		<h2 style="text-align: center;">Policy and Procedure</h2>	
Name of Policy:		Credentialing and Re-credentialing Criteria - Practitioners	
Policy Number:		QI-CR-002	
Contracts:		<input checked="" type="checkbox"/> All counties <input type="checkbox"/> Capital Area <input type="checkbox"/> Franklin / Fulton	
Primary Stakeholder:		Quality Improvement Department	
Related Stakeholder(s):		All Departments	
Applies to:		PerformCare Associates and Providers	
Original Effective Date:		10/01/01	
Last Revision Date:		09/21/21	
Last Review Date:		09/06/23	
Next Review Date:		09/01/24	

Policy: PerformCare has a relationship with a National Committee for Quality Assurance (NCQA) approved Credentials Verification Organization (CVO), which will complete the primary source verification needed to credential and re-credential independent practitioners in the PerformCare network. PerformCare has a standard credentialing procedure for admitting providers into the network. PerformCare's Credentialing Committee, chaired by the Medical Director or designee, reviews all applicants to verify license, level of training experience, and specialty. In addition, PerformCare will assure that providers adhere to credentialing requirements under the *PA Department of Health regulations, Chapter 9, Managed Care Regulations, Subchapter L, Section 9.761 through 9.763.*

Purpose: To establish procedures for the credentialing and re-credentialing of professional clinicians and physicians within the PerformCare Provider network.

Definitions: **Certified in Addiction Medicine:** Refers to clinicians who have completed the course/examination requirements to receive a Certified Alcohol and Drug Counselor (CADC); Certified Advanced Alcohol and Drug Counselor (CAADC); board certifications from the Pennsylvania Certification Board (PCB) or other equivalent boards.

Facility: This term is used in reference to an institution, or organization that provides services for enrollees. Examples include hospitals, licensed outpatient clinics, licensed partial programs, etc.

Practitioner: This term is used to define an independent individual and/or group practice of similarly licensed practitioners (e.g., MD, Psychologist) contracted to provide services to PerformCare Members.

Provider: This term may be used interchangeably to represent an individual practitioner or a facility.

Acronyms:

- ABMS:** American Board of Medical Specialties
- ACGME:** American Council on Graduate Medical Education
- AE:** Account Executive
- ASD:** Autism Spectrum Disorder
- BH MCO:** Behavioral Health Managed Care Organization
- CAQH:** Council for Affordable Quality Healthcare Universal Provider Datasource
- CP:** Licensed Psychologist
- CRNP:** Certified Registered Nurse Practitioner
- CVO:** Credentials Verification Organization
- DEA/CDS:** Drug Enforcement Administration/Controlled Dangerous Substance
- DMF:** Social Security Death Master File
- EPLS:** Excluded Parties List System
- HHS-OIG:** U.S. Department of Health & Human Services-Office of Inspector General
- IBHS:** Intensive Behavioral Health Services
- LCSW:** Licensed Clinical Social Worker
- LMFT:** Licensed Marriage and Family Therapist
- LPC:** Licensed Professional Counselor
- MA:** Medical Assistance
- NCQA:** National Committee for Quality Assurance
- NPDB:** National Practitioner Data Bank
- NPI:** National Provider Identifier
- NPES:** National Plan and Provider Enumeration System
- NTIS:** National Technical Information Service
- PHI:** Protected Health Information
- SAM:** System for Award Management

Procedure:

1. Physician practitioners include Psychiatrists or Physicians who are certified in addiction medicine. Such practitioners must comply with the following criteria:
 - 1.1. Graduation from an accredited medical school or school of osteopathy.
 - 1.2. Current unrestricted medical license in the state in which practice is to occur.
 - 1.3. Professional liability insurance coverage in the amount of \$1,000,000 per occurrence / \$3,000,000 aggregate for physicians if not participating in the PA MCare Fund or

\$500,000 per occurrence / \$1,500,000 aggregate if participating in the MCare Fund.

- 1.4. Board certification or eligibility in psychiatry or completion of a residency in psychiatry approved by the ACGME. A psychiatrist is board eligible if he/she has successfully completed all the requirements of an ACGME certified (or equivalent) residency program.
- 1.5. Current controlled substances registration, DEA/CDS certificate.
- 1.6. Current resume or curriculum vitae that details a minimum five (5) year work history and clinical training; any gap in work history of six (6) months or more must be accompanied by explanation.
- 1.7. Be eligible and willing to become an enrolled Medical Assistance practitioner in order to participate in the HealthChoices Program.
- 1.8. Provision of current or pending malpractice claims; professional liability claims history; past, current, or pending legal actions to include settlements / lawsuits; any voluntary, involuntary revocation, suspension, limitation, or restriction of state license / certification / registration; censures or sanctions by a national, state or county medical or professional association for review.
2. Non-Physician practitioners include doctoral or master's level CP; LCSW; LPC; LMFT; CRNP with Mental Health Specialty; and other licensed, certified practitioners. Such practitioners must comply with the following selection criteria:
 - 2.1. Current, unrestricted license in the state where practice is to occur.
 - 2.2. Professional liability insurance in the amount of \$1,000,000 per occurrence/\$3,000,000 aggregate; lower limits may be allowed, based upon approval by the Credentialing Committee as being consistent with current community standards.
 - 2.3. Current resume or curriculum vitae that details a minimum five (5) year work history and clinical training; any gap in work experience of six (6) months or more must be accompanied by explanation.
 - 2.4. If the practitioner has prescriptive authority for controlled substances, then they must have a current DEA/CDS certificate.
 - 2.5. Be eligible and willing to be an enrolled Medical Assistance provider in order to participate in the HealthChoices Program.
 - 2.6. Provision of current or pending malpractice claims; professional liability claims history; past, current, or

pending legal actions to include settlements / lawsuits; any voluntary, involuntary revocation, suspension, limitation, or restriction of state license / certification / registration; censures or sanctions by a national, state or county medical or professional association for review.

3. The following items apply to both Physician and Non-Physician Practitioners:
 - 3.1. A practitioner cannot have any current disciplinary investigations or restrictions, including probation or any other disciplinary conditions imposed by the state-licensing agency.
 - 3.2. All independent physician and non-physician practitioners or members of a group practice not eligible for State licensure as a mental health outpatient clinic who have a direct contractual relationship with PerformCare and /or practitioners who bill using their own Medical Assistance Identification Number must complete and submit an individual credentialing application, which requires disclosure to PerformCare if any of the following have occurred:
 - 3.2.1. A felony conviction or misdemeanor conviction.
 - 3.2.2. A pending felony or misdemeanor allegation.
 - 3.2.3. Sanctions by a federal or state payment program (Medicare, Medicaid).
 - 3.2.4. Adverse professional review actions reported by any professional review board.
 - 3.2.5. Loss, suspension or limitation of medical license or narcotics license.
 - 3.2.6. Denial, loss or limitation of hospital privileges (or action pending).
 - 3.2.7. Malpractice claim, investigation or lawsuit filed.
 - 3.2.8. Cancellation or notification of impending cancellation of professional liability insurance.
 - 3.2.9. Physical or mental condition or substance abuse problem that would impair ability to practice.
 - 3.3. For HealthChoices, LCSWs, LPCs and LMFTs are considered supplemental services and require the BH MCO to request Medical Assistance enrollment.
 - 3.3.1. PerformCare will only provide Medical Assistance enrollment assistance to practitioners who:
 - 3.3.1.1. Meet a geographic access need; or
 - 3.3.1.2. Meet a need for a certain specialty; or
 - 3.3.1.3. Is serving a Member(s) who became a HealthChoices Member during treatment; and
 - 3.3.1.4. Receives approval of County HealthChoices Primary Contractor.

4. Primary Source Verification – Initial and Re-credentialing Applications for Practitioners.
 - 4.1. Primary source verification is completed by an NCQA certified CVO for each practitioner who is determined to have an independent relationship with PerformCare. An independent relationship exists if PerformCare intends to refer Members directly to a practitioner rather than to a facility. The CVO uses the following verification sources:
 - 4.1.1. Verification of licensure in the state where the practitioner has an office. This is verified directly from the state licensing agency to include sanction information.
 - 4.1.2. Verification of clinical privileges is obtained through oral or written confirmation from the institution(s) designated on the application.
 - 4.1.3. DEA / CDS certificate is verified by obtaining a copy or verified by the NTIS as current.
 - 4.1.4. Verification of education when not board certified. Verification is obtained directly from the school or from the Pennsylvania state licensing agency. The education verification is required at initial credentialing only.
 - 4.1.5. Verification of board certification. The CVO is a data warehouse and information is provided directly to CVO from the ABMS. Verification is completed by review of data provided directly to the CVO from Medical Boards.
 - 4.1.6. Documentation of minimum five (5) years' work history per review of the resume or vitae.
 - 4.1.7. Verification of malpractice insurance coverage by obtaining current face sheet.
 - 4.1.8. Verification of malpractice claims history by collecting history of malpractice settlements from the NPDB or directly from the insurance carrier when available.
 - 4.1.9. Verification of Medicare and Medicaid sanctions completed via a query of NPDB.
 - 4.1.10. Medichex is referenced to assure practitioners are not precluded or excluded from PA Medical Assistance.
 - 4.1.11. HHS-OIG is referenced to assure practitioners are not excluded from participation in any federal health care program.
 - 4.1.12. SAM formerly known as EPLS is referenced to assure that practitioners are not excluded from

receiving Federal contracts, certain subcontracts and certain Federal financial and/or financial benefits.

- 4.1.13. NPPES is referenced to assure that practitioners have a valid NPI number.
 - 4.1.14. DMF is referenced to assure that the social security number reported on the practitioner's application has not been reported to the Social Security Administration as belonging to a deceased person.
5. Delegation Activities and Oversight
- 5.1. PerformCare has made a business decision to delegate primary source verification activities to a NCQA approved CVO. The CVO is contracted to mail initial and re-credentialing applications and complete the primary source verification needed to credential and re-credential practitioners in the PerformCare network. PerformCare credentials and re-credentials the following types of practitioners:
 - 5.1.1. All practitioners who have an independent relationship with PerformCare.
 - 5.1.2. Practitioners who see enrollees outside an inpatient hospital setting or outside provider-based settings.
 - 5.1.3. Practitioners who are provider-based but see PerformCare's enrollees as a result of their independent relationship with PerformCare.
 - 5.1.4. Non-physician practitioners who have an independent relationship with PerformCare and who provide care under PerformCare benefits.
 - 5.2. A specific description of the activities performed by the CVO is located in section 3 and 4 of this policy. PA Standard Applications or CAQH numbers are submitted to the CVO by PerformCare and returned with completed verifications within 45 days.
 - 5.3. The CVO provides an audit sheet with each returned file so that PerformCare can monitor quality continuously. Upon receipt of each credentialing file, the Quality Performance Specialist assigned to Credentialing reviews the audit sheet to assure that timeframes and requirements are met for the file.
 - 5.4. The CVO is required to report on a monthly basis practitioners whose credentials were verified in the previous month. The CVO will also provide a report of practitioners that should be in the process of re-credentialing on a monthly basis. PerformCare reviews the CVO's performance relative to quality of work via weekly reports and monthly monitoring meetings.

- 5.5. PerformCare monitors the length of time it takes the CVO to complete a file. Per the contractual agreement, the average turnaround time must be under 30 days.
- 5.6. All CVO verifications of practitioner credentialing files are reviewed for quality and accuracy as they are received for processing. Upon receipt from CVO, PerformCare Quality Performance Specialist assigned to Credentialing conducts a final review of each application for completeness.
6. Credentialing Decision Notification and Practitioner Right to Correct Erroneous Information
 - 6.1. A practitioner may request information about the status of their application at any time upon request. Such requests will be made to the Quality Performance Specialist assigned to Credentialing who is free to provide all information about the status of the application such as that it was received, sent to the CVO for primary source verification, that it is scheduled to be presented to credentialing committee, etc.
 - 6.2. The practitioner will be notified of the decision of the Credentialing Committee within 20 business days of the decision. With the exception of NPDB information and peer references, the practitioner has the right to review information received by PerformCare and to be notified if information received from the CVO is substantially different than was reported by the provider. The practitioner will be notified of the right to review information in the request for application forms; the decision notification letter; and the provider manual. Applications will be processed, and credentialing activities will be completed within 180 days of the attestation date.
 - 6.3. The practitioner has the right to correct erroneous information submitted by another party. Corrections will be submitted in writing to the Director of Quality Improvement within 10 business days of notification. Corrections or information received will be reviewed and documented in the practitioner's file. The practitioner will be notified of this right in the credentialing decision notification letter as described above. During the process of correcting the erroneous information, the provider status will be pended if the error impacts the credentialing decision.
 - 6.4. The credentialing program described above applies to any behavioral health provider. Provider rights

information is distributed to all providers in the PerformCare Provider Manual.

7. Site Visit Requirements for Credentialing and Re-credentialing
 - 7.1. Initial site visits will be required for any potential high-volume practitioner.
 - 7.1.1. Outpatient services (individual, family and group therapy, medication management and psychiatric evaluations) are considered to be high-volume services. Outpatient is typically the gateway to higher levels of care and captures the largest segment of unique Members served.
 - 7.1.2. In order to be identified as a potential high-volume practitioner who would require a site visit, the practitioner will indicate that they have existing capacity to serve more than 200 unique Members.
 - 7.1.2.1. The initial site visit to the office of potential high-volume behavioral healthcare practitioners will occur prior to the credentialing decision.
 - 7.1.2.2. The office site visit includes evaluation of the site for accessibility, appearance, adequacy of waiting and treatment rooms, appointment availability, and appropriate treatment record keeping practices.
 - 7.1.2.3. The minimum score for initial and re-credentialing visits is 80%. The site visit tool is included as an attachment, *Attachment 1 PerformCare Site Visit Tool*.
 - 7.2. If the practitioner's site does not meet PerformCare thresholds for acceptable performance, the AE will notify the practitioner of deficiencies and re-evaluate the site within six (6) months. If the practitioner does not meet the threshold after six (6) months, PerformCare has the option to discontinue efforts. In such a case, the practitioner may reapply when corrections have been made.
 - 7.3. AEs are responsible to complete all credentialing and re-credentialing site visits. Every effort will be made to coordinate the AE site visit with the treatment record review as outlined in section 9.1.2 of this policy. The Vice President of Operations is responsible to assure that each AE has initial training in the survey process as well as the survey tool. New employees are trained on the survey process and tool as part of new employee training. Ongoing training is provided through staff meetings and individual supervision meetings. Detailed instruction is

also available in the Provider Relations Handbook for reference.

- 7.3.1. For re-credentialing of high-volume practitioners, the AE will conduct the site visit in-person for the first re-credentialing cycle. Subsequent re-credentialing site visits will be conducted in the following manner based on upon the score of the first re-credentialing site visit:
 - 7.3.1.1. 95-100%: The PerformCare site visit will be replaced by the most recent state licensure inspection report;
 - 7.3.1.2. 80-94%: The site visit will be conducted by the AE in-person, via self-audit tools, or a combination of both;
 - 7.3.1.3. 79% or lower: The AE will follow the process as outlined in Section 7.2.
8. Performance and Quality of Care Monitoring at time of Re-credentialing
 - 8.1. PerformCare's review of network practitioners' performance is an ongoing process; however, all practitioners are formally re-credentialed at least every three (3) years. PerformCare reviews the practitioner's licensure, malpractice insurance, and membership in their respective national organizations, compliance with PerformCare standards, accessibility to Members, clinical and administrative outcomes, and the results of satisfaction surveys mailed to all treated Members, when available. The re-credentialing process also includes review of the practitioner's performance since the last credentialing decision.
9. Performance Monitoring
 - 9.1. Ongoing performance monitoring for independent practitioners is completed on the following:
 - 9.1.1. Member Complaints and Grievances
 - 9.1.2. Results of quality improvement initiatives, monitoring, and evaluation activities including Treatment Record Reviews as outlined in *QI-026 Provider Treatment/Service Record Reviews*.
 - 9.1.3. Practitioner Profiles, when applicable
 - 9.1.4. PerformCare Member Satisfaction Surveys, when available
 - 9.1.5. Critical Incident Reports
 - 9.2. In addition, PerformCare monitors independent practitioner performance relative to evaluation of clinical outcomes, administrative outcomes, and internal concerns on an ongoing basis. The Re-Credentialing

Provider Summary is attached, *Attachment 2 Re-Credentialing Provider Summary*. The summary is completed for each independent Practitioner as they undergo re-credentialing.

9.3. Problematic issues discovered through the profiling process are addressed immediately with the practitioner. Profiling results are also reviewed and considered during the re-credentialing process.

10. The Credentialing Committee

10.1. The completed, verified application of a practitioner is presented to the Credentialing Committee as defined in *QI-CR-005 Credentialing Committee*.

10.2. At least every three years, PerformCare network practitioners undergo a re-credentialing process including re-verification of credentials and review of other relevant clinical and administrative information.

11. Listings in Provider Directory

11.1. PerformCare ensures that Practitioner information that is published in the Provider Directory and shared with Members is as accurate as possible. Practitioners receive a form to complete and fax to PerformCare should changes to their information be necessary. The form is provided upon request and included in the Provider Manual.

Related Policies: *PR-010 Provider Training and Orientation*
QI-015 Incorporating Consumer Satisfaction Information in the Quality Improvement Process
QI-026 Provider Treatment/Service Record Reviews
QI-CR-003 Credentialing Progressive Disciplinary Actions for Providers
QI-CR-005-Credentialing Committee

Related Reports: None

**Source Documents
and References:**

PA Department of Health regulations, Chapter 9, Managed Care Regulations, Subchapter L, Section 9.761 through 9.763.


**Superseded Policies
and/or Procedures:**

PR-004 Credentialing and Re-Credentialing Criteria

Attachments:

Attachment 1 PerformCare Site Visit Tool
Attachment 2 Re-Credentialing Provider Summary

Approved by:


Primary Stakeholder

Initial/Recredentialing
Credentialing Site Visit Tool

Date of Site Visit:	
Initial/Recredentialing	
Name of AE completing Site Visit:	
Provider Score:	#DIV/0!
Total Yes:	0
Total No:	0
Pass/Fail:	
Recommendations to Providers:	
Required Corrective action plan required and accepted:	
Comments:	
PROVIDER DEMOGRAPHICS:	
Provider ID:	
Name of Provider:	
Physical Address Where Credentialing Review Occurred:	
Phone Number of Facility:	
Fax Number of Facility:	
Contact Person Name:	
Title of Contact Person:	
Contact Person Email Address:	
AFTER HOURS TELEPHONE VERIFICATION:	
Date Of Call:	
Time of Call:	
Are urgent/emergent instructions provided including on-call staff/Crisis/ER/911:	
PROVIDER MANUAL REVIEW:	
Copy of or link to provider manual given:	
Member Rights:	
Access Standards:	
Freedom of Choice:	
Claims Submission Timeframes:	
Authorization Processes:	
Review of TPL requirements by provider:	
PerformCare Complaints and Grievances Brochure distributed:	
QUALITY IMPROVEMENT:	
Corporate Compliance policy and/or plan exists:	
Name of Corporate Compliance officer:	
GROUP ONLY:	
The group has an adequate QI plan to detect and address quality issues:	
Process to identify quality issues (i.e. routine self audits-must be quantified):	
Process identified to report quality issues:	
Process identified to analyze/track and determine action steps:	
GENERAL POLICY & PROCEDURE REVIEW:	
Protect patient confidentiality (GROUP ONLY):	
Confidentiality agreements for staff and vendors:	
Report program and licensure changes to BH-MCO and appropriate entities:	
Critical Incident Reporting to BH-MCO and appropriate entities:	
Address offering of provider choice:	
Address compliance with the Child Protective Services Law (previously Act 124 of 1975) relative to mandatory reporting. Mandated Reporter training must be done, and redone every 2 years:	

Initial/Recredentialing
Credentialing Site Visit Tool

Management and disposal of data storage (paper and electronic) for current and archived files that is HIPAA compliant:	
Policy that outlines all staff trainings required per year and how individual staff plans are generated:	
Individual Staff training plan example provided:	
HR POLICY & PROCEDURE REVIEW:	
PA Code Check Policy: <i>(all checked prior to hire and every 3 years)</i>	
Resume reflects continuous work experience and breaks are explained:	
Primary source verification of education is conducted for all clinical staff:	
Verification of licenses directly with Department of State (DOS):	
Documentation of disciplinary actions identified by DOS:	
Board Certification Status:	
For prescribers, DEA Certification is confirmed and current:	
Evidence of malpractice/liability insurance:	
Child Abuse Clearances (PA Act 33) Policy: <i>(checked prior to hire and every 5 years)</i>	
PA Child Abuse History Clearances:	
PA Criminal Record Checks:	
FBI Criminal Background Checks:	
Sanction/Exclusion Check Policy: <i>(checked monthly)</i>	
HHS-OIG is referenced to assure employee is not excluded from participation in any federal health care program:	
SAM is references to assure that employees are not excluded from receiving federal contracts, certain subcontracts and certain federal financial and non-financial benefits:	
Medicheck is referenced to assure employees are not precluded or excluded from PA MA:	
NPDB - National Practitioner Data Bank (optional):	
FACILITIES ONLY:	
Have sanction/exclusion checks been submitted to PerformCare Corporate Credentialing?	
Date Submitted:	
Verified by AE:	

Initial/Recredentialing
Credentialing Site Visit Tool

EMPLOYEE FILE REVIEW (FACILITY ONLY):
(Review of 2 licensed staff files, with one staff being an MD/DO) :

EMPLOYEE NAME #1 (Licensed Staff):

PA Code checks:
(all to be checked prior to hire and every 3 years)

Work History - Resume reflects continuous work experience. Breaks are explained:	
Education/Training - Highest level of education is verified at the primary source:	
License verified on DOS website - print out in employee chart: Board Certification Status:	
For Prescribers, DEA Certification is confirmed and current: Evidence of malpractice/liability insurance:	

Child Abuse Clearances (PA Act 33) checks:
(all to be checked prior to hire and every 5 years)

PA Child Abuse History Clearances:	
PA Criminal Record Checks:	
FBI Criminal Background Checks:	

EMPLOYEE NAME #2 (MD/DO):

PA Code checks:
(all to be checked prior to hire and every 3 years)

Work History - Resume reflects continuous work experience. Breaks are explained:	
Education/Training - Highest level of education is verified at the primary source:	
Original license reviewed:	
License verified on DOS website - print out in employee chart: Board Certification Status:	
For Prescribers, DEA Certification is confirmed and current: Evidence of malpractice/liability insurance:	

Child Abuse Clearances (PA Act 33) checks:
(all to be checked prior to hire and every 5 years)

PA Child Abuse History Clearances:	
PA Criminal Record Checks:	
FBI Criminal Background Checks:	

Initial/Recredentialing
Credentialing Site Visit Tool

FREEDOM OF CHOICE REVIEW:	
Documentation of freedom of choice Member #1:	
Documentation of freedom of choice Member #2:	
Documentation of freedom of choice Member #3:	
Documentation of freedom of choice Member #4:	
Documentation of freedom of choice Member #5:	
PHYSICAL SPACE INSPECTION:	
GROUP INSPECTIONS:	
Printed material is appropriate to age and developmental needs of population:	
Signs and brochures are in language based on population (<i>Spanish materials required for Dauphin, Franklin, Lancaster, Lebanon only</i>):	
Medical records are kept in a separate area and locked:	
Medical records are stored in an organized manner and a specific member file can be easily located:	
Policy and procedure manuals are readily available:	
Appointment book indicates provider has capacity to offer a routine appointment within 7 calendar days: <i>(If self audit, date required)</i>	
Waiting area accommodates the site of the OP practice (minimum of 4 chairs or 2 chairs per practitioner on duty):	
Waiting area is well-lit:	
Waiting area has office hours posted:	
Patient's rights are posted in waiting area OR provided at intake:	
Office is handicapped accessible (i.e. bathrooms equipped with handrails / emergency exits are handicapped accessible). For offices that are not handicapped accessible, staff are willing to make special provisions to accommodate:	
Information about other services available:	
Certificate of Occupancy available:	

Re-credentialing Provider Summary

PROVIDER DEMOGRAPHICS	
PROVIDER NAME:	
LEVELS OF CARE:	
TOTAL NUMBER OF SITES:	
TOTAL NUMBER OF UNIQUE MEMBERS SERVED:	
TIME PERIOD UNDER REVIEW:	

CREDENTIALING DISCIPLINARY HISTORY	
Has this provider been referred to the Credentialing Committee during the period under review?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If YES, brief description of the reason for the referral:	
Have referrals been suspended to this provider during the period under review?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If YES, list the source (i.e. QOCC, Credentialing); the reason; and date range of the suspension:	

ACCOUNT EXECUTIVE REVIEW	
High Volume – AE Site Visit Required?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Date of Site Visit:	
Score:	

LEVEL OF CARE REVIEW			
		LEVEL OF CARE:	
QI REVIEW:	NUMBER OF REFERRALS DURING THE PERIOD UNDER REVIEW:		
	NON-ROUTINE SITE VISIT REQUIRED?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
	QUALITY REVIEW COMPLETE?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
TREATMENT RECORD REVIEW:	CONTRACT(S):	<input type="checkbox"/> CABHC	<input type="checkbox"/> TMCA
	SCORE(S):		
	QIP REQUIRED?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	QIP RECEIVED AND APPROVED?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A

STATISTICS (All Levels of Care and Contracts)	
NUMBER OF MEMBER COMPLAINTS DURING THE PERIOD UNDER REVIEW:	
OF THOSE, NUMBER OF SUBSTANTIATED COMPLAINTS:	
NUMBER OF ADMINISTRATIVE APPEALS DURING THE PERIOD UNDER REVIEW:	
OF THOSE, NUMBER OF APPEALS REJECTED/DENIED:	

SUMMARY COMPLETED BY:	
DATE OF SUMMARY:	