



CREDENTIALING

Based on standards set forth by the National Committee for Quality Assurance (NCQA) all Providers listed in literature for Molina Healthcare of Michigan, Inc. (MHM) will be credentialed.

All designated practitioners, including physicians (DO's and MD's), podiatrists (DPM's), dentists (DMD's), and chiropractors (DC's), as well as mid-level professionals such as Physician Assistants (PA's), Nurse Practitioners (NP's), and Certified Nurse Midwives (CNM's) will have their credentials reviewed in a manner that is non-discriminatory, objective and uniform. This will assure that care is rendered to MHM members by qualified practitioners. This also includes behavioral health practitioners, such as Psychologists, Psychiatrists, Social Workers and Counselors who are credentialed by Compare, an NCQA accredited Managed Behavioral Health Organization delegate.

MHM will credential designated Practitioners prior to granting Provider status. All mid-level professionals, as defined above, must be credentialed prior to allowing them to provide services to MHM members. The plan requires initial credentialing of all practitioners and mid-level professionals who seek reinstatement after having a break in service beyond 30 calendar days.

MHM does not make credentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures or types of patients the practitioner discipline of care.



Who Should Be Credentialed

Credentialing standards must apply to all licensed independent practitioners or groups of practitioners who provide care for MHM's members. NCQA standards do not address the types of practitioners with whom MHM may contract.

Practitioners who must be credentialed

NCQA required MHM to credential the following types of practitioners:

- Practitioners who have an independent relationship with the organization. An independent relationship exists when the organization selects and directs its members to see a specific practitioner or group of practitioners.
- Practitioners who see members outside the inpatient hospital setting or outside ambulatory freestanding facilities.
- Practitioners who are hospital based, but see MHM's members as a result of their independent relationship with the organization.
- Dentists who provide primary dental care only under a dental plan rider.
- Pharmacists who work for a pharmacy benefit manager (PBM) to which the organization delegates utilization management.
- Covering practitioners (e.g. locum tenens)
- Practitioners who do not provide care for members in a treatment setting (e.g. board certified consultants)

Documents Required For Credentialing

MHM must verify that the following elements are present and within the prescribed time limits:

- A valid Drug Enforcement Agency (DEA) certificate
- Verification of education
- Verification of training
- If a provider states on the application that he or she is Board Certified, verification of board certification.
- Verification of work history
- A history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioners
- Verification of license



Credentialing Application

The applicant will have the responsibility of producing adequate information for a proper evaluation of his/her experience, background, training, demonstrated ability, and ability to provide services without limitations including physical and mental health status as allowed by law, and the responsibility of resolving any doubts about these or any of the other basic qualifications required by MHM.

Network Development sends an unsigned contract and an application packet to each requesting practitioner, mid-level professional, and/or IPS/medical group with whom MHM has chosen to pursue a business relationship.

The application packet will contain the application form, release and consent forms and instructions for completing and submitting credentialing information to MHM. Although the applicant's contracted medical group or IPA may return the completed application to the Credentialing Coordinator, the applicant is responsible for completing all of the information and providing the supporting documentation. The contract is fully executed once the applicant has completed the Peer Review/Credentialing Review process.

Application Form

The applicant shall complete the Application (see attachment A at the end of this section). Each application for MHM Provider or mid-level professional status shall provide current information, be submitted on the written application form prescribed by the Governing Board and be signed by the applicant. The application shall request at least the following:

- A current, valid Michigan license or certificate to practice his/her profession, including a copy of such license or certificate.
- A current, valid DEA certificate, including a copy of such certificate, as applicable.
- Documentation of professional liability insurance at a minimum amount of \$200,000 per occurrence and \$600,000 aggregate coverage appropriate to the medical practice under contractual consideration. This coverage shall extend to MHM members and the applicant's activities on MHM's behalf. The name of the insurance carrier and date of expiration must be included.
- A list of all malpractice actions for at least the last ten (10) years, with explanations of the actions and current status.
- Education.
- Board Certification status, if applicable.
- Educational background, including professional school, graduation date and degree.

The credentialing process will be completed with 60 working days of application submission unless extenuating circumstances exist (i.e. Verification of education is delayed), assuming the information submitted by the applicant is determined by the Peer Review/Credentialing Committee to be sufficient to make a determination of the mid-level professional's qualifications or current competence. If any time sensitive application information and/or verification, as defined by current NCQA guidelines, becomes over one hundred and eighty (180) calendar days old prior to a final decision by the Peer Review/Credentialing Committee regarding the applicant, updated information must be obtained and included in the review of the application.



Credentialing Site Visits

As part of the credentialing process, MHM must assess the quality, safety and accessibility of the office sites where care is delivered. In addition MHM sets standards for medical/treatment record practice. MHM contracts with Medical Site Reviewers (MSR) to conduct office site visits.

1. A standard site visit survey form that is completed at the time of the site visit (See attachment B at the end of this section)
2. A set of criteria for the office review, which include an assessment of:
 - Physical accessibility
 - Physical appearance
 - Adequacy of waiting and exam room space
 - Availability of appointments
 - Adequacy of medical/treatment record keeping
 - Standards and thresholds for acceptable performance

Practitioner office sites must pass with an 80% in order to be considered to enter the MHM network.

Practitioner Appeal Rights

Procedural rights provided to Molina Healthcare of Michigan, Inc's (MHM) practitioners when an action or recommendation of a MHM Quality Improvement Committee, Peer Review/Credentialing Committee or the Board will, if it becomes a final action, result in a report to the Michigan State Board of Medicine. This applies to practitioners with MHM active status as well as those who are applicants for MHM.

Grounds for a Hearing

Grounds for a Hearing exist whenever the MHM Quality Improvement Committee or Peer Review/Credentialing Committee take or recommend any of the following Adverse Actions:

- Denial of initial application for MHM Provider status;
- Revocation or termination of, or expulsion from MHM participation;
- Reduction or revocation of authority to provide care to MHM patients;
- Suspension or restriction of authority to provide care to MHM patients for a cumulative period of more than thirty (30) days in any twelve (12) month period;
- Summary suspension of authority to provide care to MHM patients for more than fourteen (14) consecutive days.



Notice of Action

If the MHM Quality Improvement Committee or Peer Review/Credentialing Committee has recommended an Adverse Action as defined above, the Committee taking or recommending the adverse action shall give written notice to the Provider by certified mail with appropriate return receipt. This notice shall:

- Describe the nature of the proposed action or recommendation; and
- State that the proposed action or recommendation, if adopted, must be reported to the National Practitioners Data Bank; and the State Licensing Board within fifteen (15) days from the date the adverse action is taken.
- Advise the Provider that he/she has the right to request a Hearing on the proposed action or recommendation; and
- Inform the Provider that any request for Hearing must be made in writing within thirty (30) days following receipt of the Notice of Action and must be sent to the Medical Director; and
- Contain a summary of the Provider's hearing rights.

Request for a Hearing

If the Provider has not requested a Hearing within the time and manner described above, the Provider shall be deemed to have accepted the action or recommendation, and such action or recommendation shall become the MHM Quality Improvement Committee's or Peer Review/Credentialing Committee's final action or recommendation, which shall be forwarded to the Board for their information. In the event that a timely written request for a Hearing is received, a Hearing Panel shall be appointed and the practitioner shall be provided a Notice of Hearing and Statement of Charges consistent with this policy.



ATTACHMENT A

MICHIGAN ASSOCIATION OF HEALTH PLANS Standard Practitioner Application

This document was developed by the Michigan Association of Health Plans (MAHP) to serve as a standard, single application for practitioner credentialing and cannot be used without permission of MAHP. © Copyright 1998, 2000, 2004 MAHP. All Rights Reserved.

PLEASE:

1. COMPLETE THIS ENTIRE APPLICATION.
2. SUBMIT A COPY AND RETAIN THE ORIGINAL FOR YOUR RECORDS.
3. CURRICULUM VITAE WILL NOT BE ACCEPTED AS REPLACEMENT FOR A PART OF THIS APPLICATION.
4. SIGN AND DATE: ATTESTATION ON PAGE 9 AND/OR 10.
5. SIGN AND DATE: RELEASE OF INFORMATION ON PAGE 11.

I A. PERSONAL INFORMATION

1. _____
Name (Last, First, Middle)
2. _____
Degree/Professional Title
3. _____
Other Names You May Have Used (Maiden, a.k.a., etc.)
4. Gender: Male Female
5. _____
Home Address/Street
6. _____
City/State/Zip
7. (_____) _____
Home Telephone No.
8. (_____) _____
Home Fax No.
9. _____
E-mail Address
10. _____
Date of Birth (Month/Day/Year)
11. _____
Citizenship/Place of Birth
12. _____
Languages fluently spoken in addition to English
13. _____
Languages written in addition to English
14. _____
Social Security No.
15. _____
Ethnicity (Optional)
16. If you are not a US Citizen do you have authorization to work in the US? Yes No

I B. PRACTICE SPECIALTY FOR WHICH YOU ARE SEEKING AFFILIATION

1. Are you applying as a:

Primary Care Physician:

- | | | |
|--|---|---|
| <input type="checkbox"/> Family Practice | <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Pediatrics |
| <input type="checkbox"/> Family Practice with Deliveries | <input type="checkbox"/> Internal Medicine/Pediatrics | <input type="checkbox"/> General Practice |
| <input type="checkbox"/> OB/Gyn | <input type="checkbox"/> Other _____ | |

Specialist:

- Specialty _____
 Sub-Specialty _____

Allied Health Practitioner:

- | | | |
|--|--|--|
| <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Clinical Nurse Specialist | <input type="checkbox"/> Nurse Midwife | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Optometrist | <input type="checkbox"/> Other _____ | |

2. Other medical interests in practice, research, etc: _____

II A. PRIMARY OFFICE PRACTICE INFORMATION Information will be published unless box checked:

1. List the health plans this office location accepts: _____

2. Type of Practice: Corporation Partnership Solo Institution
 Hospital Based Hospital Employed Rural/Federal Qualified Health Clinic

3. _____ 4. _____
 Group Practice Name as Appears on SS4 or W-9 Form Federal Tax ID No.

5. _____
 Address Suite City State County Zip

6. Mailing address if different than above: newsletters, etc. _____

7. (_____) _____ 8. (_____) _____ 9. _____
 Telephone No. Fax No. Office E-mail Address

10. (_____) _____ 11. (_____) _____ 12. Internet access: Yes No
 Emergency On-call No. Beeper No.

13. _____ 14. (_____) _____ 15. (_____) _____
 Office Manager Telephone No. Fax No.

16. Billing address where payments are to be sent Suite City State Zip

17. Claims Payable to _____

18. Languages other than English spoken by staff _____

19. Medicaid No. _____ Effective Date _____ 20. Is office Handicap accessible: Yes No

21. List physicians practicing at this location: _____ Specialty: _____

22. Office Hours:

	OFFICE HOURS			PRIMARY CARE APPOINTMENT HOURS AVAILABLE FOR PATIENT CARE	
	FROM	TO		FROM	TO
Monday			Monday		
Tuesday			Tuesday		
Wednesday			Wednesday		
Thursday			Thursday		
Friday			Friday		
Saturday			Saturday		
Sunday			Sunday		

23. Indicate the waiting time to obtain an appointment in your office for:
 a. Routine visits _____ days b. Well exams _____ days c. Urgent problems _____ days

Do you currently? (Check response)	Yes	No	Yes	No
Place an age limit on your patients? Minimum Age: ____ Maximum Age: ____			Accept Medicare Assignment?	
			Accept Medicaid Assignment?	
Accept new patients into practice?			Have 24-hour phone coverage?	
Accept new patients by physician referral only?			Have electronic medical record keeping system?	
Place limitation on patient gender? If "Yes", please specify limitation: <input type="checkbox"/> Male <input type="checkbox"/> Female			Have capability for electronic billing? Electronic Billing Code: _____	

25. Do you have an investment or other financial interest in any health care delivery organization? i.e. home health care, lab, managed care organization, etc. Yes No If yes, describe: _____

26. List financial partners: _____

II B. CROSS COVERAGE [Please list covering practitioners. If additional information, please attach.]

1. _____ (_____) _____
Name of Practitioner Specialty Telephone No.

 Address Suite City State Zip

 Hospital Affiliations

2. _____ (_____) _____
Name of Practitioner Specialty Telephone No.

 Address Suite City State Zip

 Hospital Affiliations

3. _____ (_____) _____
Name of Practitioner Specialty Telephone No.

 Address Suite City State Zip

 Hospital Affiliations

II C. 24-HOUR COVERAGE AND ADMITTING ARRANGEMENTS N/A

1. Do you have arrangements for 24-hour, 7-days-a-week medical coverage for your patients? Yes No
 If no, please explain: _____

2. Do you currently admit and care for your hospitalized patients? Yes No If no, please explain the formal inpatient coverage arrangement(s) for each inpatient facility: _____

II D. RADIOLOGY N/A

1. Do you perform/provide radiology services in your office? Yes No X-ray License No. _____
 If yes, at what site(s): _____

2. Do you perform mammograms? Yes No If yes, attach copy of State of Michigan and FDA certificate.

II E. DIAGNOSTICS N/A

1. If you provide direct laboratory services, please indicate the Tax ID No. utilized and provide CLIA or COLA information. Attach a copy of your CLIA or COLA certificate or waiver if you have one:

 Tax ID Billing Name: CLIA / COLA Type of Service Provided

2. Do you provide in-house Endoscopy procedures? Yes No

II F. SURGICAL N/A

1. If you have multiple office locations, which one(s) has a surgical suite(s): _____
 If yes, is it: (check all that apply) State licensed Medicare Certified ACR/FDA
 MQC Accredited AAAASF Accredited AAAHC Accredited
 Other _____

2. Other Certifications (e.g. Fluoroscopy, Radiography, etc.)

 Type Number Expiration

 Type Number Expiration

II G. ALLIED HEALTH PRACTITIONER SUPERVISING PHYSICIANS N/A

1. _____
 Name of Supervising Physician Specialty Telephone No. (_____) _____

2. _____
 Address Suite City State Zip

3. _____
 Hospital Affiliations

III A. MEDICAL / PROFESSIONAL SCHOOL

List all Medical Schools/Institutions attended including undergraduate and graduate school for allied health practitioners. Enclose copies of your diplomas and certificates.

1. _____
 Medical/Professional School Degree Awarded Date of Graduation (mm/yy)

 Address City State Zip

2. _____
 Medical/Professional School Degree Awarded Date of Graduation (mm/yy)

 Address City State Zip

III B. POST GRADUATE TRAINING

List all training attended. Enclose copies of your certificates. Explain any 30-day or greater gap in your training on a separate sheet.

1. INTERNSHIP Program successfully completed? Yes No

 Institution/Hospital Dates From (mm/yy) Dates To (mm/yy)

 Address City State Zip

_____ (_____) _____
 Program Specialty Program Director Telephone No.

2. RESIDENCY Program successfully completed? Yes No

 Institution/Hospital Dates From (mm/yy) Dates To (mm/yy)

 Address City State Zip

_____ (_____) _____
 Program Specialty Program Director Telephone No.

3. FELLOWSHIP Program successfully completed? Yes No

 Institution/Hospital Dates From (mm/yy) Dates To (mm/yy)

 Address City State Zip

_____ (_____) _____
 Program Specialty Program Director Telephone No.

4. OTHER Program successfully completed? Yes No

 Institution/Hospital Dates From (mm/yy) Dates To (mm/yy)

 Address City State Zip

_____ (_____) _____
 Program Specialty Program Director Telephone No.

Directions for Sections IV & V: List in chronological order (with the current affiliation first) all institutions where you have current affiliations and have had previous hospital privileges. This includes hospitals, residential treatment and rehabilitation centers, surgery centers, institutions, corporations, military assignments, or government agencies. Work history should include self-employment. If more space is needed, attach additional sheet(s). **A curriculum vitae (CV) is not sufficient as replacement for these sections.**

IV. HOSPITAL / FACILITY HISTORY

1. _____
CURRENT Primary Admitting Facility _____ Dates From (mm/yy) _____ Dates To (mm/yy) _____
 Address _____ Suite _____ City _____ State _____ Zip _____
 Department/Specialty _____ Staff Category _____ Chairperson _____ Telephone No. _____

2. _____
Admitting Facility _____ Dates From (mm/yy) _____ Dates To (mm/yy) _____
 Address _____ Suite _____ City _____ State _____ Zip _____
 Department/Specialty _____ Staff Category _____ Chairperson _____ Telephone No. _____

3. _____
Admitting Facility _____ Dates From (mm/yy) _____ Dates To (mm/yy) _____
 Address _____ Suite _____ City _____ State _____ Zip _____
 Department/Specialty _____ Staff Category _____ Chairperson _____ Telephone No. _____

4. _____
Admitting Facility _____ Dates From (mm/yy) _____ Dates To (mm/yy) _____
 Address _____ Suite _____ City _____ State _____ Zip _____
 Department/Specialty _____ Staff Category _____ Chairperson _____ Telephone No. _____

V. WORK HISTORY [Add additional sheets if more space required.]

Chronologically list all work history activities since completion of postgraduate training. Explain any gaps of more than thirty days.

1. _____
Current Practice _____ Contact Name _____ Dates From (mm/yy) _____ Dates To (mm/yy) _____
 Address _____ Suite _____ City _____ State _____ Zip _____ Telephone No. _____

2. _____
Previous Practice/Employer _____ Contact Name _____ Dates From (mm/yy) _____ Dates To (mm/yy) _____
 Address _____ Suite _____ City _____ State _____ Zip _____ Telephone No. _____

3. _____
Previous Practice/Employer _____ Contact Name _____ Dates From (mm/yy) _____ Dates To (mm/yy) _____
 Address _____ Suite _____ City _____ State _____ Zip _____ Telephone No. _____

VI. TIME INTERVALS [Explain any time intervals not accounted for in application.]

Suspended from Practice _____ From _____ To _____
 Loss of License _____ From _____ To _____
 Served in Military _____ From _____ To _____
 Personal Leave _____ From _____ To _____
 Other (Please describe) _____ From _____ To _____

VII. MEDICAL / PROFESSIONAL LICENSURE

1. _____
Michigan State Medical / Professional License No. _____ Date First Issued _____ Expiration Date _____
2. _____
Michigan State Controlled Substance No. _____ Expiration Date _____
3. _____
Drug Enforcement Administration Certification No. (DEA) _____ Expiration Date _____
4. ALL OTHER STATE MEDICAL/PROFESSIONAL LICENSES:
State: _____ License No.: _____ Expiration Date: _____
State: _____ License No.: _____ Expiration Date: _____
5. _____ Medicare ID No. 6. _____ or N/A
ECFMG No. _____
7. _____ UPIN 8. _____ National Provider Identification No. 9. _____ HIPAA Taxonomy Codes

VIII. BOARD CERTIFICATION/CERTIFYING ENTITY

Name of Board/Certifying Entity	Certificate No.	Date Certified / Re-certified	Expiration Date	Specialty
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____

Have you applied for board certification other than those indicated above? Yes No

If yes, list board(s) and date(s): _____

If not certified, do you intend to apply? Yes Specify timeframe: _____

No Specify reason: _____

Have you ever taken and not passed a medical board examination? Yes No If yes, will you re-take? Yes No

IX. REFERENCES

List three professional references, preferably from your specialty area, not including relatives, and no more than one current partner or associate. NOTE: References must be from individuals who are directly familiar with your work, either clinical observation or close working relations.

1. _____
Name _____ Title/Relationship _____ Telephone No. _____
Address _____ City _____ State _____ Zip _____ Fax No _____
Email Address: _____
2. _____
Name _____ Title/Relationship _____ Telephone No. _____
Address _____ City _____ State _____ Zip _____ Fax No _____
Email Address: _____
3. _____
Name _____ Title/Relationship _____ Telephone No. _____
Address _____ City _____ State _____ Zip _____ Fax No _____
Email Address: _____

X. PROFESSIONAL LIABILITY CARRIER INFORMATION

Please list all of your professional liability carriers for the **past ten years**:

Does your current professional liability insurance cover you in all of your practice locations? Yes No

1. _____
 Current Insurance Carrier Policy No. _____

 Address City State Zip Telephone No. (_____) _____

 Coverage Amount: (Claim/Aggregate) Type of Coverage Exclusions from Coverage

 Initial Date of Coverage Retroactive Date of Coverage Expiration Date

2. _____
 Insurance Carrier Policy No. _____

 Address City State Zip Telephone No. (_____) _____

 Coverage Amount: (Claim/Aggregate) Type of Coverage Exclusions from Coverage

 Initial Date of Coverage Retroactive Date of Coverage Expiration Date

3. _____
 Insurance Carrier Policy No. _____

 Address City State Zip Telephone No. (_____) _____

 Coverage Amount: (Claim/Aggregate) Type of Coverage Exclusions from Coverage

 Initial Date of Coverage Retroactive Date of Coverage Expiration Date

4. _____
 Insurance Carrier Policy No. _____

 Address City State Zip Telephone No. (_____) _____

 Coverage Amount: (Claim/Aggregate) Type of Coverage Exclusions from Coverage

 Initial Date of Coverage Retroactive Date of Coverage Expiration Date

5. _____
 Insurance Carrier Policy No. _____

 Address City State Zip Telephone No. (_____) _____

 Coverage Amount: (Claim/Aggregate) Type of Coverage Exclusions from Coverage

 Initial Date of Coverage Retroactive Date of Coverage Expiration Date

XI. CLAIM / LAWSUIT HISTORY - 10 YR. HISTORY

If you answer "YES" to any of the following questions, please provide details per the attached claims information sheet. Please explain any surcharge to your professional liability coverage on a separate sheet.	YES	NO
Have you ever been a defendant in a malpractice suit?		
Have any judgments been made against you or settlements been agreed to in any professional liability cases?		
Are there any professional liability lawsuits pending against you at the present time?		
Has your professional liability insurance ever been terminated or restricted or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance?		

XII. HEALTH STATUS

If the answer to any question is "YES", reference the question on a separate sheet. Please provide a full explanation and attach.	YES	NO
Are you currently using any chemical substance(s), which in any way may impair or limit your ability to practice medicine with reasonable skill and safety?		
Are you currently engaged in the illegal use of controlled substances?		
Do you have a mental or physical condition, which in any way may impair or limit your ability to practice medicine with reasonable skill and safety with or without reasonable accommodation?		

XIII. PROFESSIONAL PRACTICE

Have any of the following been or are currently in the process of being denied, revoked, not renewed, suspended, limited, restricted, reviewed, placed on probation, or placed under other disciplinary action, either voluntarily or involuntarily in this or any other state, territory or country? If "YES", provide full explanation and attach.	YES	NO
Medical or professional license		
DEA Registration or Controlled Substance license		
Hospital medical staff membership		
Clinical privileges or other rights on any hospital medical staff		
Employment by any hospital, institution or the military		
Professional society membership		
Participation in any private, federal, or state health insurance program (i.e. Medicare, CHAMPUS, Medicaid)		
Participation in an HMO, PPO, or any other managed care organization		
Board Certification		

XIV. OTHER DISCLOSURES

At any time have you ever been:	YES	NO
Convicted of any criminal offense in any jurisdiction		
Convicted of a misdemeanor relating to a health profession, or received probation without a verdict, disposition in lieu of trial, or an accelerated rehabilitation disposition of felony charges in any state, territory or country		
Have you ever, at any time, or are you currently:	YES	NO
Under audit by a Health Care Agency (i.e. Medicare, Medicaid, MDCH, or any insurance)		
Under indictment for any crime		
The subject of an investigation by any private, federal or state health insurance program or state, territory or country licensing board		
The subject of any adverse action reports to a state or federal agency		
Sanctioned by a government program or agency for any reason		
Have you ever, at any time, either voluntarily or involuntarily:	YES	NO
Withdrawn your application for medical staff membership at any facility		
Withdrawn your request for any clinical privileges at any facility		

XV. ATTESTATION STATEMENT

I agree to the contents thereof as evidenced by my signature that the information provided in this application is true and complete to the best of my knowledge and that omission or falsification of information may be cause for ineligibility or disaffiliation. I further agree that I have current malpractice insurance and I have disclosed the history of loss or limitation of privileges or disciplinary activity.

Signature: _____

Date: _____

Go To Next Page To Update Attestations

XVI. UPDATE ATTESTATION STATEMENT

One signature block below is to be signed if a previously completed application is being reviewed and updated for submission to an additional organization.

The application was designed so that a practitioner need complete it in its entirety only once. If application is then made to another organization which accepts this Standard Application and it has been more than 60 days since the practitioner completed or updated the application, the practitioner may review the application, make any needed modifications and then sign one of the attestation statement blocks below, reconfirming that the application is complete, true and accurate. It is particularly important that the Disclosure Questions be reviewed and any changes made with appropriate documentation included.

I agree to the contents thereof as evidenced by my signature that the information provided in this application is true and complete to the best of my knowledge and that omission or falsification of information may be cause for ineligibility or disaffiliation. I further agree that I have current malpractice insurance and I have disclosed the history of loss or limitation of privileges or disciplinary activity.

Signature:

Date:

I agree to the contents thereof as evidenced by my signature that the information provided in this application is true and complete to the best of my knowledge and that omission or falsification of information may be cause for ineligibility or disaffiliation. I further agree that I have current malpractice insurance and I have disclosed the history of loss or limitation of privileges or disciplinary activity.

Signature:

Date:

I agree to the contents thereof as evidenced by my signature that the information provided in this application is true and complete to the best of my knowledge and that omission or falsification of information may be cause for ineligibility or disaffiliation. I further agree that I have current malpractice insurance and I have disclosed the history of loss or limitation of privileges or disciplinary activity.

Signature:

Date:

I agree to the contents thereof as evidenced by my signature that the information provided in this application is true and complete to the best of my knowledge and that omission or falsification of information may be cause for ineligibility or disaffiliation. I further agree that I have current malpractice insurance and I have disclosed the history of loss or limitation of privileges or disciplinary activity.

Signature:

Date:

I agree to the contents thereof as evidenced by my signature that the information provided in this application is true and complete to the best of my knowledge and that omission or falsification of information may be cause for ineligibility or disaffiliation. I further agree that I have current malpractice insurance and I have disclosed the history of loss or limitation of privileges or disciplinary activity.

Signature:

Date:

Michigan Association of Health Plans Standard Practitioner Application

CONSENT TO RELEASE OF INFORMATION FORM

I understand that this Consent to Release Information is made in connection with Physician/Practitioner contracting, credentialing, recredentialing or reappointment activity of the Plan. I further understand that the Plan is responsible for the evaluation of my professional training, experience, professional conduct and judgment. All information submitted by me or on my behalf pursuant to this Consent to Release Information is true and complete to the best of my knowledge and belief. I fully understand that any misstatement in or omission related thereto may constitute cause for the summary dismissal/denial of such participation in the Plan. I understand and agree that as an applicant for participation with the Plan, I have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

I hereby authorize the Plan and its representative to contact and/or consult with any persons, entities or institutions (including, but not limited to, hospitals, HMOs, PPOs, other group practices and professional liability carriers) which I have been affiliated, have used for liability insurance or who may have information relevant to my character and professional competence and qualifications, whether or not such persons or institutions are listed as references by me. I consent to the release and communication of information and documents between the Plan and persons, entities or institutions in jurisdictions in which I have trained, resided, practiced, or applied for professional licensure, privileges or membership in plans for the purpose of evaluation of my professional training, experience, character, conduct, ethics and judgment, and to determine professional liability insurance and/or malpractice insurance claims history.

I also authorize and direct persons contacted by the Plan to provide such information regarding my character and/or professional competence and qualifications, my professional liability insurance and/or malpractice insurance claims history to representatives of the Plan and I understand in doing so, I am waiving my confidentiality rights to this information. I release and hold harmless from liability all persons, entities, or institutions who, in good faith and without malice for acts performed in gathering or exchanging information in this credentialing or recredentialing process. This release and hold harmless provision applies to all persons, entities and institutions who will provide and/or receive, as part of the Plan's credentialing or recredentialing process, information which may relate to my past or present physical and/or mental condition, including substance abuse, alcohol dependency and mental health information.

I further authorize the release of the above information or any other information obtained from the application by a credentialing verification organization (CVO) to any health care organization designated by me or one that has entered into an agreement with the CVO where I currently have, am currently applying, or in the future will be applying for participation. I also authorize the CVO or the Plan to allow my file to be reviewed by the organizations' state or national accrediting and licensing bodies.

I further affirm that I currently do not have any physical and/or mental conditions and/or impairments, such as substance abuse, alcohol dependency and/or mental health concerns which interfere with my ability to practice medicine. I agree to notify representatives of the Plan of any changes in my professional licensure, scope of hospital privileges, participating Plan status, status of my malpractice insurance, malpractice claims history information and practice locations. I understand that this application shall not be deemed complete until an on-site medical practice office review is completed, if applicable, as well as receipt of all information required by this application process. I further agree to appear before the Plan for interviews, if requested, or inquiries regarding evaluations of my professional qualifications at reasonable times and places.

A photocopy of this consent shall be as effective as an original when presented.

Practitioner's Printed Name: _____

Practitioner's Signature: _____

Date: _____

Updated Signature: _____

Date: _____

Updated Signature: _____

Date: _____

Updated Signature: _____

Date: _____

Updated Signature: _____

Date: _____

Updated Signature: _____

Date: _____

(PLEASE COMPLETE A SEPARATE FORM FOR EACH CLAIM)

Claim Number or Patient Initials: _____ Age: _____ Gender: _____

Incident Is: Pending _____ Closed Date: _____

Dismissed Date _____

Settlement Date _____ \$ _____

Judgment Date _____ \$ _____

You Are: Solo Defendant

Co-Defendant With _____

Other _____

Were the Settlement Terms Confidential? Yes No

Settlement/Judgment Details: _____

Amount Paid on Your Behalf: _____

Date of Incident: _____ Date Suit Filed: _____

Court: _____ Case No.: _____

Name and Address of Insurance Carrier at Time of Incident: _____

Name of Additional Defendant(s): _____

Explain in Detail the Plaintiff's Allegations: _____

Explain in Detail your Defenses to These Allegations: _____

Patient's Condition Post-Incident: _____

Whom may we consult for further legal information about the suit: _____

Signature of Applicant _____ Date _____

Print Name _____

Additional Documentation / Attachments

Please enclose the following copies with your application:

- Signed Authorization For Release of Information/Liability (Page 11)
- For updating of the MAHP application ONLY please sign Page 10 and 11
- Current Licensure
 - Michigan License to Practice
 - Michigan Drug Control License (if applicable)
 - Michigan Controlled Substance (if applicable)
 - Federal Controlled Substance Registration Certificate (DEA) (if applicable)
- Board Certification Certificate(s)
- Medical School, Internship, Residency, Fellowship certificates
- ECFMG Certificate for International Medical Graduates
- Current Professional Liability Coverage
- Completed Supplemental Claims Information Form indicating involvement in any suits or judgments (pending, settled or otherwise)
- CLIA/COLA Registration
- Mammography Certification (ACR & FDA)
- W-9
- Federal Tax Deposit Coupon
- Curriculum Vitae (with work history)
- X-ray License

ATTACHMENT B

MOLINA HEALTHCARE OF MICHIGAN, INC.

AMBULATORY SITE REVIEW



Molina Healthcare of Michigan Ambulatory Site Review

Site: _____
Address: _____
Phone: _____ Fax: _____
Contact Person: _____

Site Physicians

Physician	Specialty

Reviewer : _____
Date: _____ Score: _____

External Review of Premises

QID	Element	Score	Comment
10010	External property appears clean and maintained		
10040	Appropriate number of parking spaces for disabled persons		
10070	Appropriate security measures in place for patient safety		
10080	Entrance to building and office accommodates disabled persons		
10085	Year facility was built Year: _____	N/A	(Bldgs after 7/20/75 must meet barrier free design requirements of Michigan Building code)

Internal Review of Premises

QID	Element	Score	Comment
10140	Adequate number of waiting room seats		# of seats: Seating should accommodate comfort and not restrict routine traffic flow of the facility
10150	Internal premises appear clean and well maintained		
10170	Restroom(s) contain soap, paper towels (or automatic air dry) and toilet paper		
10180	Exits are clearly marked		
10190	All corridors & exits are clear of obstruction		
10200	Early warning fire detection system present		
10220	Fire extinguishers are present with evidence of annual inspection		Date of last inspection:
10210	Interior evacuation routes posted		
10230	All items near furnace are non-combustible		

Emergency Equipment

QID	Element	Score	Comment
10640	Emergency kit/crash cart present and accessible to appropriate personnel		
10660	Emergency kit medications are current (if present)		
10670	Log documenting review of emergency kit contents		(Each review signed & dated)

Storage

QID	Element	Score	Comment
10750	Pressurized gas tanks in stand or mounted		
10760	Patient care supplies stored off of floor		

Exam Rooms and Treatment Area

QID	Element	Score	Comment
10260	Exam rooms provide patient privacy		
10270	Exam rooms contain soap & paper towel dispensers		
10280	Exam table papered or disinfected		
10980	Syringes are stored in a secure area		
10710	Syringes disposed of in puncture-resistant containers with leak-proof sides & bottoms		

Medication Management

QID	Element	Score	Comment
10970	Prescription pads are stored in secure, supervised location		
10800	Medications stored in secure location away from patient care areas		
10850	Medications are routinely reviewed for expiration		
10860	Controlled substances are double locked with restricted access		
10870	Log/sign-out sheet maintained for controlled substances		
10880	Medications requiring refrigeration are stored in dedicated refrigerator		
10890	Refrigerator thermometer present		
10900	Daily refrigerator temperature log maintained		
10910	Refrigerator temperature = 36 to 46 degrees Fahrenheit or 2 to 8 degrees Celsius		
10920	Medications requiring freezer storage are stored in a dedicated freezer		
10930	Freezer thermometer present		
10940	Daily Freezer temperature log maintained		
10950	Freezer temperature = 0 to -5 degree Fahrenheit or -15 to 0 degree Celsius		

Sterilization and Asepsis

QID	Element	Score	Comment
11040	Autoclave present		
11051	Live spore test frequency is appropriate to frequency of autoclave equipment		
11060	Documentation/log of spore test results		
11070	Log of dated indicator strips maintained		
11080	Autoclaved supplies marked consistently with either date of sterilization or expiration		
11090	Expiration dates appropriate to type of packaging media		
11130	Separation of clean & dirty work areas		
11140	Instrument disinfectant solution labeled		
11150	Change date noted		
11155	Instrument disinfectant solution is appropriate for intended use		
11170	Instrument disinfection policy is followed		
11030	Disposable items not autoclaved or reused		
11000	Reusable otoscope tips properly cleaned and stored or uses disposables		
11010	Glass thermometers properly cleaned and stored or uses disposable ones		
11020	Reusable vaginal specula properly sterilized (cold / heat) and stored or uses disposables		
10990	Demonstrates appropriate cleaning and storage of patient care equipment		

Ancillary Services

QID	Element	Score	Comment
11180	Radiology license is current		Expiration date: License #:
11190	Radiation protection " Notice to Employees " posted		
11220	Protective coverings/apron present		
11260	Warning sign posted for pregnant women		
11240	Over-read plan available (PCPs)		
11290	Laboratory is performing only waived tests		CLIA License#:

Patient Encounter/Access

QID	Element	Score	Comment
11460	Preventive care appointment		1 st available: Next available:
11470	Symptomatic, non-urgent or follow-up care		1 st available: Next available:
11480	Urgent care		
11490	Emergency		
11510	Average waiting room time		Length of time:
11520	After hour/weekend access to physician		

Employee Documents and Training

QID	Element	Score	Comment
10340	All employee files contain confidentiality agreements signed by employee		
10440	All new employees are orientated to the safety manual prior to starting office duties		
10530	All employee files contain documentation of annual training & testing on the bloodborne pathogen, TB infection control and hazardous materials standards		
10510	Employees are trained in needlestick exposure and management		
10480	Employees know how to handle blood spills		

Office Documents (Policies & Procedures)

QID	Element	Score	Comment
10628	Practice participates in Michigan Childhood Immunization Registry (MCIR)		
10629	Practice participates in Vaccines for Children Program		
11810	Early Periodic Screening Diagnostic Testing (EPSDT) protocols present		
10500	Written exposure control plan		
10630	Written medical emergency plan		
11160	Written instrument disinfection policy		
11330	Written procedure to ensure physician notifies patients of abnormal lab and diagnostic test results		
11660	Procedure for reviewing diagnostic test results		
11722	Procedure for documenting patient telephone calls for clinical advice		
QID	Element	Score	Comment

11452	Procedure to contact patients with significant problems who have cancelled appointments and not rescheduled		
10623	Procedure for referring 3 year old children to an appropriate dental provider		
10627	Procedure for reporting communicable disease and other health indicators to the appropriate authority(ies)		

Medical Record Practices

QID	Element	Score	Comment
11590	Organized medical record storage/retrieval system		
11600	Medical records are stored away from patient care access		
11615	Inactive records retained	N/A	Number of years:
11580	Individual clinical record maintained for each patient		
11620	Medical record conforms to a standard format		
11630	Patient identified on all pages of medical record		
11640	Standardized format includes practitioner signature on each entry		
11650	Standardized format includes dating all entries		
11700	Standardized format includes problem list		
11710	Standardized format includes a medication list		
11740	Standardized format includes Medication Allergies/Adverse Reactions prominently noted or NKA clearly documented		
11750	Standardized format includes a durable power of Attorney /Advance Directives		
11781	Standardized format includes an authorization for use and disclosure of individually identifiable protected health information		
11790	Standardized format includes notations of immunizations		
11800	Standardized format includes Age/Gender appropriate health screening services		
11690	Standardized format includes family history		

QID	Element	Score	Comment
11820	Standardized format includes patient education		
11825	Patient education includes anticipatory guidance		
11830	Patient education includes safety		
11840	Patient education includes Family Planning (Sexually transmitted disease, HIV/AIDS)		
11850	Patient education includes smoking cessation		
11860	Patient education includes weight loss		
11870	Patient education includes social factors		(Alcohol/Substance Abuse)
11880	Patient education includes exercise		
11890	Patient education includes environmental risk factors		