



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

## **Presenters:**

- **Angela Ross** – Aetna Health of California Inc.
- **Kywana Stevenson** – EPIC Management, L.P.
- **Kris Simmons** – Health Net, Inc.



# CR 7: Recredentialing Verification

**The organization formally recredentials its practitioners through information verified from primary sources, unless otherwise indicated.**

## **Element A: Licensure Verification**

**The organization verifies that a current, valid license to practice is present and within the prescribed time limits.**

## **Element B: Recredentialing Verification**

**The organization verifies the following factors within the prescribed time limits:**

- 1. A valid DEA or CDS certificate, as applicable**
- 2. Board certification, as specified**

Verification Time Limit – Board certification: 180 calendar days (Eff. 7/07)

- If a practitioner is board certified, current board certification must be verified. The expiration date must be documented in the file.



## CR 7: Recredentialing Verification, cont.

### Board certification scenarios:

- During initial credentialing the practitioner is board certified. Board certification expires prior to recredentialing and the practitioner does not renew his/her board certification. PSV is not required.
- During initial credentialing the practitioner is board certified. Board certification expires prior to recredentialing and the practitioner renews board certification. PSV is required. Organization must re-verify board certification with the appropriate primary source. If not, this is considered non-compliant.
- During initial credentialing the practitioner is board certified. The board certification does not expire prior to recredentialing. PSV is required and this practitioner is counted as compliant and applicable for this factor.
- If practitioner has a lifetime certification status, verification of lifetime status must be documented in the credentialing file. PSV is not required, and this practitioner is counted as compliant for this factor.



## **CR 7: Recredentialing Verification, cont.**

- 3. History of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner.**



# **CR 7: Recredentialing Verification, cont.**

## **Element C: 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 action**
- 5. Current malpractice insurance coverage**
- 6. Correctness and completeness of the application**



## CR 7: Recredentialing Verification, cont.

Verification Time Limit – 180 calendar days

- NCQA changed the time limit verification from 180 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.
- NCQA does not require a date stamp on the recredentialing application.
- 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.
- If the attestation is not signed, all application elements are non-compliant (except current malpractice coverage and DE/CDS if a copy of the document is obtained.)



## **CR 7: Recredentialing Verification, cont.**

### **Element D: Sanction Information**

**The organization verifies the following sanction information for recredentialing:**

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



## **CR 7: Recredentialing 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 6/05)**

- 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 provider organization must have a written statement delineating the inpatient coverage arrangement.
- Primary source verification is not required.
- Data Source: Reappointment application, current curriculum vitae or current hospital listing.



# CR 7: Recredentialing 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.**

- The organization must verify and document that all 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.
- For recredentialing, if the license has not expired since the current recredentialing process, then look back at one previous license renewal to score this element.

- Examples:

1. Recredentialed in 2005. License expired in 2006 on 10/31/06. Re-verification needs to be conducted within 30 days after the expiration date (Before 11/30/06)
  
1. Recredentialed in 2007. License has not expired since recredentialing. Review previous cycle (2005) and see if license was re-verified.



# CR 7: Recredentialing Verification, cont.

## **Quality of Care Issues (CMS/DHCS)**

**(Source: Medicare Managed Care Manual, Chapter 6, section 60.3. and MMCD Policy Letter 02-03)**

**The organization's recredentialing information considers Performance Indicators. Performance indicators include:**

- 1. Quality activities (e.g., utilization management system, enrollee satisfaction surveys, other activities of the organization)**
- 2. Grievance/complaints**
  - This indicator is relevant for all practitioners (e.g., PCPs, SCPs, etc).
  - Not all quality activities need to be present to be compliant.
  - Other activities may consist of medical record site review, medical record review and/or access studies.



# CR 8: Recredentialing Cycle Length

**The organization formally recredentials its practitioners at least every 36 months**

## **Element A: Recredentialing Cycle Length**

**The length of the recredentialing cycle is within the required 36 month time frame.**

- An organization that determined that there was a system-wide problem with its initial credentialing process, and as a result implemented corrective action through early recredentialing, may present evidence of such actions to NCQA during the onsite survey.
- NCQA notes such actions during its assessment of provider organization credentialing files and may recommend a higher performance score than file review results would otherwise indicate. NCQA does not give the organization a performance designation higher than 80%.



# CR 9: Ongoing Monitoring

**The organization develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality.**

## **Element A: Ongoing Monitoring and Interventions**

**The organization implements ongoing monitoring and takes appropriate interventions by:**

- 1. Collecting and reviewing Medicare and Medicaid sanctions**
  - Possible Sources: NPDB, HIPDB, FSMB, OIG List of Excluded Individuals and Entities (LEIE), Medicare and Medicaid Sanctions and Reinstatement Report, FEHB Program department record, and/or AMA Physician Master File
- 2. Collecting and reviewing sanctions or limitations on licensure**
  - Organization is responsible for reviewing information within 30 calendar days of its release.
  - Need to collect for all types of practitioners within the scope of the credentialing program. (MD, DO, behavioral health, etc.)



# CR 9: Ongoing Monitoring, cont.

## 3. Collecting and reviewing complaints

- The organization must have mechanisms in place to investigate practitioner specific complaints from members upon receipt. The organization must evaluate both the specific complaint and the practitioner's history of issues if applicable. This factor requires evidence and evaluation of the history of complaints for all practitioners at least every six months.

## 4. Collecting and reviewing information from identified adverse events

- An adverse event is an injury that occurs while a member is receiving healthcare services from a practitioner.
- The organization must monitor at least every six months.



## CR 9: Ongoing Monitoring, cont.

- To assess implementation and compliance, NCQA reviews documentation of how the organization collects and reviews information on sanctions, complaints and adverse events.
- 5. Implementing appropriate interventions when it identifies instances of poor quality, when appropriate**
- Factor 5 is not applicable if there are no sanction/complaints or adverse events identified between recredentialing cycles.



## **CR 9: Ongoing Monitoring, cont.**

### **Monitoring Medicare Opt-Out Report (CMS)**

**The organization maintains a documented process for monitoring whether network physicians have opted out of participating in the Medicare program. (Source: Medicare Managed Care Manual, Chapter 6, 60.2)**

- Opt-Out Reports are distributed on a quarterly basis and must be monitored/checked within 30 days of report date.



# **CR 10: Notification to Authorities and Practitioner Appeal Rights**

**An organization that has taken actions against a practitioner for quality reasons reports the action to the appropriate authorities and offers the practitioner a formal appeal process.**

## **Element A: Actions Against Practitioners**

**The organization has policies and procedures for:**

- 1. The range of actions available to the organization**
- 2. Reporting to authorities**
- 3. A well-defined appeal process**
- 4. Making the appeal process known to practitioners**



## CR 10: Notification to Authorities and Practitioner Appeal Rights, cont.

- The organization's policies and procedures must give practitioners the right to appeal and must include the following steps within the appeal process. (Note: If any of the following six steps are missing, factor 4 is non-compliant.)
  - Provide written notification indicating that a professional review action has been brought against the practitioner, reasons for the action and a summary of the appeal rights and process.
  - Allow the practitioner to request a hearing and the specific time period for submitting the request.
  - Allow at least 30 calendar days after the notification for the practitioner to request a hearing.



## CR 10: Notification to Authorities and Practitioner Appeal Rights, cont.

- Allow the practitioner to be represented by an attorney or another person of the practitioner's choice
  - A practitioner has a right to an attorney. An organization cannot have an attorney if the practitioner does not have attorney representation. [Business & Professions Code 809.3(c)]
  - Policy cannot state that it is at the discretion of the chairperson for attorney representation.
- Appoint a hearing officer or a panel of individuals appointed by the organization to review the appeal.
- Provide written notification of the appeal decision that contains the specific reasons for the decision.



## **CR 10: Notification to Authorities and Practitioner Appeal Rights, cont.**

### **Element B: Reporting to Appropriate Authorities**

**There is documentation that the organization reports practitioner suspension or termination to the appropriate authorities.**



# **CR 10: Notification to Authorities and Practitioner Appeal Rights cont.**

## **Element C: Practitioner Appeal Process**

**The organization has an appeal process for instances in which it chooses to alter the conditions of a practitioners' participation based on issues of quality of care or service. The organization informs practitioners of the appeal process.**

- The organization must provide evidence that it followed its appeal process if it altered the conditions of practitioners' participation. The appeal process must cover the following criteria (Note: all factors below must be present for full compliance):
  - Provide written notification indicating that a professional review action has been brought against the practitioner, reasons for the action and a summary of the appeal rights and process.
  - Allow the practitioner to request a hearing and the specific time period for submitting the request.



## **CR 10: Notification to Authorities and Practitioner Appeal Rights, cont.**

- Allow at least 30 days after the notification for the practitioner to request a hearing.
- Allow the practitioner to be represented by an attorney or another person of the practitioner's choice.
- Appoint a hearing officer or a panel of individuals appointed by the organization to review the appeal.
- Provide written notification of the appeal decision that contains the specific reasons for the decision.



# CR 10: Notification to Authorities and Practitioner Appeal Rights, cont.

## **Medicare Advantage Policies and Procedures (CMS)**

The Medicare Advantage organization's policies and procedures regarding suspension or termination of a participating physician require the organization to:

**Provide that the majority of the hearing panel members are peers of the affected physician. (Source: Medicare Manage Care Manual, Chapter 6, 60.4)**

- A peer is an appropriately trained and licensed physician in a practice similar to the affected physician. Panel members do not have to possess identical specialty training.
- Policies and procedures do not always have to state the word "majority", but at least 51% of the members must be peers.



# CR 11 Assessment of Organizational Providers

**The organization has written policies and procedures for the initial and ongoing assessment of providers with which it intends to contract.**

## **Element A: Review and Approval of Provider**

**The organization's policy for assessing of health care delivery providers specifies that it:**

- 1. Confirms that the provider is in good standing with state and federal regulatory bodies**
  - The federal portion of this factor must show the Organization's policy for querying an approved source such as the OIG exclusions database to ascertain whether the provider has been excluded from participation in Medicare, Medicaid and all Federal health care programs.
- 2. Confirms that the provider has been reviewed and approved by an accrediting body**



# **CR 11 Assessment of Organizational Providers cont.**

- 3. Conducts an on-site quality assessment, if there is no accreditation status**
  
- 4. Confirms, at least every 3 years, that the provider continues to be in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body.**



# CR 11 Assessment of Organizational Providers cont.

## Element B: Medical Providers

The organization includes at least the following medical providers:

1. hospitals
  2. home health agencies
  3. skilled nursing facilities
  4. free-standing surgical centers
- Per NCQA on 2/8/05, if an Organization does not contract with a specific type of facility (e.g., skilled nursing facilities), the Organization must state so in the policy and procedure; however, if the policies and procedures state “all medical facilities, as applicable”, this will be compliant.



# CR 11 Assessment of Organizational Providers cont.

## Element C: Mental Health and Substance Abuse

The organization includes behavioral health facilities providing mental health or substance abuse services in the following settings:

1. inpatient
2. residential
3. ambulatory
  - If the Organization has “carved out” mental health, this is not applicable.
  - Policies must address each facility (inpatient, residential, ambulatory) whether contracted or not contracted.
  - Organization will not be compliant if their policies and procedures state “all behavioral facilities, as applicable.”



# **CR 11 Assessment of Organizational Providers cont.**

## **Element D: Assessing Medical Providers**

**The organization has documentation of assessment of contracted medical health care delivery providers.**

## **Element E: Assessing Behavioral Health Providers**

**The organization has documentation of assessment of contracted behavioral health care delivery providers.**



# CR 11 Assessment of Organizational Providers cont.

## Provider Organization Random File Audit Tool

PO NAME: \_\_\_\_\_

DATE OF AUDIT: \_\_\_\_\_

CONDUCTED BY: \_\_\_\_\_

Facility Name	Facility Type	Prior Validation Date/ License Status	Current Validation Date/ License Status	Prior Accreditation Validation Date/Body/ Status	Current Accreditation Validation Date/Body/ Status	Medicare Cert #	Prior Review Date- Medicare & Medicaid Sanctions Report	Current Review Date- Medicare & Medicaid Sanctions Report	Prior Site Visit Date/ Status	Current Site Visit Date/ Status
Exp1	Home Health	4/1/04, Active	4/5/07, Active	4/10/04, TJC, Active	4/15/07, TJC, Active	N/A	4/1/04	4/5/07	N/A	N/A
Exp2	SNF	3/1/04	3/5/07	N/A	N/A	N/A	3/1/04	3/5/07	2/5/04, DHCS Compliant	2/7/07, DHCS, Compliant



# CR 11 Assessment of Organizational Providers cont.

## Element D & E:

- Use Spreadsheet tracking grid to score Element D & E.
- All elements in grid are required by NCQA.
- Committee Approval is not required if grid is complete.



# HDO Accrediting Agencies

## Hospitals

- The Joint Commission (TJC)
- American Osteopathic Association (AOA)

## Home Health Agencies

- The Joint Commission (TJC)
- Community Health Accreditation Program (CHAP)



# HDO Accrediting Agencies

## Skilled Nursing Facilities

- The Joint Commission (TJC)
- Commission on Accreditation or Rehabilitation Facilities (CARF)
- Continuing Care Accreditation Commission (CCAC)

## Free-Standing Surgical Centers

- The Joint Commission (TJC)
- American Association for Accreditation of Ambulatory Surgical Facilities (AAASF)
- Accreditation Association for Ambulatory Health Care (AAAHC)

## Behavioral Health Providers

- The Joint Commission (TJC)
- Commission on Accreditation or Rehabilitation Facilities (CARF)



# CR 11 Assessment of Organizational Providers cont.

Verification is conducted on all medical providers and behavioral health providers prior to completion of the credentialing process and on-going Every three (3) years.

**The Provider Organizations verifies the following:**

**Confirms that the provider is in good standing with state and federal regulatory bodies**

- **State regulatory bodies**

- State – license number and expiration date
- OPM (EPLS) Exclusion Report (<http://www.epls.gov/FAQEPLS.html>)

- **Federal regulatory bodies**

- OIG Report – The monthly review of the OIG report as part of the “Ongoing Monitoring” qualifies as compliant for this section as long as the facilities are included on the OIG Report. The facilities are located at the top of the report.
- If Medicare and Medicaid are not reviewed, this will be scored non-compliant for Federal Regulatory bodies, as applicable.
- See Exhibit B on how to pull the OIG report.



# CR 11 Assessment of Organizational Providers cont.

Confirmation that the organizational provider has been reviewed and approved by an accrediting body. (Organization must specify in its P&Ps which accrediting bodies it recognizes and accepts for the different types of organizational providers.)

- **The Joint Commission (TJC)**
  - accreditation report or a letter from the regulatory and accrediting bodies regarding the status of the provider
  - website: <http://www.jointcommission.org>
- **American Osteopathic Association (AOA)**
  - accreditation report or a letter from the regulatory and accrediting bodies regarding the status of the provider
- **Community Health Accreditation Program (CHAP)**
  - accreditation report or a letter from the regulatory and accrediting bodies regarding the status of the provider
  - website: <http://www.chapinc.org>



# CR 11 Assessment of Organizational Providers cont.

- **Commission on Accreditation or Rehabilitation Facilities (CARF)**
  - accreditation report or a letter from the regulatory and accrediting bodies regarding the status of the provider
  - website: <http://www.carf.org>
- **Continuing Care Accreditation Commission (CCAC) (this is part of CARF)**
  - accreditation report or a letter from the regulatory and accrediting bodies regarding the status of the provider
  - website: <http://www.carf.org>
- **Accreditation Association for Ambulatory Health Care (AAAHHC)**
  - accreditation report or a letter from the regulatory and accrediting bodies regarding the status of the provider
  - website: <http://www.aaahc.org> American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF)
  - accreditation report or a letter from the regulatory and accrediting bodies regarding the status of the provider
  - website: <http://www.aaaasf.org>



# CR 11 Assessment of Organizational Providers cont.

## Conducts an on-site quality assessment, if there is no accreditation status

- If an organizational provider is not accredited, the Organization develops and implements standards of participation, including conducting a site visit. The exception to this is free standing surgery centers. Free standing surgery centers must either be accredited or Medicare certified.
- CMS or state review or certification does not serve as accreditation of an institution; however, in the case of non-accredited institutions, the organization may substitute a CMS or state review in lieu of the required site visit. However, a letter from CMS which shows that the facility was reviewed and indicates that the facility passed inspection is applicable in lieu of the survey report if the Organization reviewed and approved CMS criteria as meeting its standards.
- If the organization is not approved by an accrediting body, then an onsite quality assessment must be conducted every three years



# CR 11 Assessment of Organizational Providers cont.

**Confirms at least every three years that the provider continues to be in good standing with state and federal regulatory bodies and, if applicable is reviewed and approved by an accrediting body**

- In order to confirm that Organizations are conducting organizational provider recredentialing timely, one must ensure the appropriate documents are date stamped or have some indication of a verification date. Although there is no time limit for gathering the credentialing verifications for organizational providers (e.g., 180-day rule), date stamps/verification dates are needed in order to ensure the information is being re-verified every three (3) years as required.



# CR 11 Assessment of Organizational Providers cont.

## Accreditation/Certification of Free-Standing Surgical Centers in California (CH&SC)

The organization has documentation of assessment of free-standing surgical centers to ensure that if the organization is not accredited by an agency accepted by the State of California, the organization is certified to participate in the Medicare Program, in compliance with California Health and Safety Code 1248.1.

- The Organization must have a certificate/letter from Medicare stating the facility is certified.
- Free-Standing Surgical Centers Scenarios:
  - If a surgical center is associated with a TJC (The Joint Commission), American Association for Accreditation of Ambulatory Surgical Facilities (AAASF), Accreditation Association for Ambulatory Healthcare (AAAHC) accredited hospital, CR 11.F is not applicable.

# CR 12 Delegation of Credentialing

**If the organization delegate any NCQA – required credentialing activities, there is evidence of oversight of the delegated activities.**

## **Element A: Written Delegation Agreement**

**The written delegation document:**

- 1. is mutually agreed upon**
- 2. describes the responsibilities of the organization and the delegated entity**
- 3. describes the delegated activities**
- 4. requires at least semiannual reporting to the organization**
- 5. describes the process by which the organization evaluates the delegated entity's performance**
- 6. describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement**



# CR 12 Delegation of Credentialing cont.

At a minimum, the delegation agreement must state which entity (the organization or the delegate, or both) is responsible for:

- Accepting application, reapplications and attestation.
- Collecting all data elements from NCQA approved sources.
- Conducting site visits and medical record keeping review (if applicable)
- Making decisions on initial credentialing.
- Collecting and evaluating ongoing monitoring information.

## Element B: Provision for Protected Health Information

- **Majority of credentialing delegated arrangements do not include the use of PHI.**



# CR 12 Delegation of Credentialing cont.

## **Element C: Right to Approve and to Terminate**

**The organization retains the right, based on quality issues, to approve, suspend and terminate individual practitioners, Providers and sites in situations where it has delegated decision making. This right is reflected in the delegation documents.**

- An Organization that does not delegate credentialing decisions is not required to state in the delegation agreement its right to approve new, terminated or suspended practitioners from the network.
- An Organization must document that it has retained the right to approve and terminate individual practitioner, providers and sites in situations where it has delegated decision making.



# **CR 12 Delegation of Credentialing cont.**

## **Element D: Pre-Delegation Evaluation**

**For delegation agreements that have been in effect for less than 12 months, the organization evaluated delegate capacity before delegation began.**

## **Element E: Annual File Audit**

**For delegation arrangements in effect for 12 months or longer, the organization has audited credentialing files against NCQA standards for each year that the delegation has been in effect.**



# **CR 12 Delegation of Credentialing cont.**

## **Element F: Annual Evaluation**

**For delegation arrangements that have been in effect for more than 12 months, the organization has performed an annual substantive evaluation of delegated activities against delegated NCQA standards and organization expectations.**

- This audit includes all pieces of the credentialing process (e.g., policies and procedures, site visits, as applicable, file audit, etc.)



# CR 12 Delegation of Credentialing cont.

## Element G: Reporting

**For delegation arrangements in effect for 12 months or longer, the organization evaluated regular reports.**

- Assess the Quality or Credentialing Committee Minutes
- It is acceptable to only receive lists of credentialed and recredentialed practitioners from NCQA-accredited or NCQA-certified delegates.
- Delegates that are not NCQA-accredited or NCQA-certified need to demonstrate that it collects credentialing data from the delegate, evaluates that data, takes corrective action if needed and follow-up on deficiencies.
- If no performance issues are identified, reporting could be limited to lists of credentialed and recredentialed practitioners.



# **CR 12 Delegation of Credentialing cont.**

## **Element H: Opportunities for Improvement**

**For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization has identified and followed up on opportunities for improvement, if applicable.**



# Identification of HIV/AIDS Specialists

## Written Process

**There is a written policy and procedure describing the process that the organization identifies or reconfirms the appropriately qualified physicians who meet the definition of an HIV/AIDS specialist according to California State regulations on an annual Basis.**

- The 2005 CR 13.A has been split into two elements (A & B). In 2006, Element A is requesting a written policy and procedure regarding the identification of HIV/AIDS specialists.



# Identification of HIV/AIDS Specialists cont.

## Evidence of Implementation

**On an annual basis, the organization identifies or reconfirms the appropriately qualified physicians who meet the definition of an HIV/AIDS specialist according to California State regulations.**

- This does not require screening of all of the Organization's practitioners, only those who potentially may qualify and wish to be listed as HIV/AIDS specialists.
- If Organization contracts with a specialty organization or has an agreement (ie. Letter of Agreement (LOA), Memorandum of Understanding (MOU)), annual screening must be documented by the Organization.



# Identification of HIV/AIDS Specialists cont.

## Distribution of Findings

**The list of identified qualifying physicians is provided to the department responsible for authorizing standing referrals.**

- Once the Organization has determined which, if any, of its physicians qualify as HIV/AIDS specialists under the above regulations, this list of qualifying practitioners is sent or made available to the department responsible for authorizing standing referrals. If the survey revealed that none of the physicians within the Organization qualify as HIV/AIDS specialists, this information should be communicated to the appropriate department.
- A verbal statement that the list was provided to the appropriate department is not acceptable evidence of compliance with Element C.



# Updates/FYI

## 2008 NCQA Updates

### \*HMO and PPO standards aligned

#### ▪ CR 6 Practitioner Office Site Quality

- **Question:** For the 2008 standard year, are organizations required under CR 6 to conduct a site visit after each complaint, or may they set standards that require a site visit after multiple complaints?
- **Resolution:** Organizations are required to conduct a site visit if they receive a single member complaint regarding the quality of a practitioner's office related to: 1) physical accessibility; 2) physical appearance; 3) adequacy of waiting and examining room space; 4) availability of appointments; and 5) adequacy of treatment record keeping. The organization must conduct ongoing monitoring of an office site that does not meet performance thresholds.



# Updates/FYI

## 2008 NCQA Updates cont.

- **CR 6 Practitioner Office Site Quality**
  - **Question:** For standard year 2008, NCQA eliminated CR 6, Element B: Site Visits and Medical Record Keeping. Are organizations that are undergoing surveys under the 2007 standards still required to conduct an initial site visit prior to credentialing a new practitioner?
  - **Resolution:** Yes. Organizations that will be surveyed under the 2007 standards are required to conduct an initial site visit prior to credentialing a new practitioner.



# Updates/FYI

## Medicare Advantage Policies and Procedures (CMS)

### Contracts: Opt-Out Provisions

- **The MA organization does not employ or contract with physicians who have opted out of participation in the Medicare Program.**
  - Policies and Procedures  
The MA organization has policies and procedures to ensure that it only contracts with physicians who have not opted out.
  - Monitoring Physicians Who Have Opted Out  
The MA organization monitors its credentialing files to ensure that it only contracts with physicians who have not opted out.

# Questions???

