ICE Shared Credentialing Audit Program & Oversight of NCQA Standards & Other Regulations

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AGENDA

- Introduction
- Overview of ICE Program
- Review of NCQA/CMS/DMHC/DHCS Standards & Regulations
- Updates & FYIs
- Q & A

Introduction

- Antitrust Statement
- ICE Purpose Statement
- Introduction of Presenters
- Get to Know the Audience!

ICE Credentialing Shared Audit Program

ICE Credentialing Shared Audit Policy Team

- Background
- Main Objective & Goals
- Overview
- Reporting Workgroups or Teams
  - Clarification Workgroup
  - Scheduling Team

NCQA Standards and Other Regulations

CR 1: Credentialing Policies

The organization has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members.

Element A: Practitioner Credentialing Guidelines

The organization's credentialing policies and procedures specify:

1. **Types of practitioners to credential and recredential**
   - Practitioners who need to be credentialed are those who have an independent relationship* with an organization, which exists when the organization selects and directs members to see a specific practitioner or group of practitioners.

     * *"Independent relationship is not synonymous with <u>independent contract</u>."*
   - Practitioners who see members outside the inpatient hospital setting or outside free-standing ambulatory facilities.

CR 1: Credentialing Policies, cont.

- Practitioners who are hospital based and see members as a result of their independent relationship with the organization.
- Dentists who provide care under medical benefits.
- Non physician practitioners who have an independent relationship with the organization and provide care under medical benefits.

2. **Verification sources used**
   - The organization must describe the sources it uses to verify credentialing information. Verification of credentialing information must come directly from: The primary source the entity that originally issued the credential or a contracted agent of the primary source.
   - If one type of verification source is missing, then this factor is non-compliant (license, DEA, education/training, board certification, work history, malpractice claim history, state sanctions, restrictions on licensure, limitations on scope of practice, Medicare/Medicaid sanctions or malpractice coverage).

CR 1: Credentialing Policies, cont.

3. **Criteria for credentialing and recredentialing**
4. **The process for making credentialing and recredentialing decisions**
   - The organization's policies must explicitly define the process used and the criteria required to reach a credentialing decision.
   - The criteria must be designed to assess a practitioner's ability to deliver care based on information collected and verified prior to the credentialing decision. NCQA requires an organization to assess the ability to deliver care based on the credentialing information collected and verified prior to making a credentialing decision.

CR 1: Credentialing Policies, cont.

5. **The process for managing credentialing files that meet the organization's established criteria**
   - At a minimum, the Credentialing Committee must receive and review the credentials of practitioners who *do not* meet the organization's established criteria.
   - The organization's policies and procedures must describe the process used to determine and approve "clean files." Policies must identify a medical director as the individual with the authority to determine that a file is "clean" and to sign off on it as complete, clean and approved. If the organization identifies an equally qualified practitioner to review clean files, the practitioner must be responsible for oversight of the credentialing process.
     - If the Medical Director signs off on clean files, the sign-off date is the committee/approval date.
     - If the Physician Organization (PO) decides not to use the Medical Director signoff process, it can send "clean files" to the Credentialing Committee for review and decision-making.

CR 1: Credentialing Policies, cont.

6. **The process to delegate credentialing or recredentialing**

    - Policies must describe the process used to delegate (i.e., “what” and “how”).
    - If the organization does not delegate, the credentialing policies and procedures must state that the organization does not delegate credentialing activities to receive full credit.
    - This element cannot be scored as not applicable.

CR 1: Credentialing Policies, cont.

- **The process for ensuring that credentialing and recredentialing are conducted in a nondiscriminatory manner**
  - The organization’s procedures for monitoring and preventing discriminatory credentialing decisions may include, but are not limited to: Periodic audits of practitioner complaints to determine if there are complaints alleging discrimination; maintaining a heterogeneous Credentialing Committee membership and requiring those responsible for credentialing decisions to sign an affirmative statement to make decisions in a nondiscriminatory manner.
  - The above information is intended to provide examples of how to ensure the nondiscriminatory credentialing process. NCQA will be looking for a description in the credentialing policies and procedures of how the organization ensures credentialing and recredentialing are conducted in a nondiscriminatory manner.

CR 1: Credentialing Policies, cont.

8. The process for notifying a practitioner if information obtained during the organization's credentialing process varies substantially from the information provided to the organization by the practitioner.

9. The process for ensuring that practitioners are notified of the credentialing decision within 60 calendar days of the committee's decision.

CR 1: Credentialing Policies, cont.

10. **The medical director or other designated physician's direct responsibility and participation in the credentialing program**
    - The organization must have a physician who has overall responsibility for the credentialing process. Policies and procedures must clearly indicate the physician directly responsible for the credentialing program and must include a description of his/her participation.

11. **The process used to ensure the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law**
    - The organization must describe the mechanisms in effect to ensure confidentiality of information collected. The organization must ensure that information obtained is kept confidential and that practitioners can access their own credentialing information, as outlined in Element 'B' of this standard.

12. ***Health Plans/POs are not audited on CR 1.12 – PHI Information***

CR 1: Credentialing Policies, cont.

Element B: Practitioner Rights

The organization's policies and procedures include the following practitioner rights:

1. **The right of practitioners to review information submitted to support their credentialing application**
2. **The right of practitioners to correct erroneous information (submitted by another source)**
   - Policy must clearly state:
     - The time frame for changes
     - The format for submitting corrections
     - The person to whom corrections must be submitted
     - The documentation of receipt of the corrections
     - How practitioners are notified of their right to correct erroneous information
3. **The right of practitioners to be informed of the status of their credentialing or recredentialing application upon request**
4. **Notification of these rights**

CR 1: Credentialing Policies, cont.

License Renewal Verification (DMHC)

The credentialing policy and procedures outline the process of the organization to primary source verify license renewal at the time of expiration of license between credentialing cycles. (Source: DMHC Tag 6/05).

- This process must occur within 30 calendar days of the license expiration date.
- Audited for HMO & PPO products.

CR 2: Credentialing Committee

The organization designates a credentialing committee that uses a peer – review process to make recommendations regarding credentialing decisions.

Element A: Credentialing Committee

The Credentialing Committee includes representation from a range of participating practitioners.

- For PPO only organizations, the committee should include representation from two of the following key specialties:
  - Family practice, pediatrics, general and internal medicine, OB/GYN, and other high volume specialty (i.e. cardiology, neurology)

CR 2: Credentialing Committee, cont.

Element B: Credentialing Committee Decisions

The organization provides evidence of:

1. **Credentialing Committee review of credentials for practitioners who *do not* meet established thresholds**
2. **Medical director or equally qualified individual review and approval of clean files**
   - The organization may choose to continue to submit all practitioner files to the Credentialing Committee for review, or it may implement a process for the medical director to review clean files, as described in the credentialing policies and procedures.
   - If the medical director reviews the clean files, there must be evidence of the designated medical director's or equally qualified practitioner's review and sign-off on a list of the names of all practitioners who meet the established criteria.
   - Ad-hoc Credentialing Committee meeting minutes must be documented at the time of the ad-hoc meeting.

CR 3 Initial Credentialing Verification

The organization verifies credentialing information through primary sources, unless otherwise indicated.

<u>Licensure Verification</u>
The organization verifies that a current, valid license to practice is present and within the prescribed time limits.

*Verification Time Limit – 180 calendar days

CR 3 Initial Credentialing Verification cont.

- **Department of Consumer Affairs (DCA) website: The DCA website is the public MBC website. The 805 information is not available on this website, therefore if the Provider Organization uses this public site they must conduct PSV using the NPDB in order to obtain 805 sanction information. The HIPDB will not be accepted without the NPDB).**

- **Administrators in Medicine (AIM) website: If the AIM website is used, the Organization must obtain at least once, written confirmation from the Medical Board of California (MBC) attesting to the accuracy of the “primary source” data provided by AIM.)**

CR 3 Initial Credentialing Verification cont.

Element B: Initial Primary Source Verification

The organization verifies that the following factors are present and within the prescribed time limits:

1. **A valid DEA or CDS certificate, if applicable**

Verification Time Limit – None. The certificate must be effective at the time of the credentialing decision.

- The Organization may credential a practitioner whose DEA certificate is pending if the organization has a documented process for allowing a practitioner with a valid DEA certificate to write all prescriptions requiring a DEA number for the prescribing practitioner until the practitioner has a valid DEA certificate

CR 3 Initial Credentialing Verification cont.

2. **Education and training including board certification, if the practitioner states on the application that he or she is board certified**

   Verification Time Limit – education/training: None.

   Verification Time Limit – Board Certification: 180 calendar days (Effective for files approved after 7/07)

   - If an Organization uses an AMA report, the report must state that the education/training/board certification has been "verified". "Being verified" or "being re-verified" is non-compliant.
   - If a practitioner is board certified, current board certification must be verified.
   - Expiration date of the board certification must be documented in the credentialing file.
   - If practitioner has a lifetime certification status, verification of lifetime status must be documented in the credentialing file.
   - ABMS Compendium: The ABMS Compendium is no longer acceptable for primary source verification for board certification.

CR 3 Initial Credentialing Verification cont.

3. **Work history**

   Verification Time Limit – 180 calendar days

   - NCQA changed the time limit verification to 365 in November, 2005; however, due to other California regulators (e.g., CMS, DMHC, etc.), it has been decided to continue to require the 180 calendar day time frame.
   - work history must include the beginning and ending month and year for each work experience.
   - If a practitioner has had continuous employment for five years or more, then there is no gap. In this case, there is no need to provide the month and year; providing the year meets the intent.

4. **A history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner.**

   Verification Time Limit – 180 calendar days

CR 3 Initial Credentialing Verification cont.

Hospital Admitting Privileges (CMS/DMHC/DHCS)

Physicians must indicate their current hospital affiliation or admitting privileges at participating hospitals. (Source: Medicare Managed Care Manual, Chapter 6, section 60.3., DMHC Tag 6/05, MMCD Policy Letter 02-03)

- This will be applicable for all products.
- If a health care professional does have admitting privileges she/he lists the current status and type of admitting privileges.
- Practitioners (in the appropriate specialties) must have a formal inpatient coverage arrangement. If the practitioner does not have clinical privileges, the Organization must have a written statement delineating the inpatient coverage arrangement.
- Data Source: Application, Curriculum Vitae, Hospital Listing.

CR 3 Initial Credentialing Verification cont.

Licensure Renewal Verification (DMHC)

Pursuant to Title 16 of the California Code of Regulations, License Renewals are verified at the time of expiration. (Source: DMHC Tag 6/05)

- Not applicable if license has not expired and if no initial credentialing was performed during the audit period. This standard must be scored.
- Copy of license is not acceptable.
- The Organization must verify and document that all practitioner's licenses are valid and current at all times by using Primary Source Verification (i.e.. Department of Consumer Affairs (DCA)-public website).
- License verification can be conducted up to one month after the license expires. Use print date, not stamped date to determine date of verification.

CR 4 Application & Attestation

Practitioners complete an application for network participation that includes a current and signed attestation regarding his or her health status and any history of loss or limitations of licensure or privileges.

Element A: Contents of the Application

The application includes a current and signed attestation and addresses:

1. Reasons for any inability to perform the essential functions of the position, with or without accommodation
2. Lack of present illegal drug use
3. History of loss of license and felony convictions
4. History of loss or limitation of privileges or disciplinary activity
5. Current malpractice insurance coverage
6. The correctness and completeness of the application

CR 4 Application & Attestation cont.

Verification Time Limit: 180 calendar days

- NCQA changed the time limit verification to 365 days in November, 2005; however, due to other California regulators (e.g., CMS, DMHC, etc.) the ICE Policy Committee has decided to continue to require the 180 calendar day time frame.
- The 180-day time frame is based on the date the practitioner signed the application.
- Malpractice Coverage can be obtained by either the question on the attestation or a copy of the Certificate of Insurance (COI) /Insurance face sheet.

CR 5 Initial Sanction Information

The organization receives information on practitioner sanctions before making a credentialing decision.

Element A: Sanctions Information

The organization verifies the following sanction information for initial credentialing:

1. State sanctions, restrictions on licensure and/or limitations on scope of practice
2. Medicare and Medicaid sanctions

Verification Time Limit: 180 calendar days

- As of 12/13/05, NCQA accepts the Healthcare Integrity and Protection Databank (HIPDB)

CR 6 Initial Credentialing Site Visits

The organization has a process to ensure that the offices of all primary care practitioners, OB/GYNs, and high – volume behavioral health care practitioners meet its office – site standards.

Element A: Performance Standards and Thresholds

The organization:

1. Sets standards and performance thresholds for office site criteria
2. Sets standards performance thresholds for medical /treatment record-keeping criteria

CR 6 Initial Credentialing Site Visits cont.

Site Visit and Medical/Treatment Record Keeping requirements:

- Elements included for medical/treatment record keeping practice:
  - Documentation Practices
  - Forms and methods for consistency (orderliness)
  - Confidentiality
- Organization must have separate standards and thresholds for medical record keeping practices and office site-visit criteria.
- A combined overall score for office site criteria and medical/treatment record is acceptable.

CR 6 Initial Credentialing Site Visits cont.

Element B: Site Visit and Medical Record-Keeping

For PCPs, OB/GYNs and potential high-volume behavioral health specialists, the organization conducts:

1. **An initial site visit**

2. **An initial evaluation of medical/treatment record-keeping practices at each site**
   - The Organization is eligible to receive automatic credit during file review for practitioners that are recognized by NCQA's Physician Practice Connections Program. NCQA review the practitioners Recognition Letter as evidence.

CR 6 Initial Credentialing Site Visits cont.

- If a practitioner's office is located in an accredited facility, the Organization may accept a survey report rather than conduct a site visit. The survey report must show that the survey:
  - included the practitioner's office
  - meets the organization's quality assessment criteria
- Using a survey report in lieu of a site visit for an accredited facility is not delegation and NCQA does not require oversight.
- Evidence of site review is required. Providing a numeric score is not acceptable.   However, for Medi-Cal Health Plan Collaborative & Cal Optima site reviews, summary of findings indicating score, CAP information and site audit location will be sufficient documentation.

CR 6 Initial Credentialing Site Visits cont.

Element C: Follow-Up for Initial Site Visits

The organization implements ongoing monitoring and takes appropriate interventions by:

1. **instituting actions for improving PCP's, OB/GYN's and High-volume behavioral health sites that do not meet the thresholds**
   - For site visits that did not meet the thresholds during the initial site visit.
2. **evaluating the effectiveness of the actions at least every six months, until deficient sites meet the thresholds**
   - If a deficiency is found in an initial site visit, a follow-up visit must occur within 6 months.

CR 6 Initial Credentialing Site Visits cont.

3. **Monitoring all PCP's, OB/GYN's and high-volume behavioral health sites for any deficiencies subsequent to the initial site visit at least every six months**
   - The organization must have a process for detecting deficiencies after the initial site visit. The process must include monitoring of member complaints and other data, if available, every six months. (This factor is always applicable, except for PPO only audits)
   - This information may be found in the Quality Committee minutes or QI/QA department.
4. **Documenting follow-up visits for sites that had subsequent deficiencies, if applicable.**
   - This factor pertains to factor 3.