

10 Quality Management

QUALITY PROGRAM

The vision of Empire's Quality Program (QI) is to achieve levels of excellence in clinical care and member service that will be viewed as a model in our service area.

Quality Improvement Program Structure

The ultimate accountability for the management and improvement of the quality of clinical care and service provided to members rests with the Board of Directors (BoD). The BoD delegated authority for the oversight of the QI Program to the Continuous Quality Improvement Committee (CQI).

The Chief Medical Officer chairs the CQI and has overall responsibility for the QI Program. The CMO designates two senior physicians to key roles in the QI program: the Medical Director, Quality; and the Medical Director,

Credentialing. The Director of Quality Improvement is responsible for day-to-day implementation of the QI Program.

Quality Improvement Committee Structure

The Continuous Quality Improvement Committee is responsible for monitoring and evaluating the Quality Program. Eight subcommittees currently report to this committee.

- Credentialing Committee
- Provider Appeals Panel
- Service Quality Committee
- Clinical Quality Committee
- Utilization Management Committee
- Pharmacy and Therapeutics Committee
- Medical Society Forums
- Delegation Review Committee



Quality Improvement Program Activities

The following activities are conducted under the umbrella of our Quality Improvement Program:

- Credentialing and re-credentialing of network providers
- Developing and monitoring practice guidelines for acute and chronic conditions and preventive health-care (guidelines are chosen based on the demographic and epidemiological profiles of the managed care population)
- Monitoring and evaluating clinical and service trends
- Measuring availability of and accessibility to care and service
- Monitoring medical and behavioral health continuity and coordination of care
- Resolving and tracking complaints, grievances, and appeals from members and providers (Please refer to Chapter 12: Complaints, Grievances and Appeals for more information)
- Assessing member and provider satisfaction through the review and analysis of member and provider satisfaction surveys, complaint, grievance, and appeal data

If you are interested in learning more about our commitments or the Quality Program, contact your Quality Improvement Coordinator.

CREDENTIALING/RE-CREDENTIALING STANDARDS

Empire credentials eligible MDs, DOs, DPMs and DCs who apply for participation in our network. The following are Empire's credentialing criteria:

The provider must have

- a license to practice medicine in the state(s) where offices are maintained.
- a valid, active, unrestricted Drug Enforcement Administration (DEA) certificate (not including exceptions as noted below).
- active, unrestricted network hospital privileges (not including exceptions as noted).
- board certification/eligibility malpractice insurance (minimum of \$1 million/\$3 million).
- met the access requirements for Empire patients.
- if the provider is a PCP and/or OB/GYN he/she
 - must be available or have back-up 24 hours/day, 365 days/year.
 - must have a minimum of 16 hours/week at primary office site.
 - additional appointment availability standards as

described in this Sourcebook.

- successful completion of a site visit for all PCPs, OB/GYNs and high-volume behavioral health specialists applying for network privileges.

Exceptions to Credentialing Standards

The following specialties **do not require a DEA certificate:**

- Allergy/Immunology
- Cytopathology
- Dermatology
- Diagnostic Radiology
- Radiology
- Neuro-Radiology
- Nuclear Medicine
- Nurse-Midwifery
- Pathology (Clinical)
- Pediatric Allergy/Immunology
- Pediatric Dermatology
- Allied Health Professional
 - Chiropractic
 - Physical Therapy
 - Occupational Therapy
 - Audiology
 - Speech Therapy
 - Optometry

The following specialties do not require admitting privileges:

- Allergy/Immunology
- Anesthesiology
- Child Psychiatry
- Cytopathology
- Dermatology
- Diagnostic Radiology
- Emergency Medicine
- Radiology
- Neuro-Radiology
- Nuclear Medicine
- Pain Management
- Pathology (Clinical)
- Pediatric Allergy/Immunology
- Pediatric Dermatology
- Physical Medicine/Rehabilitation
- Psychiatry
- Radiation Oncology
- Allied Health Professional
 - Chiropractic
 - Physical Therapy
 - Occupational Therapy

- Audiology
- Speech Therapy
- Optometry
- Certified Diabetes Educator

All providers in Empire’s managed care networks are recredentialed every three years.

Recredentialing applications are reviewed as necessary by Empire’s Credentialing Committee. All criteria required in the initial credentialing of the provider (except work history) must be verified in the recredentialing process. In addition, Empire integrates results of quality-of-care reviews and member complaints into the recredentialing review.

Right to Review Credentialing Information

Physicians have the right to review information obtained by Empire to evaluate their credentialing applications. This evaluation includes information obtained from any outside primary source (i.e., malpractice insurance carriers and state licensing boards).

To receive this information, please write to:
 Empire BlueCross BlueShield
 Network Practitioner Credentialing Department
 15 Metrotech Center, 2nd Floor
 Brooklyn, NY 11201

CLINICAL PRACTICE GUIDELINES

Empire’s Clinical Practice Guidelines are designed to assist you in providing quality diagnosis and treatment of diseases. You can now access them online at www.empireblue.com.

Empire’s Clinical Quality Committee — which includes community-based and Empire staff physicians — develops the guidelines. Committee members review the scientific literature and publications of the recognized specialty medical bodies to determine optimal guideline content.

Empire utilizes the Health Employer Data and Information Set (HEDIS) Medical Record Review process to assess compliance with the guidelines. If you do not have access to the Internet, please call Physician Services at 1-800-552-6630, 8:30 a.m. to 5:00 p.m. EST, Monday – Friday.

MANAGED CARE REPORTING

The Health Plan Employer Data Information Set (HEDIS®) and Quality Assurance Reporting Requirements (QARR) measure performance on important aspects of preven-

tive, acute and chronic healthcare issues. Empire collects and reports these measures annually.

Why Empire collects this data:

- Empire uses HEDIS/QARR results to measure its performance on important aspects of preventive, acute and chronic care.
- The performance measures in HEDIS are related to significant public health issues such as cancer, diabetes, smoking and heart disease.
- In addition to clinical measures, HEDIS also includes a standardized survey of consumers’ experiences that evaluates plan performance in areas such as customer service, access to care and claims processing.
- Empire annually compares its HEDIS/QARR rates to the regional and national benchmarks to evaluate its performance and identify opportunities for improvement of the quality of care its members receive and to address the needs of its members along the health continuum.

How you can help

Physicians play an integral role in promoting the health of Empire’s members. We realize the data collection process can be time-consuming, but your efforts assist us in assuring that all Empire members receive the appropriate preventive health interventions. To assist us in accurately capturing the data, please...

- document recommended services in a patient’s medical record (i.e., mammogram screenings, cervical cancer screenings, colon cancer screenings, immunizations). If the member has declined the recommendation, please include this information in your documentation as well. This will allow us to target our interventions more appropriately.
- document the outcomes of any specialist referrals.
- encourage members to provide you with the name of any specialists that they may have seen without a referral. This will help us ensure continuity and coordination of care and obtain additional information from the specialists.
- take time to review a medical record when it is requested by Empire for clinical information and please provide Empire with the requested information.
- submit claims in a timely manner.

Empire’s HEDIS/QARR results are available on Empire’s website at www.empireblue.com.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

PRACTICE ANALYSIS REPORT

The Practice Analysis Report is Empire’s semiannual physician profile that is mailed to participating primary care physicians who have delivered healthcare services to 50 or more managed care members and have a monthly average of at least 50 members on their panel.

The report contains health-related articles and personalized key indicators that allow physicians to evaluate practice patterns, see how they compare to their peers and identify strengths and opportunities for improvement in providing preventive services.

Empire is committed to working with our participating physicians to keep our members healthy. If you would like additional information regarding the Practice Analysis Report, please contact your Quality Coordinator.

PATIENT SAFETY INITIATIVES

Empire supports practitioners and providers of care in their efforts to promote patient safety. Systematic Analysis Review and Assistance (SARA) utilizes laboratory results, pharmacy, claims and utilization data to flag certain predefined occurrences that may identify patient safety issues. Empire Pharmacy programs alert pharmacists of potential drug to disease and drug-to-drug interactions. Empire actively participates in national programs, such as Leapfrog, to improve patient safety and the overall value of healthcare to consumers. The program provides a web-based tool that allows easy access and review of the Leapfrog analysis data, on a hospital-by-hospital basis.

CONTINUITY AND COORDINATION OF CARE

Empire’s goal is to facilitate the provision of seamless, continuous and appropriate medical and behavioral health services to members across all practitioner and provider sites. To achieve this goal, Empire monitors continuity and coordination of medical care and collaborates with our behavioral health vendor to monitor continuity and coordination of medical care with behavioral healthcare.

Empire conducts medical record documentation audits and practitioner satisfaction surveys to monitor continuity and coordination of care between PCP practice sites with 50 or more members and medical specialists, behavioral health specialists, hospitals, home care agencies, free standing surgical centers, and skilled nursing

facilities (SNF).

In addition, Empire’s behavioral health vendor assesses continuity and coordination of care between medical and behavioral health through their annual practitioner satisfaction survey as well as treatment record audits of practitioners who provided care for 50 or more of Empire members within the last two years.

You can help ensure appropriate continuity and coordination of care by encouraging open communication and adhering to the requirements outlined in our Medical Record Documentation Standards below.

MEDICAL RECORD MAINTENANCE & DOCUMENTATION STANDARDS

The Primary Care Physician (PCP) is responsible for maintaining a comprehensive medical record for each member. Practitioners are expected to maintain complete and accurate medical records in a confidential manner in accordance with all state and federal regulatory requirements. This record documents all services provided by the PCP, referral specialists (whether or not they participate in the plan/network) and physician(s) providing back-up coverage. This record also must include documentation of non-physician provider services, e.g., physical therapists, audiologists, home healthcare, and diagnostic/laboratory services. If a member is hospitalized, the medical record maintained by the PCP must include a summary of the hospitalization, including operative notes and a discharge summary.

Referral specialists and other providers are required to maintain accurate patient medical records of treatment and diagnostic procedures authorized by the PCP. Referral specialists are also obligated to communicate the results of consultations or treatment to the PCP. Specialists should send written copies of the medical records describing the services provided, diagnosis, and treatment plan to the PCP as soon as possible.

Medical Record Documentation Standards

1. Significant illnesses and medical conditions are prominently documented on the problem list.
2. Medication list is current and prominently documented.
3. Medication allergies and adverse reactions to medications are prominently noted in the record. If the patient has no known allergies or history of

adverse reactions, this is prominently noted as well.

4. Past medical history is easily identified and includes serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses as well as those components referenced in the Pediatric Health Guidelines.
5. The history and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.
6. Working diagnosis is consistent with findings.
7. Treatment plans are consistent with diagnosis.
8. Patient education/instruction is appropriate to diagnosis.
9. Unresolved problems from previous office visits are addressed in subsequent visits.
10. Review for underutilization and over utilization of consultants.
11. If a consultation is requested, is there a note from the consultant in the record? This includes referrals for behavioral health services.
12. Consultations, lab reports, and imaging reports filed in the medical record are initialed by the ordering practitioner to signify review. Review and signature by professionals other than the ordering practitioner do not meet this requirement. A stamp, highlighting of results, or a check mark on the report is not sufficient. If the reports are presented electronically, or by some other method there is also representation of physician review. Consultations, abnormal labs and imaging study results have an explicit notation in the record of follow-up plans.
13. Hospital admissions, SNF placement, Home Care services, and/or freestanding surgical center services are reflected appropriately in the medical record.
14. Advanced Directives must be placed in a prominent part of the medical record. All members, aged 65 and older, should have prominent documentation of whether or not the member has executed an Advanced Directive.
15. There is no evidence that patient is placed at inappropriate risk by the management of diagnostic or therapeutic procedures, including overutilization or underutilization of services.
16. Capillary or venous blood test for lead by the end of the 25th month of life.

We encourage you to use the Wellness Checklists located in Chapter 13: Sample Forms to assist you in your documentation efforts.

Medical Record Review

Your compliance with these standards is assessed through medical record audits. These audits are conducted at least every three years by nurses from our Quality Improvement Department and individual scores are communicated to the physician. Empire has set a minimum compliance threshold of 85 percent for these standards. All physicians are expected to achieve or surpass this threshold score. Any physician scoring below this threshold will be reviewed again the following year. If the physician scores below this threshold on two consecutive reviews he/she will be referred to Empire's Credentialing Committee for evaluation and recommendation. Possible actions by the Credentialing Committee may include educational efforts, focused reviews, and in some cases, termination from Empire's physician network.

The review of medical records may also be done for one or more of the following, when applicable:

- Follow-up on prior review findings or corrective action plan
- HEDIS/QARR quality improvement studies
- Investigation of quality of care complaints
- Sentinel Event review

All physicians are required to participate in Empire's Quality and Medical Management Programs to meet New York State Department of Health, federal and regulatory requirements. Physicians are obligated by contract to allow inspection, auditing, and duplication of medical records during quality improvement, medical management, and peer or grievance reviews. Empire, or a designated representative, will request submission of medical records in connection with such reviews. PCPs are also required to assist in the orderly transfer of medical records when a patient changes his or her primary care physician.

If you have any question regarding the medical record documentation standards or the quality improvement process in general, contact Empire Physician Services at 1-800-552-6630, 8:30 a.m. to 5:00 p.m. EST, Monday to Friday.

NETWORK PRACTITIONER TERMINATION AND APPEALS

Purpose and Goal

The Network Practitioner Termination and Appeals Policy and Procedure is designed to define the criteria by which Empire evaluates certain managed healthcare

practitioners participating in our network for possible termination or other actions, as necessary.

Policy Statement

Empire contracts with various practitioners so that it can offer quality, accessible, cost-efficient healthcare to its managed care network members. Empire monitors the care provided by the practitioners participating in our managed care network and recredentials them every three years to ensure that such healthcare is being rendered.

Certain circumstances, including but not limited to, professional misconduct of a participating practitioner within our managed care network may require Empire to take certain actions with respect to the practitioner's participation in the network. Actions may include termination of the practitioner's network participation privileges, as set forth below.

Termination of Practitioners

A. Immediate Terminations

These can occur when there has been:

- a determination that the conduct of a participating practitioner in our managed care network poses the threat of imminent harm to the health of network members;
- a finding that a participating practitioner in our managed care network has perpetrated an act of fraud; or
- a final disciplinary action by a state licensing board or other governmental agency that impairs the ability of a participating practitioner in our managed care network to practice.

In the above cases, the participating practitioner in our managed care network will be immediately terminated from all managed care networks.

If a practitioner's network participation privileges are terminated due to quality of care concerns, professional misconduct or fraud, Empire will notify the National Practitioner Data Bank and/or the appropriate state licensing board(s) of its actions.

B. Administrative (Nonquality) Terminations

These can occur when an administrative (nonquality) issue arises with respect to a participating practitioner in our managed care network and may include, but is not limited to, one or more of the following:

- failure to maintain compliance with the requirements of Empire's Credentialing and Recredentialing Policies and Procedures; or
- the participating practitioner in our managed care

network fails to properly submit recredentialing application or attestation.

Possible actions that the Credentialing Committee may take include, but are not limited to, the sending of a Correction of Deficiency letter, continuing peer observation, focused reviews or a recommendation that the practitioner's network participation privileges be terminated.

When the Credentialing Committee recommends that a practitioner's network participation privileges be terminated pursuant to this section, the Credentialing Committee will issue and forward to the practitioner a Notice of Proposed Action. The Notice of Proposed Action will state the recommended action, the reason for the recommended action and the manner in which the practitioner may seek to challenge the recommendation of the Credentialing Committee.

A recommendation to terminate by the Credentialing Committee will become effective 35 days following the date upon which the Notice of Proposed Action is sent to the practitioner, unless the recommendation is challenged by the practitioner within this time frame.

C. Quality-Based Terminations

These can occur when a quality issue arises with respect to a participating practitioner in our managed care network and may include, but is not limited to, one or more of the following:

1. Poses a threat of imminent harm to the health of Empire's members
2. Has perpetrated an act of fraud
3. Repeated noncompliance with Empire managed care network procedures
4. Inappropriate utilization patterns based on focused reviews
5. Pattern or trend of quality of care complaints and/or adverse occurrences
6. Nonresponsiveness to corrective actions
7. Pattern or trend of member dissatisfaction
8. Loss or suspension of a Drug Enforcement Administration (DEA) identification number
9. Loss or suspension of admitting privileges at a managed care network participating hospital

The issue will be considered by the Credentialing Committee, which will recommend what action, if any, should be taken.

In performing its review, the Credentialing Committee will consider all available material concerning the practitioner. The Credentialing Committee may, at its discre-

tion, request that the practitioner submit a detailed written explanation of the issues under review or that the practitioner submit written responses to questions posed by or on behalf of the Credentialing Committee. Requested submissions must be sent by certified mail, return receipt requested or via overnight delivery and be received by the Credentialing Committee no later than the date set forth in the request. Responses received after this date will be accepted for consideration by the Credentialing Committee at its discretion.

Possible actions that the Credentialing Committee may take include, but are not limited to, the sending of an education letter, continuing peer observation or the recommendation that the practitioner's network participation privileges be in some way limited or terminated.

When the Credentialing Committee recommends that a practitioner's network participation privileges be terminated, the Credentialing Committee will issue and forward to the practitioner a written Notice of Proposed Action. The Notice of Proposed Action will state the recommended action, the reason for the recommended action and the manner in which the practitioner may seek to challenge the recommendation of the Credentialing Committee. A recommendation to terminate by the Credentialing Committee will become effective thirty five days following the date upon which the Notice of Proposed Action is sent to the practitioner, unless the recommendation is challenged by the practitioner within this time frame.

If a practitioner's network participation privileges are terminated in relation to the reasons listed above, Empire will notify the National Practitioner Data Bank and/or the appropriate state licensing board(s) of its actions.

D. Limitation on Terminations

A practitioner's network participation privileges will not be terminated due to any of the following reasons:

- Advocating on behalf of a member
- Filing a complaint against Empire
- Appealing a decision by Empire
- Providing information or filing a report that Empire engaged in conduct prohibited pursuant to Section 4406-c of the Public Health Law
- Requesting a hearing or review

Appeals Procedure

1. To challenge the Credentialing Committee's recommendation to terminate, a practitioner must notify Empire in writing of his or her intention to seek modification or reversal of that decision. The practitioner must send a written request for a hearing to modify or reverse a recommendation to terminate to the address listed in the Notice of Proposed Action. The request must be sent by certified mail, return receipt requested or via overnight delivery and postmarked or dated no later than thirty-five days following the date of the Notice of Proposed Action.
2. Within thirty days of receipt of a request for a hearing to modify or reverse the recommendation to terminate, a Provider Appeals Committee will be scheduled and convened to consider the matter. The Provider Appeals Committee will be comprised of a minimum of three persons, of whom at least one-third will be a clinical peer in the same discipline and the same or similar specialty as the practitioner. Notice of the hearing will be sent at least ten days before the scheduled hearing date.
3. If the practitioner wishes to reschedule the hearing, the request to reschedule must be made in writing, sent by certified mail, return receipt requested or via overnight delivery and be received at the address noted in the Notice of Proposed Action at least five calendar days before the scheduled hearing date. A practitioner may make only one request to reschedule the hearing. Thereafter, the right to reschedule the hearing is at the exclusive discretion of Empire. The Provider Appeals Committee is not authorized to reschedule the hearing. If the practitioner fails to appear as scheduled, the hearing will be conducted in his or her absence and any decision rendered will be considered binding.
4. Any documentation to be submitted by the practitioner at the hearing before the Provider Appeals Committee must be sent to the address listed in the Notice of Proposed Action by certified mail, return receipt requested or via overnight delivery and be received at least five calendar days before the scheduled hearing date. Documentation received after this date will be accepted for consideration at the discretion of the Provider Appeals Committee.

5. The names, addresses and medical credentials, if applicable, of any witnesses the practitioner intends to call at the hearing must be sent to the address listed in the Notice of Proposed Action by certified mail, return receipt requested or via overnight delivery and be received at least five calendar days before the scheduled hearing date. Witnesses whose identities are disclosed after this date will be allowed to testify at the discretion of the Provider Appeals Committee.
6. Copies of the documentation Empire intends to submit at the hearing and the names, addresses and medical credentials, if applicable, of any witnesses Empire intends to call at the hearing will be made available to the practitioner or his or her representative upon request. The request must be sent by certified mail, return receipt requested or via overnight delivery. Empire will respond to such requests as soon as practicable; however, if the request is received within five calendar days of the scheduled hearing date, Empire may provide the requested information at the time of the hearing.
7. At the hearing, Empire or its representative will present its case in support of the recommendation to terminate. The practitioner or his or her representative will then present his or her case as to why the recommendation to terminate should not be adopted.
8. The Provider Appeals Committee will prepare a report containing its findings and a decision with respect to the recommendation to terminate. The committee will forward the report to the Chairperson of Empire's Credentialing Committee within thirty days of the hearing. The Provider Appeals Committee can reject the recommendation to terminate, reject the recommendation to terminate subject to provisions that are acceptable to Empire, or accept the recommendation to terminate. The Chairperson of Empire's Credentialing Committee will advise the practitioner in writing of the decision made by the Provider Appeals Committee within fifteen days after receiving the Provider Appeals Committee's findings and decision. A copy of the committee's decision will be enclosed with the letter.
9. Where the decision of the Provider Appeals Committee results in the termination of a practitioner's network privileges...
 - Empire will notify the practitioner in writing of his or her effective termination date, which shall be at least thirty days following the date on which the practitioner receives notice of the decision to terminate from the Chairperson of Empire's Credentialing Committee.
 - Empire will also notify the National Practitioner Data Bank and/or the appropriate state licensing board(s) of its actions as outlined above.

Conflict of Interest

Neither an Empire Medical Director nor any Credentialing or Provider Appeals Committee member who reviews practitioners for continued managed care network participation shall have any prior relationship with the practitioner under review that would result in a conflict of interest or compromise the Medical Director's or Committee member's judgment.

Confidentiality

Empire, its employees, the members and staff of the Credentialing Committee and anyone else who may otherwise participate in the termination and appeals process, including those practitioners who sit on the Credentialing or the Provider Appeals Committees, its assigns and delegates, will protect and keep confidential all of the information that they may come into contact with in the course of the termination and appeals process, in accordance with Empire's Confidentiality Policies and Procedures and applicable federal and state laws and regulations.