5 - Credentialing

Credentialing is the process of assessing and validating the qualifications of a licensed independent practitioner to provide services for Health Plan of Nevada (HPN) members.

Credentialing is a requirement for participation in the HPN provider network(s) and all providers must be credentialed prior to contracting. Re-credentialing is conducted every three (3) years, unless the Credentialing Committee specifies a shorter period between reviews, issues are identified, or special credentialing is required to align the provider's credentialing with HPN's credentialing schedule. HPN's credentialing process complies with the National Committee for Quality Assurance (NCQA) credentialing standards, the credentialing requirement of the Centers for Medicare & Medicaid Services (CMS), and the State of Nevada Medicaid Contract.

It is the Credentialing Committee's policy that if all information required to complete the credentialing process is not received, in its entirety, within 180 days the application will be withdrawn from the process.

For questions regarding credentialing, please contact the Credentialing Department at **(702) 242-7559**.

5.1 Credentialing Committee

The Credentialing Committee is a peer review body, which includes representation by providers practicing in HPN's network. The committee is also a multidisciplinary committee with representation from various types of practitioners. Other members of the committee include medical management and administrative staff. Practitioners are the only voting members of the committee. The Credentialing Committee meets a minimum of eight (8) times per year.

5.2 Providers Eligible for Credentialing

HPN has established credentialing standards for the following practitioners:

Physicians:
MD, DO, DMD, DDS, DC, DPM, OMD

Extenders:
APN (including NP, CNM), CNS, CRNA, PA-C

Allied practitioners:
OD, PT, OT, SLP, Audiologists, BCAB (Board Certified Behavior Analyst) and Autism Behavioral Interventionist

Non-physician behavioral health practitioners, who may or may not be master's prepared:
Practitioners, who are "Registered" or "Intern" licensed by the state in which they are practicing. Examples include, but are not limited to: marriage and family therapists; professional counselors; mental health counselors, alcoholism and drug abuse practitioners and clinical social workers.

Effective October 1, 2017, a NV State approved credentialing application will no longer be required for **HOSPITAL BASED** providers to participate in the various Health Plan of Nevada (HPN) and Sierra Health and Life (SHL) provider networks. The provider types included in this update are Anesthesiologists, Hospitalists, Neonatologists, Pathologists and Radiologists. A Provider Add Request Form and a Hospital Based Provider Enrollment Form must still be submitted for consideration in order to participate as a participating provider under the specific provider group contract. For APRN's (as applicable), PAC's or other physician extenders, an APRN/PA Competency Statement Form must be submitted along with the aforementioned forms.

5.3 HPN Credentialing Process

The HPN credentialing process includes:

1. Completion, by the provider, of the credentialing application and submission of evidence of professional licensure, malpractice insurance, DEA and state pharmacy certificates. The application must include attestations regarding:
   - Reasons for any inability to perform the essential functions of the position, with or without accommodation,
   - Lack of current illegal drug use and/or sobriety (completion of Health Status Form)
     If applicable: HPN requires you to provide the address and a full description of any rehabilitation program in which you are now participating or have participated in and to complete a Health Status Form which provides the name and title of the individual/organization (counselor / diversion program / treating provider) who can advocate on behalf of your sobriety status and/or program completion.
   - History of loss of license or disciplinary activity,
   - Felony convictions,
   - History of loss or limitation of privileges or disciplinary activity,
   - History of any malpractice claim or report to the National Provider Database (NPDB) or Healthcare Integrity and Protection Data Bank (HIPDB),
   - Current malpractice insurance coverage,
   - Correctness and completeness of the application.

2. Primary verification by HPN of the provider's credentials and query of appropriate monitoring agencies.

   Verification of information from primary sources:
   - License: confirmation from appropriate state agency of license validity, expiration and information as to past, present or pending investigations or sanctions
   - DEA certificate and/or state Pharmacy license
   - Education and training: graduation from medical school, completion of a residency, board certification (if applicable), graduation from an ACGME professional school (if applicable), etc.
   - History of professional liability claims which resulted in settlements or judgments paid by or on behalf of the provider

   Queries performed:
   - National Practitioner Data Bank
   - Medicare and Medicaid Sanction Report
   - NPI
   - SAM

3. Review and approval or disapproval by the Credentialing Committee

4. Notification to the provider of the Credentialing Committee's decision. Initial Credentialing notification will come from Network Development and Contracts within sixty (60) days of the decision. There will be no notification of positive recredentialing decisions. Decisions to deny initial or renewal of credentialing will be communicated in writing by the Credentialing Department.

At the time of recredentialing, HPN also considers quality indicators. These indicators may include data from member complaints, results of quality reviews, utilization management and patient satisfaction surveys.

Between credentialing cycles, HPN conducts ongoing monitoring of practitioner sanctions and complaints and takes appropriate action against practitioners when occurrences of poor quality are identified. Monitoring of sanctions includes a review of information for Medicare and Medicaid sanctions and limitations or sanctions on licensure. HPN also monitors complaints against practitioners for both quality of care and quality of service issues.

An office site visit and a review of medical record keeping practices are conducted for all PCPs and OB/GYN's at the time of initial credentialing. (HPN monitors for deficiencies subsequent to the initial site visit through member complaints, feedback from health plan staff and other data. If deficiencies are identified, HPN re-evaluates the site and works with the practitioner's office to institute actions for improvement, review and approval or disapproval by the Credentialing Committee).

Practitioners are required to notify HPN within 15 days of any loss of licensure, loss of privileges or Medicare/Medicaid sanctions and exclusions.

5.4 Expired Credentialing

Providers are required to be recredentialed every three (3) years. All HPN providers must be willing to cooperate in the recredentialing process and provide a completed re-credentialing application and any other requested documentation in a timely manner.

Six months prior to the end of the three-year credentialing cycle HPN sends a letter and an abbreviated re-credentialing application (preprinted demographic profile, screening questions and Consent and Release, including an attestation/signature page). Providers must return their application within 60 days. If a provider does not return a completed application in the appropriate time frame, Network Development and Contracting will send a certified letter to the provider advising his/her contract is in jeopardy of termination. Any provider whose contract is terminated will no longer be paid as a contracted provider. A provider whose credentialing has expired may apply for initial credentialing, however, any historical credentialing-related information HPN has regarding the provider (e.g., previous claims history, sanctions or restrictions history, or performance information) is used in consideration of that application and the provider's rights and privileges from previous credentialing are lost.

5.5 Provider Rights

Practitioners are provided the opportunity to review information submitted in support of their credentialing applications. This evaluation includes information obtained from outside primary sources (e.g., malpractice insurance carriers or state licensing boards). In the event that credentialing information obtained from other sources varies substantially from that provided by

the practitioner, HPN notifies the provider. This review does not include references or recommendations or other information that is peer review protected.

Practitioners also have the right to correct erroneous information submitted by another party for use in the credentialing process. The corrected information must be submitted in writing.

Practitioners have the right to be informed of the status of their application upon request. Practitioners may call the Credentialing Department at **(702) 242-7559**.

Network Development and Contracting notifies the practitioner of the final positive initial credentialing decision within sixty (60) days. The Credentialing Department notifies the practitioner of any negative decision within sixty (60) days.

5.6 Provider Credentialing Disapproval Reasons

A practitioner may be disapproved by the Credentialing Committee for any of the following**:**

At the time of initial credentialing:

- The practitioner has been disciplined by the licensing board of any state in which he/she is or has been licensed, registered, certified, or otherwise authorized to practice;
- The practitioner has been convicted, whether as a result of a guilty plea, a plea of nolo contendere or a verdict of guilty, of a felony, any offense involving moral turpitude, or any offense related to the practice of, or the ability to practice, medicine or the related healing arts;
- The practitioner has been expelled or suspended from the Medicare or Medicaid programs;
- Gross or repeated malpractice which may be evidenced by claims of malpractice settled against the practitioner or by judgments of malpractice against the practitioner;
- Aggregate malpractice settlements in excess of established thresholds;
- The practitioner has made a misrepresentation or a false, misleading, inaccurate or incomplete statement in his/her application;
- The practitioner has been voluntarily or involuntarily suspended or expelled from any hospital medical staff, has had his/her hospital privileges suspended, revoked or limited, or has had action by a managed care organization that affected his/her participation, or
- Other reasons deemed by the committee to be appropriate.

At the time of re-credentialing:

- Any of the issues specified above under “Initial Credentialing”;
- Unsatisfactory performance, including:
  - Quality of care issues;
  - Risk management issues;
  - Non-care complaints;
  - Satisfaction survey results;
  - Site visit or medical record review results;
  - Number of member complaints; or
  - Other issues as identified by the Credentialing Committee.

A practitioner seeking participation in the HPN Network who has been reviewed by the Credentialing Committee (CC) and has been disapproved for initial credentialing will not be allowed to reapply for one (1) year from the date of the denial. If a practitioner is disapproved by the CC two or more times, he/she will not be allowed to reapply for the number of years equal to the number of denials he/she has received from the date of the last denial.

A practitioner, to whom the Committee determines it intend to deny recredentialing in the HPN Network, is offered the opportunity to respond to the identified issues within 10 business days of notification of the pre-denial. Notification is sent to provider's address of record by Certified Mail. The practitioner may rebut, send new or additional evidence or explain issues in further detail. The Credentialing Committee will review the information submitted by the practitioner prior to making a final decision. **If no response is received from the affected practitioner within 10 business days, the Credentialing Committee will proceed with the denial following and the processes/procedures detailed in the "Practitioner Fair Hearing Procedure".**

5.7 Operational Policy Decisions

Practitioners requesting participation in the HPN network as a specialist or generalist must furnish evidence of training related to the contracted area of practice. In support of this requirement the Credentialing Committee has defined the following criteria for credentialing of generalists and certain specialties:

1. Regarding the requirements to be credentialed as a general specialist (as of September 2006):

   POLICY: Any practitioner contracting with HPN to serve as a general specialist must meet requirements determined by the Credentialing Committee. Practitioners seeking contracts to provide general medical care in a non-PCP setting are evaluated on a case-by case basis. This evaluation is based on evidence the practitioner has provided to demonstrate appropriate education and training preparation to act as a general specialist.

   During its evaluation the Credentialing Committee will consider the practitioner's: 1) prior and continuing education; 2) training; 3) experience; 4) utilization practice patterns; and 5) current ability to perform this work in a hospital setting. 6) Peer References when requested.

2. Regarding the requirements to be credentialed as a Pain Management Specialist (as of April 2005):

   DEFINITION:
   Intractable pain affects millions of people worldwide and can decimate the pain sufferer's quality of life, destroying his ability to work and to interact with friends and family. Although a multidisciplinary approach and conservative treatment with a variety of medications often brings pain relief, a subset of patients require more aggressive management using interventional approaches.

   INDICATIONS:
   The specialty of Pain Management is reserved for physicians who have been credentialed as pain management providers by the Credentialing Department of Health Plan of Nevada.

   Provider Services can request an exception be approved by the CMAC on a case-by-case basis for the rural areas and underserved areas where there is not a qualified provider. A comprehensive review by our internal pain specialist will be performed as needed.

   Other providers can contribute to the management of pain as far as it is within their scope of practice. Only providers recognized by the Health Plan to be Pain Management specialists may perform invasive pain management procedures.

3. Regarding the requirements to be credentialed as a Hospitalist (as of July 2002):

   POLICY: The Credentialing Committee requires that any practitioner contracting with HPN to serve as a Hospitalist must provide evidence of completion of an approved AOA or ABMS residency as a Family Practitioner, Internal Medicine Practitioner, or a Pediatric Practitioner or hold board certification in one of these specialties.

5.8 Provider Fair Hearing Procedure

Element	Procedure
Law	**Health Care Quality Improvement Act of 1986, 42 U.S.C.§§ 11101-11102** Sec. 11111. – Professional review (a) In general (1) Limitation on damages for professional review actions If a professional review action (as defined in section11151(9) of this title) of a professional review body meets all the standards specified in section 11112 (a) of this title, except as provided in subsection (b) of this section - (A) the professional review body, (B) any person acting as a member or staff to the body, (C) any person under a contract or other formal agreement with the body, and (D) any person who participates with or assists the body with respect to the action, shall not be liable in damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action. The preceding sentence shall not apply to damages under any law of the United States or any State relating to the civil rights of any person or persons, including the Civil Rights Act of 1964, 42 U.S.C. 2000e, et seq. and the Civil Rights Acts, 42 U.S.C. 1981, et seq. Nothing in this paragraph shall prevent the United States or any Attorney General of a State from bringing an action, including an action under section 15c of title 15, where such an action is otherwise authorized. (2) Protection for those providing information to professional review bodies Notwithstanding any other provision of law, no person (whether as a witness or otherwise) providing information to a professional review body regarding the competence or professional conduct of a physician shall be held, by reason of having provided such information, to be liable in damages under any law of the United States or of any State (or political subdivision thereof) unless such information is false and the person providing it knew that such information was false. Sec. 11112. - Standards for professional review actions (a) In general For purposes of the protection set forth in section 11111 (a) of this title, a professional review action must be taken - (1) in the reasonable belief that the action was in the furtherance of quality health care, (2) after a reasonable effort to obtain the facts of the matter, (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3). A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111 (a) of this title unless the presumption is rebutted by a preponderance of the evidence.

Element	Procedure
	(b) Adequate notice and hearing A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) of this section with respect to a physician if the following conditions are met (or are waived voluntarily by the physician): (1) Notice of proposed action The physician has been given notice stating - (A) (i) that a professional review action has been proposed to be taken against the physician, (ii) reasons for the proposed action, (B) (i) that the physician has the right to request a hearing on the proposed action, (ii) any time limit (of not less than 30 days) within which to request such a hearing, and (C) a summary of the rights in the hearing under paragraph (3). (2) Notice of hearing If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating - (A) the place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, and (B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body. (3) Conduct of hearing and notice If a hearing is requested on a timely basis under paragraph (1)(B) - (A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity) - (i) before an arbitrator mutually acceptable to the physician and the health care entity, (ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or (iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved; (B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear; (C) in the hearing the physician involved has the right - (i) to representation by an attorney or other person of the physician's choice, (ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof, (iii) to call, examine, and cross-examine witnesses, (iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and (v) to submit a written statement at the close of the hearing; and (D) upon completion of the hearing, the physician involved has the right - (i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and (ii) to receive a written decision of the health care entity, including a statement of the basis for the decision. A professional review body's failure to meet the conditions described in this subsection shall not, in itself, constitute failure to meet the standards of subsection (a)(3) of this section. (c) Adequate procedures in investigations or health emergencies

Element	Procedure
	For purposes of section 11111 (a) of this title, nothing in this section shall be construed as: (1) requiring the procedures referred to in subsection (a)(3) of this section - (A) where there is no adverse professional review action taken, or (B) in the case of a suspension or restriction of clinical privileges, for a period of not longer than 14 days, during which an investigation is being conducted to determine the need for a professional review action; or (2) precluding an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any
Hearing Panel	A **Hearing Panel** shall be appointed as required in policy. The Medical Director shall request the appointment of a Hearing Panel composed of an odd number (at least three (3) of the Practitioner's peers).
Hearing Procedure	**Personal Presence.** The personal presence of the Practitioner at the hearing is required. A Practitioner who fails without good cause to appear and proceed at the hearing waives his rights to a hearing. **Presiding Officer.** Sierra's Medical Director, or his or her designee, shall designate an attorney at law to serve as the Presiding Officer at the hearing. The Presiding Officer may be legal counsel to Sierra, but shall not act as the prosecuting officer or as an advocate for either side at the hearing. The Presiding Officer may participate in the private deliberations of the Hearing Panel and may be a legal advisor to the Panel, but may not vote on the Panel's recommendations. The Presiding Officer shall be responsible for assuring that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence, and that decorum is maintained throughout the hearing. The Presiding Officer shall oversee and supervise the entire hearing process, and shall have the sole authority and discretion to rule on all questions such as those pertaining to discovery, procedure, and the admissibility of evidence. **Representation.** The Practitioner has the right to representation by an attorney or other person of his choice. The body whose actions constituted the adverse recommendation shall appoint an individual to represent it as spokesman, and also may be entitled to be represented by an attorney. **Rights of Parties.** At the hearing, each party may: 1. Be represented by an attorney or other person of the party's choice; 2. Have a record made of the proceedings and to obtain a copy of that record upon payment of any reasonable charges associated with the preparation thereof; 3. Call, examine, and cross-examine witnesses; 4. Present evidence determined to be relevant by the Presiding Officer, regardless of its admissibility in a court of law; and, 5. Submit a written statement at the close of the hearing. **Procedure and Evidence**. This is not a **de novo** hearing. The hearing need not be conducted strictly according to the rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs may be considered, regardless of the admissibility of such evidence in a court of law. Each party is entitled, prior to or during the hearing, to submit memoranda concerning any issue of law or fact, and those memoranda become part of the hearing record.

Element	Procedure
Burden of Proof	The Practitioner has the burden of proving by a preponderance of the evidence, that the adverse action or recommendation is arbitrary and capricious. The body whose adverse action or recommendation occasioned the hearing has the initial obligation to present evidence in support thereof, but the Practitioner thereafter is responsible for supporting, by a preponderance of the evidence, his challenge that the adverse action or recommendation was arbitrary and capricious.
Consideration of New or Additional Matter.	**Consideration of New or Additional Matter.** New or additional matters or evidence not raised or presented during the original consideration by the Credentiaing Committee may be introduced at the hearing only at the discretion of the Hearing Officer, only if the party requesting consideration of the matter or evidence shows that it could not have been discovered in time for the Committee's review. The requesting party shall provide, a written substantive description of the matter or evidence to the Hearing Officer and the other party at least three (3) days prior to the scheduled date of the review.
Post Hearing	**Post Hearing:** Within fifteen (15) days after final adjournment of the hearing, the Hearing Panel shall make a written report of its findings and recommendations; and a copy of its findings and recommendations shall be sent to the Plan and the affected Practitioner. If the Hearing Panel's result is favorable to the Practitioner, it is effective immediately. If the Hearing Panel's result is not favorable to the Practitioner the decision will be forwarded to the Credentialing Committee for review and action.

5.9 Confidentiality of Credentialing Information

Through its credentialing policies and procedures, HPN ensures the confidentiality of information obtained in the credentialing process, except as otherwise provided by law. HPN is required to provide information about a provider's educational preparation, board certification and re-certification status, and names of hospitals where a provider has admitting privileges, as well as the number of years of practice as a physician and as a specialist.

5.10 Office Site Visits

HPN conducts site visits that result in a structured review of the office site, including physical accessibility, physical appearance, adequacy of waiting and examining room space, availability of appointments, and medical/treatment record-keeping practices.

Site visits are conducted by an HPN representative who is trained to perform a structured review of the site and to assess the adequacy of treatment recordkeeping. This reviewer works closely with the Vice President of Healthcare Quality and Education to make recommendations to the Credentialing Committee Chair and/or Credentialing Committee and, when necessary, to oversee corrective action plans with individual practitioner offices.

Site visits are considered site or location based. The site visit is effective for all practitioners who are at or who join a site or location. Results of the site visit are considered at the time of the Credentialing Committee's review and then communicated to the practitioner's office in a follow-up letter.

HPN conducts an initial site visit for all locations at which PCPs, OB/GYNs, and high-volume behavioral healthcare practitioners provide services. HPN also conducts an initial site visit when

a practitioner relocates or opens a new site and the site has never been evaluated. HPN does not conduct a site visit for new practitioners who join existing groups or for practitioners who relocate, if the office was previously reviewed and meets HPN standards. HPN also does not conduct site visits for a behavioral health practitioner who becomes high-volume subsequent to the practitioner's initial credentialing or for a behavioral health practitioner who was previously categorized as high-volume and is re-categorized as low-volume.

HPN conducts ongoing monitoring to detect deficiencies after the initial site visit. In order to respond as quickly as necessary to subsequent deficiencies, monitoring is conducted in a concurrent manner as information is received from the various sources for monitoring. Sources for monitoring include: member complaints or HPN staff concerns; patient satisfaction surveys for those practitioner offices identified as outliers on measures related to the condition of the facility; and feedback received from another health plan department that a problem may exist. Issues are triaged by the site reviewer who determines whether a site visit needs to be conducted immediately, if he/she believes a significant health or safety problem may be present, or whether the issue is to be tracked and trended to determine if a pattern exists. The Credentialing Committee may, at its discretion, request that a site visit be conducted at any time.

A site/location may be placed on corrective action if the overall site visit score is less than 80% or if the site is non-compliant for any one of the following issues: safety, patient care, confidentiality practices, or medical recordkeeping practices. The site/location is advised of the areas of noncompliance and required to implement a corrective action plan and achieve an overall compliance score of at least 80%, or come into compliance for any of the issues identified above, within 90 to 180 days. HPN monitors the corrective action plan for compliance and revisits the site for physical deficiencies and/or collects evidence of compliance with written deficiencies at least every 180 days until the performance standards have been met.

Results of corrective action monitoring are presented to the Credentialing Committee Chair and/or Credentialing Committee for approval or additional corrective action if performance standards are not met. The Chair or the Committee may, at its discretion, request additional follow-up site visits be conducted after a specified time to determine continued compliance. If the site fails to meet the established goals of the corrective action plan, further action may be taken by the Committee, including loss of participatory status for practitioners associated with the site.

Standards of Provider Office Facilities

TOPIC REQUIREMENT	
I.	**FACILITY ACCESS/APPEARANCE (EXTERIOR**
A.	***Building & Ground Maintenance***
1.	✓ Address visible
2.	✓ Outside clean, well maintained
3.	✓ Exterior doors accessible and not blocked / handrails stable/secure, if present
4.	✓ Walkways free of hazards/obstructions (i.e. potholes/tree roots)
B.	***Parking***
1.	✓ Adequate parking in close proximity to office
2.	✓ Handicap parking easily identified by visible signs or stencils
C.	***Handicap Access (Exterior)***
1.	✓ Curb ramp present
2.	✓ Doors open easily (automatic or semi-automatic or provisions have been made to provide assistance
3.	✓ Door width is adequate for wheelchair

4.	✓ If elevators **(exterior or interior)**: ❖ Elevator buttons accessible (low enough) ❖ ADA provisions: Braille/auditory references in elevator ❖ Doors wide enough for wheelchair access ❖ Emergency phone available in elevator
II.	**FACILITY ACCESS / APPEARANCE (INTERIOR)**
A.	***Handicap Access (Interior)***
1.	✓ Ramps if different levels
2.	✓ Reception counter wheelchair accessible **or** a process to accommodate patients in wheelchair
3.	✓ Doors / halls wide enough for wheelchair access
B.	***Bathrooms***
1.	✓ Clean
2.	✓ Appropriately stocked (soap, paper towels, toilet seat covers)
3.	✓ At least 1 bathroom in building is wheelchair accessible with grab bars
C.	***Office Appearance / Signage***
1.	✓ Practitioner name on office suite door and/or practitioner listed in building directory
2.	✓ Practice specific information available (days/hours of operation). Must be posted **or** in patient brochure/business card
3.	✓ Non-discriminatory practices based on race, age, sex or ethnicity must be posted **or** in patient brochure/business card
4.	✓ Health education information is available appropriate to practice
5.	✓ Routine housekeeping and maintenance are evident (office clean, uncluttered, comfortable)
6.	✓ Adequate seating in waiting room (no one standing)
7.	✓ Adequate lighting provided for reading
8.	✓ Exit signs clearly visible
D.	***Entry/Hallways***
1.	✓ Obstruction free
2.	✓ Fire extinguishers available/serviced within last year
3.	✓ Smoke detectors **or** sprinklers present
E.	***Emergency Evacuation***
1.	✓ Evacuation map posted **or** process in place for emergency evacuation
III.	**PATIENT RIGHTS/PRIVACY/CONFIDENTIALITY**
1.	✓ Staff sign confidentiality agreements
2.	✓ Policy/process for the "release of medical record information" (PHI) ❖ Written authorization form is required for the release of medical records ❖ Identification required to ensure release to patient or authorized representative
3.	✓ Process is in place to verify identity of an individual on the phone prior to releasing PHI
4.	✓ An area is provided where financial and insurance discussions will not be overheard by other patients
IV.	**SYSTEMS/ADEQUACY OF EQUIPMENT**
A.	***Exam Room/Close Proximity***
1.	✓ Exam tables are positioned away from exam door **or** privacy curtain/screen provides privacy when exam door is opened
2.	✓ Exam rooms (at least one per scheduled MD): The following equipment is available in **or** within close proximity of each exam room: ❖ B/P Cuff Y/N/NA ❖ Opthamaloscope/Otoscope Y/N/NA ❖ Exam Tables Y/N ❖ Handwashing Facilities **or** Hand Sanitizers Are Available (Alcohol Based) Y/N ❖ Disposable Gloves Y/N ❖ Scale Y/N ❖ Disposable Table Covers Y/N

	❖ Disposable Covers/Gowns **or** Linen Service Y/N ❖ Sharps Disposal Receptacles Y/N (If Shots Given In The Exam Room)
B.	***Laboratory (if office conducts laboratory testing: i.e. FOB, Pregnancy Tests, Urine Dip, etc.)***
1.	✓ CLIA Certification **or** Certificate of Waiver posted
2.	✓ State of Nevada license to conduct CLIA waived tests
C.	***X-Ray (if applicable)***
1.	✓ Current State Certification posted
D.	***Infection Control***
1.	✓ Autoclave instruments wrapped/dated or solution is dated and used in accordance with manufacturer's instructions (meets OSHA guidelines)
2.	✓ Spore testing maintained per manufacturer's directions
3.	✓ Needle disposal receptacles are available where shots are given
4.	✓ Hazardous waste disposal/labeled **and/or** red bags are separate from regular trash. Hazardous waste is located in a designated area and is disposed of separately from regular trash utilizing red bags/labels
5.	✓ Process for cleaning equipment, including exam tables, daily
E.	***Other Equipment***
1.	✓ Evidence of annual maintenance available (calibration of EKG machines, suction equipment, BP equipment, scales, etc) (i.e. logs or stickers on equipment)
V.	**PHARMACY**
A.	***Medication Storage***
1.	✓ All medication stored in a secure manner with access limited only to authorized persons (e.g. locked storage cabinet, not visible to patients)
2.	✓ Medication expiration dates are monitored and expired medication is discarded (includes samples) **or** process in place to check medication expiration date before dispensing
3.	✓ Refrigerated medication stored separately; not co-mingled with food
4.	✓ Temperature log maintained (35-45 degrees F) - Evidence of daily log
5.	✓ Recall system is in place for pharmaceuticals (including samples)
B.	***Prescription Pads/Needles/Syringes***
1.	✓ All inaccessible to patients; stored in drawer or closet
2.	✓ Prescription pads stored in locked drawer or closet
C.	***Narcotics (if applicable)***
1.	✓ Logs kept and narcotics accounted for
2.	✓ Limited access/locked cabinet
3.	✓ Written procedures for narcotics (only authorized personnel to dispense)
4.	✓ Disposal of unused and/or expired narcotics
VI.	**EMERGENCY SERVICES**
A.	***Emergency Supplies***
1.	✓ Protective mask and/or Ambu bag available as appropriate to practice (i.e. pediatric bag for pediatric offices)
2.	✓ Oxygen tanks, if present, are secured to prevent injury and cannula or mask is readily available
3.	✓ Emergency process (description ok)
B.	***CPR***
1.	✓ A CPR certified staff member (verify current certification) is available when patients are present
C.	***Crash Cart (if present)***
1.	✓ ACLS certified personnel when patients present
2.	✓ Crash cart checked regularly with log
3.	✓ Easily accessible, breakaway locks (if applicable)
4.	✓ Evidence of crash cart/defibrillator being maintained
5.	✓ Evidence of checking expiration dates of medications on crash cart

VII.	MEDICAL RECORD KEEPING
A.	***General*** *Hard Copy Medical Record **or** Electronic Medical Record*
1.	✓ Identify person(s) responsible for maintaining safekeeping of medical records **and/or** appropriate system back-up for electronic medical records
2.	✓ Practitioner has standard format (recommend chart dividers for sections, i.e. Lab/X-ray/Progress Notes, etc)
3.	✓ Each patient has their own medical record
4.	✓ Contents fastened securely **or** electronic medical record
5.	✓ Stored in area inaccessible to patients **or**, if electronic, password-protected security and appropriate system back-up
6.	✓ Each page has patient identifying information
7.	✓ Process to document/update current medications
8.	✓ Practitioner reviews all lab/x-ray, consults & other Dx tests (verify process)
9.	✓ P&P **or** process for reporting abnormal results to patients
10.	✓ Documentation of telephone calls and follow-ups including pharmacy refills are incorporated in the medical record
11.	✓ If taken off site for any reason, tracking systems in place and P&P in place for "Transporting Records"
B.	***Records include (at a minimum) the following:***
1.	✓ Demographic information (insurance, address, telephone, emergency contact, etc.)
2.	✓ Problem list (medical history, surgical history, chronic health problems, health maintenance – will include adult immunizations)
3.	✓ Allergies noted in one central location, including affirmation of "No Known Allergies"
4.	✓ Prenatal Flow Sheet (OB/GYNs only)
5.	✓ Immunization record and Growth Chart (Peds only)
C.	***Advance Directives (PCP only) for members 18+ years OR with chronic health problems***
1.	✓ Advance Directives are addressed / documented in the medical record
VIII.	**ACCESS & AVAILABILITY**
A.	***No Show/Call Back***
1.	✓ Process to evaluate and document No Shows and follow-up
B.	***Appointment System – Next available appointment per Health Plan standards***
1.	✓ Regular and routine care (Next Available Appointment_____)
2.	✓ Urgent Care (Walk in/Same day appointment)
C.	***After Hour Coverage***
1.	✓ Arrangement for after hour care – call group/answering service **or** available to take own calls and has process in place when practitioner on vacation
2.	✓ Patients advised of after hour care arrangements and how to contact
D.	***Waiting Time In Office***
1.	✓ Average wait time not to exceed 30 minutes
2.	✓ A process in place to acknowledge delays and offer patients an alternative (i.e. reschedule)
E.	***Telephone***
1.	✓ Telephone calls for appointments are triaged / screened by appropriate medical personnel P&P or process in place to determined Urgent or Routine
2.	✓ Policy **or** standards related to returning phone calls
F.	***Non-English Speaking Patients***
	✓ Interpreter service available or process in place
G.	***Hearing Impaired Patients***
	✓ TTY/TDD phone **or** service for the hearing impaired available **or** process in place

5.11 Medical Record Standards

HPN requires that practitioners maintain medical records in a manner that is current, detailed and organized. Practitioners must have a medical recordkeeping system, either hard copy or electronic, that allows for the collection, processing, maintenance, storage, retrieval and distribution of patient records. The medical records should facilitate communication, coordination, and continuity of care, and promote efficiency and effectiveness of treatment. HPN conducts clinical medical record reviews to assess the conformity with good professional medical practice and appropriate health management.

Clinical medical record reviews are conducted by a clinical professional. This UM Compliance Nurse Consultant reviewer works closely with the Vice President of Healthcare Quality and Education to make recommendations to the Credentialing Committee Chair and/or Credentialing Committee and to oversee corrective action plans with individual practitioners. If the reviewer identifies specific concerns relating to quality of care criteria, including records that are illegible by the reviewer, a copy of the record is forwarded to the Medical Director for peer review.

Medical record reviews are considered practitioner based. The medical record review is effective for the practitioner regardless of his/her site or location; if the practitioner practices at multiple sites, a review of medical records at only one site is required. HPN conducts a medical record review: annually on one or more of the following:

- Those practitioners whose files were identified as potentially problematic during the annual HEDIS medical record abstractions;
- A sample of high volume practitioners, based on impanelment;
- A sample of those practitioners who are identified as outliers on profiling reports;
- A sample of practitioners who were recently (within the past two years) added to the HPN Network; or
- Any practitioners deemed appropriate based on HPN's experience with their medical record documentation

HPN also conducts medical record reviews if feedback is received from another health plan department or staff that a problem may exist or if the site reviewer chooses to include a medical record review as part of a site visit that is being conducted mid cycle. The Credentialing Committee may, at its discretion, request that a medical record review be conducted at any time.

Results of the medical record review are considered at the time of the Chair's review or the Credentialing Committee's review and then communicated to the practitioner's office in a follow-up letter. A practitioner is placed on corrective action if the overall medical record score is less than 80%. The practitioner is advised of the areas of noncompliance and required to implement a corrective action plan and achieve a compliance score of at least 80% within 90 to 180 days. HPN monitors the corrective action plan and conducts a follow-up audit to assess compliance within the allotted timeframe. Results of corrective action monitoring are presented to the Credentialing Committee for approval or additional corrective action if performance standards are not met. The Credentialing Committee may, at its discretion, request additional medical record reviews be conducted after a specified time to assess continued compliance. If the practitioner fails to meet the established goals of the corrective action plan, further action may be taken by the Credentialing Committee, including loss of participatory status.

Confidentiality standards

- Medical records are treated as strictly confidential and protected from loss, tampering, alteration, destruction and unauthorized or inadvertent disclosure, except when otherwise required by law.
- Confidentiality is maintained at all times and records are secured in an area unavailable to persons not authorized to access medical records.
- Patients are assured confidential treatment of medical records and afforded the opportunity to approve or refuse the release of such information, except when release is required by law.
- Any individuals, other than those authorized, receive access to the medical record only upon written authorization by the patient, or when release is required by law.

Documentation standards

	ELEMENT	***STANDARD***
A.	***PATIENT DEMOGRAPHICS***	
1.	Each page of the medical record contains the patient's name or ID Number.	Patient name or ID number is required on each page of all documents reviewed during Plan-specific review period (i.e. either / or).
2.	Personal biographical data includes date of birth, address, home telephone numbers, marital status and emergency contact information. Guardian information to also be documented, if applicable. (**Note**: If Medicaid: age, race and sex also required.).	**Non-Medicaid**: Recommend all biographical data requested is documented, however, consistent documentation of 3 of 4 elements constitutes compliance. If not all requested biographical data is documented, recommendation to be included. **Medicaid**: In addition, requires documentation of age, sex and race (i.e. all or nothing for all three elements).
3.	Employer's name and work telephone number are included in patient's biographical data as applicable.	Documentation to Employer's name and work phone number is required in patient's biographical data.
B.	***CHART ORGANIZATION AND COMPLETENESS***	
1.	All entries in the medical record contain the author's identification, which may be a handwritten signature, unique electronic identifier or initials.	Each entry must be signed, including legible handwritten signature, unique electronic identifier or initials (i.e. must be one of the three). **Note**: Illegible signature or inability to identify author constitutes non-compliance.
2.	All entries are dated.	Each entry is to be dated (i.e. all or nothing).
3.	All documents are securely attached in the medical record with no loose papers.	All documents must be secured in the medical record. Unsecured paper in the file is not acceptable.
4.	Content and format of medical records are uniform including sequence of information.	Medical record documentation demonstrates consistent format used per office protocol by practitioner / staff.
5.	The record is legible to someone other than the writer. If the medical record is illegible, a copy of the record will be reviewed by the Plan Medical Director for determination.	All chart entries must be legible. Samples of illegible medical record documentation require review by the Plan Medical Director.

6.	Significant illnesses and medical conditions are indicated on the problem list, including current updates.	Documentation of presence **or** absence of significant illnesses and/or medical conditions is present **or** medical record documentation format used must clearly demonstrate a current problem list (i.e. Pediatric Well-Child, if applicable).
7.	Medication allergies and adverse reactions or the absence there of are consistently noted in the medical record.	Documentation of presence **or** absence of medication allergies, including adverse reactions, must be consistently, clearly documented in all medical records.
8.	Medication information is present, including prescribed medications, dosages, dates of initial prescription and refill prescriptions.	**Either** separate medication list is present or medical record documentation format used must clearly demonstrate a current medication list including dosages, dates of initial prescriptions and refill prescriptions.
9.	Encounter forms or notes have a notation regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed.	Documentation for each visit must include applicable follow-up plan.
10.	For competent patients 18 and older, there is documentation of advance directives or evidence the member has elected not to execute. If not executed, there is evidence that information was offered.	Medical record documentation must clearly demonstrate **either** the patient has **or** does not have advanced directives. **If yes**: Copy of advanced directive should be requested from the patient for placement in the medical record. **If no**: Requires documentation advanced directive information was offered.
C.	***PATIENT HISTORY/PHYSICAL STUDIES***	
1.	For patient's seen three or more times, past medical history is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.	**Either** separate history/physical is present **or** medical record documentation format used must clearly demonstrate a current history/physical
2.	For patients 12 and older, there is appropriate notation assessing the use of cigarettes, alcohol and/or other substances. If yes, there is also evidence of education.	Query (2 Pts): Requires documentation of use/no use indication. Education (2 Pts): If yes to query, requires documentation of education / counseling provided.
3.	The history and physical examination identifies appropriate subjective and objective information pertinent to a patient's presenting complaints.	Medical record documentation format used must clearly demonstrate appropriate subjective and objective information pertinent to patient's presenting complaint.
4.	Laboratory and other studies are ordered, as appropriate.	Laboratory and other studies are documented and appropriate to diagnosis and/or presenting complaint.
5.	Working diagnoses are consistent with findings.	Working diagnoses are documented and consistent with clinical findings.
6.	There is evidence of appropriate referral to consultants, as indicated.	There is evidence of appropriate referral to consultants, as indicated.

7.	Consultation, laboratory and imaging reports filed in the chart are initialed by the practitioner to signify review. If the reports are presented electronically or by some other method, there is representation of review by the ordering practitioner.	Medical record documentation demonstrates applicable reports are initialed by group or practitioner.
8.	Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.	Medical record documentation format demonstrates follow-up plan of abnormal reports or is addressed in SOAP notes.
D.	***TREATMENT PLAN***	
1.	Treatment plans are consistent with diagnoses.	Treatment plans are documented and consistent with diagnoses.
2.	Unresolved problems from previous office visits are addressed in subsequent visits.	Unresolved problems from previous office visits, as defined by Plan-specific review period, are addressed in subsequent visits.
3.	Documentation evidencing continuity and coordination of care is present for all aspects of care including ancillary services, consultations, diagnostic tests, therapeutic services and/or institutional services (i.e. emergency care documentation, hospital discharge summary, ambulatory surgery centers, home health, etc.) including practitioner follow-up plan, as appropriate.	Medical record demonstrates evidence of appropriate continuity and coordination of care present for all aspects of care, including appropriate follow-up plan, as applicable (i.e. ER report, operative report, phone consultation, hospital discharge summaries from all hospitalizations while a member of the health plan and prior admissions as necessary.
4.	There is no evidence the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure (i.e. unnecessary procedures, inappropriate procedures, etc.).	There is no evidence the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure (i.e. unnecessary procedures, inappropriate procedures, etc.).
5.	Documentation of patient education regarding diagnosis, treatment and medications, including risk factors.	Medical record documentation includes patient education provided.
E.	***PREVENTIVE MEASURES***	
1a.	Childhood/Adolescent Immunizations: An immunization record is up to date, including specific vaccines administered, and an appropriate history is presented in the medical record. **OR**	Medical record documentation includes a current immunization record or documentation of specific immunizations given, including dates per CDC recommendations (i.e. “immunizations up to date” reference is not adequate).
1b.	Adult Immunizations: An appropriate immunization history is documented in the medical record and age-specific immunizations are current.	Medical record documentation includes an appropriate immunization history as indicated by CDC immunization schedule (i.e. influenza, tetanus, high-risk members, etc.).
2.	There is evidence that preventive screenings and services are offered in accordance with the Plan’s preventative health guidelines.	Medical record documentation demonstrates evidence of preventative screenings and services provided, as defined by Plan-specific preventative health guidelines.

Systems of organization standards

- There is a unique identification of each patient’s medical record.
- Confidentiality, security and physical safety of medical records are maintained.
- There is timely retrieval of individual records upon request.

- There is supervision of the collection, processing, maintenance, storage, retrieval and distribution of medical records.
- Reports, histories and physicals, progress notes and other patient information (such as laboratory reports, x-ray readings, operative reports, anesthesia records, and consultations) are reviewed and incorporated into the record in a timely manner.
- When necessary to promote the continuity of care, summaries or records of a patient who was treated elsewhere (such as by another practitioner, hospital or ambulatory surgical service) are obtained.
- When necessary to promote continuity of care, summaries of the patient's records are transferred to the health care provider to whom the patient was transferred and, if appropriate, to the organization where future care will be rendered.
- Medical records are not removed from the location where care is provided, except by written policy.
- If medical records are carried from one location to another, a tracking mechanism is developed so chart location is known at all times.
- A systematic method for medical record filing and easy access is maintained.
- There is a policy in place that describes where records will be stored if the office practice is closed.

Availability standards

- Medical records are available (or information pertinent to the provision of care provided to the member is available) to authorized medical health care providers at the time of member visits.
- Medical records are available to HPN in accordance with provider contracting to allow for auditing related to quality assurance, quality improvement, utilization management and recredentialing.
- Medical records shall be available for review by duly authorized representatives of regulatory agencies in accordance with HIPAA regulations.

5.12 HEALTH STATUS FORM

I, _____, the undersigned, do hereby attest that I have been clean and sober since _____. I further attest I am currently

☐ in compliance with, OR

☐ have completed

all requirements pertaining to any fines, sanctions, monitoring, continuing education or other agreements placed upon my professional license as a result of my addiction/actions.

Organization: _____

Contact: _____

Phone: _____

Address: _____

_____

(A current, signed "Authorization and Release of Information Form" is required from the provider allowing SHS to contact the organization listed above.)

_____ _____

Provider Signature Date

5.13 Appointment of Credentialing Agent

I hereby consent and agree to the disclosure, copying, and transmission of information and documents related to my credentials, qualifications, conduct and performance by and between my credentialing agent (named below) and Sierra Health Services Credentialing Department. This exchange of information will be for the purpose of any credentialing/re-credentialing applications or mid-cycle credentialing evaluation regarding my professional training, experience, character, conduct, judgment, ethics, ability to work with others, health issues, sanctions or loss of licensure, or other items needed to complete my credentialing application process.

I am informed and acknowledge that federal and state laws provide certain immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of health care providers. I hereby release all persons and entities from any liability they might incur for their acts and/or communications in connection with the evaluation of my qualifications for employment or credentialing to the extent that those acts and/or communications are protected by law.

A photocopy of this document will serve as the original.

I hereby authorize

Agent: _____

Company Name: _____

Contact number: _____

Fax number: _____

E Mail Address: _____

To act as my agent in all matters related to credentialing until I revoke this authorization in writing.

Print Name_____

Practitioner Signature _____

Date: _____

For answers to credentialing questions please call (702) 242-7559