## Table of contents

Quality Management Program overview ................................................................. 7.2
  Quality Management activities .................................................................................. 7.3
  Member safety activities ............................................................................................ 7.3
  Member complaint process ....................................................................................... 7.4
  Medicare Advantage grievance ................................................................................. 7.4
  Monitoring of continuity and coordination of care ................................................. 7.5
  Blue Distinction® Specialty Care Designation ....................................................... 7.5
 Rights and responsibilities ......................................................................................... 7.6
  Commercial Member rights ...................................................................................... 7.6
  Commercial Member responsibilities ........................................................................ 7.8
  Medicare Advantage HMO and PPO Member rights ............................................. 7.8
  Medicare Advantage HMO and PPO Member responsibilities ............................ 7.9
  Hospital responsibilities .......................................................................................... 7.10
 Medical record keeping standards ............................................................................ 7.10
  Medical record content .......................................................................................... 7.11
  Medical record organization ................................................................................... 7.11
  Information filed in medical records ...................................................................... 7.12
  Ease of retrieving medical records ......................................................................... 7.12
  Confidentiality of information ............................................................................... 7.12
 Maintenance of records and audits ......................................................................... 7.13
  Medical and other records ..................................................................................... 7.13
Quality Management Program overview

The Independence Quality Management (QM) Program is organized around a vision of supporting optimal health outcomes and satisfaction with care for our Members, as well as meeting all applicable regulatory and accreditation requirements. A philosophy of promoting the Academy of Medicine domains of quality (i.e., Safe, Timely, Effective, Efficient, Equitable, and Patient-Centered (STEEEP) care) for our Members informs all QM activities, assessments, and performance improvement projects.

The goals of the Independence QM Program include:

- Assess and improve the **safety** of medical and behavioral health care and services provided to Members.
- Evaluate the sufficiency of the plan networks for Members to access qualified Providers for **timely** and appropriate care.
- Ensure evidence-based, **effective** care is provided to members for their medical and behavioral health conditions.
- Promote **efficient** care and reduce health care waste through facilitating communication, continuity, and coordination of care among Providers and supporting a focus on prevention and appropriate level of service.
- Promote health **equity** among diverse populations by identifying and addressing social needs, including access to care that fits cultural and linguistic preferences.
- Assess and address the satisfaction of Members with their health care plan and services to support **patient-centered** system improvements.

Our relationships with our network Providers are essential in achieving our quality goals. Since our Providers deliver care to our Members, our role is to assist their efforts and to provide the tools and information they need to maintain the highest standards of care. Likewise, participating network practitioners have a role in supporting the QM Program. They contribute to the planning, design, implementation, and review of the QM Program, policies, and goals through the Clinical Quality Committee and other quality committees, which include network Providers as voting Members. All participating Providers are required to allow the Plan to use performance data for developing and implementing clinical and service quality improvement activities, public reporting to consumers, preferred status designation in the network, and cost sharing arrangements. All Providers are expected to cooperate with the QM Program, including requests for information and actions to support Member safety activities, complaint and occurrence inquiries, coordination of care, adherence to standards of care, non-discrimination, and other efforts to promote the health and wellbeing of our Members.

Information about our QM Program is available to our Providers and Members upon request, including a description of our QM Program goals and activities. This information is available online at [www.ibx.com](http://www.ibx.com) or Providers may call Customer Service at 1-800-ASK-BLUE.
Quality Management activities

The QM Program supports an ongoing comprehensive program of continuous quality improvement throughout the organization. We monitor, evaluate, and act to improve the quality and safety of clinical care and the quality of service provided to Members by participating practitioners and Providers, as well as Plan delegates, across all our product lines. We identify opportunities and establish initiatives to improve meaningful clinical outcomes and service quality by monitoring and analyzing:

- claims, pharmacy, and other data to identify high-volume, high-risk, and problem-prone services and acute and chronic conditions;
- data from internal performance monitoring activities and satisfaction survey results;
- data from complaints and Member appeals and direct input from Members, practitioners/Providers, and Independence staff;
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and Qualified Health Plan Enrollee Experience Survey (QHP EES) Member survey data relating to primary and specialty care;
- Healthcare Effectiveness Data and Information Set (HEDIS®) data for management of certain conditions and medications.

Member safety activities

Nothing is more important than the safety of our Members when receiving clinical care. The QM Program investigates all quality of care concerns. There are a variety of ways QM staff is alerted to potentially suboptimal care or medical errors that could impact the safety of our Members: Member and Provider complaints and grievances, patient safety claim codes and never event reports, care management and coordination team reviews, records audits, appeals, and other sources. The QM team assesses all reported occurrences for quality issues.

In addition, the Member Safety program is committed to promoting an environment that fosters safe clinical practice and minimizes medical and medication errors by:

- monitoring and assessing reported safety concerns related to health care delivery to our Members;
- close monitoring of quality, claim, and safety data sources to identify and respond to trends;
- alerting Providers to potential safety concerns and gaps in care for individual Members in their care;
- monitoring the coordination of care of our Members, including between medical and specialty care and medical and behavioral healthcare;
- identifying processes and practices that have potential to contribute to the reduction of medical and medication errors within our network;
- developing and disseminating information to Providers to promote safe clinical and prescribing practices and optimal outcomes;
- educating Members about patient safety and their role in reducing medical and medication error;
- evaluating the impact of Member safety interventions on our Members’ health outcomes;
• recognizing and highlighting facilities that meet quality standards and demonstrate superior outcomes through our Blue Distinction Center® and Blue Distinction Center Plus® Specialty Care Designations;

• close collaboration with health care Providers, hospitals, consumers, and other stakeholders through the Partnership for Patient Care and other collaborations.

**Member complaint process**

The QM department investigates all quality-of-care and service concerns/complaints and occurrences, ensuring appropriate clinical review and follow-up, as well as forwarding documentation of any quality related actions to the Credentialing team for inclusion in the Provider’s Plan record. This information may also be taken into consideration as part of a facility’s organizational assessment. Members or their representatives may file a concern/complaint by calling Customer Service at the number listed on their ID card or sending their complaint in writing to us by mail or email. Quality complaints are expressions of dissatisfaction with or criticism of the quality of care or service received from an in-network Provider or the quality of a practitioner’s office site. Quality complaints are typically forwarded to the QM department by Member Services or Appeals and may also be directed from other internal departments. Member safety occurrences are defined as adverse events that occur during inpatient or outpatient treatment that may present a Member safety concern.

On receipt of a complaint, QM Complaint Coordinators assess and document the nature of the complaint, categorize it, and initiate an investigation involving review by a Medical Director. Occurrences are assessed by Clinical QM Specialists, who document the nature of the occurrence, categorize it, and initiate an investigation involving review by a Medical Director. Complaint and occurrence investigations include correspondence with the Provider and/or facility involved and may include requests for records. *Failure to respond to inquiries regarding complaints and occurrences will result in an escalation of the assigned severity of the complaint or occurrence.* Providers are notified of any review of potential quality issues and the determination of any investigation in writing. If the Medical Director determines that there was an actual significant adverse effect on the Member, a corrective action plan addressing the quality issue identified will be requested.

As part of the resolution process, QM staff maintain a tracking database to facilitate the review, investigation, resolution, and trending of Member complaints and occurrences. Resolved complaints are monitored and analyzed to facilitate the identification of individual outliers and plan-wide trends. Outliers with multiple complaints or occurrences assigned escalated severity levels are subject to further peer review and corrective action, as appropriate. Improvement initiatives may also be implemented in response to identified adverse plan-wide trends, as necessary.

**Medicare Advantage grievance**

A Medicare Advantage grievance is any complaint or dispute raised by a Medicare Advantage Member or the Member’s representative, other than a dispute involving an organizational determination. Medicare Advantage grievances may include disputes regarding such issues as office waiting times, practitioner behavior, adequacy of facilities, involuntary disenrollment situations, or coverage decisions by Independence to process a Medicare appeal request under the standard 30-day time frame rather than as an expedited appeal. A resolution will be issued no later than 30 days after the grievance is received.
Monitoring of continuity and coordination of care

Effective continuity and coordination of care promotes both Member safety and the efficient use of healthcare resources. Care transitions refer to Members moving between health care practitioners and across settings as their conditions and care needs change during the course of a chronic or acute illness. This may include transitions between practitioners (e.g., primary care and specialists, behavioral health practitioner and primary care), and movement across settings of care. Care coordination is the facilitation, across transitions and settings of care, of patients getting the care or services they need and Providers getting the necessary information to provide the highest quality care.

Our goal is for Members to receive seamless, continuous, and appropriate care. On an annual basis, we collect and analyze data about the coordination of care across settings or transitions in care in our network to identify opportunities to improve. Examples of the type of data collected to improve coordination of care and promote collaboration between Providers, including medical and behavioral health care practitioners, include:

- appropriate documentation of exchange of information and coordination between Providers;
- appropriate follow through on Referrals and studies;
- appropriate diagnosis, treatment, and Referral of behavioral health disorders commonly seen in primary care;
- appropriate use of psychopharmacological medications;
- primary or secondary preventive behavioral healthcare program implementation;
- management of treatment access and follow-up for Members with co-existing medical and behavioral health disorders, including Members with severe or persistent mental illness.

QM also works with the Clinical Services and Utilization Management departments to monitor the coordination of care when Members move from one setting to another, such as when they are discharged from a hospital. The Transition of Care program provides telephonic support to eligible Members and their caregivers as they transition from inpatient care to home. Members are made aware of how they become eligible to participate, how to use program services, and how to opt-in or out of the program. Health Coaches provide education and coordinate care services so members/caregivers learn self-management skills that will ensure their needs are met during the transition and avoid unplanned readmissions or other transitions in care. The program uses an evidence-based model that focuses on four conceptual areas: medication self-management, understanding and use of the personal health record, primary care and/or specialist follow-up and member/caregiver knowledge on identification and management of signs and symptoms. Members who require additional support are transitioned into case management or disease management. Without coordination, such transitions often result in poor quality care and risks to patient safety. Analysis of discharge planning and care management data and surveys of practitioners regarding communication and coordination informs the design and implementation of these improvement initiatives.

Blue Distinction® Specialty Care Designation

Our centers of excellence program, Blue Distinction Specialty Care, focuses on hospitals and other healthcare facilities that excel in delivering safe, effective treatment for specialty procedures. Specialties include: Bariatric (weight-loss) Surgery, Cardiac Care, Cellular Immunotherapy, Gene Therapy, Knee and Hip Replacement, Maternity Care, Spine Surgery, Substance Use Treatment and Recovery, and Transplants. Additionally, Fertility Care is included, which is a physician designation.
Blue Distinction® was created by the Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross® and Blue Shield® Plans, to give consumers more information to make informed health care decisions and to work with Providers to improve health care quality outcomes and affordability.

Providers can be recognized as:

- **Blue Distinction Center.** Demonstrates quality care, treatment expertise, and better overall Member outcomes.
- **Blue Distinction Center+.** Demonstrates more affordable care, in addition to meeting Blue Distinction Center quality criteria.

Blue Distinction Centers for Specialty Care are recognized and are searchable based on the distinction in the online Find a Doctor tool:

- **Commercial Members:** [www.ibx.com/Providerfinder](http://www.ibx.com/Providerfinder)
- **Medicare Advantage Members:** [www.ibxmedicare.com/Providerfinder](http://www.ibxmedicare.com/Providerfinder)

Specialty Care Providers can also be found on the BCBSA’s National Doctor and Hospital Finder at [www.bcbs.com/find-a-doctor](http://www.bcbs.com/find-a-doctor). Some benefit designs offer Members reduced cost sharing for choosing a Blue Distinction Center or Blue Distinction Center+ for their care.

The QM Program facilitates applications for Blue Distinction recognition. For more information about Blue Distinction Center Specialty Care, including criteria, visit the BCBSA website at [www.bcbs.com/about-us/capabilities-initiatives/blue-distinction](http://www.bcbs.com/about-us/capabilities-initiatives/blue-distinction).

**Rights and responsibilities**

**Commercial Member rights**

A Commercial Member has the *right* to:

- receive information about the health plan, its benefits, services included or excluded from coverage policies and procedures, participating practitioners/Providers, and Members’ rights and responsibilities. Written and Web-based information provided to Members will be readable and easily understood.
- be treated with courtesy, consideration, respect, and be recognized for his or her dignity and right to privacy;
- participate in decision-making with practitioners regarding his or her health care, including the right to candid discussions of appropriate or Medically Necessary treatment options for his or her condition, regardless of cost or benefits coverage.
- voice complaints or appeals about the health plan or the care it provides and receive a timely response. The Member has a right to be notified of the disposition of appeals/complaints and the right to further appeal, as appropriate.
- make recommendations regarding our Member rights and responsibilities policy by contacting Customer Service in writing;
- choose practitioners within the limits of covered benefits, availability, and participation within the Independence network;
- have confidential treatment of personally identifiable health/medical information. Members also have the right to have access to their medical record in accordance with applicable federal and State laws.
be given reasonable access to medical services;

receive health care services without discrimination based on race, ethnicity, age, mental or
disability, health status, genetic information, color, religion, gender, national origin,
source of payment, utilization of medical or mental health services or supplies, or other
unlawful basis including, without limitation, the filing by such Member of any complaint,
grievance, appeal or legal action against Professional Provider, a Group Practice Provider (if
applicable) or Independence;

formulate and have advance directives implemented. Independence will provide information
concerning advance directives to Members and practitioners and will support Members
through our medical record-keeping policies;

obtain a current directory of participating practitioners in the plan’s network, upon request.
The directory includes addresses, telephone numbers, and a listing of Providers who speak
languages other than English.

file a complaint or appeal about the health plan or care provided with the applicable
regulatory agency and to receive an answer to those complaints within a reasonable period
of time. To be notified of the disposition of an appeal or complaint and further appeal, as
appropriate.

appeal a decision to deny or limit coverage, first within the plan and then through an
independent organization for a filing fee, as applicable. Members also have the right to know
that their doctor cannot be penalized for filing a complaint or appeal on a Member’s behalf.

for Members with chronic disabilities, the right to obtain assistance and Referrals to
Providers who are experienced in treating their disabilities.

have candid discussions of appropriate or Medically Necessary treatment options for his or
her condition, regardless of cost or benefits coverage, in terms that the Member
understands, including an explanation of their medical condition, recommended treatment,
risks of treatment, expected results, and reasonable medical alternatives. If the Member is
unable to easily understand this information, he or she has the right to have an explanation
provided to his or her next of kin or guardian and documented in his or her medical record.
Independence does not direct practitioners to restrict information regarding treatment
options.

have available and accessible services when Medically Necessary, including availability of
care 24 hours a day, 7 days a week, for urgent and Emergency conditions;

call 911 in a potentially life-threatening situation without prior approval from Independence
and the right to have Independence pay per contract for a medical screening evaluation in
the emergency room to determine whether an Emergency medical condition exists;

continue receiving services from a Provider who has been terminated from the
Independence network (without cause) in the time frames as defined by applicable State
requirements of the Member’s benefit plan. This continuation of care does not apply if the
Provider is terminated for reasons that would endanger the Member, public health or safety,
breach of contract, or fraud.

have the rights afforded to Members by law or regulation as a patient in a licensed health
care facility, including the right to refuse medication and treatment after possible
consequences of this decision have been explained in language the Member understands;
• be free from balance billing by Participating Providers for Medically Necessary services that were authorized or covered except as permitted for copayments, coinsurance, and deductibles by contract;
• be free from lifetime or yearly dollar limits on coverage of essential health benefits;
• be free from unreasonable rate increases and to receive an explanation of rate increases of 15% or more before the Member’s premium is raised;
• receive prompt notification of terminations or changes in benefits, services, or Provider network.
• have a choice of specialists among Participating Providers following an authorization Referral as applicable, subject to their availability to accept new patients;
• choose an individual On-Exchange health plan rather than the one the Member’s employer offers and to be protected from employer retaliation.

Commercial Member responsibilities
A Commercial Member has the responsibility to:
• communicate, to the extent possible, information that Independence and Participating Providers need to provide care;
• follow the plans and instructions for care that he or she has agreed on with his or her practitioners. This includes consideration of the possible consequences of failure to comply with recommended treatment.
• understand his or her health problems and participate in developing mutually agreed upon treatment goals to the degree possible;
• review all benefits and Membership materials carefully and to follow the rules pertaining to the health plan;
• ask questions to assure understanding of the explanations and instructions given;
• treat others with the same respect and courtesy expected for him or herself;
• keep scheduled appointments or give adequate notice of delay or cancellation;
• pay deductibles, coinsurance, or copayments, as appropriate, according to the Member’s contract;
• pay for charges incurred that are not covered under, or authorized under, the Member’s benefit policy or contract;
• pay for charges that exceed what Independence determines as customary and reasonable (usual and customary, or usual, customary and reasonable, as appropriate) for services that are covered under the out-of-network component of the Member’s benefit contract with respect to point of service contracts.

Medicare Advantage HMO and PPO Member rights
A Medicare Advantage HMO or PPO Member has the right to:
• be treated with fairness, respect, and recognition of his or her dignity and right to privacy;
• receive health care services without discrimination based on race, ethnicity, age, mental or physical disability, health status, genetic information, color, religion, gender, sexual orientation, national origin or source of payment;
• confidential treatment of personally identifiable health/medical information. Members also have the right to have access to their medical record in accordance with applicable federal laws.

• see Independence Providers and get Covered Services within a reasonable period of time;

• know treatment choices and participate with Providers in decisions about his or her health care. Independence does not direct practitioners to restrict information regarding treatment options;

• get information the Member understands from Medicare, health care providers, and, under certain circumstances, contractors;

• get information the Member understands about Medicare to help him or her make health care decisions, including what is covered, what Medicare pays, and how much they have to pay;

• have questions about Medicare answered;

• access doctors, specialists, and hospitals within the limits of covered benefits and availability within the health plan’s network;

• have a candid discussion of appropriate or Medically Necessary treatment options for his or her medical conditions, regardless of cost or benefits coverage;

• have a choice of specialists among Participating Providers following an authorized referral, as applicable, subject to their availability to accept new patients;

• use advance directives (such as a living will or a power of attorney);

• voice complaints (sometimes called grievances) or appeals about the health plan or the care it provides and receive a timely response. Members have a right to be notified of the disposition of appeals/complaints and the right to further appeal, as appropriate;

• get information about Independence, its services, its Providers, and Member rights and responsibilities;

• make recommendations regarding the Independence Member Rights and Responsibilities policy;

• get a decision about health care payment, coverage of services, or prescription drug coverage.

Medicare Advantage HMO and PPO Member responsibilities
A Medicare Advantage HMO or PPO Member has the responsibility to:

• give Independence and Participating Providers the information they need to provide care (to the extent possible);

• follow the treatment plans and instructions for care that he or she has agreed upon with his or her practitioners. This includes consideration of the possible consequences of failure to comply with recommended treatment;

• act in a way that supports the care provided to others and helps smooth the running of Providers’ offices and facilities;

• pay premiums and any cost-sharing that he or she may owe for Covered Services and meet his or her other financial responsibilities as described in the Evidence of Coverage;
• understand his or her health problems and participate in developing mutually agreed upon treatment goals to the degree possible;
• advise the plan of any questions, concerns, problems, or suggestions;
• notify Providers that he or she is enrolled in the health plan when seeking care (unless it is an Emergency);
• notify the health plan if he or she has additional health insurance;
• notify the health plan if he or she moves out of the service area.

Hospital responsibilities
Hospitals contracted with Independence are required to comply with Independence’s QM Program and quality improvement activities, including allowing the Plan to use their performance data. Hospitals have the responsibility to:
• ensure that all necessary authorizations are obtained prior to rendering services;
• be available and accessible 24 hours per day, 7 days per week;
• notify the Primary Care Physician (PCP)/family practitioner of follow-up care for services performed in the Emergency department;
• notify the PCP/family practitioner of follow-up care for services performed after a hospital stay;
• maintain Member confidentiality and comply with HIPAA† regulations;
• respect Member rights and responsibilities;
• comply with QM Program initiatives and any related policies and procedures;
• comply with QM requirements, including, but not limited to:
  – cooperate with the onsite medical review process and provide medical records when requested for clinical and/or service outcome measures;
  – respond to investigations of Member complaints regarding quality of care and services;
  – cooperate with the development of corrective action plans when measurements identify opportunities for improvement or as a result of a quality of care inquiry.

†HIPAA, the Health Insurance Portability and Accountability Act, was enacted by the U.S. Congress in 1996, and became effective July 1, 1997. This act is a grouping of regulations that work to combat waste, fraud, and abuse in health care delivery and health insurance. The intention of HIPAA is also to improve the effectiveness and efficiency of the health care system; portability, privacy and security of protected health information, continuity of health insurance coverage in the group and individual markets; and the ability to provide consequences to those that do not apply with the regulations explicitly stated within the Act.

Medical record keeping standards
A medical record documents a Member’s medical treatment, past and current health status, and treatment plans for future health care and is an integral component in the delivery of quality health care. As such, we established medical records standards in 1996 and routinely distribute these standards to PCPs and specialists.

We regularly assess compliance with these standards and monitor the processes and procedures that physician offices use to facilitate the delivery of continuous and coordinated medical care. We have established a performance goal of 90 percent compliance with our medical record standards.
The standards are as follows:

**Medical record content**

Medical records should include the following content:

- medical history and physicals;
- significant illnesses and medical conditions indicated on the problem list;
- documentation of medications – current and updated;
- prominent documentation of medication allergies and adverse reactions. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
- food and other allergies, such as shellfish or latex, which may affect medical management;
- past medical and surgical histories (for patients seen three or more times) easily identified, including 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.
- for patients 12 years and older, appropriate notations concerning use of cigarettes, alcohol, and substance abuse (for patients seen three or more times);
- the history and physical documents appropriate subjective and objective information for presenting complaints;
- working diagnoses consistent with findings;
- treatment or action plans consistent with diagnoses;
- unresolved problems from previous office visits addressed in subsequent visits;
- documentation of clinical evaluation and findings for each visit;
- appropriate notations regarding the use of consultants;
- no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure;
- an immunization record for children that is up to date or an appropriate history in the medical record for adults;
- evidence that preventive screening and services are offered.

**Medical record organization**

Medical records should be organized as follows:

- Each page in the record contains the patient’s name or ID number.
- The record contains the patient’s personal/biographical data, including his or her address, employer, home and work telephone numbers, and marital status.
- All entries in the medical record contain the author’s identification. Author identification may be a handwritten signature, a unique electronic identifier, or initials.
- All entries are dated.
- The record is legible to someone other than the author.
Information filed in medical records

Ensure that the following information is filed in medical records:

- all services provided directly by a practitioner who provides primary care services;
- all ancillary services and diagnostic tests ordered by a practitioner;
- all diagnostic and therapeutic services for which a member was referred by a practitioner, such as:
  - home health nursing reports
  - specialty physician reports
  - hospital discharge reports
  - physical therapy reports
- laboratory and other studies ordered, as appropriate;
- encounter forms or notes that have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or on a schedule deemed necessary.
- if a consultation is requested, a note from the consultant is in the record;
- specialty physician, other consultation, laboratory, and imaging reports filed in the chart and initialed by the practitioner who ordered them to signify review. Review and signature by professionals other than the ordering practitioner do not meet this requirement.
- if the reports are presented electronically, or by some other method, there is also representation of review by the ordering practitioner;
- consultation and abnormal laboratory and imaging study results include an explicit notation in the record of follow-up plans;
- the existence of an advance directive is prominently documented in each adult (18 and older) Member’s medical record. Information as to whether the advance directive has been executed is also noted.
- records of hospital discharge summaries and emergency department visits maintained in the Member’s record.

Ease of retrieving medical records

- Medical records are to be made available to us in accordance with the terms of the Hospital, Ancillary Facility, or Ancillary Provider Agreement (Agreement).
- Medical records are to be organized and stored in a manner that allows easy retrieval.

Confidentiality of information

- Protected Health Information (PHI) is protected against unauthorized or inadvertent disclosure.
- Medical records are safeguarded against loss or destruction and are maintained according to applicable State requirements. At a minimum, medical records must be maintained for at least 11 years or age of majority plus 6 years, whichever is longer.
- Medical records are stored in a secure manner that allows access by authorized personnel only.
• Staff receives periodic training in Member information confidentiality.

For complete information on Independence’s standards for Providers, including privacy, records standards, and Member rights, please visit www.ibx.com.

**Maintenance of records and audits**

**Medical and other records**

Providers must maintain all medical and other records in accordance with the terms of their Agreement with Keystone Health Plan East and QCC Insurance Company (collectively, “Independence”) and this Hospital Manual for Participating Hospitals, Ancillary Facilities, and Ancillary Providers. Subject to applicable State or federal confidentiality or privacy laws, Independence or its designated representatives, and designated representatives of local, State, and federal regulatory agencies having jurisdiction over Independence, shall have access to Provider records, on request, at Provider’s place of business during normal business hours, to inspect, review, and make copies of such records.

When requested by Independence or its designated representatives, or designated representatives of local, State, or federal regulatory agencies, the Provider shall produce copies of any such records and will permit access to the original medical records for comparison purposes within the requested time frames and, if requested, shall submit to examination under oath regarding the same.

If a Provider fails or refuses to produce copies and/or permit access to the original medical records within 30 days as requested, Independence reserves the right to require Selective Medical Review before claims are processed for payment to verify that claims submissions are eligible for coverage under the benefits plan.