**HMO Policy and Procedure**

**Policy Name:** Corrective Action for Failed Utilization Management Adherence Audit of Participating IPAs  
**Policy Number:** Administrative – 33  
**Effective Date:** 04/01/99  
**Revision Date:** 11/01/15  
**Review Date:** 11/01/16

**Approval Signature**

Divisional Vice President and Chief Medical Officer

**Line of Business**

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**Approving Body**

- Policy and Procedure Committee  
  Date: 10/27/16
- BCBSIL QI Committee  
  Date: 11/02/16

**Details**

**Policy:**

The HMOs of Blue Cross and Blue Shield of Illinois (BCBSIL) require a Corrective Action Plan from all Individual Practice Association (IPA) or Physician Hospital Organization (PHO) (hereinafter the “IPAs”) as a result of a failed annual Utilization Management (UM) / Case Management (CM) Adherence Audit.

**Purpose/Objectives:**

- To ensure compliance with the annual UM /CM Plan of the HMOs of BCBSIL.
- To ensure the correction of any UM/CM deficiencies.

**Procedure:**

1. The HMO Nurse Liaison performs the UM /CM Adherence Audit semi-annually. A mid-year score is provided to the IPAs at the first Audit. The final UM/CM Adherence Audit results are provided to the IPA at the time of the final audit.

2. IPAs that have not received a passing score of 90% or above for any component (UM, CM or CCM) at the final Adherence Audit are required to provide a Corrective Action Plan within 30 days of the date on the annual audit results letter addressing the deficient areas. The IPA shall direct all requests for assistance concerning the Corrective Action Plan to the HMO Nurse Liaison.

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3. The Corrective Action Plan must meet guidelines established by the HMO and shall include the following:
   - A statement of the deficiency/deficiencies being addressed.
   - A description of the steps which will be taken to correct the cited deficiencies.
   - Timeframes for performing key steps in the corrective action plan process, including start-up and completion dates.
   - Identification of the responsible parties for implementing and overseeing the corrective action process.
   - A description of the new/revised procedures that will be implemented to prevent reoccurrence of the cited deficiency/deficiencies.
   - Plans for monitoring compliance with revised procedures, including identification of the individual(s) responsible for oversight.
   - Acknowledgment of the HMO planned re-audit.
   - The signature of the IPA Medical Director.

4. When the Corrective Action Plan is received, it is reviewed by the Nurse Liaison for completeness and for compliance with HMO requirements. It is discussed with the HMO Medical Director for approval.

5. Once the Corrective Action Plan has been approved by the HMO, a letter of acceptance of the corrective action plan is sent to the IPA by the NL and copied to the HMO Medical Director, HMO UM/CM Manager and the Provider Network Consultant. IPA compliance should be documented in the UM Workgroup minutes.

6. If the Corrective Action Plan is not received by the HMO within the 30 day period, an Administered Complaint will be issued.

7. If a Corrective Action Plan is not received within an additional two weeks, another Administered Complaint will be issued and a meeting with HMO and IPA Management will be required to discuss the corrective action process.

8. A monthly audit will be performed for a period up to three to six months after the date of the annual audit, based on the nature of the deficiencies and recommendations of the HMO Medical Director.

9. If the re-audit results in a failure, the following will occur:
   - An Administered Complaint will be issued.
   - The HMO Nurse Liaison, HMO Medical Director, Provider Network Consultant, HMO UM/CM Manager and Network Programs Director will meet with the IPA’s senior management to discuss additional corrective action. One or more of the following may occur: closing the IPA to new enrollment, sending an HMO representative to their UM monthly meeting, outsourcing UM to a reputable Contract Management Firm (CMF), sending of additional documentation or other activities as deemed necessary by HMO.

10. If the IPA fails the next annual UM compliance audit, the following steps will take place:
    - HMO files an Administered Complaint.
HMO Management will consider the issuance of a Medical Service Agreement (MSA) default letter. If a default letter is sent, the IPA will have 30 days to cure the default, otherwise the IPA will be departicipated from the network.

One or more of the following may occur: closing the IPA to new enrollment, sending an HMO representative to their UM/CM monthly meeting, outsourcing UM to a reputable CMF, sending of additional documentation or other activities as deemed necessary by HMO.

11. IPAs who fail the Annual UM /CM Adherence audit are not eligible for the UM Portion of the QI Fund.