5 - Contracting and Credentialing

5.1 Contracting

Requests to become a contracted provider with Sierra Health & Life should be submitted with a Letter of Intent. Requests to add additional providers to your existing group contract should be submitted with a Provider Add Request. Both forms are available at the following link: https://sierrahealthandlife.com/Provider/Join-Our-Network

Requests for your contracted fee schedule rates should be submitted using the **"Request for Allowables" in Frequently Used Forms section 19.**

The contracting department can be reached at (702) 242-7088, Toll Free (800) 745-7065, or by email at Contracting@uhc.com.

5.2 Credentialing

Credentialing is the process of assessing and validating the qualifications of a licensed independent practitioner to provide services for Sierra Health and Life (SHL) members.

Credentialing is a requirement for participation in the HPN provider network(s) and most providers must be credentialed prior to contracting (see section 5.4 for more information). 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 SHL's credentialing schedule. SHL'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to complete the credentialing process is not received, in its entirety, within 180 days the application will be withdrawn from the process.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** or email NVSierraCred@uhc.com.

5.3 Credentialing Committee

The Credentialing Committee is a peer review body, which includes representation by providers practicing in SHL'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 *ten (10)* times per year.

5.4 Providers Eligible for Credentialing

Practitioners that are Credentialed	Practitioners that are NOT Credentialed
Advanced Registered Nurse Practitioner APRN	Certified Massage Practitioner
Certified Family Nurse Practitioner CFNP	Certified Registered Nurse Anesthetist
Certified Nurse Midwife CNM	Clinical Nurse Specialist
Certified Social Worker CSW	Dentists who are not Oral Surgeons
Doctor of Chiropractic DC	Licensed Practical Nurse
Doctor of Medicine MD	Registered Behavioral Therapist
Doctor of Oral Surgery OS	Board Certified Behavior Analyst
Doctor of Osteopathy DO	Pathologist
Doctor of Philosophy PhD	Radiologist
Doctor of Podiatric Medicine DPM	Anesthesiologist
Doctor of Psychology PsyD	Emergency Room/urgent care practitioner
Licensed Marriage & Family Therapist LMFT	Neonatologist
Clinical Professional Counselor CPC	Respiratory Therapist
Licensed Clinical Social Worker LCSW	Body Imagery
Nurse Practitioners NP	
Registered Addiction Specialist RAS	
Doctors of Oriental Medicine OMD	
Licensed Clinical Alcohol & Drug Counselor LCADC	
Licensed Alcohol & Drug Counselor LADC	
Certified Alcohol & Drug Counselor CADC	
Physician Assistants/Certified PA-C	
Doctor of Optometry OD	
Audiologist AuD	
Occupational Therapist OT	
Speech Pathologist SLP	
Physical Therapist PT	
Nutritionist/Registered Dietician (including Certified Diabetic Educator) RD	

Organizational Providers that are Credentialed	Organizational Providers that are NOT Credentialed
Hospitals	Outpatient Physical Therapy
Skilled Nursing	Speech Pathology Providers
Nursing Homes	Portable x-ray Suppliers
Free Standing Surgical Centers	Hearing Aid Centers
Home Health Agency	Rural Health Clinics
Comprehensive Outpatient Rehabilitation Facilities	Federally Qualified Health Centers
Providers of End-Stage Renal Disease Services	Group Homes
Inpatient Behavioral Health Facilities	
Residential Behavioral Health Facilities	
Laboratories	
DME	
Adult Day Care Centers	

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.

5.5 SHL Credentialing Process

The SHL 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: SHL 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) Current malpractice insurance coverage,
   - Correctness and completeness of the application.

   The credentialing application will include a request for the practitioner's race and ethnicity. Disclosure of this information is voluntary and is being requested for reporting to the National Committee on Quality Assurance (NCQA). This information will be utilized to enable members to choose practitioners best able to meet their cultural and linguistic needs and will be available only upon request via a call to Member Services. It will not be published in the provider directory.
2. Primary verification by SHL 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.
   - Work History
   - Hospital Privileges
   - 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 re-credentialing decisions. Decisions to deny initial or renewal of credentialing will be communicated in writing by the Credentialing Department.

At the time of re-credentialing, SHL 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, SHL 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. SHL also monitors complaints against practitioners for both quality of care and quality of service issues.

When SHL receives notification of a publicly verifiable report initiated by a government agency, and related to a participating provider, with concerns regarding the potential for imminent harm to the safety of our members, the accusation will be subject to, and governed by United Healthcare's (UHC) Imminent Threat to Patient Safety policy. This allows UHC's National Practitioner Sanctions Committee to act on accusations, including immediate suspension, for practitioners in the SHL network. SHL will allow the UHC National Peer Review and Credentialing Policy Committee (NPRC) to have final decision-making authority for disciplinary action related to Quality of Care/Patient Safety.

Appeal Process: https://www.uhcprovider.com/content/dam/provider/docs/public/resources/join-network/Credentialing-Plan.pdf

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. (SHL monitors for deficiencies subsequent to the initial site visit through member complaints, feedback from health plan staff and other data. If deficiencies are identified, SHL 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 SHL within 15 days of any loss of licensure, loss of privileges or Medicare/Medicaid sanctions and exclusions.

5.6 Expired Credentialing

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

While it is the responsibility of the Provider to keep their credentialing current, SHL will make best efforts to remind Providers when their re-credentialing is due. Providers should keep their CAQH attestation current or submit a re-credentialing application at least 90 days prior to the re-credentialing due date. Any provider whose contract is terminated due to lapsed credentialing 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 SHL 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.

5.7 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, SHL notifies the provider. This review does not include references, 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.

5.8 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
- 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
  - UM Issues
  - Non-care complaints
  - Satisfaction survey results
  - Site visit or medical record review results
  - Concerns regarding the potential for imminent harm to the safety of members/enrollees
  - Number of member complaints
  - Other issues as identified by the Credentialing Committee

A practitioner seeking participation in the SHL 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 re-credentialing in the SHL 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.

5.9 Operational Policy Decisions

Practitioners requesting participation in the SHL 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 SHL 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.

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 Sierra Health and Life.

Provider Services can request an exception be approved by the Credentialing Committee 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.

5.10 Confidentiality of Credentialing Information

Through its credentialing policies and procedures, SHL ensures the confidentiality of information obtained in the credentialing process, except as otherwise provided by law. SHL is required to provide information about 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.

5.11 Office Site Visits

SHL 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 SHL 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 Medical Director Quality Improvement and Population Health 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.

SHL conducts an initial site visit for all locations at which PCPs, OB/GYNs, and high-volume behavioral healthcare practitioners provide services. SHL also conducts an initial site visit when a practitioner relocates or opens a new site, and the site has never been evaluated. SHL 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 SHL standards. SHL 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.

SHL 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 SHL 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. SHL 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 (e.g. 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

	❖ Ophtalmoscope/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 (If Shots Given In The Exam Room) Y/N
B.	***Laboratory (if office conducts laboratory testing: e.g. 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 (i.e. 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 (e.g. 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, e.g. 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 (e.g. 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

5.12 MEDICAL RECORD STANDARDS

SHL 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. SHL conducts clinical medical record reviews to assess the conformity with good professional medical practice and appropriate health management.

A clinical professional conducts random clinical medical record reviews. This RN works closely with the Quality Improvement Department and if necessary, makes recommendations to the Credentialing Committee Chair and/or Credentialing Committee 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. SHL 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 empanelment
- A sample of those practitioners who are identified as outliers on profiling reports
- A random sample based on specialty, community trends or any other identifier
- A sample of practitioners who were recently (within the past two years) added to the SHL Network
- Any practitioners deemed appropriate based on SHL's experience with their medical record documentation

SHL 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. SHL 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 see additional requirements in right column).	**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, race, ethnicity, primary language, and disability status (all or nothing for all 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 (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 (e.g., 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 (e.g., 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 (e.g., 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 (e.g., unnecessary procedures, inappropriate procedures, etc.).	There is no evidence the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure (e.g., 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 (e.g., influenza, tetanus, high-risk members, etc.).
2.	There is evidence that preventive screenings and services are offered in accordance with the Plan's preventive health guidelines.	Medical record documentation demonstrates evidence of preventive screenings and services provided, as defined by Plan-specific preventive 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 always known.
- 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 SHL in accordance with provider contracting to allow for auditing related to quality assurance, quality improvement, utilization management and re-credentialing.
- Medical records shall be available for review by duly authorized representatives of regulatory agencies in accordance with HIPAA regulations.