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| Policy: | GG.1611 |
| Title: | **Potential Quality Issue Review Process** |
| Department: | Medical Management |
| Section: | Quality Improvement |
| *CEO Approval:* | */s/ Michael Hunn 10/10/2024* |
| Effective Date: | 01/01/1996 |
| Revised Date: | 10/01/2024 |
| Applicable to: | ☒ Medi-Cal<br>☒ OneCare<br>☐ PACE<br>☐ Administrative |

## I. PURPOSE

This policy defines the procedure for reviewing and processing of a Potential Quality Issue (PQI) referred to the CalOptima Health Quality Improvement (QI) Department.

## II. POLICY

A. CalOptima Health departments, Practitioners, Providers, Health Networks, and Organizational Providers (OPs) shall refer a Potential Quality Issue (PQI) to the CalOptima Health Quality Improvement (QI) Department for review and investigation.

B. The QI Department shall conduct a review of all PQIs by appropriately trained and qualified staff, including QI nurses and Medical Directors.

C. The QI Department shall conduct an investigation and request medical records and/or other CalOptima Health records as well as pertinent documentation from Providers, as needed.

D. CalOptima Health's Chief Medical Officer (CMO) or Designee shall refer PQI cases to the CalOptima Health Credentialing and Peer Review Committee (CPRC) for further evaluation and action, pursuant to the CalOptima Health Quality Improvement Program.

E. The QI Department shall trend and analyze individual Practitioner, Provider, Health Network, and OP PQI data every six (6) months to identify emerging patterns.

1. A pattern is defined as two (2) or more Quality of Care (QOC) PQIs, with severity levels one (1), two (2), and three (3) within a six (6) month period.

2. This data shall be reviewed by the CMO or Designee who shall report any issues and/or emerging patterns to the CalOptima Health CPRC for further evaluation and action, as necessary.

F. The QI Department shall prepare a summary report of all QI case activities and submit the report for review to the CalOptima Health CPRC.

G. The CPRC shall report a summary of trends and activities to the CalOptima Health Quality Improvement Health Equity Committee (QIHEC) and to the Board of Directors Quality Assurance Committee (QAC).

H. CalOptima Health shall maintain confidentiality of quality improvement case review information, in accordance with this Policy.

## III. PROCEDURE

A. Case Referral and Identification

1. Providers, Practitioners, Health Networks, and OPs may identify and refer a PQI to CalOptima Health's QI Department.

2. For Grievances related to potential QOC issues received from the Grievance and Appeals Resolution Services (GARS) Department, the QI Department shall immediately refer such Grievances to the CMO or Designee for review. This includes declined Grievances where the Member declines to file a Grievance, but a QOC issue is identified in the complaint.

3. A PQI may be referred from an internal CalOptima Health department, including but not limited to, Behavioral Health Integration, Customer Service, Pharmacy Management, Utilization Management, Case Management and the Office of Compliance.

4. Supporting documentation (e.g., correspondence, grievances, claims data, case management notes) shall accompany the referral.

    a. Any entity referring a PQI case shall identify if the Member chooses to remain anonymous.

B. Process, Review, and Evaluation of PQI Cases

1. PQI cases will be opened by the CalOptima Health PQI team and documented in CalOptima Health's care management system.

    a. If the Member chooses to remain anonymous, the case will be flagged as confidential in the electronic system.

    b. A QI Nurse shall perform an initial clinical review upon receipt, determine if the Member has any urgent clinical issues, and provide care coordination interventions as needed.

    c. The QI nurse shall request pertinent medical records and a response to the complaint from the appropriate Provider(s), Practitioner(s), Health Network, and/or OP(s) that rendered medical services or were involved in rendering the medical service(s), as needed.

        i. Medical records and a response may or may not be able to be obtained for confidential cases in order to maintain the Member's anonymity.

        ii. If a Provider, Practitioner, Health Network, or OP fails to respond:

            a) CalOptima Health's QI Department, in consultation with a Medical Director, may take any and all reasonable actions it deems to be in the best interest of Member, including the issuance of a Corrective Action Plan (CAP), pursuant to CalOptima Health Policy GG.1615: Corrective Action Plan for Practitioners and Organizational Providers.

2. CalOptima Health's QI Department may deem it appropriate to deploy CalOptima Health's copying vendor to copy and provide medical records.

3. CalOptima Health's QI Department shall target to have the preliminary review information prepared for the medical director review, within ninety (90) calendar days of receipt of the PQI.

4. Declined Grievances shall be reviewed by a medical director within thirty (30) days.

5. The CalOptima Health Medical Director shall review the case. Based upon the outcome of the case review, the Medical Director shall assign an outcome score to the case that reflects the severity of the outcome.

| Outcome Score | Description of Outcome Score |
|---|---|
| 0 | No quality of care or quality of service issue identified. |
| 1 | Mild clinical judgment or operational issue with or without an adverse outcome. |
| 2 | Moderate clinical judgment or operational issue with or without an adverse outcome. |
| 3 | Severe clinical judgment or operational issue with or without an adverse outcome. |
| S0 | Service-related issue, unable to verify. |
| S1 | Service-related issue, verified, resulting in inconvenience or dissatisfaction to the Member. |

6. CalOptima Health shall utilize an external review entity if a second opinion is determined to be needed.

7. If the CalOptima Health Medical Director does not identify a QOC issue, the case will be given an outcome score and no further action regarding the review process shall occur.

8. If the CalOptima Health Medical Director identifies a QOC issue, the case will be given an outcome score and, based on severity, be closed by the CalOptima Health Medical Director, or be presented to the CalOptima Health CPRC for recommendation(s).

    a. Higher severity cases will be presented to CPRC for discussion and recommendation of action.

    b. Other cases may be presented to CPRC upon Medical Director's discretion.

9. If a case is presented to CPRC and the committee confirms that the identified issue is a QOC issue, the CPRC may recommend further action.

    a. A corrective action from the specific CalOptima Health department, Health Network, OP, Practitioner, or Provider;

    b. Require the Practitioner, Provider, Health Network, OP, or CalOptima Health department to perform additional educational training; or

    c. Require other appropriate action(s) as recommended by the CPRC.

10. QI Staff shall present a summary of closed cases to the CPRC; this includes any remediation needed from CAPs issued to the Health Network, OP, Practitioner, Provider, or CalOptima Health Department.

11. Once the review process is completed, a resolution letter will be sent to the Provider.

    a. If the case was a confidential case, the Member information will be blinded in the Provider resolution letter.

    b. If the Provider disagrees with the determination, they may file a complaint pursuant to CalOptima Health Policies HH.1101: CalOptima Health Provider Complaint and MA.9006: Contracted Provider Complaint Process.

C. Reporting Requirements and Follow up Actions

1. The QI Department shall generate trend reports of PQI cases and shall report to the CPRC at least every six (6) months.

2. Patterns that are identified in the trend report as described in Section II.E. of this Policy, will be presented to CPRC to determine if any action is needed.

3. The QI Department shall submit all case findings and recommended actions to the CalOptima Health CPRC.

4. The QI Department shall follow-up on all actions that the CPRC recommends, ensuring compliance and appropriate remediation.

5. CPRC shall submit a summary report of all case reviews, including the conclusions and recommendations of the CPRC, to the QIHEC on a quarterly basis.

6. Additionally, the CalOptima Health CMO, their Designee, and/or the Executive Director of Quality & Analytics, shall submit summary reports on behalf of CPRC and QIHEC to the CalOptima Health Board of Directors' Quality Assurance Committee (QAC), in accordance with the CalOptima Health QI Plan.

7. The QI Department shall extract relevant information from case reviews, including those where no quality issues were identified, for trending and future study.

8. The QI Department shall include a summary of the case review findings in the Provider or Practitioner's Credentialing file. Information shall be brought forward at time of Recredentialing.

9. The QI Department shall submit a quarterly report to the Health Networks, reporting all closed PQIs affiliated with the specific Health Network. Members who choose to remain confidential will have their information blinded in the report.

## IV. ATTACHMENT(S)

A. Peer Review Conclusion

## V. REFERENCE(S)

A. California Business and Professions Code, §§805 and 1000-1
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for OneCare

D. CalOptima Health Policy GG.1615: Corrective Action Plan for Practitioners and Organizational Providers
E. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
F. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
G. CalOptima Health Quality Improvement Plan
H. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011: Grievance and Appeals Requirements, Notice and "Your Rights" Templates (Supersedes APL 17-006)
I. Title 22, California Code of Regulations (C.C.R), §51051
J. Title 28, California Code of Regulations (C.C.R), §1300.85.1
K. Title 42, Code of Federal Regulations (C.F.R), §422.152(a)(3), (c)(2), and (d)
L. Title 42, Code of Federal Regulations (C.F.R.), §438.330(d)

## VI. REGULATORY AGENCY APPROVAL(S)

| Date | Regulatory Agency | Response |
|---|---|---|
| 11/23/2015 | Department of Health Care Services (DHCS) | Approved as Submitted |
| 03/28/2016 | Department of Health Care Services (DHCS) | Approved as Submitted |
| 06/11/2021 | Department of Health Care Services (DHCS) | Approved as Submitted |
| 03/03/2022 | Department of Health Care Services (DHCS) | File and Use |
| 10/23/2023 | Department of Health Care Services (DHCS) | File and Use |

## VII. BOARD ACTION(S)

| Date | Meeting |
|---|---|
| 03/04/2021 | Regular Meeting of the CalOptima Board of Directors |

## VIII. REVISION HISTORY

| Action | Date | Policy | Policy Title | Program(s) |
|---|---|---|---|---|
| Effective | 01/01/1996 | GG.1611 | Potential Quality Issue Review Process | Medi-Cal |
| Revised | 03/01/1999 | GG.1611 | Potential Quality Issue Review Process | Medi-Cal |
| Revised | 12/01/1999 | GG.1611 | Potential Quality Issue Review Process | Medi-Cal |
| Revised | 05/01/2007 | GG.1611 | Potential Quality Issue Review Process | Medi-Cal |
| Revised | 01/01/2009 | GG.1611 | Potential Quality Issue Review Process | Medi-Cal |
| Revised | 03/01/2013 | GG.1611 | Potential Quality Issue Review Process | Medi-Cal<br>OneCare |
| Revised | 08/01/2015 | GG.1611 | Potential Quality Issue Review Process | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 11/01/2015 | GG.1611 | Potential Quality Issue Review Process | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 08/01/2016 | GG.1611 | Potential Quality Issue Review Process | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 05/01/2017 | GG.1611 | Potential Quality Issue Review Process | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 03/04/2021 | GG.1611 | Potential Quality Issue Review Process | Medi-Cal<br>OneCare<br>OneCare Connect |

| Action | Date | Policy | Policy Title | Program(s) |
|---|---|---|---|---|
| Revised | 02/01/2022 | GG.1611 | Potential Quality Issue Review Process | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 12/31/2022 | GG.1611 | Potential Quality Issue Review Process | Medi-Cal<br>OneCare |
| Revised | 10/01/2023 | GG.1611 | Potential Quality Issue Review Process | Medi-Cal<br>OneCare |
| Revised | 10/01/2024 | GG.1611 | Potential Quality Issue Review Process | Medi-Cal<br>OneCare |

## IX. GLOSSARY

| Term | Definition |
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| Credentialing | Medi-Cal: The process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure and professional association membership.<br><br>OneCare: The process of obtaining, verifying, assessing, and monitoring the qualifications of a practitioner to provide quality and safe patient care services. |
| Credentialing Peer Review Committee (CPRC) | The Credentialing and Peer Review Committee makes decisions, provides guidance, and provides peer input into the CalOptima Health provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima Health members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Health Quality Improvement Health Equity Committee (QIHEC). |
| Designee | A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.<br><br>For the purposes of this policy, a designee acting on behalf of the CalOptima Health Chief Medical Officer (CMO) shall be a CalOptima Health Medical Director. |
| Grievance | Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance.<br><br>OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination. |

| Term | Definition |
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| Health Network | A Physician Hospital Consortium (PHC), Physician Medical Group (PMG), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to members assigned to that Health Network. |
| Member | A beneficiary enrolled in a CalOptima Health program. |
| Organizational Provider | Medi-Cal: Organizations or institutions that are contracted to provide medical services such as hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, End-Stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, portable x-ray suppliers.<br><br>OneCare: Hospitals, Intermediate Care Facilities (ICF), Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N), Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H), Skilled Nursing Facilities (SNF), sub-acute facilities-adult, sub-acute facilities-pediatric, home health agencies, extended care facility, nursing home, free-standing surgical center, seating clinic, urgent care centers, radiology facilities, laboratory facilities, pathology facilities, and Durable Medical Equipment (DME) vendors. |
| Potential Quality Issue (PQI) | For the purposes of this policy, means any issue whereby a member's quality of care may have been compromised. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists. |
| Practitioner | A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing covered services. |
| Provider | Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.<br><br>OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, |

| Term | Definition |
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| | laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B. |
| Quality Improvement Health Equity Committee (QIHEC) | A committee facilitated by CalOptima Health's medical director, or the medical director's designee, in collaboration with the Health Equity officer, that meets at least quarterly to direct all Quality Improvement and Health Equity Transformation Program (QIHETP) findings and required actions. |
| Quality Improvement (QI) Nurse | For the purposes of this policy, a QI Nurse may be a CalOptima Health QI Registered Nurse (RN) or a CalOptima Health QI Licensed Vocational Nurse (LVN). |
| Quality of Care (QOC) | The degree to which health services for members and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. |
| Quality of Service (QOS) | Medi-Cal: Defined as, adequate access and availability to primary, Behavioral Health services, specialty health care, and LTSS providers and services; Continuity and coordination of care across all care and services settings, and for transitions in care; and Member experience and access to high quality, coordinated and culturally competent clinical care and services, inclusive of LTSS across the care continuum.<br><br>OneCare: Service issue resulting in inconvenience or dissatisfaction to Member. |
| Recredentialing | The process by which the qualifications of Practitioners is verified in order to make determinations relating to their continued eligibility for participation in CalOptima Health's programs. |