AAAHC Requirements for Primary Care Physicians

I. Professional

1. Must possess current state license.
2. NPI number.
3. Possess current DEA registration, if applicable.
4. Malpractice Insurance
    a. Providers who lack medical malpractice insurance must post such information in a prominent location in their office.
5. Board Certification, if applicable.
6. Practice in an ethical and legal manner.
7. Provide care consistent with current professional knowledge.
8. Comply with clinical practice guidelines.
9. Maintain proper business associate agreements.
10. Credentialing/ Re-credentialing
    a. Provide history of education, training, and experience.
    b. Provide peer evaluation/ reference.
    c. Possess medical liability coverage.
    d. Apply for re-credentialing every three years.
    e. Provide information regarding any denial, suspension, limitation, termination or nonrenewal of professional privileges at any hospital, health plan, medical group or other health care entity.
    f. Disclose any Medicare/Medicaid Sanctions.
    g. Provide information on conviction of a criminal offense (other than minor traffic violations).

II. Clinical Records/Compliances

Clinical Records**:**

1. Establish a clinical record for each member receiving care that includes at least:
    a. Name.
    b. Identification number.
    c. Date of birth.
    d. Gender.
    e. Responsible party, if applicable.
    f. Histories and physicals.
    g. Progress notes.
    h. Documentation of presence or absence of allergies and untoward reactions to drugs and/or materials which are reviewed and updated to reflect new allergies or sensitivities.
    i. Other information such as lab reports, x-rays, and operative notes and consultations.
    j. Documentation of advance directives.
    k. Documentation of any designated person or legally authorized individual and opportunity to participate in decisions or contraindication for medical reasons in clinical record including informed consents, progress notes, etc.
    l. Documentation health education and wellness promotion services.

   m. Documentation of any significant medical advice given by telephone or online, including medical advice provided after-hours. Should be signed or initialed by authorized provider.
2. Maintain complete, comprehensive, legible, and confidential records that are documented accurately in a timely manner, and readily accessible to authorized health care professionals within the provider network treatment centers.
3. Maintain electronic and/or paper clinical records and a health information system from which information can be retrieved promptly.
4. If a member has 3 or more visits/admissions, or the clinical record is complex and lengthy, a summary of past and current diagnoses or problems, including past procedures, should be documented in the member's record to ensure continuity of care.
5. Any member involved in research activity should be identified and entries in records should be clearly contrasted/separate from entries for non-research related care.

Compliance:

1. Must comply with Member's Rights and Responsibilities policy and members and providers have access to policy.
2. Must comply with Provider Contract.
3. Must comply with policies regarding release of PHI, with providers and members having access to policies.
4. Must comply with HIPAA and Omnibus
   a. Member information and records must be protected from loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure.
   b. Ensure confidentiality of records.
   c. Clinical records must be maintained in a predetermined, organized, and secure format.
5. Must comply with policies and procedures regarding:
   a. Confidentiality statements.
   b. Retention of active records and retirement of inactive records.
   c. Release of information contained in records.
6. Member's clinical record should include thorough documentation for each visit that incorporates:
   a. Date, department (if applicable), and network provider's name.
   b. Chief complaint or purpose of visit.
   c. Clinical findings.
   d. Diagnosis or impression.
   e. Studies ordered (i.e. labs and/or diagnostic imaging).
   f. Care rendered and therapies administered.
   g. Document changes in prescription and non-prescription medications with name, dosage, and instructions, when available.
   h. Disposition, recommendations, and instructions given to member.
   i. Documentation of missed and canceled appointments.
   j. Signature of physician or other author of clinical record entry.
7. Providers should implement, and have access to, policies that address the following:

   a. Provide members, their designated person(s), or a legally authorized individual with complete information concerning their diagnosis, evaluation, treatment and prognosis.
   b. Give members the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical or mental health reasons.
   c. Allow members the opportunity to approve or refuse the release of their medical records except when required by law.
8. Providers comply to provide quality healthcare and continuity by:
   a. Timely and appropriately providing a diagnosis based on findings of initial assessment.
   b. Ensuring content, format, and sequence of clinical records are uniform.
   c. Reviewing and reconciling all medications, including over-the-counter and dietary supplements.
   d. Providing treatment consistent with clinical impression or working diagnosis and performing only necessary diagnostic and/or therapeutic procedures or treatments.
   e. Ensuring authorizations and denials are consistent with EOC provided and that medically defined services are consistent with state regulations.
   f. Offering appropriate and timely consultations.
   g. Providing appropriate and timely referrals.
   h. If applicable, records of patients treated elsewhere or transferred to another healthcare provider are present.
   i. Ensuring records reflect any discussions with the patient concerning the necessity, appropriateness, and risks of proposed care, surgery, or procedures, as well as discussions of treatment alternatives and advance directives as applicable.
9. Providers must understand that members have the right to refuse to participate in research.
10. Providers should make credentials available for members if requested.
11. Specialty providers should communicate clinical findings with referring provider.
12. Providers must provide interpretive services for members as appropriate.
13. Provide convenient access to reliable, up-to-date information pertinent to clinical, educational, and administrative services.
14. Ensure educational programs are consistent with CMS Plan's mission, goals, and objectives.
15. Permit CMS Plan access to clinical records of each of its members for periodic review.
16. Make provisions for after-hours and emergency care, as well as regular care and urgent care appointments.

III. Facility/ Site Safety and Maintenance

Fire Drills and other Safety Measures:

1. Facilities must comply with state and local codes and fire prevention regulations, building codes, or any other federal regulations.
2. Facilities should be smoke-free and smoking permitted in designated areas only.
3. Fire- fighting equipment must be properly placed and maintained.

4. Have emergency exit signs prominently displayed with emergency power capability at all exits from each floor or hall.
5. There should be emergency lighting as appropriate to the facility, to provide adequate evacuation of members and staff in case of an emergency.
6. Stairwells should be protected by fire doors as applicable.

Building/ Site Safety:

1. Complies with Americans with Disabilities Act, OSHA rules and regulations, as appropriate.
2. Ensure a safe and sanitary practice environment
3. Have processes in place for proper identification, management, handling, transport, and disposal of hazardous materials, reagents, solutions, and waste.
4. Have written emergency and disaster preparedness plans to address internal and external emergencies that ensures member and staff safety and includes provisions for safe evacuation of individuals during an emergency.
5. Conduct and document emergency drills at least once annually and as per any other state and local guidelines.
6. Have processes in place for reduction and avoidance of falls or physical injuries involving patients, staff, and others.
7. Provide reception areas, restrooms, and telephones in accordance with visitor volume.
8. Provide adequately marked patient, visitor, as well as disabled parking areas.
9. Provide accommodations for disabled individuals.
10. Provide exam rooms, dressing rooms, and reception areas that are constructed and maintained to ensure member privacy during interviews, examinations, treatment, and consultation.
11. If laboratory services are available, the lab must be CLIA certified.

Staff development/ Medication Safety:

1. Have methods for identifying and preventing infections in accordance with nationally recognized standards such as those of the CDC.
2. Provide education to staff on appropriate hand hygiene and safe injection practices.
3. Have a safety program in place that includes prevention, monitoring, and management of medication errors.
4. Ensure medications, vaccines and samples are properly stored and monitor for expiration dates.
5. Ensure prescription pads are controlled and secure form unauthorized access.
6. Maintain a program to assess, and where necessary, reduce risks associated with physical hazards, violence in the workplace, and external threats such as terrorism.
7. Have in place a process for reporting known adverse incidents to the CMS Plan and to state and federal agencies as required.