditions Corporate Payment Policy
UM 08 - Medical Policy Development and Review Policy

Policy Review

Applies To: All Lines of Business

Effective Date: 07/19/04

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Department: Quality Improvement

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Definitions

Quality of Care: The degree to which health care services for individuals and populations increase the likelihood of desired health outcomes, decrease the probability of undesired health outcomes and are consistent with current professional knowledge.

Complaint: Any communication, written or verbal, which is an expression of dissatisfaction with any aspect of the plan or the resolution of a previous inquiry. These include situations caused by an error, inconvenience, or oversight by Blue Cross VT, an in-state or out of state provider (in-network), or a third-party vendor (in-network).

Issue/Concern: A quality-of-care or service issue arising from an internal review of care or an anonymous report.

Adverse Event: An injury that occurs while a member is receiving health care services from a practitioner.

Peer Review: Evaluation or review of colleague performance by professionals with similar types and degrees of expertise.

Clinical Investigator: A licensed clinician who investigates and processes quality-of-care cases. This role is typically held by the Plan's clinical quality consultant and is supported by licensed physicians. An interim clinical investigator, a licensed clinician, may step in as needed if clinical investigator attrition occurs.

Risk Investigation: The review process the clinical investigator uses to review and process quality-of-care cases.

Receiving Quality of Care Cases

Members: Any Blue Cross VT employee from any department can receive a member complaint or member request for an investigation into a quality-of-care matter by any means of communication including, but not limited to phone and email. If the member wishes to file a formal complaint, the member will be referred to customer service and the *"Complaints Policy"* will be followed. A quality-of-care case will be submitted, if necessary, in accordance with that policy.

Providers: Any network practitioner or agent of a network provider may report a quality-of-care issue/concern to any Blue Cross VT employee.

Blue Cross Staff: Any Blue Cross VT employee may report a quality-of-care issue/concern identified during the course of regular work or interactions with members and practitioners.

Never Events and Hospital Acquired Conditions: The inter-plan programs department and the data, governance, and healthcare economics department may send quarterly reports to the clinical investigator with diagnosis codes that may indicate a never event or hospital acquired condition for review. If a risk investigation is warranted, they are entered into the system and the risk investigation is performed.

All reports of quality-of-care complaints or issues/concerns are entered into the system by either the Blue Cross VT employee who receives the complaint or issue/concern or by the clinical investigator who receives the report.

Intake Procedure Prior to Initiating Risk Investigation

Quality improvement staff review all quality-of-care cases. The clinical investigator who performs the reviews needs certain information before deciding how and whether to proceed with a risk investigation. The staff member who files the quality-of-care issue/concern or complaint should include as much information as possible. As part of the intake process, the clinical investigator will return the case to the sender to request additional information if the details are not clear or present in the case. Please reference department desk procedures for guidance when submitting cases to the Quality of Care Queue in Salesforce.

Quality-of-care cases must include the following three pieces of information for a risk investigation to begin:

1. **Name of In-Network Provider/Facility**
    - If the provider/facility is out of state (OOS), the Potential Quality Incident (PQI) is forwarded to the appropriate Blues plan via the customer service research team.
    - If the provider/facility is out of network (OON), advise the member a risk investigation cannot occur as they are not under contract with our Plan.
    - Please note in the case comments if it is an OOS or OON provider.

2. **Date(s) of Service**
    - If pre-service, provide any relevant details on attempt to contact the provider/next availability/waitlist/etc.

3. **Description of Quality Issue/Concern or Complaint**
    - Within the case comments, a thorough description is REQUIRED and should include:
        - Actions performed and information provided to support the member's immediate need(s).
        - Parent case number and any other information available (files, emails, etc.).
        - Whether the member knows a case was filed on their behalf (NOTE: risk investigations are confidential and outcomes are not reported to members).

Durable Medical Equipment (DME) cases are referred to the clinical investigator if provider contracting or provider relations staff determine a quality concern/issue is present after their outreach is completed with the DME vendor. All cases involving DME are initially sent to provider contracting for vendor outreach and should include:

- Vendor Name
- Vendor Location
- Did member speak directly with facility? Y/N
- Case Details
- Actions taken thus far to mitigate concern and a plan for follow up

To protect the welfare and safety of our members, all quality-of-care cases received will be reviewed by the clinical investigator, and any potential safety concerns are reported to a Blue Cross VT medical director within two business days of receipt. This includes, but is not limited to, reports of potential never events or hospital acquired conditions (see *"Never Events and Hospital Acquired Conditions Corporate Payment Policy"*), medication adverse events, unusual infections, and unsafe transitions in care. All cases related to member safety are included in reporting to the Clinical Quality and Member Safety Team for further review as needed.

Quality of Care Categories

Following the intake process, and within 30 days of receipt of the case, the clinical investigator categorizes the complaint or issue/concern by assigning a risk category to describe the quality-of-care event. Within the primary risk categories there are sub-categories to describe the specific type of complaint or issue/concern. Some complaints or issues/concerns may fit under multiple risk categories, and this should be documented in the system.

Risk Categories and Sub-Categories
Quality of Care • Care unacceptable • Treatment outcome unacceptable • Never events
Access • Difficulty obtaining appointment • Office hours • Difficulty after hours • Telephone access
Attitude and Service • Provider behavior unacceptable • Provider communication unacceptable • Office staff rude • Office wait time
Billing or Financial Issues • Billing or coding concerns
Quality of Practitioner Office Site • Office appearance unacceptable • Adequacy of medical record or treatment record keeping

The clinical investigator investigates all cases that result in reported physical harm to the member.

In each case, the clinical investigator considers the level of harm the member incurred, the potential for future harm to this member or other members, and the continuing needs of the members affected before starting the investigation.

If the clinical investigator discovers potential or existing medical or service needs, the clinical investigator refers the member to the appropriate Blue Cross VT department for assistance, while continuing the quality-of-care risk investigation.

These needs include, but are not limited to:

Member Needs	Referral Department
Benefits review	Customer Service
Durable medical equipment	Provider Contracting
Acute medical and/or mental health needs	Integrated Health
Fraud, waste, and abuse (FWA), billing, and/or claims concerns	Payment Integrity

Risk Investigation

The clinical investigator considers the following elements in reviewing the case and assessing whether a quality-of-care matter is present:

- Provider or practitioner technique, knowledge, judgment, action, failure to act, communication, etc.
- Patient action, failure to act or communicate, compliance with care plans or instructions, etc.
- Systems within the specific care setting
- External factors, i.e., factors over which the practitioner, patient, and/or care setting had no control
- Mitigating factors

The clinical investigator may include any or all of the following in the investigation:

a. **Vermont Information Technology Leaders (VITL) Clinical Review:** The clinical investigator may review data available on the Vermont Heath Information Exchange (VHIE) through VITL access in accordance with its agreement with VITL upon receipt of quality complaints or issues/concerns.
b. **Interviewing Complainant or Reporter**: The clinical investigator may call the member or case reporter to clarify events, obtain more details, check for on-going case management needs of members, and help manage member expectations for complaint resolution.
c. **Reviewing the Recorded Complaint or Issue/Concern:** Blue Cross VT customer service and integrated health calls are recorded. If a case originated with customer service or integrated health, the investigator may retrieve the call to gain further understanding of the nature of the complaint or issue/concern and clarification of the reported events.
d. **Claims Review**: The clinical investigator may conduct a claims review to ensure the care occurred. Claims review also provides other relevant information such as co-morbidities and other providers involved.
e. **Authorization History:** The clinical investigator may conduct a review of the member's authorization history. This may include authorizations reviewed internally by the Blue Cross VT utilization management department and documented in its care management system or externally through the pharmacy benefit manager and any other utilization management delegates.
f. **Requesting Medical Records**: If the risk investigation requires review of the medical care received by the member, the clinical investigator may request related medical records from the involved providers. This information may extend beyond the time of the reported event and may include records describing the member's condition prior to and after the reported event. The clinical investigator faxes or emails a request to the relevant providers. Blue Cross VT expects providers to return the requested information within 14 days.
g. **Site Visit and Medical/Treatment Record Review:** The clinical investigator may conduct an unannounced site visit within 60 days if the member complaint concerns any of the following: physical accessibility, physical appearance, waiting/exam room space adequacy, and adequacy of medical/treatment record keeping.
h. **Other Department Activity**: The clinical investigator reaches out to other Blue Cross VT departments as appropriate to see if other activity pertaining to the complaint or issue/concern has occurred. This may include, but is not limited to, provider relations, payment integrity, customer service, utilization management, integrated health, network management, and/or the legal department.

i. **Provider/Facility Outreach**: The clinical investigator may contact providers involved to clarify procedures, policies, and actions already taken by the provider or staff to resolve the matter. Provider relations staff may assist in communicating with providers. This outreach may also include communication with facility quality departments, risk management departments and/or office managers for large facilities.

j. **Literature Review**: The clinical investigator may compare the documented care provided against Blue Cross VT's published guidelines, consistent with the Plan's *"Clinical Practice Guidelines Policy."* If the care provided is not addressed in that policy, the clinical investigator may use other resources that provide medical or scientific evidence, including but not limited to: UptoDate, MCG Health, Centers for Disease Control, National Institutes of Health, evidence-based guidelines and positions of leading national health professional organizations, and specialty society guidelines. Other acceptable resources can be found *in the "UM 08 - Medical Policy Development and Review Policy."* After reviewing the literature, the clinical investigator compares the appropriate guidelines to the care received.

k. **Credentialing and Performance Review**: The clinical investigator may use both past and present credentialing and provider performance data to substantiate quality-of-care matters when presenting to the credentialing committee for their recommendations.

l. **Medical Director Review**: When the clinical investigator determines a quality-of-care matter is a level three or above (based on the Impact Level below), they present the case to the Plan's chief medical officer or a medical director for review. The physician completes a peer review of the case. Should the Plan's physician reviewer not have the expertise to complete a fair peer review, they may refer the case to a consulting physician with the appropriate training and experience. The Plan's physician confirms or adjusts risk stratification after assessing the level of harm incurred by the member, the degree of provider consistency with current clinical guidelines, and any possible mitigating circumstances affecting the care provided.

Risk Investigation Outcomes

If the clinical investigator decides that a quality-of-care matter exists, they determine the severity of the case using the risk determination chart below. The Plan's clinical investigator, or a medical director (if physician review was required), considers the actual or potential impact of the quality-of-care issue and the probability of the issue's reoccurrence based on the scope of the identified issue. The risk determination for each case is decided using the following tables.

Risk Determination/Severity = Outcome of Investigation

Risk Score	Actionable follow up
Red (21-80)	Credentialing committee reviews and takes disciplinary or corrective action
Yellow (11-20)	Credentialing committee reviews; may take disciplinary or corrective action
Blue (5-10)	Quality staff monitors for trends; alerts provider and/or facility to situation
Green (1-4)	Quality staff monitors for trends; no further action required

If no quality-of-care matter exists, the case is closed, the member's medical records will be destroyed per the *"Records Retention and Management Policy,"* and all relevant information supporting that decision is documented in the system.

Impact Level

Level	Impact Score
Five	Resulted in a significant adverse clinical effect on the member (permanent injury or death).
Four	Had the potential to cause a significant adverse clinical effect (i.e., potential for level five) on the member or caused a major but temporary clinical effect with no long-term impact to the member (e.g., burns, drug side-effect).
Three	Had the potential to or caused a temporary insignificant or minor adverse clinical effect on the member (e.g., lacerations, contusions, minor scars, rash, infections, missed fractures, fall in hospital, recovery delayed without long-term impact to the member).
Two	Adverse effect caused to member in the form of fright, emotional harm, or financial harm.
One	Unlikely to cause an adverse clinical effect on the member (e.g., miscommunication and/or interpersonal conflicts between member and practitioner and/or office staff).
Not Leveled	Quality-of-care concern withdrawn by member or handed off to a Blue Cross and Blue Shield Association host plan.

Probability of Reoccurrence

Probability Level	Scope of Issue
Very High	Facility system design or philosophy
High	Practice system design or philosophy
Medium	Shared across a particular provider type
Low	Single circumstance, not attributable to system or philosophy; either human error or an unlikely but known risk of care
Very Low	Blue Cross VT clinical team determines error unavoidable due to mitigating circumstances

Risk Determination Chart

		Impact Level				
Probability of Reoccurrence		One	Two	Three	Four	Five
	Very High	5	10	20	40	80
	High	4	8	16	32	64
	Medium	3	6	12	24	48
	Low	2	4	8	16	32
	Very Low	1	2	4	8	16

Credentialling Committee

Every six months, the clinical investigator presents to the credentialing committee any provider who is the subject of any quality-of-care complaint or issue/concern ranking in the yellow or red categories or is the subject of three cases within 18 months ranking in the green or blue categories.

Blue Cross VT's credentialing committee reviews the case(s) and determines next steps. The committee oversees any resulting corrective actions for providers in accordance with Blue Cross VT's *"Professional Credentialing Policy"* and *"Provider Appeals from Adverse Contract Actions and Related Reporting Policy."* Actions may include, but are not limited to, a corrective action plan, a comprehensive chart review, limited credentialing periods, suspension, or termination from the network. Providers may appeal the credentialing committee decisions as outlined in the above policies.

For cases involving a provider who is not credentialed through our credentialing process (including, but not limited to, durable medical equipment providers), quality matters may be discussed with provider relations and provider contracting for appropriate actions.

Medical Board and the National Practitioner Data Bank Reporting

Blue Cross VT reports to the state medical board and National Practitioner Data Bank in accordance with applicable laws and regulations. The clinical investigator may consult the legal department about appropriate actions regarding any quality case.

Fraud, Waste and Abuse

Any suspected fraud, waste or abuse is reported to the payment integrity clinical consultant for potential recoupment of payment. This includes, but is not limited to, never events and hospital acquired conditions.

Member Experience Team

The clinical investigator presents any trends observed in quality-of-care cases twice a year to the member experience team to help inform quality improvement projects.

Case Conclusion

Closing Case: Cases are closed within 120 days. If the circumstances of the investigation or follow-up actions require it to remain open beyond 120 days, the documentation in the case will reflect the reason it remains open.

Member Communications: Many cases do not include member communications. However, as needed, the clinical investigator may contact the member, or request staff from customer service/integrated health to contact the member, and provide case closure information (i.e., claims updates, appointment schedule, etc.) without sharing specifics of the risk investigation or its outcome.

Member/Provider Education: The clinical investigator may identify a provider or member knowledge deficit that contributed to the quality-of-care case. Consulting with provider relations, a medical director, and/or other relevant departments listed under referrals, the clinical investigator may request the member/provider be provided education and information as appropriate.

Provider Notification: The clinical investigator may alert the involved providers and/or their facilities of the investigation and conclusion when appropriate.

Documentation of Process

Blue Cross VT stores all communications, medical records, and disciplinary actions related to a quality-of-care risk investigation in the Plan's electronic files. Member's medical records will be stored electronically if quality-of-care matters are confirmed. These files and records are accessible only by members of the quality improvement department, as well as the chief medical officer. Any additional access to these files must be approved by the director of quality.

If no quality-of-care matter is confirmed, the member's medical records will be deleted per company policy.

The information gathered in the peer review process is considered confidential and privileged.

Policy Distribution to Providers

Blue Cross VT distributes this policy to network practitioners and appropriate staff members via the provider manual that is available on the Provider Resource Center.

Policy Review

The Accreditation Committee reviews this policy and procedure every two years and as needed to ensure consistency with current business practice and to incorporate the latest regulatory and accreditation standards.