OPTUM® VA Community Care Network

Potential Quality Issue (PQI) Referral Form

Submit this form by fax to the Clinical Quality Management (CQM) Department.

Fax: (833) 675-2481
Email: FaxClinicalQuality1@optumserve.com
Mail: VA Community Care Network
Clinical Quality Management MS-41
3237 Airport Road
La Crosse, WI, 54603

Veteran Information:				
Name: **Last**	**First**	M.I.	Gender:	DOB: **(mm/dd/yyyy)** ___/ ___/ _____
Address: **Street**	Apt. #	**City**	**State**	**ZIP Code**

Veteran Eligibility:	
☐ M – Eligible Based on Mileage ☐ B - Basic Eligibility ☐ X - No Longer Eligible	**Veteran SSN:**

Name of Provider:		
Name:	**Specialty:**	**NPI #**:
Address: **Street**	**City**	**State** **ZIP Code**

Place of Service:		
Name:	Specialty:	**NPI/TIN:**
Address: **Street**	**City**	**State** **ZIP Code**

Date(s) of Service:	
Admit/Service Date: **From Date:**	Discharge: **To Date:**
Readmit:	Discharge:
PQI Dates:	
Approximate Date of PQI Occurrence:	Date PQI Identified:
PQI Type:	

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Potential Quality Issue (PQI) Indicator Category (See following pages — Quality Indicators.)			
☐ Surgical Events ☐ Product or Device Events ☐ Patient Protection Events	☐ Care Management Events ☐ Environmental Events ☒ Radiologic Events	☐ Criminal Events ☐ Documentation Events	☐ Access/Availability Office/Facility ☐ Appearance Attitude/ ☐ Communications

Quality of Care/Patient Safety: ☐ (e.g. infection, complication, etc.)

Quality of Service: ☐ (e.g. dirty office, provider wait time, etc.)

Unknown: ☐

Description of Events (Please be as specific as possible):

Completed by:	
Name/Title:	Phone Number:
Name of Department:	Date Submitted: (mm/dd/yyyy) ___/ ___/ _____

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Quality Indicators
Surgical Events
Surgery or other invasive procedure performed on the wrong site
Surgery or other invasive procedure performed on the wrong patient
Wrong surgical or other invasive procedure performed on a patient
Unintended retention of a foreign object in a patient after surgery or other invasive procedure
Intraoperative death or immediately postoperative/ post-procedure death in an ASA Class 1 patient
In hospital surgical discharges from an elective admission resulting in death with the serious treatable complications (deep vein thrombosis/ pulmonary embolism, pneumonia, sepsis, shock/cardiac arrest or gastrointestinal hemorrhage/acute ulcer)
Postoperative hip fracture (secondary diagnosis)
Perioperative hemorrhage or hematoma cases with control of perioperative hemorrhage, drainage of hematoma, or a miscellaneous hemorrhage- or hematoma-related procedure following surgery
Postoperative physiologic and metabolic derangements (secondary diagnosis) or acute renal failures (secondary diagnosis) with dialysis for elective surgical discharges
Postoperative respiratory failure (secondary diagnosis), mechanical ventilation, or reintubation cases for elective surgical discharges
Perioperative pulmonary embolism or deep vein thrombosis (secondary diagnosis) in surgical discharges
Postoperative sepsis cases (secondary diagnosis) in elective surgical discharges
Postoperative re-closures of the abdominal wall in abdominopelvic surgery discharges
Accidental punctures or lacerations (secondary diagnosis) during procedure
Third and fourth degree obstetric traumas in vaginal deliveries
Surgical Site Infection, Mediastinitis, following Coronary Artery Bypass Graft (CABG)
Surgical Site Infection Following Certain Orthopedic Procedures
Surgical Site Infection Following Bariatric Surgery for Obesity
Surgical Site Infection Following Cardiac Implantable Electronics Device (CIED) Procedure
Lack of medical necessity for surgery or procedure
Product or Device Events
Patient death, serious injury or any other quality issue associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting.
Patient death, serious injury or any other quality issue associated with the use of function of a device in patient care, in which the device is used or functions other than as intended.

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Patient death, serious injury, or any other quality issue associated with intravascular air embolism that occurs while being cared for in a healthcare setting.
Patient Protection Events
Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person
Patient death, serious injury or any other quality issue associated with patient elopement (disappearance)
Patient suicide, attempted suicide, or patient self-harm that results in serious injury while being care for in a healthcare setting.
Contraband Smuggled into a Facility
Care Management Events
In-hospital deaths for low mortality (< 0.5%) Diagnosis Related Groups (DRGs)
Medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
Quality issue resulting from unsafe administration of blood products (updated 2011)
Quality issue, maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting (updated 2011)
Quality issue of a neonate associated with labor or delivery in a low-risk pregnancy (updated 2011)
Fall while being cared for in a healthcare setting (also including those that did not result in death or serious injury)
Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting
Artificial insemination with the wrong donor sperm or wrong egg
Quality issue resulting from the irretrievable loss of an irreplaceable biological specimen
Quality issue resulting from failure to follow up or communicate laboratory, pathology, or radiology test results
Quality issue resulting from failure to assess, treat or a delay in treatment
Iatrogenic Pneumothorax cases (secondary diagnosis)
Central venous catheter-related bloodstream Infections (secondary diagnosis)
Transfusion Reaction
Manifestations of poor glycemic control not present on admission
Catheter-Associated Urinary Tract Infection (UTI)
Inadequate discharge planning
Ventilator associated event
Environmental Events

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Patient or staff death, serious injury or other quality issue associated with an electric shock in the course of a patient care process in a healthcare setting
Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances
Patient, staff death, or serious injury or other quality issue associated with a burn incurred from any source in the course of a patient care process in a healthcare setting
Patient death, serious injury or other quality issue associated with the use of physical restraints or bedrails while being cared for in a healthcare setting
Radiologic Events
Death, serious injury or other quality issue of a patient or staff associated with the introduction of a metallic object into the MRI area
Criminal Events
Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
Abduction of a patient/resident of any age
Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting
Death, serious injury, or any other quality issue of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.
Consensual sexual behavior in treatment setting of a minor
Documentation Events
Inadequate documentation, illegible, or incomplete medical record
Report in wrong patient chart resulting in harm or potential harm