Credentialing/Recredentialing

Credentialing

Practitioner Credentialing

Molina Healthcare of New Mexico, Inc. (Molina Healthcare) credentials practitioners/providers in accordance with internal policies and procedures. These policies and procedures meet standards and guidelines set forth by state and national accrediting bodies, including the National Committee for Quality Assurance (NCQA), the New Mexico Department of Insurance (DOI), and the New Mexico Human Services Department (HSD).

Molina Healthcare requires all licensed practitioners/providers who fall within the defined scope of Credentialing Policies and Procedures to meet and maintain standards and requirements established by Molina Healthcare. Defined practitioners/providers are required to be credentialed by Molina Healthcare prior to seeing a Molina Healthcare Member.

Molina Healthcare Incorporated, MHI performs Molina Healthcare's primary source verification of practitioner information.

If you were credentialed for Molina Healthcare by a former delegated entity, you will be required to go through the initial Credentialing process with Molina Healthcare to ensure our standards are maintained.

Practitioners will be listed in directories and other Member materials consistent with verified credentialing data to include education, training, certification and specialty.

- MD and DO board certification is mandatory during the credentialing process for urban area practitioners based on network need as determined by the Provider Contracting Department;
- Maintaining board certification is a recredentialing requirement for urban areas based on network need as determined by the Provider Contracting Department; and
- Only the American Board of Medical Specialties, the American Osteopathic Association, or their affiliate boards will be recognized for MDs or DOs.

Practitioner Rights

As a Molina Healthcare network practitioner, you have the right to:

- Review information submitted to support your credentialing application;
- Correct erroneous information collected during the credentialing process;
- Be informed of the status of your credentialing or recredentialing application; and
- Be notified of these rights.

Credentialing/Recredentialing (*continued)*

Initial Credentialing

At the time of initial credentialing, the applicant must complete a uniform New Mexico Statewide Application or CAQH Application. The uniform credentialing forms may be used in electronic or paper format, as determined by Molina Healthcare. Molina Healthcare shall not require an applicant to submit information not required by the uniform credentialing forms. An exception is made for health professionals who: (a) are subject to credentialing under Molina Healthcares internal policy; (b) practice outside of New Mexico; and (c) prefer to use the credentialing forms required by their respective states. In such circumstances, Molina Healthcare and its delegated entity, if any, may accept those forms and any applicable attachments to the application.

The credentialing process shall be completed within forty-five (45) days from receipt of completed application with all required documentation unless there are extenuating circumstances. The application must include a signed attestation (a signature stamp is not acceptable on the attestation). If the information that is attested to conflicts with itself or is shown to be incorrect through primary source verification, then the application will not be deemed 'complete' until these items are resolved. The attestation must include:

- Reason for any inability to perform the essential functions of the position, with or without accommodation;
- Lack of present illegal drug use;
- History of loss of license and felony convictions;
- History of loss or limitation of privileges or disciplinary action;
- Current malpractice insurance coverage - Molina Healthcare minimum malpractice insurance requirements are: $200,000/$600,000 for New Mexico practitioners, $100,000/$300,000 for Texas based Practitioners; $1,000,000/$3,000,000 for all organizations, or coverage provided by a federal program. Malpractice coverage for practitioners/providers contracted with Molina Healthcare practicing in other states is required to mirror malpractice standards for that state; and
- Medicare or Medicaid sanctions.

The correctness and completeness of the application will consist of:

- Practitioner's information;
- Full Name (other names & suffix if applicable);
- Social Security Number (SSN);
- Date of Birth (DOB);
- Tax Identification Number (TIN);
- National Provider Identifier (NPI);
- Practice/Group Name;
- Effective Date;
- Complete Physical Address;
- Telephone and& Fax numbers;
- Current Mailing and Billing Address;
- Home Address;

Credentialing/Recredentialing (*continued)*

- Education;
- Post Graduate Training (if applicable).
- Work History (last five (5) years – must include Month & Year);
- Specialty Board Certification (if applicable);
- Licensure/Registration/Certification Information;
- Licenses;
- Drug Enforcement Administration (DEA) or, Controlled Substance Registration (CRS) Certificate;
- Professional Liability Insurance;
- Hospital and Healthcare affiliations (if applicable);
- Professional Practice Questions (PPQs);
- Release/Attestation Currently Signed & Dated (within the last one hundred twenty [120] days of receipt);
- Admitting Arrangement Letter (if applicable);
- Educational Commission for Foreign Medical Graduates (ECFMG) (if applicable); and
- Curriculum Vitae (CV) or Resume (must include months & years for the last five (5) years.

Molina Healthcare shall take into account and make allowance for the time required to request and obtain primary source verifications and other information that must be obtained from third parties in order to authenticate the practitioner's credentials, and shall make allowance for the scheduling of a final decision by the Medical Director for files with issues and/or the PRC.

Within forty-five (45) calendar days after receipt of a completed application and with all supporting documents, Molina Healthcare shall assess and verify the practitioner's qualifications and notify the practitioner of its decision.

If, by the forty-fifth (45th) calendar day after receipt of the completed application, Molina Healthcare has not received all of the information or verifications it requires from third parties, or date-sensitive information has expired, Molina Healthcare shall issue a written notification, through standard mail, fax, or electronic mail, or other agreed upon writing, to the practitioner either closing the application and detailing Molina Healthcare's attempts to obtain the information or verification, or pending the application and detailing Molina Healthcare's attempts to obtain the information and verifications. If the application is held, Molina Healthcare shall inform the practitioner that the file will be pended for forty-five (45) calendar days and once this timeframe is exhausted the file will be closed.

Requests for Additional Information

Within ten (10) working days after receipt of an incomplete application, Molina Healthcare shall notify you in writing of all missing or incomplete information or supporting documents. The notice will include:

- A complete and detailed description of all of the missing or incomplete information or documents that must be submitted in order for review of the application to continue;
- Within forty-five (45) calendar days after receipt of all of the missing or incomplete information or documents, Molina Healthcare shall assess and verify your qualifications and notify you of its decision;
- If the missing information or documents have not been received within forty-five (45) calendar days after initial receipt of the application or if date-sensitive information has expired, Molina

Credentialing/Recredentialing (*continued)*

Healthcare shall close the application or delay final review, pending receipt of the necessary information;
- You will be informed of the closed or pending status of the application and, where applicable, the length of time the application will be pending; and
- The name, address and telephone number of a credentialing staff person who will serve as the contact person for you.

If the signature attestation will be older than one hundred eighty (180) calendar days at the time of the credentialing decision, you will be required to update the attestation. Molina Healthcare will send a copy of the completed application with a new attestation form when requesting that you update the attestation.

Practitioner/Provider Right to Correct Information

Practitioners have the right to correct erroneous information in your credentials file. You are notified of your right in a letter sent to them at the time the initial or recredentialing application is received.

Molina Healthcare will notify you by telephone, email or letter within twenty four (24) hours in the event that credentialing information obtained from other sources varies substantially from that provided by the practitioner. Examples include but are not limited to actions on a license; malpractice claims history or board certification decisions. Molina Healthcare is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by law.

The notification sent to you will detail the information in question and will include instructions to the practitioner indicating:

- Their requirement to submit a written response within ten (10) business days of receiving notification from Molina Healthcare;
- In their response, the practitioner must explain the discrepancy, may correct any erroneous information and may provide any proof that may be available; and
- Their response must be sent to Molina Healthcare of New Mexico, Inc.: Attention Credentialing Director at PO Box 2470 Spokane WA 99210

Upon receipt of notification from the practitioner, Molina Healthcare will document receipt of the information from you in your credentials file. Molina Healthcare will then re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to your credentials file. You will be notified in writing that the correction has been made to his/her credentials file. If the primary source information remains inconsistent with your notification, the Credentialing Department will notify you. You may then provide proof of correction by the primary source body to Molina Healthcare's Credentialing Department. The Credentialing Department will re-verify primary source information if such documentation is provided.

If you do not respond within ten (10) business days, his/her application processing will be discontinued and network participation will be denied.

Credentialing/Recredentialing (*continued)*

Practitioner/Provider Right to Appeal

Practitioners/providers who have applied for initial participation and have been denied by Molina Healthcare's Professional Review Committee (PRC) do not have the right to file an appeal to request reconsideration of the decision.

Practitioner/Provider Right to Request Status of Application

Practitioners have a right, upon request, to be informed of the status of their application. Practitioners applying for initial participation are sent a letter when their application is received by Molina Healthcare and are notified of their right to be informed of the status of their application in this letter.

The practitioner can request to be informed of the status of their application by telephone, mail or email. Molina Healthcare will respond to the request within two (2) working days. Molina Healthcare may share with the practitioner where the application is in the credentialing process to include any missing information or information not yet verified. Molina Healthcare does not share with or allow a practitioner to review references or recommendations, or other information that is peer-review protected.

Practitioner/Provider Right To Review Credentials File

Practitioners have the right to review their credentials file at any time. Practitioners are notified of their right in a letter sent to them at the time the initial or recredentialing application is received.

The practitioner must notify the Credentialing Department and request an appointed time to review their file and allow up to seven (7) calendar days to coordinate schedules. A Medical Director, Director of Quality Improvement and Credentialing Specialist will be present. The practitioner has the right to review all information in the credentials file except peer references or recommendations protected by law from disclosure.

The only items in the file that may be copied are the application, the license and the DEA certificate. Practitioners may not copy documents that include pieces of information that are confidential in nature, such as the practitioner credentialing checklist, the responses from monitoring organizations (i.e. National Practitioner Data Bank, State Department of Health, Health Professional Quality Assurance), and verification of hospital privileges letters.

Confidentiality

Molina Healthcare shall maintain the confidentiality of all information obtained regarding practitioners/providers in the credentialing and recredentialing process as required by law.

Credentialing/Recredentialing (*continued)*

Molina Healthcare shall not disclose confidential practitioner/provider credentialing and recredentialing information to any person or entity except with the written permission of the practitioner/provider or as otherwise permitted or required by law.

Non-Discrimination

Molina Healthcare does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures (e.g. abortions) or patients (e.g. Medicaid) in which the practitioner specializes. This does not preclude Molina Healthcare from including in its network practitioners who meet certain demographic or specialty needs; for example, to meet cultural needs of Members. Molina Healthcare maintains a heterogeneous credentialing committee membership and requires the committee members to sign an affirmative statement at every meeting to make decisions in a nondiscriminatory manner.

Office Site Visits

Molina Healthcare will conduct a site visit of the offices of all Primary Care Practitioners (PCPs), Obstetrics/Gynecological Practitioners (OB/GYN) and all potential high volume Behavioral Health Practitioners for initial credentialing, unless an approved accreditation certification is provided in accordance with internal policies and procedures.

All site visits must meet the threshold requirement for Molina Healthcare.

- If the threshold score is not met at the time of the visit, a corrective action plan will be initiated, and a re-audit will be conducted within sixty (60) days of the visit;
- If the re-audit does not produce a passing score, the practitioner will be presented to the Professional Review Committee with a recommendation from Credentialing to terminate; or
- A practitioner who relocates or opens an additional office site after being initially credentialed must notify Molina Healthcare thirty (30) days prior to the move.

Molina Healthcare will conduct a new site visit when:

- A practitioner leaves a group practice to open a new office;
- A practitioner moves from one location to another and there has been no previous office site visit at the new location; or
- A practitioner opens an additional office and there has been no previous office site visit at the new location.

A Member grievance related to an office environment issue will be cause for an additional site visit to be done at any time between credentialing cycles.

Recredentialing

Molina Healthcare recredentials its practitioners at least every thirty-six (36) months. Six (6) months before the recredentialing due date, a recredentialing packet is sent to the practitioner and the applicant must complete a uniform New Mexico Statewide Application or CAQH Application. The uniform recredentialing forms may be used in electronic or paper format, as determined by Molina Healthcare. Molina Healthcare shall not require a practitioner to submit information not required by the uniform

Credentialing/Recredentialing (*continued)*

recredentialing forms. An exception is made for health professionals who: (a) are subject to recredentialing under Molina Healthcares internal policy; (b) practice outside of New Mexico; and (c) prefer to use the recredentialing forms required by their respective states. In such circumstances, Molina Healthcare and its delegated entity, if any, may accept those forms and any applicable attachments to the application.

This packet contains the following:

- New Mexico Statewide Application or CAQH application (must be completed as noted above for initial credentialing);
- Licensure/Registration/Certification Information;
- Licenses;
- Drug Enforcement Administration (DEA) or, Controlled Substance Registration (CRS) Certificate;
- Professional Liability Insurance;
- Admitting Arrangement Letter (if applicable); and
- A Practitioner Attestation and Questions that include attestation by the practitioner regarding:
  - Reason for any inability to perform the essential functions of the position, with or without accommodation;
  - Lack of present illegal drug use;
  - History of loss of license and felony convictions;
  - History of loss or limitation of privileges or disciplinary action;
  - Current malpractice insurance coverage - Molina Healthcare minimum malpractice insurance requirements are: $200,000/$600,000 for New Mexico practitioners, $100,000/$300,000 for Texas based Practitioners; $1,000,000/$3,000,000 for all organizations, or coverage provided by a federal program. Malpractice coverage for practitioners/providers contracted with Molina Healthcare practicing in other states is required to mirror malpractice standards for that state.
  - The correctness and completeness of the application; and
  - The Practitioner Authorization and Release of Information Form.
  - Medicare and Medicaid sanctions.

Practitioners are instructed to update the information and make corrections as necessary, answer all PPQs and sign and date the attestation and release of information statements. A signature stamp is not acceptable on the attestation.

If a practitioner fails to return the completed recredentialing packet to Molina Healthcare within seven (7) weeks, it will result in an administrative termination from the Molina Healthcare network.

Molina Healthcare follows the same timeframe for processing recredentialing files as for initial files as previously described.

Board Certification During Recredentialing

As of July 1, 2004, MDs and DOs must maintain Board Certification to meet recredentialing requirements based on network need as determined by the Provider Contracting Department.

Credentialing/Recredentialing (*continued)*

Only American Board of Medical Specialties, American Osteopathic Association, or their affiliate boards will be recognized for MDs or DOs.

On-Going Performance Monitoring

It is the standard of Molina Healthcare to provide ongoing quality monitoring for all practitioners/providers to ensure the highest quality of care for our Members. Monitoring of quality and/or office environment issues occur within Molina Healthcare on a continual basis.

All practitioners/providers will be required to have performance monitoring considered by the PRC at the time of credentialing or recredentialing. Practitioner specific information that is taken into consideration:

- Quality activities;
- Member complaints;
- Utilization patterns;
- Quality of Care (QOC) issues;
- Anti-Fraud issues;
- Pharmacy and therapeutics patterns; and
- Member satisfaction survey results (optional).

Organizational Credentialing – Health Delivery Organizations (HDO)

Molina Healthcare credentials HDOs in accordance with internal policies and procedures. These policies and procedures meet standards and guidelines set forth by State, National and Accrediting bodies, including NCQA, DOI, and HSD.

Molina Healthcare requires all HDOs who fall within the defined scope of credentialing to meet and maintain standards and requirements established by Molina Healthcare.

Quality assessments are conducted on the following types of HDOs:

- Hospitals;
- Home health care agencies;
- Skilled nursing facilities/nursing homes;
- Free-standing surgical centers; and
- Behavioral Health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting.

Before contracting, Molina Healthcare verifies the HDO has met the following criteria for network participation. The detailed criterion is listed in the attached Criteria and Primary Source Verification Table.

- Meets all state and federal and licensing requirements;
- Is in good standing with state and federal regulatory agencies;
- Lack of sanctions prohibiting participation in Medicaid/Medicare;

Credentialing/Recredentialing (*continued)*

- Professional liability coverage limit of at least $1,000,000/$3,000,000 which covers the facility and all providers practicing at the facility;
- Reviewed, approved and in good standing by one of the accrediting agencies approved by Molina Healthcare or a passing site survey by an accrediting agency, state or federal government agency, or by Molina Healthcare;
- Molina confirms that the HDO has been reviewed and approved by an acceptable accrediting body or an appropriate on site quality assessment has been performed and has met minimal threshold standards. Non-accredited HDOs must provide a copy of the most recent CMS or approved survey agency results, including HDOs corrective action plans (CAPs) to any survey deficiencies; and, a copy of the letter verifying acceptance of the CAP by the survey agency. Molina Healthcare verifies that the review was done and meets Molina Healthcare standards.

Molina Healthcare requires the following documentation from HDOs:

- Completed Molina Healthcare Health Delivery Organization Application;
- Copy of state license (if applicable);
- Copy of the most recent accreditation survey or the most recent Medicare site survey including HDO's corrective action plan to any deficiencies and a copy of the letter verifying acceptance of the CAP by the survey agency;
- Professional liability insurance declaration page showing dates and amount of coverage; and
- Copy of current DEA certificate (if applicable).

Approved accrediting agencies accepted by Molina Healthcare are the following:

- The Joint Commission (JC);
- American Osteopathic Association (AOA);
- National Committee for Quality Assurance (NCQA);
- Commission for Accreditation of Rehabilitation Facilities (CARF);
- Accreditation Association for Ambulatory Health Care (AAAHC);
- American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF);
- Community Health Accreditation Program (CHAP);
- The Accreditation Commission for Health Care, Inc (ACHC); and
- The Council on Accreditation (COA).
- DNV Healthcare (DNVHC)

After the initial assessment, Molina Healthcare confirms at least every thirty-six (36) months that the HDO continues to be in good standing with state and federal regulatory bodies and if applicable, reviewed and approved by an accrediting body.

If you have questions regarding the credentialing process, please contact the Credentialing Department toll free at (800) 377-9594.