

**DEPARTMENT OF MANAGED HEALTH CARE
OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS**

TECHNICAL ASSISTANCE GUIDE

QUALITY ASSURANCE

ROUTINE CHIROPRACTIC SURVEY

OF

PLAN NAME

DATE OF SURVEY:

PLAN COPY

Issuance of this October 13, 2014 Technical Assistance Guide renders all other versions obsolete.

CHIROPRACTIC PLAN TAG

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This Technical Assistance Guide (TAG) serves as a guide for medical surveys which are conducted under the Health and Safety Code medical survey statutes and regulations. This TAG may be revised as appropriate, to incorporate new or updated relevant legal requirements as they impact the surveys, or for any other reason as determined by the Department. Health plans are responsible for complying with applicable statutes and regulations upon their effective dates and, therefore, are deemed to have prior notice of all statutes and regulations effective during the medical survey period. Health plans may be assessed for compliance with those requirements even when they have not yet been added to the TAG. The Department's medical survey authority is broad, and includes, but is not limited to, reviewing books and records, conducting interviews, making site visits, and making telephone calls to verify information as part of the survey assessment of any Key Element question in this TAG. The recipients of these telephone calls may include, but not be limited to, health plan and delegate physicians/medical directors, plan customer service representatives, triage nurses, and/or network/contracted providers.

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Requirement QA-001: QA Program Intent and Regulatory Purpose, Structure and Requirements

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- CEO
- Board Member (if feasible)
- QA Director
- QA Committee members
- Designated Chiropractor/clinician that provides oversight of QA Program
- Review licensing filing of the Plan's QA Program and confirm submission of appropriate policies and procedures

DOCUMENTS TO BE REVIEWED

- QA Program description and/or plan
- QA Work Plan or action plan
- Organizational charts showing the relationship of the QA Department and committees to the overall structure and the accountability of senior management for QA activities
- Annual QA plan evaluation for the last two years
- Minutes of the QA Committee or its equivalent and its subcommittee meetings for the last 18–24 months
- Meeting Minutes of Governing Body review of QA monitoring results
- Job description and resume of Physician or other clinician, as appropriate, who provides clinical direction to the QA Program
- Review licensing filing of the Plan's QA Program and confirm submission of appropriate policies and procedures.

QA-001 - Key Element 1:

1. The Plan has established and documented a QA Program consistent with regulatory purpose and intent.
CA Health and Safety Code section 1369; 28 CCR 1300.69; 28 CCR 1300.70(a), (b)(1)-(2) and (c).

Assessment Questions	
1.1	Does the Plan have a written description of the QA Program?
1.2	Is a chiropractor designated to provide clinical direction to the QA Program?
1.3	Does the designated chiropractor hold a current unrestricted California license to practice medicine?

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1.4	Is there evidence that the designated chiropractor is substantially involved in QA Program operations evidenced by time commitment, clinical oversight, and guidance to QA staff?
1.5	Does the QA plan confirm a quality of care monitoring cycle: 1) problems are identified; 2) effective action is taken to improve care when deficiencies are identified; and 3) follow-up is planned where indicated?
1.6	Does the scope of the QA Program address service elements, including accessibility, availability, and continuity of care?
1.7	Does the scope of the QA Program monitor whether the provision and utilization of services meets professionally recognized standards of practice?
1.8	Does the Plan have a written Public Policy Program?
1.9	Does the Public Policy Committee include the following participants; a) At least 51% of members are subscribers/enrollees? b) At least one member is from the Board of Directors? c) At least one member is from the provider (contracted) community?

QA-001 - Key Element 2:

2. The QA Program is designed/structured to ensure effective quality oversight. 28 CCR 1300.69; 28 CCR 1300.70(b)(1).

Assessment Questions	
2.1	Does the QA Program ensure that the level of care being delivered to all enrollees meets professionally recognized standards of practice?
2.2	Does the Plan have mechanisms to identify and correct quality of care problems for all provider entities?
2.3	Are chiropractors who provide care to enrollees an integral part of the QA Program?
2.4	Does the Plan track and trend quality of care provided by <i>individual</i> providers/provider groups against professionally recognized standards of practice (e.g., provider-specific rates, investigation of complaints regarding specific cases, site visits)?
2.5	Does the Plan ensure that its standing Public Policy Committee regularly and timely report recommendations and reports to the Governing Board, Governing Body, Executive Committee, or sole proprietor of the Plan?
2.6	If the standing Public Policy Committee reports a recommendation, does the Plan ensure that its Governing Board, Governing Body, Executive Committee, or sole proprietor act upon such recommendations?

QA-001 - Key Element 3:

3. The written QA Program meets defined requirements. 28 CCR 1300.70(b)(2)(A), (B), and (F).

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Assessment Questions	
3.1	Does the QA Program describe the goals and objectives of the Program and organization arrangements?
3.2	Does the Plan include staffing, clinical, and administrative staff support with sufficient knowledge and experience to assist in carrying out their assigned QA activities for the Plan and delegated entities?
3.3	Does the QA Program include the methodology for ongoing monitoring and evaluation of health services?
3.4	Does the QA Program include the scope of the Program and required levels of activity?
3.5	Does the QA Program delineate the QA authority, function, and responsibility?
3.6	Did the Plan provide evidence that the QA Program has established quality assurance activities?
3.7	Was the QA Program approved by the Governing Body?

QA-001 - Key Element 4:

- 4. The Plan's Governing Body provides adequate oversight of the QA Program (e.g., reviews detailed reports of findings and actions of the QA Program at least quarterly, periodically reviews the QA Program description, reviews and approves goals and objectives).
28 CCR 1300.70(a)(1) and (b)(2)(C).**

Assessment Questions	
4.1	Does the Plan's Governing Body review regular QA Monitoring Reports at least quarterly?
4.2	Are the reports to the Plan's Governing Body sufficiently detailed to include findings and actions taken as a result of the QA Program?
4.3	Are the reports to the Plan's Governing Body sufficiently detailed to identify any significant or chronic quality of care issues?
4.4	Does the Governing Body act upon the reports and information provided (e.g., by providing feedback, instructions and recommendations to QA Program staff)?

End of Requirement QA-001: QA Program Intent and Regulatory Purpose, Structure and Requirements

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Requirement QA-002: QA Program Monitors the Full Scope of QA Activities

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Chiropractic Director responsible to supervise the implementation of the QA Program.
- QA Director or equivalent
- Member Services Director
- UM Director/ Medical Director involved in UM review
- QA Committee members
- Participating providers
- Staff responsible for developing and analyzing reports
- Delegate Clinical Director if Plan delegates QA
- Delegate Director of Quality Improvement if Plan delegates QA

DOCUMENTS TO BE REVIEWED

- QA Reporting and Analysis Plan
 - Utilization Reports
 - Reports/analysis of complaints and grievances
 - QA activity reports, documentation and studies
 - QA Committee or applicable subcommittee minutes
 - Enrollee/provider satisfaction surveys results
 - Access and availability studies including telephone access studies
 - Special ad hoc reports to the Board, if applicable
 - Files detailing the review access/ availability complaints, continuity of care, utilization of services
- List of established performance goals and associated tracking reports
- QA Committee and subcommittee meeting minutes
- Related policies and procedures, including: the process for investigating quality of care, system issues and/ or administrative problems, monitoring procedures including problem identification, evaluation, corrective action and follow-up monitoring.
- Policy and procedure for peer review.
- Peer Review Committee minutes
- PQI Log
- Sample of PQI files to be reviewed onsite
- PQI track and trend reports by provider, by issue and by level of severity of confirmed problems

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QA-002 - Key Element 1:

1. The Plan monitors required service elements and utilization of services and identifies and corrects quality of care problems for all provider entities.
28 CCR 1300.70(a)(3), (b)(1)(B) and (b)(2)(H).

Assessment Questions	
1.1	Does the Plan monitor accessibility, availability, and continuity of care?
1.2	Does the Plan's monitoring and analysis include all provider entities? (e.g., chiropractors)
1.3	Does the Plan's monitoring and analysis include all service types? (e.g., preventive care)
1.4	Does the Plan monitor whether the provision and utilization of services meets professionally recognized standards of practice?
1.5	Are the Plan's data collection and reporting systems adequate to produce reliable and timely data and reports from various business units?
1.6	Does the Plan continuously monitor and document all service elements and utilization services?
1.7	Does the Plan use appropriate study designs and sound statistical techniques when monitoring, conducting studies and developing reports?

QA-002 - Key Element 2:

2. The QA Program must document that problems are being identified.
CA Health and Safety Code section 1369; 28 CCR 1300.69; 28 CCR 1300.70(a)(1), (b)(1)(B)-(C) and (b)(2)(C).

Assessment Questions	
2.1	Does the Plan utilize a variety of monitoring approaches (e.g., standardized performance measures; provider site visits; satisfaction surveys; investigating, tracking and trending enrollee complaints/grievances; investigating provider complaints) to identify problems in service and care?
2.2	Does the Plan refer identified issues, if any, to the QA Committee or other appropriate body (e.g. the Public Policy Committee's recommendations to the Plan's Governing Body) for input when appropriate?
2.3	Does the Plan track issues referred for quality review (e.g., complaints referred from G&A Dept. to QA Dept.) to ensure that all issues are investigated and that investigations are timely?
2.4	Where the Plan has failed to meet performance goals or targets does the Plan conduct gap analysis and investigate barriers to better isolate the problems for both clinical and non-clinical aspects of its health service delivery?

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QA-002 - Key Element 3:

- 3. When problems are confirmed or performance goals are not met, the Plan formulates and implements effective corrective actions in a timely manner. 28 CCR 1300.70(a)(1), (b)(1)(B) and (D) and (b)(2)(C) through (E).**

Assessment Questions	
3.1	Does the Plan implement corrective actions or QA Programs to address identified quality issues?
3.2	Does the Plan incorporate input from appropriate professionals into the design of its corrective action plans or QA Programs?
3.3	Does the Plan assess the effectiveness of its corrective actions or QA Programs?
3.4	Does the Plan critically evaluate the outcome of its corrective actions or QA Programs and take steps to rectify continued deficiencies?

QA-002 - Key Element 4:

- 4. The QA Program must be directed by providers and must document that the quality of care provided is being reviewed. CA Health and Safety Code section 1370; 28 CCR 1300.70(a)(1), (b)(2)(C) through (E).**

Assessment Questions	
For individual cases/providers (e.g., cases identified through complaints or sentinel events involving the quality of care provided by the provider):	
4.1	Does the Plan have an established process for investigating quality of care cases?
4.2	Does the Plan involve clinicians with the appropriate knowledge or specialty (e.g., DC's RNs, MDs) in the review process?
4.3	Does the Plan complete investigations involving quality of care issues within the timeframes established by the Quality Assurance and Peer Review Programs?
4.4	Does the Plan have a peer review mechanism in place?
4.5	Does the Plan have a system to judge the severity of issues and the care involved that relies on professionally accepted standards of practice?
4.6	Is the peer review case scoring system standardized, defined and communicated to all clinicians involved in peer review?
4.7	Does the Plan refer cases to a Peer Review Committee or other appropriate body of clinicians when appropriate?
4.8	Does the Plan either prescribe a corrective action plan or require that the offending provider submit a corrective action plan?
4.9	Does the Plan follow through and request evidence that corrective actions have been implemented by the offending providers?

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End of Requirement QA-002: QA Program Monitors the Full Scope of QA Activities

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Requirement QA-003: Precautions to Ensure Appropriate Care is Not Withheld or Delayed for Any Reason

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Chiropractic Director
- QA Director
- QA Coordinator

DOCUMENTS TO BE REVIEWED

- Organizational chart depicting reporting relationships between QA and other departments
- Clinician reviewer agreements with the health plan. Contract terms and conditions
- List of QA Committee members and titles, role and responsibility within the Committee, if any
- Quality Assurance policies and procedures

QA-003 - Key Element 1:

1. The QA Program is designed to ensure appropriate care is not delayed or withheld for any reason.
28 CCR 1300.70(b)(1)(D) and (E).

Assessment Questions	
1.1	Can the Plan demonstrate there is no financial incentive or gain to the Plan providers and/or others to delay or withhold appropriate care?
1.2	Can the Plan demonstrate that it does not pressure health care providers to render care beyond the scope of their training or experience?
1.3	Are all treatment decisions rendered by appropriate clinical staff, void of any influence or oversight by its finance department(s)?
1.4	Does the Chiropractic Director's responsibility to supervise medical management of the Plan's benefits occur without financial influence by its finance department(s)?
1.5	Does the Plan demonstrate that enrollee care is appropriate and consistent with professionally recognized standards of practice and is not withheld or delayed for any reason?
1.6	Can the Plan demonstrate that it does not exert economic pressure to cause institutions to grant privileges to health care providers that would not otherwise be granted?

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End of Requirement QA-003: Precautions to Ensure Appropriate Care is Not Withheld or Delayed for Any Reason

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Requirement QA-004: Credentialing

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff interviews are not required or recommended unless a specific concern is identified.

DOCUMENTS TO BE REVIEWED

- Related policies and procedures, including: credentialing and re-credentialing; ensuring all Plan providers and all participating providers are licensed and/or certified; identifying providers whose licenses have been suspended or revoked; etc.
- Contracts with individual providers
- Contracts with contracted entities, including provider groups
- Complaint and grievance reports
- Delegation contracts as applicable
- Monitoring and tracking reports of credentialing and re-credentialing

QA-004 - Key Element 1:

1. The Plan verifies that all Plan provider staff and all participating providers, both individual and institutional, are licensed and/or certified, as required by law.
CA Health and Safety Code section 1367(b).

Assessment Question	
1.1	Does the Plan have a mechanism to identify on a periodic basis providers whose license has been suspended or revoked?

End of Requirement QA-004: Credentialing

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Statutory/Regulatory Citations

CA Health and Safety Code section 1367(b)

...

(b) Personnel employed by or under contract to the plan shall be licensed or certified by their respective board or agency, where licensure or certification is required by law.

CA Health and Safety Code section 1369

Every plan shall establish procedures to permit subscribers and enrollees to participate in establishing the public policy of the plan. For purposes of this section, public policy means acts performed by a plan or its employees and staff to assure the comfort, dignity, and convenience of patients who rely on the plan's facilities to provide health care services to them, their families, and the public.

CA Health and Safety Code section 1370

Every plan shall establish procedures in accordance with department regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs. Notwithstanding any other provision of law, there shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any person who participates in plan or provider quality of care or utilization reviews by peer review committees which are composed chiefly of physicians and surgeons or dentists, psychologists, or optometrists, or any of the above, for any act performed during the reviews if the person acts without malice, has made a reasonable effort to obtain the facts of the matter, and believes that the action taken is warranted by the facts, and neither the proceedings nor the records of the reviews shall be subject to discovery, nor shall any person in attendance at the reviews be required to testify as to what transpired thereat. Disclosure of the proceedings or records to the governing body of a plan or to any person or entity designated by the plan to review activities of the plan or provider committees shall not alter the status of the records or of the proceedings as privileged communications.

The above prohibition relating to discovery or testimony shall not apply to the statements made by any person in attendance at a review who is a party to an action or proceeding the subject matter of which was reviewed, or to any person requesting hospital staff privileges, or in any action against an insurance carrier alleging bad faith by the carrier in refusing to accept a settlement offer within the policy limits, or to the director in conducting surveys pursuant to Section 1380.

This section shall not be construed to confer immunity from liability on any health care service plan. In any case in which, but for the enactment of the preceding provisions of this section, a cause of action would arise against a health care service plan, the cause of action shall exist notwithstanding the provisions of this section.

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28 CCR 1300.69

Unless a plan complies with the requirements of the Health Maintenance Organization Act of 1973 in affording subscribers and enrollees' procedures to participate in establishing the public policy of the plan, as defined in Section 1369 of the Act, it shall comply with each of the following requirements:

(a) If the plan is a corporation, either:

(1) At least one-third of its governing board shall be subscribers and/or enrollees, or
(2) There shall be established a standing committee which shall be responsible for participating in establishing public policy of the plan as defined in Section 1369 of the Act, and whose recommendations and reports are regularly and timely reported to the governing board. The governing board shall act upon such recommendations and such action shall be recorded in the board's minutes. The membership of the standing committee shall comply with each of the following:

(A) At least 51% of the members shall be subscribers and/or enrollees,

(B) At least one member shall be a member of the governing board of the plan, and

(C) At least one member shall be a provider.

(b) If the plan is a partnership, trust or unincorporated association, there shall be established a standing committee of the governing body or executive committee of the plan, which committee shall be responsible for participation in establishing public policy of the plan as defined in Section 1369 of the Act and whose recommendations and reports are regularly and timely reported to the governing body or executive committee of the plan. The governing body or executive committee of the plan shall act upon such recommendations and such action shall be recorded in its minutes. The membership of the standing committee shall comply with each of the following:

(1) At least 51% of the members shall be subscribers and/or enrollees,

(2) At least one member shall also be a member of the governing body or executive committee of the plan, and

(3) At least one member shall be a provider.

(c) If the plan is a sole proprietorship, it shall establish a standing committee which shall be responsible for participation in establishing public policy of the plan as defined in Section 1369 of the Act and whose recommendations are reported regularly and timely to the sole proprietor. The sole proprietor shall act upon such recommendations and such action shall be recorded. The membership of the standing committee shall comply with each of the following:

(1) At least 51% of the members shall be subscribers and/or enrollees,

(2) The sole proprietor shall be a member, and

(3) At least one provider shall be a member.

(d) Those individuals who fulfill the requirements stated in this section for subscriber and/or enrollee membership upon the governing body or standing committee shall be persons who are not employees of the plan, providers of health care services, subcontractors to the plan or group contract brokers, or persons financially interested in the plan.

(e) Advisory committees do not meet the requirements of subsections (a), (b) or (c).

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(f) Enrollees and subscribers participating in establishing public policy shall have access to information available from the plan regarding public policy, including financial information and information about the specific nature and volume of complaints received by the plan and their disposition.

(g) In connection with the selection of enrollee and subscriber members of any governing board or standing committee, the plan shall generally consider the makeup of its enrollee and subscriber population, including but not limited to factors such as ethnic extraction, demography, occupation and geography as well as identifiable and individual group participation. Any such selection or election of enrollee or subscriber members shall be conducted on a fair and reasonable basis. This subsection does not require the plan to maintain supporting statistical data.

(h) The public policy participation procedure shall be incorporated into the bylaws or other governing documents of the plan. The terms of subscriber and enrollee members of the public policy making body shall be of reasonable length and overlap so as to provide continuity and experience in representation. A standing committee shall meet at least quarterly.

(i) The plan shall (1) in each evidence of coverage or combined evidence of coverage and disclosure form, or at least annually by other means, furnish to its subscribers and enrollees a description of its system for their participation in establishing public policy, and (2) communicate material changes affecting public policy to subscribers and enrollees.

28 CCR 1300.70

(a) Intent and Regulatory Purpose.

(1) The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

(2) This section is not intended to set forth a prescriptive approach to QA methodology. This section is intended to afford each plan flexibility in meeting Act quality of care requirements.

(3) A plan's QA program must address service elements, including accessibility, availability, and continuity of care. A plan's QA program must also monitor whether the provision and utilization of services meets professionally recognized standards of practice.

(4) The Department's assessment of a plan's QA program will focus on:

(A) the scope of QA activities within the organization;

(B) the structure of the program itself and its relationship to the plan's administrative structure;

(C) the operation of the QA program; and

(D) the level of activity of the program and its effectiveness in identifying and correcting deficiencies in care.

(b) Quality Assurance Program Structure and Requirements.

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(1) Program Structure. To meet the requirements of the Act which require plans to continuously review the quality of care provided, each plan's quality assurance program shall be designed to ensure that:

- (A) a level of care which meets professionally recognized standards of practice is being delivered to all enrollees;
- (B) quality of care problems are identified and corrected for all provider entities;
- (C) physicians (or in the case of specialized plans, dentists, optometrists, psychologists or other appropriate licensed professionals) who provide care to the plan's enrollees are an integral part of the QA program;
- (D) appropriate care which is consistent with professionally recognized standards of practice is not withheld or delayed for any reason, including a potential financial gain and/or incentive to the plan providers, and/or others; and
- (E) the plan does not exert economic pressure to cause institutions to grant privileges to health care providers that would not otherwise be granted, nor to pressure health care providers or institutions to render care beyond the scope of their training or experience.

(2) Program Requirements.

In order to meet these obligations each plan's QA program shall meet all of the following requirements:

(A) There must be a written QA plan describing the goals and objectives of the program and organization arrangements, including staffing, the methodology for on-going monitoring and evaluation of health services, the scope of the program, and required levels of activity.

(B) Written documents shall delineate QA authority, function and responsibility, and provide evidence that the plan has established quality assurance activities and that the plan's governing body has approved the QA Program. To the extent that a plan's QA responsibilities are delegated within the plan or to a contracting provider, the plan documents shall provide evidence of an oversight mechanism for ensuring that delegated QA functions are adequately performed.

(C) The plan's governing body, its QA committee, if any, and any internal or contracting providers to whom QA responsibilities have been delegated, shall each meet on a quarterly basis, or more frequently if problems have been identified, to oversee their respective QA program responsibilities. Any delegated entity must maintain records of its QA activities and actions, and report to the plan on an appropriate basis and to the plan's governing body on a regularly scheduled basis, at least quarterly, which reports shall include findings and actions taken as a result of the QA program. The plan is responsible for establishing a program to monitor and evaluate the care provided by each contracting provider group to ensure that the care provided meets professionally recognized standards of practice. Reports to the plan's governing body shall be sufficiently detailed to include findings and actions taken as a result of the QA program and to identify those internal or contracting provider components which the QA program has identified as presenting significant or chronic quality of care issues.

(D) Implementation of the QA program shall be supervised by a designated physician(s), or in the case of specialized plans, a designated dentist(s), optometrist(s), psychologist(s) or other licensed professional provider, as appropriate.

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(E) Physician, dentist, optometrist, psychologist or other appropriate licensed professional participation in QA activity must be adequate to monitor the full scope of clinical services rendered, resolve problems and ensure that corrective action is taken when indicated. An appropriate range of specialist providers shall also be involved.

(F) There must be administrative and clinical staff support with sufficient knowledge and experience to assist in carrying out their assigned QA activities for the plan and delegated entities.

(G) Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees. If QA activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must do the following:

(1) Inform each provider of the plan's QA program, of the scope of that provider's QA responsibilities, and how it will be monitored by the plan.

(2) Ascertain that each provider to which QA responsibilities have been delegated has an in-place mechanism to fulfill its responsibilities, including administrative capacity, technical expertise and budgetary resources.

(3) Have ongoing oversight procedures in place to ensure that providers are fulfilling all delegated QA responsibilities.

(4) Require that standards for evaluating that enrollees receive health care consistent with professionally recognized standards of practice are included in the provider's QA program, and be assured of the entity's continued adherence to these standards.

(5) Ensure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the plan and/or delegated providers.

(6) Ensure that health services include appropriate preventive health care measures consistent with professionally recognized standards of practice. There should be screening for conditions when professionally recognized standards of practice indicate that screening should be done.

(H) A plan that has capitation or risk-sharing contracts must:

1. Ensure that each contracting provider has the administrative and financial capacity to meet its contractual obligations; the plan shall have systems in place to monitor QA functions.

2. Have a mechanism to detect and correct under-service by an at-risk provider (as determined by its patient mix), including possible under utilization of specialist services and preventive health care services.

(I) Inpatient Care.

1. A plan must have a mechanism to oversee the quality of care provided in an inpatient setting to its enrollees which monitors that:

a. providers utilize equipment and facilities appropriate to the care; and

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b. if hospital services are fully capitated that appropriate referral procedures are in place and utilized for services not customarily provided at that hospital.

2. The plan may delegate inpatient QA functions to hospitals, and may rely on the hospital's existing QA system to perform QA functions. If a plan does delegate QA responsibilities to a hospital, the plan must ascertain that the hospital's quality assurance procedure will specifically review hospital services provided to the plan's enrollees, and will review services provided by plan physicians within the hospital in the same manner as other physician services are reviewed.

(c) In addition to the internal quality of care review system, a plan shall design and implement reasonable procedures for continuously reviewing the performance of health care personnel, and the utilization of services and facilities, and cost. The reasonableness of the procedures and the adequacy of the implementation thereof shall be demonstrated to the to the Department.