BlueCross BlueShield of Illinois

Blue Cross Blue Shield of Illinois (BCBSIL) Quality of Complaints and Occurrences Process **Health Care Delivery**

BLUE CROSS AND BLUE SHIELD OF ILLINOIS
PROCEDURE

DEPARTMENT: Network Clinical Program & Oversight	**PROCEDURE NUMBER:** Quality Improvement 30	**ORIGINAL EFFECTIVE DATE (IF KNOWN):**
PROCEDURE TITLE: Blue Cross Blue Shield of Illinois (BCBSIL) Quality of Complaints and Occurrences Process		**EFFECTIVE DATE:** 04/01/2023
		LAST REVISION DATE: 04/01/2021
EXECUTIVE OWNER: DSVP, IL Health Care Delivery	**BUSINESS OWNER:** **Angelique Muhammad,** Quality Management Specialist I	**LAST REVIEW DATE:** 04/01/2023

I. SCOPE

This Procedure applies to IL Provider Performance Network Clinical Program & Oversight, which specifies the activities, responsibilities, and steps to successfully operate the functions of the QOC complaints.

This Procedure applies to the following lines of business and products:

Line of Business / Product Scope / Plan Scope/Contract Number (if applicable)	In Scope [x]
HMO Commercial	
HMO Exchange	
Health Care Delivery QI HMO Commercial	X
Health Care Delivery QI PPO Commercial	X
Health Care Delivery QI HMO Exchange	X
Health Care Delivery QI PPO Exchange	X

II. POLICIES IMPLEMENTED BY PROCEDURE

This Procedure implements the following Policies:

1. Quality of Care Complaints and Occurrences, Policy 30: To investigate potential QOC complaints involving member's provision of clinical care and/or services, ensure complaints are reviewed within a 30-calendar day timeframe.

III. PROCEDURE

HMO Line of Business

1. Per the Medical Services Agreement (MSA) the Provider/Facility/Medical Group and/or HMO IPA should respond within 7 calendar days from the date of the faxed letter requesting information for response to the potential quality of care complaint.

2. If a response is not received by the end of the 7th calendar day, an Administered Complaint will be issued on day 8 to the Provider/Facility/Medical Group and/or HMO IPA and advised that documents need to be received in 5 calendar days. NOTE: For Department of Insurance, Attorney General, and Executive Inquiry complaints, all providers must respond within four calendar days.

3. If the requested documents are not received in 5 calendar days, the HSA will send out a third (3rd) reminder. The Provider/Facility/Medical Group and/or HMO IPA will be directed to respond with medical records and supporting documents within 3 calendar days. Supporting documents include the following:

    - A summary of the member's complaint.
    - A reply from the physician and/or HMO IPA addressing the issues related to the complaint.
    - Copies of medical records and other documentation related to the complaint as requested from BCBSIL.
    - An analysis of the complaint from the physician and/or HMO IPA Medical Director or from a representative of their Quality Improvement Committee (hereafter referred to as "QIC"), responding to the complaint.

4. Once requested documents are received, the QOC complaint and HMO IPA response is forwarded to the Medical Director for review. The BCBSIL Medical Director will review the potential QOC complaint with all submitted documentation and make a final determination.

PPO Line of Business

Per the participating provider agreement, the contracting provider will furnish the plan the necessary medical records and administrative records regarding covered persons. Failure to comply could possibly result corrective actions that could include termination.

<u>BCBSIL Quality of Care (QOC) Process for PPO:</u>

1. Within 24 hours of receipt of a potential QOC complaint, the designated Customer Assistance Unit (hereafter referred to as "CAU") staff shall:

a) Review the QOC complaint to determine if it is a valid potential QOC complaint. If not, the complaint will be forwarded to the appropriate area for review and resolution.

b) The CAU staff will then send the complaint to the Health Service Assistant (hereafter referred to as "HSA") who will then send the complaint to the Clinical Quality Research Analyst (hereafter referred to as "CQRA" who will verify what medical records and documents need to be received for review by the medical director. The HSA will then send a "Notification to Provider/Facility to Provide Medical Records" medical records request letter. The notification letter will request that the provider/facility sends BCBSIL the following*:*

- A summary of the member's complaint.
- A reply from the physician addressing the issues related to the complaint.

- Copies of medical records and other documentation related to the complaint as requested from BCBSIL.
- An analysis of the complaint from the physician and/or HMO IPA Medical Director or from a representative of their Quality Improvement Committee (hereafter referred to as "QIC"), responding to the complaint.
- A summary of the facts as determined by their investigation.
- The action that has been implemented to resolve the complaint and outcome of the action.

c) The provider/facility is directed to respond to the request for medical records notification letter within 7 calendar days. The letter indicates that provider/facility can send medical records and supporting back to the HSA via secure email, fax or mail them to BCBSIL to the HSA's attention.

1. If the requested documents are not received in 7 calendar days, the HSA will send out a second (2nd) request notification letter. The provider/facility will be directed to respond to the request for medical records notification within 5 calendar days.

2. If the requested documents are not received in 5 calendar days, the HSA will send out a third (3rd) and final request notification letter. The provider/facility will be directed to respond to the request for medical records notification within 3 calendar days.

Once requested documents are received, the QOC complaint and provider response is forwarded to the Medical Director for review. The BCBSIL Medical Director will review the QOC complaint with all submitted documentation and make a final determination.

<u>Corrective Action Plan (CAP)</u>

1. If the Medical Director decides that a Corrective Action Plan (CAP) is required, the Medical Director will compose a letter for the Provider/Facility/Medical Group within 5-7 business days of receipt of documentation from Clinical Reviewer. The CAP letter will then be submitted to the CAU.

a) For standard CAP, the CAU staff will forward the CAP letter within 2-3 business days.
b) For expedited CAP, the CAU staff will forward the CAP letter within 24 hours.

If no response received:

a) Within 5-7 business days of CAP letter mailing, CAU will resend Provider/Facility/Medical Group a second letter requesting a response.

b) Within 10-14 business days of CAP letter mailing, CAU will resend a second letter to Provider/Facility/Medical Group and notifies Provider Network Consultant and Clinical Reviewer of outreach date.

c) Within 21-30 business days of CAP letter mailing, CAU will resend a final letter to Provider/Facility/Medical Group and notifies Provider Network Consultant and Clinical Reviewer of outreach date.

2. Within 24 hours of Provider/Facility/Medical Group response to CAP, the CAU sends response to Medical Director and Clinical Reviewers. The Medical Director will evaluate and forward final decision to Clinical Reviewer

3. If the Medical Director decides that an onsite audit needs to be conducted, the Medical Director will notify the Clinical Reviewer who will then notify the manager of the Onsite Auditing Team.

Quality of Care Appeals

1. Within 10-15 business days of a QOC Appeal request, the Chair of the BCBSIL QIC shall call a special, confidential session to review the appeal.

2. The appealing parties may offer additional information and/or their own interpretation of events by attending the meeting in person or via appropriate electronic technology. BCBSIL Medical Directors are allowed to attend the session for purposes of clarification or comment but cannot vote.

3. After all information is presented, the clinician members of the BCBSIL QIC will make a decision to uphold the initial finding, overturn it, or seek further information and reconsider the question subsequently.

4. *Within 5 business days of the special session, the Chair of the BCBSIL QIC communicates the sessions decision to appropriate parties in writing.*

IV. DEFINITIONS

- CAU: Customer Assistance Unit. This team member performs the initial intake process for QOC's. This unit is comprised of Service Representatives and Health Services Assistants (HSA's).
- CQRA: Clinical Quality Research Analyst. This team member reviews the QOC and determines what records and/or documentation is need for medical director review.
- CAP: Corrective Action Plan: a procedure enacted when an opportunity for improvement is identified by a medical director after review of a quality of care complaint.
- HSA: Health Service Assistant. This team member initiates and performs all tasks associated with provider/facility/medical group solicitation for medical records and requested documents for medical director review.
- QIC: Quality Improvement Committee.
- QOC: Quality of Care: Activities that BCBSIL conducts to improve patient safety and clinical care. BCBSIL collaborates with network providers to improve the safety of clinical care and services to members.

V. AUTHORITY AND RESPONSIBILITY

Customer Assistance Unit (CAU)

VI. PROCEDURE REVIEWERS

Person Responsible for Review	Title	Date of Review
Deena Hutchins		2/8/2022
Angelique Muhammad	Quality Management Specialist I	2/28/2023

VII. PROCEDURE REVISION HISTORY

Description of Changes	Revision Date
No Changes	2/8/2022
No Changes	2/28/2023

VIII. PROCEDURE APPROVALS

Company, Division, Department and/or Committee	By: Name	Title	Approval date
BCBSIL P&P			3/24/2022
BCBSIL P&P			3/23/2023