Government Business Division
Policies and Procedures

Section (Primary Department) **Quality Management**	**SUBJECT (Document Title)** **Termination of Practitioners for Non-Compliance with Facility Site or Medical Record Reviews - CA**

Effective Date	**Date of Last Review**	**Date of Last Revision**	**Dept. Approval Date**
05/25/2000	11/17/2023	11/17/2023	11/17/2023

Department Approval/Signature:

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid/CHIP**	☐ Arkansas	☐ Iowa	☐ Nevada	☐ Tennessee
☐ **Medicare/SNP**	☒ California	☐ Kentucky	☐ New Jersey	☐ Texas
☒ **MMP/Duals**	☐ Colorado	☐ Louisiana	☐ New York	☐ Virginia
	☐ District of Columbia	☐ Maryland	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Minnesota	☐ North Carolina	☐ West Virginia
	☐ Georgia	☐ Missouri	☐ Ohio	☐ Wisconsin
	☐ Indiana	☐ Nebraska	☐ South Carolina	

POLICY:

Anthem Blue Cross Medi-Cal (Plan) is responsible for assessing compliance with facility site and medical records standards, pursuant to Title 22, California Code of Regulations, Section 56230 and California Department of Health Care Services (DHCS) Managed Care Quality and Monitoring Division (MCQMD) All Plan Letter 22-017. The site review process is the part of the Plan's quality improvement program that evaluates Primary Care Provider (PCP) sites to support safe and effective provision of clinical services provided within the Plan's provider network. The Plan may initiate contract termination for physician non-compliance with the Plan's Facility Site and Medical Record Review (FSR/MRR) Process as described in policy *CA_QMXX_013 Facility Site and Medical Record Review Process.*

DEFINITIONS:

Certified Master Trainer (CMT): A Physician, Nurse Practitioner (NP), Physician Assistant (PA), or Registered Nurse (RN) certified by the State of California DHCS MCQMD to conduct reviews (as referenced in this policy as a "Reviewer") and certify candidates as Reviewers.

Certified Site Reviewer (CSR): A Physician, Nurse Practitioner (NP), Physician Assistant (PA), or Registered Nurse (RN) who has completed site review training and is certified by the Plan's CMT to conduct reviews (as referenced in this policy as a "Reviewer").

Facility Site Review (FSR): The process to ensure that all contracted PCP sites have sufficient capacity to provide appropriate primary health care services and can maintain patient safety standards and practices.

Independent Practice Association (IPA): An incorporated association of independent physicians which has entered into an Agreement with the Plan to provide and arrange for health services to members.

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Medical Record Review (MRR): The process to review medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.

Participating Medical Group (PMG): A legal entity organized under the laws of the State of California and comprised of physicians who desire to provide and arrange for health services to members.

PROCEDURE:

I. Physician Contract Requirements

1. Network physicians sign a legally binding contract with the Plan or with a PMG or IPA in which they agree to cooperate with the Plan's administration of its quality improvement program and to comply with requirements set forth in the Provider Manual provided by the Plan. The Provider Manual describes the state mandated FSR and MRR Standards.

2. There is an established corrective action plan (CAP) process to correct FSR and MRR deficiencies that physicians must follow. When a contracted physician fails to comply with the CAP process, the physician is in breach of contract and shall be subject to the termination provisions of the contract.

II. Termination Process for Non-Passing Score

1. When a network provider receives a non-passing score, the Plan that performed the review shall notify the provider of the score, all cited deficiencies and CAP requirements. Any Plan participating in the health plan collaborative process may, at its sole discretion, remove a provider with a non-passing score from its network or offer the provider an opportunity to correct the deficiencies via the CAP process.

2. Provider sites that score below 80% in either the FSR or MRR for two consecutive reviews must score a minimum of 80% in the next review in both the FSR and MRR to remain providers in good standing in the Plan network. Sites that do not receive a minimum passing score of 80% in both the FSR and MRR shall be terminated from the network per All Plan Letter 22-017.

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III. Termination Process for Non-Compliance with FSR/MRR

1. The Reviewer shall make at least three (3) attempts within a two (2) week period to contact the provider to schedule an FSR and/or MRR.

2. After failure to complete the FSR/MRR due to inability to contact the provider or to decide on a mutually agreeable date and time for the review, the Reviewer sends the *Auto Schedule Letter* via certified/tracked mail to the provider with a scheduled date of review. The letter shall advise the provider that he/she has two weeks to select another review date or the reviewer shall proceed with the review on the scheduled date in the letter. The letter also states that failure to allow completion of the review shall result in closure of the site to assignment of new members.

3. If the provider does not make contact to change the review date, the Reviewer will visit the provider's office on the scheduled date to perform the review.

4. If the provider does not allow the Reviewer to perform the survey when he/she arrives on the scheduled date, the Reviewer shall fax a copy of the *Failure to Schedule Letter* to the provider. The letter shall advise the provider that his/her Plan patient panel is immediately closed to assignment of new members. The letter also states that if the site review is not scheduled and completed within two (2) weeks, the provider shall be administratively terminated from the Plan's network for non-compliance with contractual agreements, and members shall be appropriately re-assigned. A copy of the letter shall be sent to the provider via certified/tracked mail.

5. The Reviewer initiates the internal notification process to close the panel to new members by forwarding a copy of the letter to the internal departments responsible for this activity. External groups, such as the IPA/PMG and the Collaborative Health Plans shall also be notified as applicable.

6. The Plan closes the provider's panel to assignment of new members which becomes effective on the date the transaction is processed.

7. During the two (2) week period, described above, the IPA/PMG, other Collaborative Health Plans and/or appropriate Plan representatives may be asked to assist with bringing the site into compliance.

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8. If, at the end of this two (2) week period, the provider remains non-compliant with completion of the FSR and/or MRR, the Plan initiates the administrative termination process of the provider's contract.

IV. Termination Process for Non-Compliance with DHCS CAP Timeline

1. If after thirty (30) calendar days following a completed FSR, issuance of a report of audit findings and a request for a CAP, and the provider is taken through the CAP completion and escalation process as outlined in the most current CAP Tracking Form, the provider fails to comply with the Critical Element (CE) CAP timelines as described in Policy CA_QMXX_013 *Facility Site and MRR Process*, without good cause or an extension authorized by the Plan, the provider shall be terminated from the Plan network.

2. If after ninety (90) days following a completed FSR and/or MRR, issuance of a report of audit findings and a request for a CAP, and the provider is taken through the CAP completion and escalation process as outlined in the most current CAP Tracking Form, the provider fails to comply with the non-CE CAP timelines as described in Policy CA_QMXX_013 Facility Site and MRR Process, without good cause or an extension authorized by the Plan, the provider shall be terminated from the Plan network. If the Plan approves an extension past ninety (90) days, but after one hundred twenty (120) days following a completed FSR and/or MRR and issuance of a report of audit findings and a request for a CAP, the provider fails to comply with the CAP timelines without good cause or an extension authorized by DHCS beyond the 120 days, the provider shall be terminated from the Plan network.

3. The termination letter is signed by the Medical Director and sent to the provider via certified/tracked mail. A copy of the letter is sent to the Collaborative Health Plans. The Clinical Quality Program Specialist shall forward a copy of the letter to the Plan's Demographic Data Operations (DDO) Department, which completes the termination process.

V. Reinstatement Criteria

1. Providers who were terminated for non-compliance with CAP timelines, non-compliance with completing their full-scope reviews, or who failed their FSR and/or MRR during their last three Full Scope Reviews may not reapply for participation in the network for at least twelve (12) months after the effective

date of the termination. In Los Angeles County, providers may not reapply for participation in the network for at least thirty-six (36) months after the effective date of the termination.

VI. Member Notification

1. Members are notified, in writing, of the practitioner's termination within thirty (30) days of the termination date.

REFERENCES:

- CA DHCS Contracts, Exhibit A, Attachment 4
- CA_PNXX_008: Termination of Provider for Business Reasons
- CA_QMXX_013: Facility Site and Medical Record Review Process
- California Code of Regulations, Title 22, Section 56230
- Corrective Action Plan (CAP) Tracking Form
- DHCS MCQMD All Plan Letter 22-017 - *Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review*
- LA Care Policy FSR-016 Consolidated Facility Site, Medical Record Review Process
- Medi-Cal Managed Care Program Participating Physician Agreement

RESPONSIBLE DEPARTMENTS:

Primary Department:
Quality Management Department

Secondary Department(s):
Demographic Data Operations (DDO)
Medicaid Medical Director
Provider Engagement and Contracting

EXCEPTIONS:

None

REVISION HISTORY:

Review Date	Changes
08/09/12	• Changed SSB to Medicaid

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Review Date	Changes
	• Updated definition of PMG • Changed PCDA to PDO • Changed reference from CA PNXX 303 to CA PNXX 008
10/09/12	• Changed PL 11-013 to 12-006
04/03/13	• Added Medicare-Medicaid Plan to the plans covered by this policy • Changed policy to be more generic to be inclusive of both Medi-Cal and Medicare-Medicaid Plan processes
10/01/13	• Added a copy of the termination letter is sent to the collaborative health plans • Clarified that members are notified after appeal process has been completed and decision to terminate upheld.
09/02/14	• Replaced PL 02-002 with 14-004 • Added language that provider must be removed if he/she fails the FSR two or more times
02/12/16	• Correction made to Physician Appeal Process section to remove verbiage on new timelines • Three year reinstatement clause implemented for LA County
05/19/16	• Off-cycle edit to update Primary department from Quality Management to Vendor Selection Oversight Committee (VSOC)
11/09/16	• Changed Primary Department to Quality Management • Certified Site Reviewer (CSR) replaced the Clinical Quality Compliance Administrator (CQCA) title • Quality Management Consultant title replaced the former Clinical Entity Compliance & Clinical Investigations (CEC & CI) Department • Extended reapplication process for terminated providers in LA County from 12 months to 36 months as required by LA Care • Made some updates to the References section.
12/28/17	• Annual review. • Updated policy based on current practice (CAP extension approval beyond 120 days by DHCS, and provider appeal process)
01/14/19	• Annual review – no changes
01/17/20	• Annual review – no changes
05/11/20	• Off-cycle edits based on the release of DHCS All Plan Letter 20-006 (e.g. updated FSR definition, added MRR definition, revised CAP timelines, removed provider Appeal Process, etc.)

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Review Date	Changes
	• "Reviewer" replaced the "CSR" title to allow reference to both CMT and CSR reviewer types • Updated Reinstatement Criteria including the addition of the 12 month reinstatement period for terminated providers outside of Los Angeles County • Updated Responsible Departments section • Updated References section including removal of DHCS Policy Letter 12-006 (Physical Accessibility Review Survey)
12/16/20	• Annual Review • Updated DHCS division name to Managed Care Quality and Monitoring Division (MCQMD) • Updated CAP extension requests under 120 days to be approved by Anthem per APL 20-006. • Updated policy, Certified Master Trainer definition, procedure, and references
12/02/21	• Annual review • Updated the escalation process under Termination Process for Non-Compliance with FSR/MRR and DHCS CAP Timeline • Added the CAP Tracking Form to the References Section • Removed embedded PDF file of LA Care FSR-016 Policy (dated 10/20/17)
12/08/22	• Annual Review • Updated Policy and Procedure sections; Updates based on the release of the DHCS MCQMD All Plan Letter 22-017; Removed all references to DHCS APL 20-006 • Updated Anthem references to Anthem Blue Cross and/or Plan to comply with branding guidelines throughout policy • Alphabetized and updated References section • Alphabetized Secondary Department(s) and updated the name of Provider Data Operations to Demographic Data Operations
11/17/23	• Annual Review • Removed CareMore as a secondary department • Added an "Exceptions" section to match GBD Template

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