CREDENTIALING FOR MANAGED CARE:

Compliant Processes for Health Plans and Delegated Entities

AMY M. NIEHAUS, CPMSM, CPCS, MBA

Credentialing for Managed Care

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Amy M. Niehaus,
CPMSM, CPCS, MBA

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About the Author

Amy M. Niehaus, CPMSM, CPCS, MBA

Amy M. Niehaus, CPMSM, CPCS, MBA, is a consultant with The Greeley Company, an industry-leading healthcare consulting firm. She has more than 25 years of experience in the medical services and credentialing profession. In her current role, she advises clients in the areas of accreditation, regulatory compliance, credentialing, process simplification and redesign, credentialing technology, credentials verification organization (CVO) development, and achieving delegation. Niehaus has worked in multiple environments throughout her career, including acute care hospitals, CVOs, managed care organizations (MCO), and health plans.

A member of the National Association Medical Staff Services (NAMSS) since 1991, Niehaus achieved her certified professional medical services management (CPMSM) certification in 1992 and her certified provider credentialing specialist (CPCS) certification in 2002. She is a NAMSS instructor and previously served as chair of its MCO Task Force, as well as chair and member of the NAMSS Education Committee. She is a former president of the Missouri Association Medical Staff Services and its Greater St. Louis Area Chapter.

Niehaus holds a Bachelor of Science degree from the University of Missouri and a Master's degree in Business Administration from Maryville University in St. Louis. Niehaus has developed and presented various programs to local and national audiences on topics such as credentialing and privileging processes; Joint Commission, National Committee for Quality Assurance (NCQA), and URAC accreditation standards; and delegation.

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Keith R. Boyd, MHA
President/Owner, SourceOne CVO

Carrie L. Bradford, MHA, RHIA, CPMSM, CPCS
Senior Director, Professional Staff Services and Credentialing, NorthShore University HealthSystem

Carol S. Cairns, CPMSM, CPCS
President, PRO-CON
Senior Consultant, The Greeley Company

Pamela L. Gilbert, CPMSM, CPCS
Priority Health, Manager, Provider Enrollment and Life Cycle
MAMSS, Health Plan Representative
MUCH Group, Chair

Vickie Hawkins, CPCS, CPMSM

Patricia T. Lowman, MHA, CPMSM, CPCS, CHQM-MC
Manager, Medical Staff Services, Atrium Medical Center

Michael R. Myers
President and CEO, GEMCare Mercy Memorial Health System
President, ICE Board of Directors and Director of Agency Relations

Shannon Rochon, CPCS
Molina Healthcare, Manager Delegation Oversight
Washington Credentialing Standardization Group, Shared Audit Co-Chair
Washington Association Medical Staff Services, Communications Chair

Introduction

The world of credentialing has expanded dramatically over the past few decades. Initially, medical services professionals (MSP) primarily worked in standalone hospitals and didn't need to know about the credentialing activities in other organizations, such as managed care organizations (MCO) and health plans, because, for the most part, those activities did not impact their roles and responsibilities. The same held true for MCOs, which focused on developing products and networks to provide covered healthcare services to its members. Each organization worked within its own silo and performed its credentialing activities in accordance with its own accrediting and regulatory requirements.

But then the healthcare environment started to change. Hospitals became part of larger healthcare systems, patient care services extended outside of the hospital to outpatient clinics and surgery centers, physician/hospital organizations (PHO) and independent practice associations (IPA) were created to form alliances and gain contracting leverage in the marketplace, and hospitals began employing practitioners and assuming responsibility for enrolling them with third-party payers.

Today, we have the perfect storm: Hospital credentialing, managed care credentialing, and delegated credentialing are all coming together onto the same stage. As healthcare systems and hospitals are looking for ways to integrate more fully and achieve greater efficiencies, many hospital medical staff services departments are taking on the additional responsibilities of enrolling employed practitioners and attaining delegated credentialing from commercial payers to improve the organization's revenue cycle.

Now more than ever before, MSPs and credentialing specialists in all healthcare environments need to know more about MCOs and the regulations and standards that drive their credentialing processes. This book was developed to support those MSPs and credentialing specialists by providing the information, tools, and techniques they need to succeed in this ever-changing industry. Whether you are a seasoned hospital MSP who is now tasked with integrating provider enrollment or taking on delegated credentialing or someone who needs to learn how to perform credentialing in a health plan, *Credentialing for Managed Care* was created with you in mind.

This manual will provide readers with the following information:

- An overview of the managed care environment
- Interpretation of the accreditation standards and regulatory requirements that drive the MCO credentialing process

- Understanding of a health plan's credentialing process
- Insight into what delegated credentialing entails for both parties
- The role of credentials verification organizations in delegated credentialing
- Opportunities to test their knowledge through quizzes and other learning activities
- Industry resources and tools

In addition, readers will benefit from the knowledge and experience of industry professionals, who have provided their own tips, tools, and leading practices to support health plans and MCOs in achieving compliance or to support health systems, hospitals, and provider groups in developing or improving provider enrollment practices or achieving delegated credentialing.

Disclaimer

Please note that this guide is not intended to be the sole source of information for an organization or individual desiring to learn more about the credentialing requirements for MCOs and health plans. It is intended to supplement the applicable accrediting body's standards manual with the experiences, perspectives, and knowledge from those working within the industry.

Sources Used for Credentialing Regulations and Accreditation Standards

National Committee for Quality Assurance (NCQA) Health Plan Standards effective 7/1/2016

NCQA FAQs

www.ncqa.org

URAC Health Plan Standards v7.2

URAC FAQs

www.urac.org

Centers for Medicare & Medicaid Services (CMS) *Medicare Managed Care Manual*

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html

Title 42: Public Health

PART 455—PROGRAM INTEGRITY: MEDICAID

Subpart E—Provider Screening and Enrollment

http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=a29d8c1484a8f28d5938eff29ffa2636&mc=true&n=pt42.4.455&r=PART&ty=HTML

Chapter 1

Overview of the Managed Care Environment

Before we get into the details of how and why insurers credential, let's start with a little background on the managed care environment. First, let's talk about the name. There are many terms used to describe these types of organizations. "Managed care organization" (MCO) has been used throughout the healthcare industry to describe companies that provide healthcare insurance and benefits. Examples include national organizations such as Aetna, Blue Cross Blue Shield, and United Healthcare, as well as regional and local insurers. These organizations are also known as health plans, health insurers, healthcare benefit companies, third-party payers, and commercial payers. These terms tend to be used somewhat interchangeably within the industry, but throughout this book, the most commonly used terms will be health plan, MCO, and payer.

Another nuance of the terminology used within the industry is the distinction between "provider" and "practitioner." Throughout this manual, "practitioner" will refer to an individual working in healthcare, such as a physician, chiropractor, nurse practitioner, or social worker. The term "provider" will mean practitioners plus healthcare facilities, such as hospitals, surgery centers, pharmacies, durable medical equipment companies, etc. "Provider" is a more all-encompassing term, as it includes all aspects of healthcare delivery, which is relevant to the discussion of health plans.

So what is "managed care"? According to the U.S. National Library of Medicine, managed care describes "programs intended to reduce unnecessary health care costs through a variety of mechanisms, including:

- Economic incentives to select less costly forms of care by both physicians and patients,
- Reviewing medical necessity of services,
- Increased beneficiary cost sharing,
- Controls on inpatient admissions and lengths of stay,
- Selective contracting with health care providers, and
- Intensive management of high-cost cases"

Managed care originated in 1917, when the Western Clinic in Tacoma, Washington, began to provide prepaid healthcare services for workers in the lumber industry. In 1929, a physician in Oklahoma created a health cooperative in a small farming community and, by selling shares, raised money to build a local hospital with annual membership fees assessed to cover the costs of healthcare provided to the farm families. In 1934, two physicians in the Los Angeles area entered into a prepaid contract with a local water company to provide its 2,000 employees with healthcare services.

The most notable impact on the development of managed care was the involvement of Kaiser Permanente. Starting in 1933 with the opening of a 12-bed hospital to treat construction workers building the Los Angeles Aqueduct, Kaiser partnered with insurance companies to facilitate an efficient process of receiving advance payment for each covered worker, which created financial stability for the hospital and afforded coverage for all workers. This prepayment form of healthcare was quickly embraced, and thousands enrolled for coverage at a cost of five cents per day. In 1938, Kaiser also established a prepaid practice for construction workers building the Grand Coulee Dam in Washington State and later extended that coverage to workers' families. The Kaiser Shipyards in California began offering its workers healthcare benefits during World War II through its company clinic doctors and hospitals, for a nominal weekly payment of 50 cents. The Kaiser Permanente Foundation also sponsored the Kaiser Richmond Field Hospital in 1942, creating a three-tier medical care system that also included first aid stations at the shipyards and the main Permanente Hospital in Oakland for managing critical cases. By 1944, more than 90% of shipyard employees had voluntarily joined this prepaid group health plan. Once the war ended, coverage was extended to include workers' families, and in 1945, the Permanente Health Plan was made available for public enrollment. These prepaid group plans were the precursors to health maintenance organizations (HMO). And the rest, as they say, is history.

Today's health insurers may offer numerous types of programs to its members, such as an HMO, preferred provider organization (PPO), point of service (POS), or indemnity plans. Most consumers in the United States have heard of these plans and most likely have been covered by one or more of them. Individuals participating in health insurance plans are typically referred to as "enrollees" or "members." Following is a high-level description of each of these programs:

- **HMO:** A medical insurance group that provides or arranges for coverage of specific health services needed by members for a fixed, prepaid premium
- **PPO:** A healthcare delivery system that contracts with providers of medical care to provide services at discounted fees to members
- **POS:** Combining features of both HMOs and PPOs, enrollees choose a primary care physician but have the option to receive referral services from nonparticipating providers at an out-of-network rate
- **Indemnity:** Traditional health insurance allowing members to choose any doctor or facility for eligible healthcare services, also referred to as fee-for-service

- **Medicare Advantage:** Health plan offered by commercial payers that contract with Medicare to provide benefits to enrollees in lieu of traditional Medicare
- **Medicaid:** A program established by the federal government but administered separately by each state to provide specific health coverage to individuals with limited income and resources; commercial payers may contract with the state(s) to provide managed Medicaid plans

In order for an insurer to enroll consumers into one of its programs, a provider network must be developed to deliver the various healthcare services that its members will need. These provider networks consist of physicians and other healthcare professionals, as well as hospitals, surgery centers, pharmacies, and many other healthcare entities. Insurers contract with these providers through a participation agreement and agree to reimburse for services rendered according to a negotiated fee schedule. The agreement will describe the practitioner's responsibilities and obligations of network participation, including adhering to the plan's policies for accessibility to members, participation in quality improvement programs, and confidentiality of member information and records. In addition, requirements for maintaining appropriate state licensure, Drug Enforcement Agency/Controlled Dangerous Substance certification, and the amount of malpractice insurance coverage required by the health plan are typically included. A practitioner's failure to maintain these credentials may result in an administrative termination due to breach of contract, rather than a credentialing review and determination (which is discussed in the next section).

Health Plan Credentialing Process

Before contracting with providers, health insurers typically credential their provider networks to assess whether healthcare practitioners meet its criteria. Credentialing is the process of collecting and verifying practitioner information to evaluate an applicant's qualifications, professional conduct, and competency for network participation. It is a quality and risk management tool to ensure that a practitioner has the legal authority and relevant training and experience to provide quality care *before* he or she is approved to provide healthcare services to members. The key is for this to occur before members receive care. A robust, compliant credentialing process that is well documented and consistently followed enables an organization to identify practitioners that meet its credentialing criteria to provide the level of quality expected for its members' healthcare needs. The goal of the health plan's credentialing process is to represent only qualified and competent practitioners to its members to receive healthcare services.

A typical health plan credentialing process is summarized here, with more details provided in subsequent chapters:

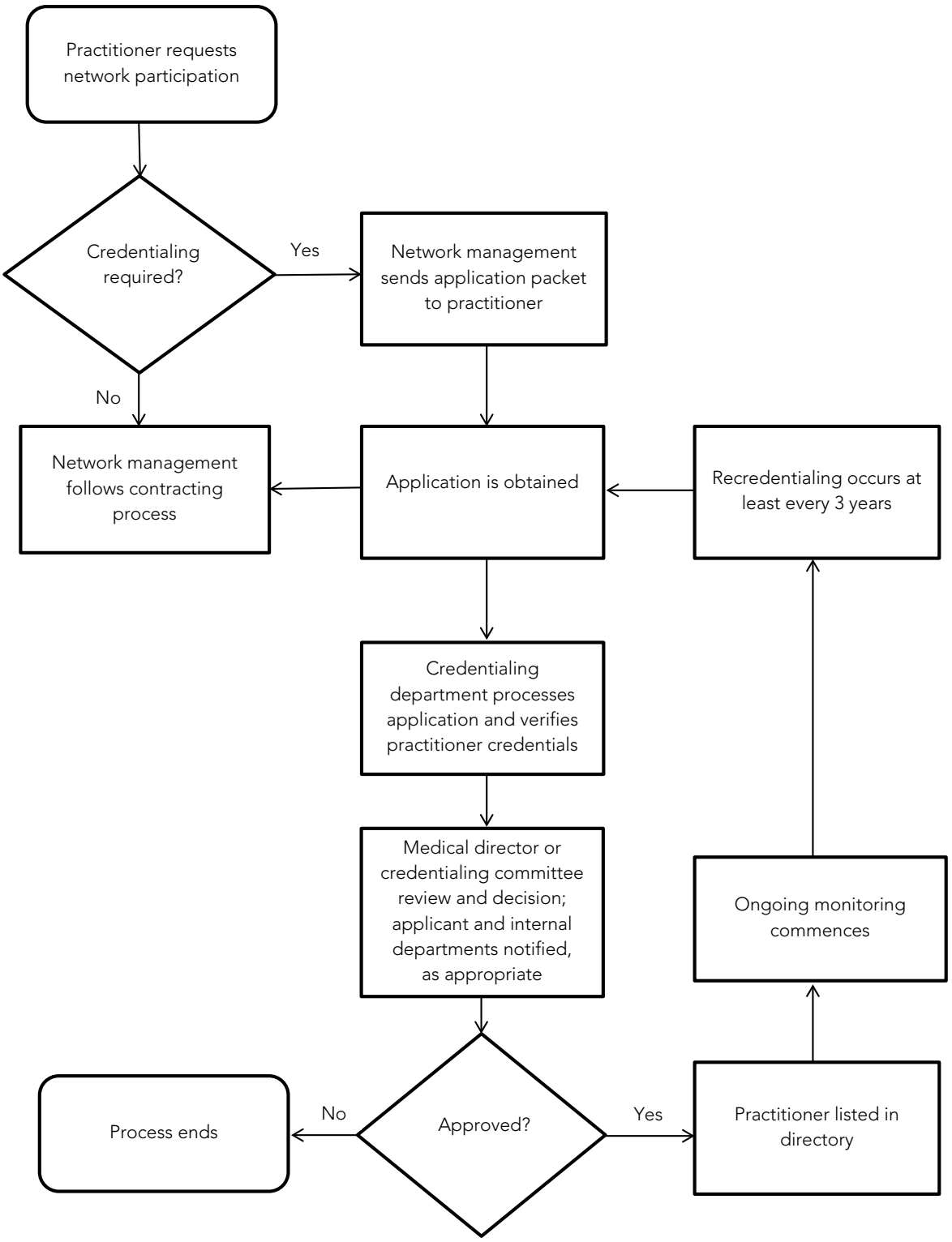
1. Receive application for participation (CAQH, organization or state specific)
2. Process application by confirming that information is complete (including supporting documents), conduct accreditor-recognized source verification as appropriate, and review for potential issues or discrepancies (i.e., "red flags")
3. Review and make decision (approve/deny/pend)
    - » Performed by medical director, if granted authority by credentialing committee to approve complete, "clean" applications that meet all criteria
    - » Performed by credentialing committee for files that do not meet criteria for "clean" designation or if medical director decisionmaking not granted
4. Notify applicant and internal departments of final decision

In a MCO, the credentialing process may be initiated within the contracting or network management area. If the decision is made to contract with a provider, the organization determines whether credentialing is required. (Under National Committee for Quality Assurance (NCQA) and URAC accreditation standards, not all contracted providers are required to be credentialed; more details are provided in Chapter 2.) The Credentialing department is notified of the provider contract, and the application is obtained and processed.

Once the credentialing process is completed, the final decision is communicated to the applicant and network management. If approved, the contract is finalized, and provider demographics, fee schedules, etc., are loaded into the plan's provider database/claims system so that the practitioner can be recognized as a participating provider and be listed in the member directories. A provider identification number is assigned for submitting claims for healthcare services provided.

Figure 1.1 illustrates at a high level the process by which a practitioner may be credentialed and contracted within a health plan. Please note that this example does not necessarily apply to all health plans but rather is intended to provide the reader with a general overview of the process.

Figure 1.1 Example of High-Level Credentialing Workflow in a Health Plan



Source: AMN Consulting, LLC. Reprinted with permission.

Accreditation

The healthcare industry has long used credentialing processes, especially in the hospital setting, which must follow the requirements of the Centers for Medicare & Medicaid Services (CMS), The Joint Commission, and other organizations that accredit healthcare entities. In the health insurance environment, NCQA and URAC are the main accrediting bodies. For the purposes of this manual, NCQA will be the primary focus, although some of URAC's and CMS' differences will be referenced.

Accreditation or certification for managed care credentialing is designed to establish a minimum standard that health plans can use to identify individuals and facilities that are appropriately qualified to participate in their networks and provide quality care to their members. The following is a high-level overview of the two accreditors recognized within the health insurance industry.

NCQA

NCQA is an independent, nonprofit organization dedicated to improving healthcare quality. Founded in 1990, NCQA currently offers a variety of accreditation, certification, and recognition programs, some of which are listed in the following table.

NCQA programs*		
Accreditation	**Certification**	**Recognition**
Accountable Care Organization Case Management Disease Management Health Plan Managed Behavioral Healthcare Organization Wellness & Health Promotion	Credentials Verification Organization Disease Management Health Information Products Physician and Hospital Quality Utilization Management and Credentialing	Practice Programs: • Patient-Centered Medical Home/Specialty Practice • Patient-Centered Connected Care • Government Recognition Clinician Programs: • Diabetes • Heart/Stroke

**Programs available as of August 2016*

Organizations seeking NCQA's seal of approval must meet a comprehensive set of quality standards and performance measures, in addition to submitting annual reports that NCQA uses to track the improvements in the quality of healthcare. According to its website, NCQA currently accredits health plans in every state, the District of Columbia, and Puerto Rico, covering 109 million Americans, or 71% of all Americans enrolled in health plans. For more information on NCQA and its programs and services, visit *www.ncqa.org*.

In addition to complying with NCQA's accreditation standards, health plans must also comply with NCQA's requirements for HEDIS® and CAHPS®.

HEDIS®

The Healthcare Effectiveness Data and Information Set (HEDIS®) is an NCQA initiative to develop, collect, and report on a set of standardized measures that assess a health plan's performance. The vast majority of health plans in the United States use the HEDIS® tool, so the results are a reliable method of comparing how well health plans follow accepted standards of medical care, and they allow plans to identify opportunities for improvement. NCQA-accredited health plans must submit data on a variety of healthcare measures, including immunization rates, breast cancer screenings, and management of acute/chronic illnesses such as diabetes. HEDIS® results are submitted annually to ensure that quality and performance are maintained between on-site surveys. These yearly reports are audited by an NCQA-certified auditor to ensure the information's validity.

CAHPS®

One element of HEDIS® reporting is the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys, which are administered by the Agency for Healthcare Research and Quality (AHRQ). These consumer surveys are used to obtain information on consumer healthcare experiences. The survey may include questions regarding a consumer's experience with claims processing, customer service, and the ability to obtain needed care. For example, the survey may ask questions such as, "Were you able to make an appointment within a reasonable length of time?" and "How well did your doctor communicate with you?" CAHPS® data is gathered on a continuous basis. For more information on CAHPS® and to view comparative data, visit the AHRQ website at *www.ahrq.gov/cahps*.

Together, HEDIS® and CAHPS® data are used to provide consumers of healthcare with an "apples to apples" comparison of health plan performance. NCQA evaluates health plans using the scores from standards review and HEDIS®/CAHPS®. Although HEDIS scores are separate from accreditation scores, the results of the annual HEDIS® audit may affect a health plan's accreditation status. A health plan is awarded such a status based on its overall score, but NCQA uses the audited annual results to redetermine accreditation status, which can be moved higher or lower depending upon whether the HEDIS® results have changed significantly during the prior year.

URAC

URAC was established in 1990 as a nonprofit organization to promote the continuous improvement in quality and efficiency of healthcare management through processes of accreditation and education. Originally, URAC was incorporated under the name Utilization Review Accreditation Commission because its originating focus was on developing uniform standards for utilization review (UR) services. UR is the process by which organizations determine whether healthcare is medically necessary for a patient or an insured individual. The name was shortened to the acronym URAC in 1996, when URAC began accrediting other types of organizations, such as health plans and PPOs.

URAC currently offers numerous accreditation programs, which are listed in the following table. URAC also requires its accredited health plans to report their results from CAHPS® surveys, as well as internally collected consumer satisfaction data. For more information on URAC's accreditation programs, go to *www.urac.org*.

URAC programs	
Accountable Care	Health Plan Quality Measures
Case Management	Health Web Site
Clinical Integration	Health Utilization Management (UM)
Community Pharmacy	Independent Review Organization
Credentials Verification Organization	Mail Service Pharmacy
Dental Network	Medicare Advantage
Disease Management	Patient Centered Medical Home
Drug Therapy Management	Pharmacy Benefit Management (PBM)
Health Call Center	Specialty Pharmacy
Health Content Provider	Telehealth
Health Network	Transitions of Care Designation
Health Plan	Workers Compensation Property and Casualty PBM/UM
Health Plan with Health Insurance Marketplace	

**Programs available as of August 2016*

Regulatory Requirements

In addition to accreditation standards, health plans must also adhere to regulatory requirements. Health plans are typically regulated by individual state Departments of Insurance, whose requirements may differ from accreditation standards. Keep in mind that state law will supersede accreditation standards in those situations. Readers are encouraged to become familiar with their applicable state regulations that affect managed care and credentialing.

Health plans that offer Medicare and Medicaid products are also subject to CMS requirements. CMS regulations for credentialing within Medicare Advantage plans are very similar to the NCQA credentialing standards and are located in the *Medicare Managed Care Manual,* Chapter 6—Relationships with Providers, which can be accessed by visiting *www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html*. For health plans contracted with state Medicaid agencies, provider enrollment and screening criteria ("credentialing") are available from the Government Publishing Office in the Electronic Code of Federal Regulations by visiting *www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr455_main_02.tpl*.

Key legislation

There have been several key pieces of legislation that influence the way health plans operate and provide products and services to consumers.

Health Maintenance Organization (HMO) Act of 1973

The HMO Act of 1973 was established to address the increasing costs of medical care and encouraged the startup and expansion of HMOs by authorizing funding and ensuring access to the employer-based health insurance market. Key components of this act included the following:

- HMOs are licensed/regulated at the state level
- Voluntary federal certification program provided "seal of approval"
    - » Ensured access to employer market
    - » Made HMOs eligible for federal grants and loans

The HMO Act of 1973 was instrumental in the rapid growth of HMOs and managed care in the United States and created greater competition within the healthcare market. The Act also led to the introduction of for-profit organizations in what was traditionally known as a nonprofit industry.

Health Care Quality Improvement Act (HCQIA) of 1986

The HCQIA was enacted as a result of *Patrick v. Burget* (800 F. 2d 1498 [1986] [9th Cir], 108 S. Ct. 1658 [1988]), a federal anti-trust case in which physicians were held liable for damages caused to Dr. Patrick by abusive and inappropriate peer review. The HCQIA extended immunity to good faith peer review of physicians and dentists. It also established the National Practitioner Data Bank (NPDB), which serves as a data clearinghouse to collect and release information related to professional competence and conduct of physicians and dentists. The intent of the NPDB is to restrict the ability of practitioners to move from state to state without full disclosure of their history. More information on the NPDB is available at *www.npdb.hrsa.gov.*

Health Insurance Portability and Accountability Act (HIPAA) of 1996

HIPAA protects a consumer's health insurance coverage due to change or loss of employment. It also established standards for electronic healthcare data exchange, the National Provider Identifier (NPI), and the security and privacy of data. It established privacy rules for protected health information (PHI), and it created the Healthcare Integrity and Protection Data Bank (HIPDB) to combat fraud and abuse in health insurance and healthcare delivery. Due to overlap in some reporting and querying requirements, the HIPDB data was transferred into the NPDB in 2013, thereby eliminating the duplication.

Patient Protection and Affordable Care Act of 2010

Also known as the Affordable Care Act (ACA), or "Obamacare," this piece of federal legislation was enacted with the intent to transform healthcare in several ways, including 1) increasing the quality and affordability of health insurance, 2) lowering the number of uninsured Americans by expanding both

public and private insurance coverage, and 3) reducing the costs of healthcare for individuals and the government. It introduced insurance exchanges, through which individuals and small businesses in every state can compare the policies offered by participating health insurance providers and purchase coverage. In addition, the ACA requires insurance companies to cover all applicants with new minimum standards and to offer the same rates regardless of preexisting conditions or gender.

Legal Precedent

Legal cases have significantly affected how health plans operate with regard to their credentialing practices. There are several ways in which MCOs can be held liable for their actions or for the actions of their providers related to the care received by members. Following are summaries of key cases.

Boyd v. Albert Einstein Medical Center, Health Maintenance Organization of Pennsylvania, Dr. Rosenthal, Dr. Dornstein and Dr. Cohen (Surgeon)

547 A.2d 1229 (Pa. 1988)

Case summary: Mrs. Boyd underwent a breast biopsy during which the chest wall was perforated, causing a hemothorax, and requiring two days of hospitalization. Over the next several weeks, the patient experienced chest pain and other symptoms that were treated by both her surgeon and primary care physicians. Her condition worsened, and Mrs. Boyd subsequently died as a result of a myocardial infarction.

Court findings: The HMO was found to be negligent for not overseeing the physicians and hospital that were acting as its agents (or employees) when providing medical care. This was based on the theory of ostensible or apparent agency, meaning that the HMO was responsible or liable for another because of the appearance of control. This decision was based on the fact that the HMO advertised that it evaluated physician competency and based on documents it provided to its members, in which it identified itself as the care provider and guaranteed the quality of care.

Harrell v. Total Health Care, Inc.

781 S.W. 2d 58 (Mo. 1989)

Case summary: Ms. Harrell underwent a surgical procedure and, due to complications, required further surgery. The physician, hospital, and Total Health Care were named in a lawsuit. It was discovered that the doctor had prior lawsuits and quality complaints on his record, including complaints to the state medical board; however, no privilege actions were taken by the hospital. It was proven that the HMO had not performed reasonable inquiries into the doctor's competence, which would have uncovered the malpractice claims history.

Court findings: This case determined that an HMO owes a duty to the patient to conduct a reasonable investigation of a physician's credentials and reputation in the community. The corporate responsibility doctrine applies to managed care providers. Although it was ultimately held by the Missouri

Supreme Court that Total Health Care was immune from liability due to an unrelated statute, it did uphold the theory of corporate liability.

McClellan v. Health Maintenance Organization of Pennsylvania

604 A. 2d 1053 (Pa. 1992)

Case summary: Mrs. McClellan had a mole removed by her primary care physician, and despite her statement that the mole had recently undergone significant changes in size and color, the physician did not send a tissue sample for testing. It was malignant, and Mrs. McClellan died of melanoma two years later. A suit was filed against the physician for negligence, and then later a suit was filed against the HMO on the basis that the HMO was also negligent in not fully screening or evaluating the physician whom it held out to be its agent.

Court findings: HMOs are liable for the actions of their physicians on much the same basis as hospitals are liable for the negligence of members of their medical staff in the hospital. The HMO had a corporate responsibility and a contractual duty to provide reasonably competent physicians and referrals. The HMO was determined to be negligent in not fully screening or evaluating the physician whom it had held out to be its agent (ostensible agency).

Note: These three cases are considered landmark cases that set legal precedent within the managed care industry. Readers may research additional legal cases to further enhance their knowledge on this topic.

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New to managed care credentialing? Whether you work for a health plan or a hospital medical staff services department, this how-to guide answers all of your health plan credentialing and enrollment questions. Learn the regulatory and accreditation requirements related to managed care credentialing, including those from CMS, NCQA, and URAC. Author **Amy M. Niehaus, CPMSM, CPCS, MBA,** provides readers with the guidance to create a comprehensive and compliant credentialing program to support your health plan or to streamline your hospital's provider enrollment process through delegation. MSPs in all healthcare environments can benefit from understanding credentialing in the managed care world to support their organizational goals of compliance, operational efficiency, cost savings, and practitioner satisfaction.

This book will help you:

- Understand NCQA, URAC, and CMS requirements for health plans
- Develop a comprehensive and compliant managed care credentialing program
- Establish delegated credentialing agreements
- Audit credentials files
- Recognize how payer credentialing requirements impact other healthcare organizations
- Streamline provider enrollment through delegation
- Identify the differences between hospital and managed care credentialing
- Evaluate whether a credentials verification organization is right for your organization

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a division of BLR
100 Winners Circle, Suite 300
Brentwood, TN 37027
www.hcmarketplace.com

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