

Provider Manual

Section 10.0

Quality Improvement

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10.0 Quality Improvement

10.1 Quality Improvement Program Description

Passport Health Plan's Quality Improvement department is central to achieving the Plan's mission of improving the health and quality of life of our members. The goal of the Quality Improvement (QI) Program is to link together the knowledge, structure, and processes throughout the managed care organization as well as to assess and improve the quality of care and service for members. The Plan utilizes quality improvement tools to assess and improve key processes and outcomes throughout the organization.

The objectives of Passport Health Plan's QI Program are:

- To continually monitor key clinical and service indicators.
- To analyze aggregate data on specific occurrences.
- To manage disease and health programs.
- To conduct outreach and health education activities.
- To develop programs for populations with special needs.
- To conduct intervention studies in clinical and service areas that were selected based on review of data.
- To perform appropriate oversight of delegated activities.
- To conduct member and practitioner satisfaction surveys.
- To evaluate the effectiveness of the QI program.
- To coordinate activities related to structure and process with cross-functional areas to improve care and service.
- To foster an environment to help providers improve the safety of their practices.

Providers may request a copy of Passport Health Plan's complete "Quality Improvement Program Description" or a copy of a summary of its annual evaluation by contacting their Provider Relations representatives.

10.2 Quality Review of Key Clinical and Service Indicators

One of the Plan's QI Program objectives is to perform a quality review of key clinical and service indicators to assess and improve member and practitioner satisfaction. These clinical and service indicators include reviews of:

- Member and provider complaints for care or service.
- Sentinel events defined as any event involving member care that warrants further investigation for quality of care concerns.
- National Committee for Quality Assurance's (NCQA's) Healthcare Effectiveness Data and Information Set (HEDIS®).
- Application of clinical guidelines.

- Application of medical record documentation and continuity and coordination of care standards.
- Health outcome intervention studies or activities.

The Plan looks to its provider partners to participate in quality improvement committees, special ad hoc work groups, and its medical records review activities to improve the health and quality of life of its members.

The medical records of the Plan's members must be made available to the Plan for support of any of the above activities upon request from the Plan.

10.3 Practitioner Credentialing

10.3.1 Application Process

To begin the application process and join the Passport Health Plan (PHP), first call our Provider Contracting department at (502) 585-8357. We will send you a provider application packet and work with you to become credentialed as a PHP network provider.

Passport Health Plan participates with the Council for Affordable Quality Healthcare (CAQH). Providers who are participating with this common credentialing application database should contact our Provider Credentialing department at (502) 588-8578 or passportcredentialing@amerihealthmercy.org and/or include their CAQH provider ID number with documents submitted to the Plan.

New practitioner applicants are required to submit their completed applications with the following list of attachments:

- Documentation of any malpractice suits or complaints.
- Documentation of any restrictions placed on practitioner by hospital, medical review board, licensing board, or other medical body or governing agency.
- Documentation of any conviction of a criminal offense within the last five years (excluding traffic violations).
- Completed Provider Application (KAPER1 or CAQH), including:
 - Additional copies of pages from the application (as needed); and,
 - The attestation page (including the original signature and current date).
- Two signed Participating Provider Agreements.
- Original, complete, and signed MAP Forms.
- A copy of your current State License Registration Certificate.
- A copy of your current Federal Drug Enforcement Agency Registration - if applicable.
- Curriculum vitae or a summary specifying month and year, explaining any lapse in time exceeding six months.
- A copy of a W-9 in the name of the facility, including the Tax Identification Number and mailing address for all tax information.

- A copy of your current professional liability insurance Certificate of Coverage, including the name and address of the agent and the minimum amount, in accordance with existing Kentucky laws at the time of the application submission.
- A letter adding practitioner to the existing group contract, including group ID number/numbers. See Section 19 for a template of the Plan's *Adding a Practitioner* letter.
- A copy of your Medicare Certificate (a letter from the Centers for Medicare & Medicaid Services (CMS) with your unique Medicare provider identification number), as applicable.
- A copy of your social security card.
- ECFMG (Education Council for Medical Graduates), if applicable.
- FOX verification documentation for National Provider Identifier (NPI) and Taxonomy Code(s), if assigned.

Practitioners may contact the Provider Credentialing department at (502) 588-8578 to check the status of their applications.

10.3.2 Credentialing Process

Passport Health Plan assesses practitioner applicants through the Plan's credentialing process. With the receipt of all application materials, primary source verification is conducted by the Plan's Credentialing department. Following the verification of credentials, the Plan's Chief Medical Officer or Credentialing Committee reviews each application for participation.

Passport Health Plan will not initiate the credentialing review until a completed and signed application with attachments has been received. The normal processing time is between 60 to 90 days from date of submission of a completed application.

10.3.3 Reimbursement and the Credentialing Process

Kentucky Legislature enacted House Bill 440 to provide payment to providers seeking participation in the Plan's provider network. Effective January 1, 2009, providers in the credentialing process will be reimbursed at the participating provider rate, starting from the date the Plan receives a completed and signed application packet.

Providers may begin submitting claims for services provided to PHP members once they have been notified of the receipt of their completed application and have been assigned a Provider ID number. Providers are required to submit all claims within 180 days of service. Please note, claims submitted without a Kentucky Medicaid Identification (MAID) number will initially deny for "No MAID."

Providers will receive notification from DMS when a MAID number is assigned. Providers are encouraged to notify the Plan of receipt of a MAID number assignment.

After the Plan receives notification of a provider MAID number assignment, all claims received from the provider will be automatically reprocessed, starting from the date the Plan received a completed and signed provider application.

Providers will be considered participating Plan providers once they have met the Plan's credentialing requirements. Providers will be notified by PHP when they have been credentialed by the Plan. Providers applying for participation are excluded from the *Provider Directory* until the credentialing process has been completed in its entirety.

10.3.4 Providing Services Prior to Becoming a Credentialed Plan Provider

If a provider feels he/she must see a PHP member prior to the assignment of a Provider ID number and notification of the receipt of a completed and signed application by the Plan, the provider must obtain an authorization from the Plan's Medical Management department in order to receive payment for services.

10.3.5 Recredentialing Process

Passport Health Plan recredentials its practitioners, at a minimum, every three years. In addition, Passport Health Plan conducts ongoing monitoring of Medicare and Medicaid sanctions and sanctions or limitations on licensure. Practitioners who become participating and subsequently have restrictions placed upon their license will be reviewed by the committee and evaluated on a case-by-case basis, based upon their ability to continue serving the Plan's members.

Member complaints and adverse member outcomes are also monitored and the Plan will implement actions as necessary to improve trends or address individual incidents. If efforts to improve practitioner performance are not successful, the practitioner may be referred to the Credentialing Committee for review prior to his/her normally scheduled review date.

The Plan will generate a recredentialing application on all practitioners with current CAQH applications on file. Practitioners without a CAQH on file will be notified by telephone or letter to submit a recredentialing application (KAPER 1 or CAQH) with the following list of attachments:

- Documentation of any malpractice suits or complaints.
- Active malpractice facesheet noting coverage up to the minimum amount in accordance with existing Kentucky laws at the time of the credentialing decision.
- Documentation of any restrictions placed on practitioner by hospital, medical review board, licensing board, or other medical body or governing agency.
- Documentation of any conviction of a criminal offense within the last five years (excluding traffic violations).
- Copy of your current State License Registration Certificate.
- Copy of your current Federal Drug Enforcement Agency Registration - if applicable.

Failure to return documents in a timely fashion may result in a period of non-participation. The initial credentialing process will need to be completed in order to re-enroll as a participating provider.

Practitioners may contact the Provider Credentialing department at (502) 585-8578 to check the status of their recredentialing application.

Should Passport Health Plan decide to deny or terminate a practitioner from participation with the Plan, the practitioner will receive notification of the decision. The notification will include the reasons for the denial or termination, the practitioner's rights to appeal and request a hearing within 30 days of the date of the denial notice, and a summary of the practitioner's hearing rights.

10.4 Practitioner Sanctioning Policy

In the event Passport Health Plan identifies health care services rendered to a Passport Health Plan member by a participating practitioner that are outside the recognized treatment patterns of the organized medical community and quality management and/or credentialing standards, the practitioner may be subject to sanctions. The National Practitioner Data Bank (NPDB) may be notified of all negative outcomes if formal sanctioning proceedings are implemented and if the outcome is to last 30 days or more.

In addition to the above, Passport Health Plan's program integrity coordinator (PIC) will exclude and/or penalize a provider under any of the following conditions:

- PIC has received recommendations to take such actions as a result of an investigation conducted by the Office of the Inspector General or other appropriate state and/or federal agency.
- The provider fails to cooperate with an investigation of alleged fraud and abuse.
- The provider has been listed on the Medicare/Medicaid Sanctions Report.

Possible sanctions for deviation from accepted quality management and/or credentialing standards and program integrity violations include:

- Limiting a PCP's panel.
- Termination of participating provider status.
- Withholds from future claims payments of amounts that are improperly paid or reasonable estimates of such amounts.
- Suspension of claims activity.