DEPARTMENT OF HEALTH
BUREAU OF MANAGED CARE
GUIDELINES AND TECHNICAL ADVICE TO HMO APPLICANTS REGARDING CREDENTIALING SYSTEMS

The following items must be integrated into the credentialing system described in the Certificate of Authority application. The crosswalk form for credentialing is contained in Appendix 6.

1) **Credentialing process, policies and procedures for all services, levels and facilities (all providers the plan wishes to contract with).***

   With substance abuse providers, one of the credentialing standards should be that the facility or provider be certified by the Office of Drug and Alcohol Programs (ODAP).

2) **Description of Credentialing Committee functions and activities with Medical Director involvement.***

3) **A copy of the provider application including the following:***

   * **physical and mental health status**
   * **history of impairment due to chemical dependency/substance abuse**
   * **history of loss of license and/or felony convictions**
   * **history of loss or limitation of privileges or disciplinary activity**
   * **work history or CV**
   * **attestation to the correctness/completeness of application**

4) **Primary verification[1] of the following items:***

   * **state license to practice from the State Board**
   * **active, full hospital privileges at a plan participating hospital from that hospital**
   * **valid DEA license (xerox copy is sufficient)**
   * **graduation from medical school, completion of residency, or other from school or hospital where residency was completed**

5) **Investigation in professional liability claims history from the National Practitioner's**

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[1] primary verification is defined by the National Committee on Quality Assurance (NCQA) as written or oral verification from primary sources. However, oral verification requires a dated, signed note in the credentialing file stating who verified the item and how it was verified.

Data Bank and judgement process of what is acceptable.*

6) Investigation from State Board regarding any sanctions pertaining to providers license.*

7) Investigation from HCFA and DPW (Medicheck) regarding any sanctions by Medicare and Medicaid.*

8) An on-site visit to all PCP's and high volume specialists (e.g., OB-GYN) is required.*

9) The Plan should set minimum standards for participation and develop a tool to be used at the on-site visit. The standards and tool developed for the on-site visit should include number of patients per hour (no more than 5 as reviewed by the appointment book), after-hour availability and minimum work week.*

10) It is permissible for plan's to accept applicant physicians conditionally, on the basis of an identified corrective action plan. If the plan makes the decision to accept applicants with such deficiencies, the Department of Health would expect to find in the physician's credentialing file a letter/memo to the physician specifically identifying the deficiency, the corrective action required and time period for re-review.

11) A medical record review of all PCP's and high volume specialists (e.g., OB-GYN) is required. The records to be reviewed should be a random sample chosen by the reviewer at the time of the visit. Physicians may choose to sanitize the chosen records.*

12) The Plan, as part of its credentialing of primary care physicians and high volume specialists (e.g., OB-GYN), must arrange for the Medical Director to review a minimum of 3 medical records for each physician visited. The Medical Director's review shall be for the purpose of determining/certifying that the applicant physician meets minimum clinical competency standards as reflected through use of the NCQA medical record review form, which has been adopted with NCQA permission, as the standard for documentation of medical record review. Applicants will note that several questions on the NCQA medical record review form require exercise of clinical judgement, e.g. "Are working diagnoses consistent with findings?" Are plans of action/treatment consistent with diagnosis(es)?" "Does the care seem to be medically appropriate?" These are the question that need to be addressed by the plan's Medical Director. It is permissible for plan's to have qualified quality assurance nurses review medical records at the physician applicant's office, complete the medical record review form, particularly for the non-clinical judgement questions, and then arrange to have three random medical records copied and delivered to the Medical Director for his review.

13) **Feedback should be given to the physician or his/her office staff to give preliminary findings of the on-site and medical record review.***

14) **The forms for documenting completion of the medical record review by the Plan's Medical Director must be included with credentialing materials submitted for review and approval. Again, there must be evidence of medical director review and sign-off on the medical record review form.**

*Recredentialing must be completed every two years. These items are those which must be completed during the recredentialing process.

DELEGATION OF CREDENTIALING ACTIVITIES

The Department of Health permits an HMO to delegate the data collection portion of credentialing activities to another organization. However, the following issues must be addressed in the Certificate of Authority application for approval of this delegation:

1) **There must be a written description of the delegated activities and the accountability for these activities.**

2) **The HMO must retain the right to approve or disapprove new providers and sites and to terminate or suspend individual providers.**

3) **The HMO must have a plan to monitor the effectiveness of the delegated activities and processes annually.**