KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Credentialing Program				POLICY #: 23.05-P	
DEPARTMENT: Contracting/Quality Performance					
Effective Date: 01/1997	Review/Revised Date: 10/3/2024	DMHC	X	PAC	X
		DHCS	X	EQIHE COMMITTEE	X
		BOD	X	FINANCE COMMITTEE	

_____ Date _____
Emily Duran
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Senior Director of Quality Performance

POLICY:

Kern Health Systems ("KHS") members are entitled to quality health care. It is the policy of KHS that every reasonable effort is made to verify health care providers with whom KHS contracts meet the basic standards of training, certification, and performance. Credentialing and recredentialing requirements are applicable to all licensed practitioners, non-physician practitioners, ancillary and facility providers contracted with KHS (collectively referred to herein as "provider(s)"). A contracted provider must be credentialed with KHS in order to treat KHS members.

PROCEDURES:

Credentialing is defined as the recognition of professional or technical competence. The process involved may include registration, certification, licensure, and professional association membership.

It is the process by which health care providers are evaluated and approved for provider status as

contractors and subcontractors in the KHS network. The credentialing program has been developed in accordance with state and federal requirements, accreditation guidelines and comply with the Department of Managed Health Care ("DMHC") and the Department of Health Care Services ("DHCS") requirements, including DHCS All Plan Letter ("APL") 22-013 and subsequent updates to this APL, if any. KHS meets all DMHC and DHCS requirements, and has established credentialing criteria, including the verification sources used, based on state, federal and current accreditation guidelines from the National Committee for Quality Assurance ("NCQA") credentialing standards.

A. SCOPE OF PROVIDERS COVERED BY CREDENTIALING

All contracted practitioners and facility providers (Hospitals, Skilled Nursing Facility (SNF), Surgery Centers, Home Health Agencies, Hospices, Dialysis Centers, Urgent Care Centers), including ancillary providers participating in the KHS network and who are published in the provider health plan directory must be credentialed. This includes, but is not limited to, Doctor of Medicine (MDs), Doctor of Osteopathic Medicine (Dos), Doctor of Podiatric Medicine (DPMs), Doctor of Chiropractic (DCs), and doctoral level Psychologists (Doctorate of Philosophy (PhD), Doctorate of Psychology (PsyD)). Non-physician practitioners, including behavioral health providers (Marriage and Family Therapists (MFTs), Licensed Clinical Social Worker (LCSWs), and Behavioral Analyst) and substance use disorder providers, Optometrists, Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants who are certified or registered by the state to practice independently (with or without supervision), will also be credentialed. KHS will credential and recredential:

1. All providers who have a contracted, independent relationship with KHS.
2. All providers who see KHS members outside the inpatient hospital setting.
3. All providers who see KHS members in outpatient ambulatory free-standing facilities.
4. All physician executives who serve in an administrative capacity for KHS.
5. All providers who are hospital based but render services or care to KHS members as a result of their independent relationship with KHS. Examples include: an anesthesiologist who is contracted to provide pain management to KHS members in an outpatient setting.
6. All providers who practice as a hospitalist or SNF.
7. All providers who provide telemedicine consults interacting with members.
8. All non-physician practitioners who may or may not have an independent relationship with KHS.
9. All behavioral health care providers such as doctoral or master's-level psychologists, clinical social workers, psychiatric nurses, or other behavioral health care specialists who are licensed, certified, or registered by the state to practice independently.
10. All ancillary, pharmacies and organization providers who have a contract with KHS.

B. PROVIDERS WHO DO NOT NEED TO BE CREDENTIALED

Providers who practice exclusively within the inpatient setting (hospital-based) who provide care for KHS members only as a result of the members being directed to the hospital or another inpatient setting and do not meet the definition of a "Network Provider" as defined by DHCS APL 19-001 and any subsequent updates. Examples include Pathologists, Radiologists, Anesthesiologists, Neonatologists, Emergency Department Physicians, and Resident Physicians in a teaching facility. Enhanced Care Management (ECM) and Community Supports (CS), or In Lieu of Services (ILOS) Providers without a state level enrollment pathway may also be subject

to a different vetting process. KHS reserves the right to require any credentialing deemed necessary for any hospital-based provider type, including but not limited to:

1. Hospitalist practicing exclusively in an inpatient setting.
2. Radiologist practicing in an outpatient setting.
3. Anesthesiologist in an ambulatory care setting or practicing in an office setting specific to pain management.

C. NON-DISCRIMINATORY CREDENTIALING FOR PROVIDERS

Credentialing and recredentialing will be conducted in a manner that is non-discriminatory. Credentialing and recredentialing decisions are made solely based on the results of the verification process. No decisions will be based on an applicant's race, ethnicity, national origin, religious creed, gender, age, sexual orientation, disability, or area of practice (e.g., Medicaid) in which the provider specializes.

All credentialing applicants are logged, and their status (Approved/Denied) are recorded on a monthly report to the KHS Physician Advisory Committee ("PAC"). Annually, the voting members of PAC sign an affirmation confirming that credentialing decisions are solely based in a manner that is non-discriminatory and confidential.

Monitoring will be conducted semi-annually (February & August) by tracking and identifying discrimination in the credentialing and recredentialing processes to assure discriminatory practices do not occur. Any Executive Officer, provider, or employee who believes or becomes aware of any discriminatory act shall promptly report any violation in person or in writing to their supervisor or directly to the KHS Credentialing Manager. The Credentialing Manager reports semi-annually to the Physician Advisory Committee the number of complaints made alleging discrimination at credentialing or recredentialing. Additionally, a detailed summary of the credentialed and recredentialed practitioners age, gender and specialty type is presented semi-annually to the Physicians Advisory Committee (report excludes organization providers).

Pursuant to DMHC APL 23-025 - Senate Bill 487 (Atkins, Ch.261, Stats. 2023) Abortion: Provider Protections Codified under Health and Safety Code, Section 1375.61, prohibits discriminating, with respect to the provision of, or contracts for, professional services, against a licensed provider solely on the basis of civil judgment issued in another state, a criminal conviction in another state, or another disciplinary action in another state if the judgment, conviction, or disciplinary action is based solely on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in California.

1. APPLICATION

Application for provider status is made by submitting a completed application together with the applicable and required supporting documents to the Provider Network Management Department. Application forms are available through the Provider Network Management Department and are available electronically on the KHS Provider Portal.

All documents for any applicant or reapplicant must be no more than 180 days old at the

time they are considered for participation or reapplication. Primary source verification will be obtained from the most accurate, current, and complete source available.

No application shall be acted upon unless it is complete, signed and dated, which includes completion of the application form, attestation questionnaire, release of information and submission of all supporting documents, including any additional information requested by the PAC. If the provider is notified that the application (or supporting documents) is incomplete or illegible, the provider must provide the missing information for the credentialing process to continue within 10-calendar days. The provider is responsible for providing the information to satisfy the process or request by the PAC. It is the provider's burden to provide all information requested and to resolve any difficulties in verifying or obtaining the documentation required to satisfy the credentialing requirements. If the provider fails to provide this information, the credentialing application will be deemed incomplete and will result in an administrative denial or withdrawal of application from the KHS network. Providers who fail to provide this burden of proof do not have the right to submit an appeal.

Applications are evaluated according to the credentialing criteria and verification sources set forth in Attachments A & B. An application that does not satisfy these criteria, as determined by the PAC or Board of Directors, may be denied. The PAC may deny provider status if the information submitted is insufficient to resolve reasonable doubts as to the provider's qualifications. KHS reserves the right to exercise discretion when applying any criteria and to exclude providers who do not meet the criteria. KHS Board of Directors, after considering PAC recommendation, may waive any requirement for network participation established by these policies and procedures for good cause if it is determined that such waiver is necessary to meet the needs of KHS and the community it serves. The refusal to waive any requirement shall not entitle the provider to a hearing or any other rights of review.

a. Required Attestation

The application includes an attestation which includes, but is not limited to the following statements by the applicant:

i. Any limitation or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation, and reasons for the same.
ii. History of loss of license and/or felony conviction(s), including plea of nolo contendere.
iii. History of loss or limitation of privileges and/or disciplinary activity.
iv. Lack of present illegal drug use.
v. A current and signed attestation by the applicant of the accuracy and completeness of the application.

2. APPLICATION REVIEW/COMMITTEE AND BOARD REVIEW

a. Application Review

The PAC shall serve as the Credentials Committee and shall be responsible for the review of all applications.

KHS monitors the initial credentialing process and verifies the following information[i] along with other documents required by DMHC, DHCS, NCQA and KHS:

i. The appropriate license and/or board certification or registration to practice in California. (Verification Source: applicable state licensing or certifying agency via verbal, written or internet/electronic method.)

ii. Evidence of graduation or completion of any required education (Verification Source: American Medical Association (AMA) Masterfile, American Osteopathic Association (AOA) Official Osteopathic Master file, American Board of Medical Specialties (ABMS) Board Certification or directly from primary source Medical, Residency, Fellowship or Professional training Program.)

iii. Proof of completion of any relevant medical residency and/or specialty training. (Verification Source: AMA Masterfile, AOA Official Osteopathic Master file, ABMS Board Certification or directly from primary source Medical, Residency, Fellowship or Professional training Program.)

iv. Proof of completion of any relevant professional training (non-physicians) (Verification Source: National Student Clearinghouse or appropriate board/registry when the board or registry performs primary source verification of education.)

v. Work history (Verification Source: Documented on application or curriculum vitae/resume in month/year format)

vi. Hospital and clinic privileges in good standing (Verification Source: Verbal, written or internet/electronic verification directly with the institution, hospital letter or directory.)

vii. History of suspension or curtailment of hospital and clinic privileges (Verification Source: National Practitioner Data Bank (NPDB) with Continuous Query)

viii. Current Drug Enforcement Administration identification number. (Verification Source: Drug Enforcement Administration (DEA) Office of Diversion Control, AMA Masterfile, AOA Official Osteopathic Masterfile, DEA or Centers for Disease Control and Prevention (CDC) Certificate or

photocopy of the certificate, or visual inspection of the original DEA or CDC Certificate including DEA waivers)

ix. National Provider Identifier number (Verification Source: National Plan and Provider Enumeration System (NPPES) Registry)

x. Current malpractice or professional insurance in an adequate amount, as required for the particular provider type. (Verification Source: Copy of certificate face-sheet, Federal Tort Letter, or if the provider's malpractice insurance coverage is current and provided in the application.)

xi. History of liability claims against the provider (Verification Source: NPDB with Continuous Query)

xii. Provider information, if any, entered in the National Practitioner Data Bank, when applicable (Verification Source: NPDB with Continuous Query)

xiii. History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal. Providers terminated from either Medicare or Medicaid/Medi-Cal, or on the Suspended and Ineligible Provider List, may not participate in the Managed Care Plan (MCP's) provider network. (Verification Source: NPDB with Continuous Query and/or including but not limited to; Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) Database, Centers for Medicare and Medicaid Services (CMS) Medicare Opt Out Affidavit, DHCS Medi-Cal Suspended/Ineligible List, DHCS Restricted Provider List (RPD) and the System for Award Management (SAM) Database.)

xiv. Meets the requirements for Medi-Cal Fee for Service (FFS) enrollment and is approved with DHCS as defined by the relevant DHCS All Plan Letter and/or within the established process outlined in KHS Policy & Procedure 4.43-P Medi-Cal Enrollment Policy. (Verification Source: California Health and Human Services (CHHS) Portal for Enrolled Medi-Cal Fee for Service Provider; Copy of welcome/approval letter from DHCS; DHCS Medi-Cal Ordering, Referring & Prescribing (ORP) Portal; Other health plan attestation of enrollment at KHS discretion.)

3. Discrepancies in Credentialing Information

In the event there is information obtained by the credentialing staff that substantially differs from that supplied by the provider, the credentialing staff will contact the provider to have them either correct or provide an explanation of the differences. Providers have the right to correct erroneous information submitted during the application process; corrections must be submitted in writing to the credentialing staff within 10-calendar days of the notification.

4. Area of Practice / Listing in Provider Directories and Other Member Materials

Providers will only be credentialed in the area of practice in which they have adequate education and training verified through primary source verification, if applicable, from an ACGME accredited residency and/or fellowship as set forth by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) for requested sub-specialties (see credentialing requirements in Attachments A). KHS uses specialties and sub-specialties recognized by the ABMS and AOA. It is expected that providers confine their practice to their credentialed specialty when providing services to KHS members. KHS will list provider specialties in member materials and practitioner directories that are consistent with the information obtained during the credentialing process including education/training verified through primary source, board certification specialties recognized according to ABMS/AOA, or as verified on other professional license certificate.

5. Provider Rights

Providers have the right, upon request, to review the information submitted in support of their credentialing application; additionally, providers have the right to:

a. Right to review credentials information: The provider may request to review information obtained by KHS for the purpose of evaluating their credentialing and recredentialing application. This includes information obtained from outside sources such as malpractice carriers or state licensing agencies, and/or board certification, but does not extend to review of information from peer reference recommendations, hospital privileges verifications or other information protected by law from disclosure including peer review protected information. Providers may submit their request for review to their Provider Relations Representative via written request, certified mail. The Credentialing Manager or Coordinator will coordinate a time and date for such access during regular business hours and in the presence of a credentialing staff personnel, KHS Chief Medical Officer or KHS Executive Officer within 72-hours of request. The provider is not permitted to remove, destroy, or photocopy documentation from the credentials file except what was originally provided by the provider upon application.

b. Right to correct erroneous/inaccurate information: The provider may correct erroneous or inaccurate information obtained by KHS for the purpose of evaluating their credentialing and recredentialing application in the event that credentialing information obtained from primary sources varies substantially from that provided by a provider. The provider will have the opportunity to correct information in the application which is inconsistent with the information received via primary source verification process. The Credentialing Coordinator will notify the provider within fourteen (14) days via email, letter or fax of the discrepancy and will include the items found to be inconsistent. Such notice will not contain protected peer review information or copies of the NPDB Summary. The provider shall respond within 48-hours of the plan's notification or within 24-hours of provider's credentialing file review, in writing via email, letter or fax, regarding the inconsistent information on the application and return a formal response to the Credentialing Staff, PR Representative, or KHS Chief Medical Officer (CMO), within fourteen (14) days. The Credentialing Staff will reverify the primary source information until the

discrepancy is resolved. If the discrepancy is not resolved within ninety (90) days or within 180-days from attestation date, whichever is sooner, the application will be deemed incomplete and will be considered administratively withdrawn and the file closed with no further action.

c. **Right to request/receive status update on application**: The provider may request review of information obtained by KHS for the purpose of evaluating their credentialing and recredentialing application. Providers may submit their request for review to their Provider Relations Representative via email, letter, or fax. The Credentialing Manager or Coordinator will review and provide the requested information in a timely and courteous manner no more than seven 7-business days of the request.

6. Confidentiality

The KHS credentialing program has transitioned from a paper-based file to an electronic credentialing (paperless) file system as of March 2020. All existing paper credentialing files have been scanned and archived into an electronic filing central repository. Existing paper-files will be maintained at an off-site, secured file room. Access to the off-site, secured file room is restricted and accessible to Provider Network Management (PNM) credentialing staff under the oversight of the Chief Network Administrative Officer.

The electronic credentialing files will be maintained in a central repository that can only be accessed by PNM/Credentialing Staff who have been issued access using their unique electronic identifier and user-specific password for access to prevent unauthorized access or release of information.

All information collected during the credentialing, recredentialing and through the proceedings of PAC shall be confidential and protected from discovery pursuant to California Evidence Code Section 1157 and Health and Safety Code 1370 and will be maintained as confidential records. Annually, PAC members will sign confidentiality statements.

7. Credentialing File Review

The Provider Network Management Department and the Chief Medical Officer, (CMO) or his/her designee assist the PAC in investigating and evaluating applications. The Provider Network Department representatives and the CMO shall be deemed agents of the PAC in any such investigation or evaluation.

All providers participating in the KHS network must be approved by the PAC. The CMO has the authority to determine whether or not credentialing or recredentialing files are "clean" and meet established criteria. A file must meet the following criteria to be considered a "clean file":

a. No malpractice cases that resulted in settlement or judgment paid on behalf of the provider within the previous 5-years for initial applicants or since the last credentialing/recredentialing review date.

b. No 805/805.1 reports, State Licensing accusations, limitations, or sanctions on licensure.

c. No adverse events from other regulatory, state, or federal agencies, i.e., OIG, NPDB, Medicare Opt-Out, Medi-Cal Suspended or Ineligible list, System for Award Management, etc.

d. Current and signed attestation confirming correctness and completeness of application.

e. For those offices requiring an office site visit, overall score of 90% or higher.

f. For recredentialing, no more than seven (7) member complaints, no internal quality of care case reviews, no utilization management or compliance issues or trends in the prior 3-years.

g. The CMO will have the discretion to refer any member complaint or quality of care concern for a comprehensive review by the PAC regardless of the severity score.

h. Those files determined by the CMO not meeting the above criteria or at his/her sole discretion, will require comprehensive review by the PAC.

8. Comprehensive Reviews

Credentialing files determined to not meet "clean file" criteria (as listed above in 2.6) will require comprehensive review by PAC.

The CMO or his/her designee reviews the applications and prepares his/her approval or recommendations to the PAC, as follows:

a. The recommendation is reviewed by the PAC which prepares its approval or recommendation, such as modification or denial, which is submitted to the Board of Directors.

b. If the PAC recommends the denial of the application based on:

   i. A perceived medical disciplinary cause or reason, indicating the potential for a provider's conduct to be detrimental to patient safety or to the delivery of patient care; and/or

   ii. A perceived issue with conduct or professional competence which affects or could affect adversely the health or welfare of a patient or patients.

Then the application shall be referred to Peer Review and/or the Board for consideration and recommendation. The Peer Review and/or Board has the authority to request additional information, interview the applicant, or implement the Fair Hearing Policy before it is submitted to the Board for final action. If the Peer Review determines that neither of the above factors exist or should be cited as grounds for denial, the matter shall be forwarded,

with associated recommendations, to the Board.

9. Provisional Approval/Clean file Approval

In the circumstance where a provider file is ready for presentation to the PAC, however there is no PAC meeting scheduled, or was cancelled due to member scheduling conflicts, including but not limited to; lack of quorum to vote on matters, prior to the next Board of Directors meeting, the CMO may recommend the applicant(s) to the Board of Directors for provisional/clean file approval. In order to be considered for provisional approval, the applicant must meet the criteria in the applicable exhibit (Attachments A& B) and have no malpractice action (pending or closed) within the previous five years (three years if the applicant is being recredentialed). In the case of recredentialing, in addition, there may not be any pending or current issues, requiring comprehensive review, reported by the Quality Improvement, Utilization Management, Member Services or Compliance Departments in the interval since the applicant was last credentialed.

If provisional/clean file approvals are granted by the CMO, the applicant shall be presented to the PAC at its next meeting for ratification. The CMO approval date becomes the official approval date.

10. Locum Tenens

KHS providers may utilize Locum Tenens if an existing contracted provider is unavailable to seen KHS members. KHS providers, joining an existing contracted group may also utilize a newly hired provider as a Locum Tenens while the new provider is in the process of being credentialed when there is a written request documenting the urgent or emergent need. In either situation, the following conditions must be met prior to a Locum Tenens rendering services to KHS Members.

a. Locum Tenens must be of the same provider type and specialty as the provider on leave, e.g., a physician must substitute for a physician in same designated specialty, a non-physician for a non-physician.

b. KHS must be notified of the request for Locum Tenens in writing from the existing contracted group or provider.

c. If the request is received after services are rendered, KHS will only retroactively pay for services rendered within the prior fourteen (14)-days. Claims for services outside that timeframe may be denied.

d. KHS must be provided with a copy of a current, valid, and unrestricted California medical license.

e. KHS must be provided with a copy of a current, valid, and unrestricted DEA issued with a California address, if applicable.

f. KHS must have copy of the practitioner's professional liability insurance in the amounts of $1,000,000.00 per occurrences and $3,000,000.00 in aggregate.

g. In order to be considered for Locum Tenens, the applicant must meet the established clean file criteria, and have no malpractice actions (pending or closed).

If there are malpractice actions pending and/or closed against a Locum Tenens provider, KHS may at its sole discretion allow for the provider to serve as a Locum Tenens depending on the nature of the malpractice actions. In any of the described situations, the Locum Tenens provider must receive written approval from KHS prior to rendering services to KHS members, if payment is to be made.

If the Locum Tenens status is approved by KHS, the Locum Tenens provider will be compensated for services at the same rate as the KHS contracted provider. However, KHS is not responsible for the compensation arrangement between the provider on leave and the Locum Tenens provider. The use of the same Locum Tenens provider will be limited to ninety (90) consecutive days. KHS reserves the right to approve a Locum Tenens status extension due to extenuating circumstances.

KHS will deny payment for any services provided by or ordered by the Locum Tenens Provider if not all the conditions above are met. The contracted provider will be responsible for all charges associated with same.

11. PAC Decision Regarding Credentialing

Decisions made by PAC are considered to be final. The Board of Directors will be notified of all determinations in accordance with this policy.

If provider is approved for network participation, an official letter of appointment is sent to the provider and two copies of the Provider Agreements with a request for signature and return to KHS. Once fully executed, a copy of the contract is returned to the new provider.

If provider is denied for network participation, a letter of denial is sent to the provider by certified mail, return receipt required. A provider who has been denied network participation is not eligible to reapply for a period of three years. Exceptions may be made based on the need for providers in the provider's area of practice or when incomplete information was obtained with the original application. A second or subsequent application, pursuant to an applicable exception, is processed as if it is the original application, and the process will start over.

If the recommendation by the PAC is to deny the application, the recommendation alone, without any supporting information, is forwarded to the Board of Directors. The Board shall not take any action on the recommendation or review other information regarding the application except in accordance with KHS Policy and Procedure #4.35-P – Provider Hearings.

12. Effective Date

An applicant's provider status shall take effect on the first day of the month following the PAC Meeting in which the provider is approved to provide health care services to KHS members.

13. Notification of Decisions Regarding Initial Applicants

KHS will notify, in writing, initial credentialing applicants of the decision within 60-days from the date of the PAC's credentialing decision. Initial applicants should refrain from rendering treatment, care, or services until they are in receipt of the official KHS letter with effective date.

14. Notification of Adverse Decisions Regarding Recredentialing

KHS will notify, in writing, recredentialing applicants of any adverse recredentialing decisions, including denial of recredentialing, within 60-days from the date of the PAC's credentialing decision.

D. PROVIDER RESPONSIBILITY TO REPORT CHANGES

Once approved, each provider shall remain in compliance with the credentialing criteria and report to the CMO all of the following:

1. The commencement or resolution of any civil action against the provider for professional negligence.

2. Any change in the provider's license or DEA status

3. The initiation of and reason for any investigation or the filing of any complaint against the provider by any government agency

4. Any adverse determination by any facility or entity with a credentialing or peer review process concerning provider's quality of care.

5. A change in any hospital or practice privilege granted to the practitioner by any facility or entity with a credentialing or peer review process.

6. Any change in the provider's errors and omissions or professional negligence insurance coverage including changes affecting coverage of specific clinical procedures or privileges of the practitioner.

7. Conviction of the provider or entry of a plea of nolo contendere to any felony.

8. Conviction of a provider or entry of a plea of nolo contendere to any misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of services.

9. Conviction of the provider of any crime or an entry of a plea of nolo contendere to any crime involving moral turpitude or otherwise relating to the provider's fitness or ability to

practice medicine or deliver health care services.

10. The filing of any charges against the provider alleging unlawful sale, use, or possession of any controlled substance.
11. Suspension from the federal Medicare or Medicaid programs for any reason.
12. Lost or surrendered a license, certificate, or approval to provide health care.
13. Any other adverse occurrence that relates to the provider's license or practice, including but not limited to revocation or suspension of a license by a federal, California, or another state's licensing, certification, or approval authority.
14. If the provider is a clinic, group, corporation or other association, conviction of any officer, director, or shareholder with a 10 percent or greater interest in that organization of any crimes set forth above.

E. RECREDENTIALING AND COMPLIANCE WITH LAWS

Each provider is recredentialed every 36-months. However, recredentialing may be made sooner when required by a change in relevant provider information or if the PAC makes such recommendation.[ii] The process includes a review of all applicable areas for credentialing.

Provider shall provide all requested documentation to KHS for recredentialing, and KHS reserves the right to consider information from other sources pertinent to the credentialing process, such as quality improvement activities, member grievances, and medical record reviews.

A provider may be reviewed any time at the request of the Executive Quality Improvement Health Equity Committee (EQIHEC), the PAC, the Chief Executive Officer, the Chief Medical Officer, or the KHS Board of Directors. During recredentialing, KHS will consider information from other sources pertinent to the credentialing process, including but not limited to, quality improvement activities, member grievances, and medical record reviews.

KHS complies with all reporting requirements, including those required by the California Business & Professions Code and the Federal Health Care Quality Improvement Act.

All credentialing and peer review records and proceedings shall be confidential as contemplated by section 1157 of the California Evidence Code, section 1370 of the California Health & Safety Code, and section 14087.38 of the California Welfare & Institutions Code.

In the event of any conflict between these credentialing policies and the Federal Health Care Quality Improvement Act, the latter shall be deemed to prevail.

These credentialing policies shall be reviewed at least annually by the PAC which may recommend revisions or amendments to the Board of Directors.

F. HEARING RIGHTS

Hearing rights, if any, are as set forth in KHS Policy and Procedure #4.35-P – Provider Hearings.

G. RELEASE

By applying for or accepting provider status, an applicant releases KHS and its members, employees, officers, and agents from any liability associated with processing and investigating the application and submits to KHS' corrective action and disciplinary process and to the relevant KHS Policies and Procedures, including but not limited to, KHS Policy and Procedure #4.35-P – Provider Hearings. This release is in addition to any immunities available under California or federal law.

H. ADDITIONAL INFORMATION

1. Specialists Practicing Primary Care

Providers with sub-specialties recognized by the ABMS or one of its Member Boards may function in the role of a Primary Care Practitioner (PCP) if they meet the requirements to be a PCP (See Attachment A). However, KHS credentialed specialists functioning as a KHS credentialed PCP may not self-refer for specialty care. If the provider sees a member assigned to him/her for primary care, he/she may not bill as a specialist even if that member's condition is within the provider's sub-specialty. The provider may accept authorized sub-specialty referrals from providers outside of his/her group for those services provided as a sub-specialist.

2. Scope of Mid-Level Practitioners

KHS members either select or are randomly assigned to a contracted PCP. The PCP may choose to arrange with a mid-level practitioner to provide primary care to assigned members but must provide active supervision of the care delivered.

A current specialty practitioner may employ a mid-level practitioner and may permit this practitioner to participate in the care delivered to members in accordance with the Standardized Procedure Guidelines, Delegation of Services Agreement, and KHS Policy and Procedure 4.04-P Non-Physician Medical Practitioners. Mid-level practitioners will be credentialed in the specific specialty in which they will be working. The credentialing will be dependent on the training and experience in the field in which the mid-level is requesting to be credentialed.[iii]

KHS will require either 6 months formal training in a program or one year of full-time experience in the field which credentialing is requested.

Nurse Practitioners with a furnishing license may furnish drugs. Physician Assistants may administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device pursuant to the guidelines in California Business and Professions Code, Section 3502.1 subdivisions (c) and (d).

3. Facility and Ancillary Providers/ Assessment of Organizational Providers

KHS will contract with new facilities, pharmacies, and ancillary (non-practitioner) providers if these providers meet and remain in compliance with KHS requirements including but not limited to:

a. Provider must be physically located in and providing services in Kern County for one year prior to application.

b. must be in good standing with KHS.

c. must be able to submit claims electronically.

d. must be able to participate in the KHS electronic funds transfer (EFT) program.

e. laboratory providers must be able to submit lab results/data to KHS electronically.

f. Durable medical equipment (DME) providers must be able to service Kern Family Health Care (KFHC) Members seven (7) days a week.

g. Meets the requirements for Medi-Cal FFS enrollment and is approved with DHCS as defined by the DHCS APL 19-004 and/or within the established process outlined in KHS Policy & Procedure 4.43-P Medi-Cal Enrollment Policy.

KHS will conduct an initial and ongoing assessment of the providers with which it contracts. The assessment of the health care delivery provider will be conducted before it contracts with a provider, and for at least every 36-months thereafter, in accordance with KHS Policy & Procedure 4.55-I "Assessment of Organizational Providers & Behavioral Health Providers."

i. Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF/DD) Effective January 1, 2024, KHS will maintain an adequate Network consisting of ICF/DD Homes, ICF/DD-H Homes, and ICF/DD-N Homes licensed and certified by the California Department of Public Health (CDPH). To meet KHS credentialing requirements, ICF-DD Homes must submit:
    1) KHS Organizational/Ancillary/Facility Application –
    2) An annual ICF/DD Attestation[1] under penalty of perjury that the following credentialing requirements are satisfied:
        a) Completion of the MCP's specific Provider Training within the last two (2) years
        b) Facility Site Audit from State Agency
        c) No Change in 5% Ownership Disclosure since the last submission to MCP
        d) Possess an active CDPH License and CMS Certification
        e) In good standing as a Regional Center Vendor

3) For the initial credentialing, ICF/DD Homes must submit the below items in addition to the annual ICF/DD Attestation:
4) W-9 Request for Taxpayer Identification Number and Certification
5) MCP Ancillary Facility Network Provider Application
6) Certificates of Insurance (Professional and General Liability)
7) City or County Business License (excludes ICF/DD-H and -N homes with six or less residents)
8) 5% Ownership Disclosure

ii. For the recredentialing, ICF/DD Homes must submit the below items every 2-years:
1) KHS Organizational/Ancillary/Facility Application –
2) An annual ICF/DD Attestation[2] under penalty of perjury that the following credentialing requirements are satisfied:
a) Completion of the MCP's specific Provider Training within the last two (2) years
b) Facility Site Audit from State Agency
c) No Change in 5% Ownership Disclosure since the last submission to MCP
d) Possess an active CDPH License and CMS Certification
e) In good standing as a Regional Center Vendor

For changes in between credentialing cycles, the ICF/DD Home must report that change to KHS Credentialing including any required documentation within 90-days of when the change occurred.

4. Medical Transportation Providers (Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT)

KHS will require all NMT/NEMT providers to be credentialed and contracted by KHS in accordance with ancillary credentialing requirements, as applicable, and subject to utilization controls, grievances/appeals process, and permissible time and distance standards. KHS may subcontract with transportation brokers for the provision of the NMT/NEMT services who may have their own network of NMT/NEMT providers; however, KHS cannot delegate their obligation related to grievances and appeals, enrollment of NMT/NEMT providers as Medi-Cal providers, or utilization management functions including the review of Physician Certification Statement (PCS) forms to a transportation broker.

All current and prospective NMT/NEMT providers must be screened, enrolled, and approved through DHCS Medi-Cal Fee-For-Service in accordance with APL 22-013 Screening and Enrollment and KHS Policy and Procedure, 4.43-P Medi-Cal Enrollment Policy and 5.15-P Member Transportation Assistance to be considered for KHS Network.

5. Enhanced Care Management (ECM) and Community Supports (CS) Providers

If there is no state-level Medi-Cal FFS enrollment pathway, ECM, and Community Support Providers (CS) are not subject to APL 22-013 related to Medi-Cal screening and enrollment, credentialing, and background checks. To include an ECM/CS Provider, when there is no state-level Medi-Cal enrollment pathway, KHS is required to vet the qualifications of the Provider or Provider organization to ensure they meet the standards and capabilities required to be an ECM or CS Provider and comply with all applicable state and federal laws, regulations, ECM/CS requirements, contract requirements, and other DHCS guidance, including relevant APLs and Policy Letters.

6. Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Provider

On an annual basis, providers recognized as HIV/AIDS specialist providers must complete the HIV/AIDS Specialist Certification certifying their completion of the requirements set forth in AB 2168-Standing Referral for HIV/AIDS Patients, California Health & Safety Code 1374.16, and Title 28 Section 1300.67.60 to be recognized as an HIV/AIDS specialist provider.

All infectious disease specialists and/or other qualified physicians will be surveyed annually to determine the following:

a. Whether they wish to be designated an HIV/AIDS specialist
b. Whether they meet the defined criteria as per California Health and Safety (H&S) Code 1374.16

A list of those specialists who meet the defined criteria and who wish to be designated as HIV/AIDS specialist will be sent to the UM Department responsible for referrals (e.g., UM Director) via e-mail annually. If the survey reveals that none of the physicians within the KHS network qualify as HIV/AIDS specialist, this information will be communicated to the UM Director.

7. Mental Health and Substance use Disorder Provider Credentials

Effective January 1, 2023, Managed Care Plans that cover and who credential health care providers in mental health and substance use disorder services for its network, will assess and verify the qualifications of a health care provider within 60-calendar days after receiving a completed provider credentialing application.

Upon receipt of an application from a mental health or substance abuse provider, the KHS Credentialing Staff will notify the applicant within seven (7) business days of receiving the application to verify receipt and inform the applicant whether the application is complete. Applications returned as “incomplete” will be given 15-calendar days to return any incomplete or missing required information.

A mental health or substance abuse provider application is considered complete based on the requirements set forth in this Policy and Procedure, Sections 1.0 Application, Section

2.0 Application Review and Attachment B – Behavioral Health Practitioner Provider Specific Credentialing Criteria.

Pursuant to Section 2.8, Provisional Approval will be granted and approved for those applicants whose credentialing file meet clean file criteria and are absent of, but not limited to, any adverse actions, disciplinary licensing actions, including conduct or professional competency. Files with adverse actions or information will be reviewed at the next scheduled Physician Advisory Committee for determination. [Reference: AB 2581 (Salas, CH. 533, Stats. 2022)]

8. Community Health Worker (CHW)

CHW Providers must have a lived experience that aligns with and provides a connection between the CHW, and the member or population being served. CHW Providers are not licensed providers, require a Supervising Provider, do not follow traditional credentialing requirements, and do not have a corresponding state-level enrollment pathway.

KHS Provider Network Management's Credentialing Staff will conduct an assessment to validate the CHW Provider meets the requirements outlined in the DHCS APL 22-016 Community Health Worker, including but not limited to having valid National Provider Identifier (NPI) Number, possess lived experience that aligns with and provides a connection between the CHW and the member or population being served; has obtained a minimum of six (6) hours of additional relevant training annually; has a Supervising Provider employed by the same organization overseeing the CHW with which is KHS Contracted. CHW Providers are required to demonstrate, and Supervising Provider must maintain evidence of, minimum qualifications through a Certificate Pathway or a Lived Experience Pathway consistent with APL 22-016, or any superseding APL. Refer to provider specific criteria is listed in "Attachment D Non-Licensed Other Provider Types" of this policy.

Supervising Providers, with a state-level Medi-Cal enrollment pathway, must follow the standard process for enrolling through the DHCS' Provider Enrollment Division. For the Supervising Providers that do not have a corresponding state-level enrollment pathway, they will not be required to enroll in the Medi-Cal program. Supervising Providers, without a state level enrollment pathway, must complete the appropriate provider application, Supervising Attestation and Acknowledgement form for submission to KHS Credentialing for review and approval. KHS will verify the supervising provider meets the qualification as a licensed provider, or other acceptable supervising provider designated within a hospital, outpatient clinic, local health jurisdiction (LHJ) or a community-based organization (CBO), employing or otherwise overseeing the CHW, with which Kern Health Systems (KHS) contracts.

9. Doula Providers

KHS Provider Network Management's Credentialing Staff will conduct an assessment to validate the doula provider meets the requirements outlined in the DHCS All Plan Letter (APL) 22-031 Doula Services, or any superseding APL. Doulas are not licensed providers, do not require supervision, do not follow traditional credentialing requirements, and have a corresponding state-level pathway for enrolling in Medi-Cal. Refer to provider specific criteria is listed in "Attachment D Non-Licensed Other Provider Types" of this policy.

10. Dyadic Service Care Providers / Non-Specialty Mental Health Services Provider Manual (NSMHS)

KHS Provider Network will include Psychiatric and Psychological Service providers as outlined in the DHCS NSMHS provider manual and/or who provide Dyadic Care Services by Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychologists, Psychiatric Physician Assistants, Psychiatric Nurse Practitioners, and Psychiatrists. Additionally, Associate Marriage and Family Therapists, Associate Professional Clinical Counselors, Associate Clinical Social Workers, and Psychology Assistants may render these services under the supervision of credentialed practitioner, who is qualified to provide supervision and whose licensure is not currently suspended, limited/restricted or on probation.

Network Providers who are licensed independent practitioners will be subject to the credentialing and enrollment process outlined in Section 1.0 -6.0 of this policy and are required to enroll as Medi-Cal Providers, consistent with APL 22-013, or any superseding APL, if there is a state-level enrollment pathway for them to do so. For Associate or Assistant provider types, when there is no state-level enrollment pathway, the KHS Provider Network Management's Credentialing Staff will conduct an assessment to validate these providers meets the requirements outlined in the DHCS NSMHS Provider Manual and/or DHCS APL 22-029 Dyadic Care Services and Family Therapy Benefit. Refer to provider specific criteria is listed in "Attachment D Non-Licensed Other Provider Types" of this policy.

ATTACHMENTS:

- Attachment A: Provider Specific Credentialing Criteria – Practitioners
- Attachment B: Provider Specific Credentialing Criteria – BH-Practitioners
- Attachment C: Org-Facilities, Ancillary Services, Pharmacies
- Attachment D: Non-Licensed Other Provider Types

REFERENCE:

Revision 08/2024: Effective 8/2024, the policy was transferred to the QP Department, as a result the policy was

renumbered to QP 23.05-P and Signatories were updated. **Revisions 03/2024:** Page 3 – Non-Discriminatory Credentialing added DMHC APL 23-025 Section 12 Abortion-Provider Protections language prohibiting discrimination against providers disciplined in other states that interfere with person's right to receive care that is lawful in this state. Approved by DMHC on 5/15/24.
Revisions 02/2024: Page 3 - changed Non-Discriminatory Credentialing report dates to February & August. **Revisions 01-2024:** Section 7.3.1 added in accordance with DHCS APL 23-023 ICF/DD Credentialing Requirements. DHCS approved 3/22/2024 for APL 23-023. **Revisions 11-2023:** Section 2.1 Recommended by NCQA Consultants to add Primary Verification Approved Sources used by Credentialing to verify each item; Section 2.4 Provider Rights: Language restructured as recommended by NCQA Consultant to match Provider Rights Addendum; Section 2.8 revised to include CR1A-Factors 3-5 for Managing files that meet clean-file criteria and approval by CMO; **Revisions 08-2023:** Credentialing Policy Section 2.9 – Added time-limited retroactive payment of 14-days on Locum Tenens request received after services are rendered as approved by Executive Roundtable on 07/25/23. **Revision 06-2023:** NCQA CR1A-6 added Nondiscriminatory monitoring; NCQA CR1A-11 - 2.3 added process to ensure information in member materials is consistent with information obtained in credentialing; NCQA CR1B-1-3 Practitioner Rights added language regarding all practitioners rights; Section 2.5 added PAC Members will annually sign confidentiality statements; NCQA CR1A-8 Section 2.13 added Notification of adverse recred decision; NCQA CR7 added language regarding assessment of organizational providers. **Revision 04-2023:** Credentialing Policy Section 7.0 has been revised to add related credentialing requirements specific to Doula Service Providers, Dyadic Care Service Providers and Community Health Workers. References include: APL 22-016 Community Health Workers; APL 22-031 Doula Services; DHCS APL 22-029 Dyadic Services, DHCS Provider Manual NSMHS & CA Board of Behavioral Sciences. Approved by DMHC 11/2/2023 for DMHC APL 22-031. Approved by DHCS File and use 5/26/2023 and 8/2/2023 for DHCS APL 22-029. **Revision 03-2023:** Credentialing Policy Section 7.0 has been revised to add section related to compliance with Assembly Bill 2581 Health Care Coverage: Mental Health and Substance Use Disorders – Provider Credentials. **Revision 01-2023:** Credentialing Policy has gone through a comprehensive revision by KHS PNM Management and legal review with DSR Health Law to bring into current practice and compliance with all state, federal, DHCS APLs and NCQA credentialing standards. In addition, DSR Health Law performed a regulatory review making further updates and revisions to bring into compliance with DHCS Contract language, DHCS All Plan Letters related to credentialing and screening/enrollment processes, CalAIM and California Business and Professions Code where applicable. KHS PAC Approved 2/1/2023 and KHS BOD Approved 2/16/2023**.** DHCS File and Use disposition given on 6/2/2023. **Revision 2015-06:** QAS Provider requirements per DHCS 14-026; and Behavioral Health Provider requirements. **Policy version 2015-06** was submitted and approved by DHCS for 2024 OR R.0025 on 9/3/2022. Policy Version was submitted and approved by DHCS for 2024 OR R.0045 on 2/6/2023. Policy version was submitted and approved by DHCS for 2024 OR R.0101 on 1/23/2023. **Revision 2014-12:** Item B. in Section 7.4 "cannot be physician owned, either directly or indirectly;" was deleted as requested by Compliance Director 10/01/2014. SBIRT training removed from Policy 2.22-I Facility Site Review and added to credentialing per COO. **Revision 2013-07**: New Attachment "N" Walk in Clinic Providers. Approved at the Physician Advisory Committee (PAC) Meeting on March 6, 2013. [1]**Revision 2012-10:** Language added to allow Mid-levels participate in a specialty setting and perform initial evaluations. The specialty physician must see the patient at lease every third visit. **Revision 2012-08**: Deleted requirement for non-physicians to pay $100 Credentialing process fee. R**evision 2012-01:** Revisions to attachments only. **Revision 2011-06:** Policy approved by management 11/15/10. However additional changes we provided by Director of Claims and Provider Relations regarding SPD members, Specialists and Emergency Room Physicians. Policy KHS Board approved 4/14/11. Revision to Attachments A and D regarding credentialing criteria. Board approved on 10/14/2010. Additional language added (01/2011) per Director of Claims and Provider Relations see Section 7.3 and 7.4 language from policies 4.4-P and 4.25-P, respectively. **Revision 2010-05:** Physicians Advisory Committee added clarification of credentialing requirements in Attachment A #6. **Revision 2009-09: Revised by Provider Relation Director. Revision 2007-03:** Revised per DHS/DMHC Medical Review Audit (YE 10/31/06). **Revision 2005-11:** Revised per DHS Work Plan (07/10/05). **Revision 2005-04**: **Revision 2003-06**: Revised per DHS comment letter 03/04/03. **Revision 2002-08:** Routine review/revision. Revised per DHS Comment (10/30/01). Hospital Based Physicians section added per request of Medical Director. Radiology claims section added per request of Medical Director. Policy #4.03 – Pharmacy Credentialing deleted, and necessary information added to this policy. Pharmacy portion revised per DHS Comment (09/19/01). Revised per MMCD Policy Letter 02-03.

[i] DHS Contract Section 6.5.4.2
[ii] MMCD Policy Letter 02-03 § II

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Practitioners / Mid-Levels-Advanced Practice Practitioners

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
Application Form Form/Document which includes elements required by this Policy, completed by an applicant who is requesting network participation with KHS. ***Verification Time Limit:*** 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ LIPs ☒ APP/Non-Physician Medical Practitioner ☒ Other practitioner types approved by the KHS Physician Advisory Committee	**Requirement:** Application must be signed, dated, complete, accurate and current. The application includes an attestation which includes, but is not limited to the following statements by the applicant: A. Any limitation or inabilities that affect the provider's ability to perform any of the position's essential functions, with our without accommodation and reasons for the same; B. History of loss of license and/or past or present felony conviction(s); C. History of loss or limitation of privileges and/or disciplinary activity voluntary or in-voluntary; D. Lack of present illegal drug use; E. Current and signed attestation by the applicant of the accuracy and completeness of the application. **Criteria**: 1) All attestations questions answered "no" and written explanation for affirmative "yes" answers; 2) All credentials verified must be consistent with attested application; and 3) Providers can clarify discrepancies in writing or verbally. **Source**: Application – Faxed, digital, electronic, scanned or photocopied signatures will be accepted. Stamped signatures or font print will not be accepted on the credentialing application. **Exceptions**: 1) Incomplete applications will be returned to the applicant with a request for the missing items and will be considered incomplete and withdrawn if no response. 2) Applications exceeding 180-days will require provider to update the information, sign and date with statement attesting the application is current, complete and accurate.	✔ Initial Credentialing ✔ Recredentialing
California State License State Sanctions, restrictions on licensure or limitations on scope of practice ***Verification Time Limit:*** 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ LIPs ☒ APP/Non-Physician Medical Practitioner	**Requirement:** Current and valid California Licensure with no previous or current state sanctions, restrictions on license, or limitations to scope of practice including 805 Reports. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: applicable state licensing or certifying agency via verbal, written or internet/electronic method. **Criteria**: 1) Providers must provide explanations in writing for any previous, current or pending state sanction, restriction on license or limitations to scope of practice. PAC will review on case by case basis. **Exceptions**: None	✔ Initial Credentialing ✔ Recredentialing ✔ Credential Expiration ✔ NPDB Continuous Query

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Practitioners / Mid-Levels-Advanced Practice Practitioners

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
☒ Other practitioner types with State License		
Certifying Agency Verification Time Limit: 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ BCBA, BCBA-D ☒ RD ☒ Other practitioner types with professional certificate	**Requirement:** Current and valid professional certificate with no previous or current sanctions, restrictions on certification, or limitations to scope of practice. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: applicable state licensing or certifying agency via verbal, written or internet/electronic method. **Criteria**: 1) Providers must provide explanations in writing for any previous, current or pending state sanction, restriction on license/certification or limitations to scope of practice. PAC will review on case by case basis. **Exceptions**: None	✔ Initial Credentialing ✔ Recredentialing ✔ Credential Expiration
Drug Enforcement Agency (DEA) ***Verification Time Limit:*** 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ LIPs ☒ APP/Non-Physician Medical Practitioner ☒ Other practitioner and non-practitioner types with DEA Certificate and/or furnishing licensure	**Requirement:** A current valid Drug Enforcement Agency (DEA) registration number as applicable. - DEA must be issued to practitioner's California address - Practitioners with pending DEA or those who choose not to have a DEA: must submit written letter from an alternate credentialed practitioner who is in possession of DEA and willing to write prescriptions on his/her behalf. - DEA cannot be linked to another facility or institution only or reflect "exempt" or "Limited to" status. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: DEA Office of Diversion Control, AMA Masterfile, AOA Official Osteopathic Masterfile, DEA or CDC Certificate or photocopy of the certificate, or visual inspection of the original DEA or CDS Certificate. **Criteria**: 1) DEA Certificate must be current at all times and reflect an address in the state of California; 2) If provider does not have a DEA as a result of disciplinary action, including but not limited to, being revoked, or relinquished (voluntary or involuntary) the practitioner may not be eligible to participate in the KHS Network, PAC will review on case by case basis if alternate arrangements met the satisfaction of this requirement. **Exceptions**: Radiology, Pathology, CRNAs *Other practitioners who do not prescribe scheduled medications may be exempt on a case by case basis and may be required to submit a DEA Waiver Form.	✔ Initial Credentialing ✔ Recredentialing ✔ Credential Expiration

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Practitioners / Mid-Levels-Advanced Practice Practitioners

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
NPI Number ***Verification Time Limit:*** 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ All practitioner types / Type 1 Individual NPI ☒ All provider types / Type 2 Organizational NPI	**Requirement:** A current valid NPI number. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: NPPES Registry **Exceptions**: Atypical Providers who may not require NPI Number, example Qualified Autism Service Professionals or Paraprofessionals, and Community Healthcare Workers.	✔ Initial Credentialing ✔ Recredentialing
Education and Training ***Verification Time Limit:*** Prior to the credentialing decision. *Note: verification must be conducted after the completion date of the highest level of education, if not board certified.* ***Practitioner Type:*** ☒ LIPs ☒ APP/Non-Physician Medical Practitioner ☒ Other practitioner and non-practitioner types with State Licensure or professional certification	**Requirement:** Graduation from a medical/professional school, or completion of an accredited residency and/or an accredited fellowship. Successful completion of accredited residency training, approved by the Accreditation Council for Graduate Medical Education (ACCGME), in the applicable field of practice is necessary in order to be credentialed as a specialist. For Chiropractors, Optometry, and other non-physician practitioners, including behavioral health practitioner, the highest level of education will be verified. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: For physicians: AMA Masterfile, AOA Official Osteopathic Masterfile, ABMS Board Certification, or Medical, Residency, Fellowship or Professional School Programs directly from primary source. For Non-Physicians: National Student Clearinghouse or appropriate board/registry when the board or registry performs primary source verification of education. KHS Credentialing Team will maintain the board/registries statement that it conducts primary source verification of education on an annual basis. **Criteria**: 1) Primary source verification without red flags; 2) Post-Graduate training is fully completed. **Exceptions**: None	✔ Initial Credentialing

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Practitioners / Mid-Levels-Advanced Practice Practitioners

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
Board Certification ***Verification Time Limit:*** 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ MD/DO ☒ DPM ☒ PA, NP, CNM ☒ Other practitioner and non-practitioner types with board certifying agency.	Board certification as applicable; verification of education is not required if provider meets board certification as highest level of education requirements. Board certification is not required but is verified when indicated on the credentialing application or when newly reported. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: American Board of Medical Specialties (Certifacts), AMA Masterfile, AOA Official Osteopathic Masterfile, or American Board of Podiatric Surgery Foot & Ankle. For non-physician providers appropriate board/registry if indicated on the application or newly reported. **Criteria**: 1) Board Certification (if applicable) is current, with our without Maintenance of Certification (MOC); 2) If Board Certification has expired it may be used for verification of education/training (per NCQA MD/DO/DPM Only)	✔ Initial Credentialing ✔ Recredentialing ✔ Credential Expiration ✔ Upon New Certification
Specialty / Scope of Practice ***Practitioner Type:*** ☒ MD/DO	**Requirements:** Completion of accredited residency training or ACGME accredited fellowship in the applicable field of practice is necessary in order to be credentialed as a specialist. Specialists that want to serve as SPD member's primary care physician must have completed a residency in Internal medicine, or a residency in Pediatrics. **Criteria:** Only those specialties and sub-specialties recognized by the ABMS will be listed in the Kern Health Systems Provider Directory. Additionally, the Medical Board of California & CA Business & Professions Code Section 651 recognizes ABMS and 4-additional Boards that meet the equivalent certification requirements as with ABMS. The 4-Boards include: American Board of Facial and Reconstructive Surgery, American Board of Pain Medicine, American Board of Sleep Medicine, and American Board of Spine Surgery.	✔ Initial Credentialing ✔ Upon newly reported

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Practitioners / Mid-Levels-Advanced Practice Practitioners

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
Primary Care Providers ***Practitioner Type:*** ☒ MD/DO	**Requirements/Criteria:** Completion of a Family Practice, Pediatric, Internal Medicine or an Obstetrics and Gynecology residency is necessary in order to be credentialed as a PCP. **Exceptions:** Providers who do not meet the above criteria, must have practiced exclusively in the Primary Care setting for at least five (5) consecutive years to be considered a General Practitioner eligible to be a PCP and have members assigned. PCPs who were credentialed prior to 04/01/02 and who meet the above criteria will be allowed to continue as PCPs. General Practitioner must agree as part of their credentialing to provide evidence of participation in at least twelve hours a year in prior authorized primary care CME activity, upon request.	
Advanced Practice Professionals (formerly Mid-Levels): PA, NP, CNM, CRNA • ***Education and Training*** • ***Provider Information Letter*** **Verification Time Limit:** *Prior to the credentialing decision.* ***Practitioner Type:*** ☒ PA, NP, CNM, CRNA	**Requirement:** Successful completion from a relevant professional school. ***Specialty Training:*** Mid-level training is variable. Not only are there differences between Nurse Practitioners and Physician Assistants, but there are significant differences between the programs themselves. In addition, some mid-levels go on to receive formal "specialty" training in areas like OB, peds, surgery, ortho, oncology, etc.. KHS will require either 6 months formal training in a program or one year of full-time experience in the field which credentialing is requested. ***Supervising Physician Agreement:*** Designated Physician Supervisor(s) with signed supervision agreement per group affiliation **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: Professional School directly, AMA Masterfile, National Student Clearinghouse for non-physician providers or appropriate board/registry if board performs primary source verification education & is confirmed annually. **Criteria**: 1) Primary source verification without red flags. **Exceptions**: None	✔ Initial Credentialing ✔ Initial Credentialing ✔ Upon newly reported

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Practitioners / Mid-Levels-Advanced Practice Practitioners

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
Hospital Clinical Privileges (CMS/DHCS/DMHC) ***Verification Time Limit:*** 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ MD/DO ☒ DPM ☒ CRNA	**Requirement:** Practitioner must have clinical privileges in good standing. Practitioner must indicate their current hospital affiliation or admitting privileges at a participating hospital (Source: Medicare Managed Care Manual, Chapter 6 § 60.3; All Plan Letter (APL) 22-013 and DMHC Tag 6/09/14) Formal inpatient coverage arrangements in a written and dated letter delineating the inpatient coverage is sufficient and Contracted Ambulatory Surgery Centers may also satisfy this requirement if provider does not utilize the hospital. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: verbal, written or internet/electronic verification directly with the institution, hospital letter or directory which must include include current status (e.g. unrestricted or restricted), type of admitting privileges (e.g. Active, Courtesy, temporary), and practitioner specialty. **Exceptions**: *Specialties deemed by KHS not to have hospital privileges and are documented to be limited to outpatient services include: Dermatology, Podiatry, Ophthalmology, Chiropractor, Psychiatry, Optometry, Physical Medicine &Rehabilitation, Radiology, Pain Medicine, Behavioral Health Providers, and/or practice limited to outpatient services only, including Mid-Level Providers	✔ Initial Credentialing ✔ Recredentialing ✔ Upon newly reported
Work History ***Verification Time Limit:*** 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ LIPs ☒ APP/Non-Physician Medical Practitioner ☒ Other practitioner and non-practitioner types with State Licensure or professional certification	**Requirement:** A minimum of five (5) years work history will be included in the initial credentialing file on the application or curriculum vitae. Relevant work history includes work history as a health professional in month/year beginning and month/year end dates. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: Documented on application or curriculum vitae/resume in month/year format. **Criteria**: 1) If practitioner has practiced less than 5-years, work history begins at the time of initial licensure date. 2) If the practitioner has had continuous employment for five years or more with no gap, providing the year is sufficient. 3) If gap in employment exceeds six (6)-months, but less than 1-year, the provider clarifies the gap verbally or in writing/email. 4) If the gap in employment exceeds one (1)-year the provider must clarify in writing and the organization documents review. **Exceptions**: Academic, Unpaid voluntary work, or unrelated to practice of medicine or health care.	✔ Initial Credentialing

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Practitioners / Mid-Levels-Advanced Practice Practitioners

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
NPDB (National Practitioner Data Bank) and Continuous Query (CQ) **Verification Time Limit:** 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ LIPs ☒ APP/Non-Physician Medical Practitioner ☒ Other practitioner and non-practitioner types with State Licensure or professional certification	**Description:** Provider specific medical malpractice payments, licensure/disciplinary actions, adverse professional review actions taken by a health care entity, adverse actions affecting professional society membership, specific exclusions from State and Federal Programs (including Medicare/Medi-Cal), civil judgments, criminal convictions, and contract terminations. **Requirements: Verification of issues profiled in the NPDB Report** **Criteria: NPDB Reports no activity for the provider – Any NPDB Reports are submitted to the Chief Medical Officer for review and determination.** **Initial Review** – The Credentialing Staff will enroll all newly credentialed providers into NPDB Continuous Query. **Recredentialing** - The Credentialing Staff will re-enroll all current credentialed providers into NPDB Continuous Query on annual basis and extract summary for recredentialing profile. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: National Practitioner Data Bank (NPDB) **Criteria for malpractice cases**: **Initial**: NPDB Reports no activity of the past five (5) years of malpractice or professional liability claims history that resulted in settlement or judgment paid on behalf of the practitioner. **Recredentialing -** Verification of the past three (3) years or since last credentialing cycle.	✔ Initial Credentialing ✔ Recredentialing ✔ **Ongoing -** Continuous Enrollment
Sanction Information: Medicare, Medi-Cal, OIG/LEIE Database, DHCS Restricted Provider List and EPLS/SAM ***Verification Time Limit:*** 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ LIPs ☒ APP/Non-Physician Medical Practitioner	**Requirement:** Eligibility in good standing to provide services to Medicare and Medi-Cal beneficiaries. KHS will query the required state and federal databases to ensure there are no providers who have been sanctioned, restricted, terminated or debarred from any state or federal agency/registry. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: NPDB, OIG-Office of the Inspector General LEIE Database, CMS Medicare Opt Out Affidavit, DHCS Medi-Cal Suspended/Ineligible List, DHCS Restricted Provider List (RPD) and the SAM-System for Award Management Database. **Exceptions**: None.	✔ Initial Credentialing ✔ Recredentialing ✔ Continuous Query

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Practitioners / Mid-Levels-Advanced Practice Practitioners

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
☒ Other practitioner and non-practitioner types with State Licensure or professional certification		
DHCS Medi-Cal Fee-For-Service Proof of enrollment or applicable alternate enrollment process, when applicable ***Practitioner Type:*** ☒ Practitioner & Provider Types as Per DHCS State Level Resource Listing who have a State Pathway for Enrollment	**Requirement:** Proof of Medi-Cal Fee-for-Service screening, enrollment and approval with the Department of Health Care Services (DHCS) as defined by the DHCS All Plan Letter 22-013 and/or within the established process outlined in KHS Policy & Procedure 4.43-P "Medi-Cal Enrollment Policy" for those practitioner and provider types where there is a state pathway for enrollment. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: CHHS Portal for Enrolled Medi-Cal Fee For Service Provider; Copy of welcome/approval letter from DHCS; DHCS Medi-Cal Ordering, Referring & Prescribing (ORP) Portal; Other health plan attestation of enrollment at KHS discretion. **Exceptions:** When there is no state pathway or KHS, at their discretion, choses to screen and enroll at the plan level or other Managed Care health plan approval.	✔ Initial Credentialing ✔ Recredentialing ✔ Changes in Group Affiliations
Professional Liability Coverage **Verification Time Limit:** *Prior to the credentialing decision.* ***Practitioner Type:*** ☒ LIPs ☒ APP/Non-Physician Medical Practitioner ☒ Other practitioner and non-practitioner types with State Licensure or professional certification	**Requirement:** Professional liability coverage of at least $1,000,000.00 per occurrence and $3,000,000.00 annual aggregate, covering designated specialty or services the provider expects to perform for KFHC members. Certificate of Insurance must include the name of the provider(s) covered under that certificate. If certificate is a group policy, the declaration page or group roster with list of providers covered is acceptable. *Self-Insured Policies must also indicate the provider's name or group roster of covered providers. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source:** Copy of Certificate Face Sheet, Federal Tort Letter, or if the practitioner's malpractice insurance coverage is current and is provided in the application, it must be current as of the date when the practitioner signed the attestation and include the amount of coverage the practitioner has on the date when the attestation was signed. If the practitioner does not have current malpractice coverage, then it is acceptable to include future coverage with the effective and expiration dates. **Exceptions**: None	✔ Initial Credentialing ✔ Recredentialing ✔ Changes in Group Affiliations
Facility Site Review ***Verification Time Limit:*** *Prior to the credentialing decision*	**Requirement:** Satisfactory site audit (is required for all primary care providers and OB/GYNs serving as an SPD member's PCP. It is necessary to have a minimum passing score of 80% and a completed CAP.	✔ Initial Credentialing ✔ Recredentialing

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Practitioners / Mid-Levels-Advanced Practice Practitioners

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
☒ PCPs ☒ OB/GYN who are SPD member's PCP,	**Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: KHS QI Dept / FSR Database **Exceptions**: As required or determined by QI Policy and Procedure	
Contract: Provider Service Agreement, Facility Agreement and Pharmacy Agreement ☒ All Contract Providers	**Requirement:** Signed contract between KHS and the provider to provide health care services to KFHC Members. Support Documents Includes: • Contract pre-review criteria • W9 • 274 Group and Site Forms • Roster of Providers, if applicable	✔ Initial Credentialing

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Behavioral Health Practitioners

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
Application Form Form/Document which includes elements required by this Policy, completed by an applicant who is requesting network participation with KHS. ***Verification Time Limit:*** 180 calendar days at time of the decision. ***Practitioner Type:*** *KHS individually credentials and recredentials the following categories of clinicians in private solo or group behavioral health practice settings:* • Behavior Analyst – All Levels • Licensed Marriage and Family Therapist • Licensed Clinical Social Worker • Nurse – RN, LPN, NA • Nurse Practitioner/PA/Advance/Masters RN • Psychiatrist/Physician/MD/DO • Psychologist – PhD-Level • Substance Abuse Professional – All Levels	**Requirement:** Application must be signed, dated, complete, accurate and current. The application includes an attestation which includes, but is not limited to the following statements by the applicant: A. Any limitation or inabilities that affect the provider's ability to perform any of the position's essential functions, with our without accommodation and reasons for the same; B. History of loss of license and/or past or present felony conviction(s); C. History of loss or limitation of privileges and/or disciplinary activity voluntary or in-voluntary; D. Lack of present illegal drug use; E. Current and signed attestation by the applicant of the accuracy and completeness of the application. **Criteria**: 1) All attestations questions answered "no" and written explanation for affirmative "yes" answers; 2) All credentials verified must be consistent with attested application; and 3) Providers can clarify discrepancies in writing or verbally. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: Application – Faxed, digital, electronic, scanned or photocopied signatures will be accepted. Stamped signatures or font print will not be accepted on the credentialing application. **Exceptions**: 1) Incomplete applications will be returned to the applicant with a request for the missing items and will be considered incomplete and withdrawn if no response. 2) Applications exceeding 180-days will require provider to update the information, sign and date with statement attesting the application is current, complete and accurate.	✔ Initial Credentialing ✔ Recredentialing
California State License State Sanctions, restrictions on licensure or limitations on scope of practice ***Verification Time Limit:*** 180 calendar days at time of the decision. ***Practitioner Type:***	**Requirement:** Current and valid California Licensure with no previous or current state sanctions, restrictions on license, or limitations to scope of practice including 805 Reports. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: applicable state licensing or certifying agency via verbal, written or internet/electronic method.	✔ Initial Credentialing ✔ Recredentialing ✔ Credential Expiration ✔ NPDB Continuous Query

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Behavioral Health Practitioners

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
☒ ALL BH Practitioner Types	**Criteria**: 1) Providers must provide explanations in writing for any previous, current or pending state sanction, restriction on license or limitations to scope of practice. PAC will review on case by case basis. **Exceptions**: None	
Certifying Agency Verification Time Limit: 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ BCBA, BCBA-D ☒ BCaBA, RDT ☒ Other practitioner types with professional certificate	**Requirement:** Current and valid professional certificate with no previous or current sanctions, restrictions on certification, or limitations to scope of practice. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: applicable state licensing or certifying agency via verbal, written or internet/electronic method. **Criteria**: 1) Providers must provide explanations in writing for any previous, current or pending state sanction, restriction on license/certification or limitations to scope of practice. PAC will review on case by case basis. **Exceptions**: None	✔ Initial Credentialing ✔ Recredentialing ✔ Credential Expiration
Drug Enforcement Agency (DEA) ***Verification Time Limit:*** 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ ALL BH Practitioner Types, if applicable	**Requirement:** A current valid Drug Enforcement Agency (DEA) registration number as applicable. - DEA must be issued to practitioner's California address - Practitioners with pending DEA or those who choose not to have a DEA: must submit written letter from an alternate credentialed practitioner who is in possession of DEA and willing to write prescriptions on his/her behalf. - DEA cannot be linked to another facility or institution only or reflect "exempt" or "Limited to" status. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: DEA Office of Diversion Control, AMA Masterfile, AOA Official Osteopathic Masterfile. **Criteria**: 1) DEA Certificate must be current at all times and reflect an address in the state of California; 2) If provider does not have a DEA as a result of disciplinary action, including but not limited to, being revoked, or relinquished (voluntary or involuntary) the practitioner may not be eligible to participate in the KHS Network, PAC will review on case by case basis if alternate arrangements met the satisfaction of this requirement. **Exceptions**: Radiology, Pathology, CRNAs	✔ Initial Credentialing ✔ Recredentialing ✔ Credential Expiration

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Behavioral Health Practitioners

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
	*Other practitioners who do not prescribe scheduled medications may be exempt on a case by case basis.	
NPI Number ***Verification Time Limit:*** 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ ALL BH Practitioner Types, if applicable	**Requirement:** A current valid NPI number. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: NPPES Registry **Exceptions**: Atypical Providers who may not require NPI Number, example Qualified Autism Service Professionals or Paraprofessionals, and Community Healthcare Workers.	✔ Initial Credentialing ✔ Recredentialing
Education and Training ***Verification Time Limit:*** Prior to the credentialing decision. *Note: verification must be conducted after the completion date of the highest level of education, if not board certified.* ***Practitioner Type:*** ☒ ALL BH Practitioner Types, if applicable	**Requirement:** Graduation from a medical/professional school, or completion of an accredited residency and/or an accredited fellowship. Successful completion of accredited residency training, approved by the Accreditation Council for Graduate Medical Education (ACCGME), in the applicable field of practice is necessary in order to be credentialed as a specialist. For Chiropractors, Optometry, and other non-physician practitioners, including behavioral health practitioner, the highest level of education will be verified. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: Medical or Professional School directly, AMA Masterfile, AOA Official Osteopathic Masterfile, ABMS Board Certification, National Student Clearinghouse for non physician providers or appropriate board/registry if board performs primary source verification education & is confirmed annually. **Criteria**: 1) Primary source verification without red flags; 2) Post-Graduate training is fully completed. **Exceptions**: None	✔ Initial Credentialing
Board Certification	Board certification as applicable; verification of education is not required if provider meets board certification as highest level of education requirements.	✔ Initial Credentialing ✔ Recredentialing

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Behavioral Health Practitioners

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
Verification Time Limit: 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ ALL BH Practitioner Types, if applicable	Board certification is not required but is verified when indicated on the credentialing application or when newly reported. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: American Board of Medical Specialties (Certifacts), AMA Masterfile, AOA Official Osteopathic Masterfile, or American Board of Podiatric Surgery Foot & Ankle. For non-physician providers appropriate board/registry if indicated on the application or newly reported. **Criteria**: 1) Board Certification (if applicable) is current, with our without Maintenance of Certification (MOC); 2) If Board Certification has expired it may be used for verification of education/training (per NCQA MD/DO/DPM Only)	✔ Credential Expiration ✔ Upon New Certification
Specialty / Scope of Practice ***Practitioner Type:*** ☒ ALL BH Practitioner Types, if applicable	**Requirements:** Completion of accredited residency training or ACGME accredited fellowship in the applicable field of practice is necessary in order to be credentialed as a specialist. Specialists that want to serve as SPD member's primary care physician must have completed a residency in Internal medicine, or a residency in Pediatrics. **Criteria:** Only those specialties and sub-specialties recognized by the ABMS will be listed in the Kern Health Systems Provider Directory. Additionally, the Medical Board of California & CA Business & Professions Code Section 651 recognizes ABMS and 4-additional Boards that meet the equivalent certification requirements as with ABMS. The 4-Boards include: American Board of Facial and Reconstructive Surgery, American Board of Pain Medicine, American Board of Sleep Medicine, and American Board of Spine Surgery.	✔ Initial Credentialing ✔ Upon newly reported
Scope of Practice / Pervasive Developmental Disorder or Autism Provider Credentialing	Requirements: 1. QAS Provider must meet the following requirements: 2. Be certified by a national entity accredited by the National Commission for Certifying Agencies (e.g. Behavior Analyst Certification Board (BACB)); supervise the work of	✔ Initial Credentialing ✔ Upon newly reported

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Behavioral Health Practitioners

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Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
Practitioner Type: Services must be provided under a treatment plan developed and approved by a contracted and credentialed qualified autism service as defined by Health & Safety Code Section 1374.73. Treatment may be administered by one of the following: • Qualified Autism Service (QAS) Provider • QAS Professional • QAS Paraprofessional	qualified autism service (QAS) Professionals and Paraprofessionals who implement behavior analytic interventions; and, have minimum of master's degree, including: 3. 225 classroom hours of graduate level instruction; 4. 1500 hours of supervised independent fieldwork; and, 5. 1000 hours of practicum or 750 hours of intensive practicum in behavior analysis. OR 6. Be licensed as a physician, psychologist, marriage and family therapist, educational psychologist, clinical social worker, and professional clinical counselor provided the duties are within the experience and competence of the licensee. 7. Graduated from a medical school or professional school; completion of a residency; and, education as required. Completion of accredited residency training in the applicable field of practice is necessary in order to be credentialed as a specialist. (Proof of highest level of education (e.g. diploma, transcript, etc.) must be submitted with application.) 8. Adequate experience, education, and training (as documented by curriculum vitae covering all work history over at least the past five years). 9. Current valid Drug Enforcement Agency (DEA) and/or Controlled Substance Distribution (CSD) certification, if applicable. Other practitioners who do not prescribe scheduled medications may be exempted on a case by case basis. 10. Required to submit National Provider Identifier (NPI) with each KHS behavioral health application packet. 11. Board certified or Board eligible, as applicable. 12. Documentation of any state sanctions, restrictions on licensure or limitations on scope of practice (only for the most recent 5 years). 13. Documentation of any sanctions imposed by Medi-Cal, Medicaid, and Medicare. 14. Eligibility in good standing to provide services to Medicare and Medi-Cal patients. 15. All applicants must provide reasons for the inability to perform the essential functions of the position with or without accommodation and attest to the lack of present illegal drug use and attest to the loss or limitation of privileges or disciplinary actions taken. 16. Document history of loss license, history of felony convictions, and history of past and present issues regarding loss or limitation of clinical privileges as all facilities or organizations with which a practitioner has had privileges. 17. Professional (Malpractice) Liability Certificate of Insurance in the amounts of: $1,000,000.00 per occurrence $3,000,000.00 annual aggregate 18. Documentation of any professional liability claims that resulted in settlement or judgment paid on behalf of the practitioner.	

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Behavioral Health Practitioners

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Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
	19. Signed and dated QAS Supervisor Agreement which designates QAS Provider Supervisor(s) and alternate QAS Provider supervisor(s) with signed supervision agreement (including supervision guidelines) with a KHS credentialed QAS Provider (renewed annually). (Applicable to ALL Non-Licensed QAS Professionals and Paraprofessionals.) **20. QAS Staff Roster including:** Please note: The QAS Professional may assist a QAS Provider with the design and delivery of introductory level instruction in behavior analysis. It is mandatory that each QAS Professional practice under the supervision of a QAS Provider who has submitted a QAS Supervisory Agreement attesting to the qualifications of the QAS Professional and Paraprofessionals as follows: 1. QAS Professional (Non-Licensed): a) Be certified by a national entity accredited by the National Commission for Certifying Agencies (e.g. Behavior Analyst Certification Board (BACB)); and, educational and training requirements include possession of a minimum of a bachelor's degree, including: i. 135 classroom hours of instruction; ii. 1000 hours of supervised independent fieldwork; and, iii. 670 hours of practicum or 500 hours of intensive practicum in behavior analysis. OR b) Possesses a Bachelor of Arts or Science Degree and has either: i. 12 semester units in applied behavior analysis and one year of experience in designing and/or implementing behavior modification intervention services; or, ii. 2 years of experience in designing and/or implementing behavior modification intervention services. OR c) Is registered as either: i. Psychological assistant of psychologist by the Medical Board of California or Psychology Examining Board; or, ii. An associate Licensed Clinical Social Worker. 2. QAS Paraprofessional: Have any combination equivalent to completion of the twelfth grade education, supplemented by courses in the following:	

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Behavioral Health Practitioners

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
	a) childcare; b) psychology; c) education and training of autistic students; and, d) some experience working with autistic students in a structured environment.	
Work History ***Verification Time Limit:*** 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ ALL BH Practitioner Types, if applicable	**Requirement:** A minimum of five (5) years work history will be included in the initial credentialing file on the application or curriculum vitae. Relevant work history includes work history as a health professional in month/year beginning and month/year end dates. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: Documented on application or curriculum vitae/resume in month/year format. **Criteria**: 1) If practitioner has practiced less than 5-years, work history begins at the time of initial licensure date. 2) If the practitioner has had continuous employment for five years or more with no gap, providing the year is sufficient. 3) If gap in employment exceeds six (6)-months, but less than 1-year, the provider clarifies the gap verbally or in writing/email. 4) If the gap in employment exceeds one (1)-year the provider must clarify in writing and the organization documents review. **Exceptions**: Academic, Unpaid voluntary work, or unrelated to practice of medicine or health care.	✔ Initial Credentialing
Malpractice History (NPDB) **Verification Time Limit:** 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ ALL BH Practitioner Types, if applicable	**Requirements:** **Initial** - Verification of the past five (5) years of malpractice or professional liability claims history that resulted in settlement or judgment paid on behalf of the practitioner. **Recredentialing** - Verification of the past three (3) years or since last credentialing cycle. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: National Practitioner Data Bank (NPDB) **Exceptions**: None	✔ Initial Credentialing ✔ Recredentialing ✔ **Ongoing -** Continuous Enrollment
Sanction Information: Medicare, Medi-Cal, OIG/LEIE Database, DHCS Restricted Provider List and EPLS/SAM ***Verification Time Limit:*** 180 calendar days at time of the decision.	**Requirement:** Eligibility in good standing to provide services to Medicare and Medi-Cal beneficiaries. KHS will query the required state and federal databases to ensure there are no providers who have been sanctioned, restricted, terminated or debarred from any state or federal agency/registry. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source:** NPDB, OIG-Office of the Inspector General LEIE Database, CMS Medicare Opt Out Affidavit, DHCS Medi-	✔ Initial Credentialing ✔ Recredentialing ✔ Continuous Query

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Behavioral Health Practitioners

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
Practitioner Type: ☒ ALL BH Practitioner Types, if applicable	Cal Suspended/Ineligible List, DHCS Restricted Provider List (RPD) and the SAM-System for Award Management Database. **Exceptions**: None.	
DHCS Medi-Cal Fee-For-Service Proof of enrollment or applicable alternate enrollment process, when applicable ***Practitioner Type:*** ☒ ALL BH Practitioner Types, if applicable	**Requirement:** Proof of Medi-Cal Fee-for-Service screening, enrollment and approval with the Department of Health Care Services (DHCS) as defined by the DHCS All Plan Letter 22-013 and/or within the established process outlined in KHS Policy & Procedure 4.43-P "Medi-Cal Enrollment Policy" for those practitioner and provider types where there is a state pathway for enrollment. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: CHHS Portal for Enrolled Medi-Cal Fee For Service Provider; Copy of welcome/approval letter from DHCS; DHCS Medi-Cal Ordering, Referring & Prescribing (ORP) Portal; Other health plan attestation of enrollment at KHS discretion. **Exceptions:** When there is no state pathway or KHS, at their discretion, choses to screen and enroll at the plan level or other Managed Care health plan approval.	✔ Initial Credentialing ✔ Recredentialing ✔ Changes in Group Affiliatons
Professional Liability Coverage **Verification Time Limit:** *Prior to the credentialing decision.* ***Practitioner Type:*** ☒ ALL BH Practitioner Types	**Requirement:** Professional liability coverage of at least $1,000,000.00 per occurrence and $3,000,000.00 annual aggregate, covering designated specialty or services the provider expects to perform for KFHC members. **Primary Source**: Copy of Certificate Face Sheet, Federal Tort Letter, or if the practitioner's malpractice insurance coverage is current and is provided in the application, it must be current as of the date when the practitioner signed the attestation and include the amount of coverage the practitioner has on the date when the attestation was signed. If the practitioner does not have current malpractice coverage, then it is acceptable to include future coverage with the effective and expiration dates. **Exceptions**: None	✔ Initial Credentialing ✔ Recredentialing ✔ Changes in Group Affiliatons

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Behavioral Health Practitioners

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
Contract: Provider Service Agreement, Facility Agreement and Pharmacy Agreement ☒ All Contract Providers	**Requirement:** Signed contract between KHS and the provider to provide health care services to KFHC Members.	✔ Initial Credentialing

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Organizational (HDO) / Pharmacy / Facilities / Ancillary Providers

Criteria	Requirement/Verification Source	Credentialing Instance
Application **Organization/HDO** ***Provider Type:*** ☒ Organizations/HDO	Current Organizational Application is completed, signed, and dated. • Signed and dated attestation questions. • Signed and dated information release and acknowledgements. Organizational Providers/HDO include: Hospital; Home Health; Skilled Nursing Facilities (SNF); Free-Standing Ambulatory Surgery Centers. Additional HDO Providers: Hospices; clinical laboratories; comprehensive outpatient rehab facilities (CORF); Outpatient Physical Therapy Clinics; Outpatient Speech Therapy; Dialysis/ESRD Clinic; Imaging Services/Portable X-Ray; DMEPOS; Home Infusion; Ambulance; Transportation Providers; Hearing Aid Dispenser; and Urgent Care Centers. **Exceptions**: None	✔ Initial Credentialing ✔ Recredentialing
Application **Pharmacies** ***Provider Type:*** ☒ Pharmacy ☒ Pharmacy additional locations	Current Organizational Application is completed, signed, and dated. • Signed and dated attestation questions. • Signed and dated information release and acknowledgements. **Exceptions**: None	✔ Initial Credentialing ✔ Recredentialing ✔ Additional Site Locations
California State License State Sanctions, restrictions on licensure or limitations on scope of practice Verification Time Limit: 180 calendar days at time of the decision. ***Provider Type:*** ***Provider Type:*** ☒ CBAS-Adult Day Care	KHS: Eligibility in good standing to provide services to Medicare and Medi-Cal patients Current and valid California State Licensure with no previous or current state sanctions, restrictions on license, or limitations to scope of practice, if applicable. Pharmacies: 1. Valid pharmacy permit 2. Valid pharmacist-in-charge license **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: California Department of Public Health (CDPH), applicable state licensing or certifying agency via verbal, written or internet/electronic method.	✔ Initial Credentialing ✔ Recredentialing

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Organizational (HDO) / Pharmacy / Facilities / Ancillary Providers

Criteria	Requirement/Verification Source	Credentialing Instance
☒ Dialysis Clinic ☒ Home Health ☒ Hospice ☒ Hospitals ☒ Lab License ☒ X-Ray Division ☒ SNFs	**Exceptions**: None	
NPI Number Verification Time Limit: 180 calendar days at time of the decision. ***Provider Type:*** ☒ ALL - Type 2	A current valid NPI number. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: NPPES Registry **Exceptions**: None	✔ Initial Credentialing ✔ Recredentialing
Drug Enforcement Agency (DEA) Verification Time Limit: 180 calendar days at time of the decision. ***Provider Type:*** ☒ Organizations/HDO, if applicable ☒ Pharmacy ☒ Hospitals ☒ Ambulatory Surgery Centers	A current valid Drug Enforcement Agency (DEA) registration number as applicable. If facility does not have a DEA as a result of disciplinary action, including but not limited to, being revoked, or relinquished (voluntary or involuntary) the practitioner is not eligible to participate in the KHS Network. - DEA must be issued to provider's California address location **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: DEA Office of Diversion Control Agency **Exceptions**: None	✔ Initial Credentialing ✔ Recredentialing ✔ Credential Expiration
Accreditation Verification Time Limit: Prior to the decision.	**Hospitals**: Documentation of accreditation letter from AOA/HFAP, DNV, TJC, CIHQ **KHS Policy Requirement**: Surgery Centers must be accredited by one of the following agencies: AAAHC, AAAASF, TJC, AOA, HFAP • AOA – American Osteopathic Association	✔ Initial Credentialing ✔ Recredentialing

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Organizational (HDO) / Pharmacy / Facilities / Ancillary Providers

Criteria	Requirement/Verification Source	Credentialing Instance
Provider Type: ☒ Hospitals ☒ Ambulatory Surgery Centers ☒ Home Health ☒ Hospice ☒ Imaging Clinics/Centers ☒ Laboratories	• HFAP- Healthcare Facilities Accreditation Program **Laboratories** must be accredited by the following agencies: CLIA, COLA, CAP, other CMS approved sources **Home Health**: ACHC, CHAP, TJC **Hospice**: CHAP, TJC **Imaging Services/Portable X-Ray**: Documentation of FDA Certificate **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: applicable accreditation agency via verbal, written or internet/electronic method. **Exceptions**: *HH, Hospice, Imaging & Labs – If not accredited a site review or CMS / State Report is required.	
CMS or California Dept of Public Health Site Visit Verification Time Limit: Current within 36-months prior to the credentialing decision. ***Provider Type:*** ☒ Dialysis/ESRD Clinic ☒ DMEPOS ☒ Home Health ☒ Home Infusion ☒ Hospice ☒ Imaging Service and or Portable X-Ray ☒ Laboratory ☒ SNF	**Requirement:** When organizational facility is not accredited, an on-site quality assessment must be conducted or a CMS or State of California Dept of Public Health Site Review may be used in lieu of an on-site visit and may not be greater than 3-years old at the time of verification/approval. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: California Department of Public Health (CDPH.CA.GOV) **Exceptions**: None	✔ Initial Credentialing ✔ Recredentialing

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Organizational (HDO) / Pharmacy / Facilities / Ancillary Providers

Criteria	Requirement/Verification Source	Credentialing Instance
City Business License Verification Time Limit: 180 calendar days at time of the decision. ***Provider Type:*** ☒ Ambulance ☒ Dialysis Clinic ☒ DMEPOS ☒ Hearing Aid Dispenser ☒ Imaging Service and or Portable X-Ray ☒ Laboratory ☒ SNF	**City Business license as applicable.** **Ambulance**: CHP Business License & Kern County Ambulance Service Operations Permit **DME**: Retail License (additional) **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: Copy of city business license or applicable agency who issues city business licenses via verbal, written or internet/electronic method. **Exceptions**: None	✔ Initial Credentialing ✔ Recredentialing
Clinical Lab License & CLIA Accreditation Certificate ***Provider Type:*** ☒ Ambulatory Surg Ctr ☒ Dialysis Clinic ☒ Laboratory ☒ Urgent Care	Copy of CLIA Accreditation Certificate. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: Copy and verified via CMS CLIA Website **Exceptions**: None	✔ Initial Credentialing ✔ Recredentialing
Malpractice History (NPDB) Verification Time Limit: 180 calendar days at time of the decision. ***Provider Type:*** ☒ ALL	**Initial** - Verification of the past five (5) years of malpractice or professional liability claims history that resulted in settlement or judgment paid on behalf of the practitioner. **Recredentialing** - Verification of the past three (3) years or since last credentialing cycle. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: National Practitioner Data Bank (NPDB) **Exceptions**: None	✔ Initial Credentialing ✔ Recredentialing
Sanction Information:	Eligibility in good standing to provide services to Medicare and Medi-Cal beneficiaries. KHS will query the required state and federal databases to ensure there are no organizational providers or pharmacies who	✔ Initial Credentialing ✔ Recredentialing

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Organizational (HDO) / Pharmacy / Facilities / Ancillary Providers

Criteria	Requirement/Verification Source	Credentialing Instance
Medicare, Medi-Cal, OIG/LEIE Database, and SAM Verification Time Limit: 180 calendar days at time of the decision. ***Provider Type:*** ☒ ALL	have been sanctioned, restricted, terminated or debarred. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: OIG-Office of the Inspector General LEIE Database, CMS Medicare Opt Out Affidavit, DHCS Medi-Cal Suspended/Ineligible List and the SAM-System for Award Management **Exceptions**: None	✔ Ongoing Monitoring
Department of Health Care Services (DHCS) Medi-Cal Fee-For-Service Proof of enrollment or applicable alternate enrollment process, when applicable ***Provider Type:*** ☒ ALL	Proof of Medi-Cal Fee-for-Service enrollment and approval by the DHCS All Plan Letter and/or within the established process outlined in KHS Policy & Procedure 4.43-P Medi-Cal Enrollment Policy for those practitioner and provider types where there is a state pathway for enrollment. Risk Level 3 Providers: DMEPOS and Home Health agencies must be enrolled and approved through DHCS Medi-Cal FFS Program. Alternate pathways are not acceptable. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: CHHS Portal; Copy of welcome/approval letter from DHCS; ORP Portal for rendering providers; attestation of enrollment at KHS discretion. **Exceptions**: When there is no state pathway or plan opts, at their discretion to screen and enroll at the plan level or other MCP approval.	✔ Initial Credentialing ✔ Recredentialing ✔ Additional location requests
Professional Liability Coverage ***Provider Type:*** ☒ ALL	Professional liability insurance: a. **Acute care hospitals**: at least $3,000,000.00 per occurrence and $5,000,000.00 annual aggregate, covering all of the procedures or services the provider expects to perform for Kern Health Systems b. **Other facilities:** at least $1,000,000.00 per occurrence and $3,000,000.00 annual aggregate, covering all of the procedures or services the provider expects to perform for KHS **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: Copy of Certificate Exceptions: None	✔ Initial Credentialing ✔ Recredentialing

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Organizational (HDO) / Pharmacy / Facilities / Ancillary Providers

Criteria	Requirement/Verification Source	Credentialing Instance
General Liability Coverage ***Provider Type:*** ☒ ALL	Current general liability insurance, at least $1,000,000.000 **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: Copy of Certificate Exceptions: None	✔ Initial Credentialing ✔ Recredentialing
Contract: Provider Service Agreement, Facility Agreement and Pharmacy Agreement ***Provider Type:*** ☒ ALL	Signed contract between KHS and the provider to provide health care services to KFHC Members. **KHS requirement**: Must by physically located in and providing services in Kern County for one year prior to application; tertiary are excluded from this requirement KHS reserves the right to review and approve facilities policy & procedures, quality management program, upon request **Exceptions**: None	✔ Initial Credentialing

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
NON-LICENSED PROVIDERS

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Attestation Instance
Attestation Form Attestation Form to be completed by a prospective provider who is requesting network participation with KHS pursuant to APL 22-016 Community Health Worker Services Benefit, or any superseding APL. ***Practitioner Type:*** ☒ *Non-Licensed Provider* • **CHW Providers**	**Requirement**: Attestation form must be signed, dated, complete, accurate and current. 1) Shall have a valid NPI Number through the NPPES Registry 2) Possess lived experience that aligns with and provides a connection between the CHW and the member or population being served. 3) Minimum of six (6) hours of additional relevant training annually. The Supervising Provider must maintain evidence of this training. Supervising Providers may require additional training at their discretion. 4) Supervising Provider familiar with the CHW who are familiar with and/or have experience in the geographic communities they are serving and must be capable to maintain evidence of this experience. 5) CHW Providers are required to demonstrate, and Supervising Provider must maintain evidence of, minimum qualifications through one of the following pathways, as determined by the Supervising Provider consistent with APL 22-016, or any superseding APL: **Criteria:** Must qualify by meeting either the training or experience pathway as described below: <u>*Certificate Pathway*</u>: • Certificate Pathway: CHWs demonstrating qualifications through the Certificate Pathway must provide proof of completion of at least one of the following certificates: o **CHW Certificate:** A valid certificate of completion of a curriculum that attests to demonstrated skills and/or practical training in the following areas: communication, interpersonal and relationship building, service coordination and navigation, capacity building, advocacy, education and facilitation, individual and community assessment, professional skills and conduct, outreach, evaluation and research, and basic knowledge in public health principles and social drivers of health (SDOH), as determined by the Supervising Provider. Certificate programs must also include field experience as a requirement. o **A CHW Certificate** allows a CHW to provide all covered CHW services described in APL 22-016, including violence prevention services. o **Violence Prevention Professional Certificate**: For individuals providing CHW violence prevention services only, a Violence Prevention Professional (VPP) Certificate issued by Health Alliance for Violence Intervention or a certificate of completion in gang intervention training form the Urban Peace Institute. A VPP Certificate allows a CHW to provide CHW violence prevention services only. A CHW providing services other than violence prevention services must demonstrate qualification through either the Work Experience Pathway or by completion of a General Certificate.	✔ Initial Assessment ✔ New Contract Assessment ✔ Revalidation (36-months)

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
NON-LICENSED PROVIDERS

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Attestation Instance
	Lived Experience Pathway: All of the following: • Work Experience Pathway**:** An individual who has at least 2,000 hours working as a CHW in paid or volunteer positions within the previous three years • Has demonstrated skills and practical training in the areas described above, as determined and validated by the Supervising Provider, may provide CHW services without a certificate of completion for a maximum period of 18 months. ***A CHW who does not have a certificate of completion must earn a certificate of completion, as described above, within 18 months of the first CHW visit provided to a Member*** **Source**: Attestation Form – Faxed, digital, electronic, scanned or photocopied signatures will be accepted. Stamped signatures or font print will not be accepted on the attestation form. **Exceptions**: None	
Attestation Form Attestation Form to be completed by a prospective provider who is requesting network participation with KHS pursuant to APL 22-031 Doula Services, or any superseding APL. ***Practitioner Type:*** ☒ *Non-Licensed Provider* • **Doula Birth Worker**	**Requirement**: Attestation form must be signed, dated, complete, accurate and current. 1) Must be at least 18 years old 2) Must have a valid NPI Number through the NPPES Registry 3) Possess current & active adult/infant Cardiopulmonary Resuscitation (i.e., CPR) Certification 3) Documentation of completed Health Insurance Portability and Accountability Act Training 4) Documentation of completion of three (3)-hours of continuing education in maternal, perinatal, and/or infant care every three (3)-years. Doulas must maintain evidence of completed training to be made available to DHCS upon request. 5) Doula Providers are required to be enrolled in the DHCS Medi-Cal Fee-For-Service Program consistent with APL 22-013, or any superseding APL, if there is a state-level pathway. **Criteria:** Must qualify by meeting either the training or experience pathway as described below: *Training Pathway*: • Complete a minimum of 16 hours of training in the following areas: • Lactation support • Childbirth education • Foundations on anatomy of pregnancy and childbirth • Non-medical comfort measures, prenatal support, and labor support techniques • Developing a community resource list • Provide support at a minimum of three births *Experience Pathway: All of the following*: • At least five years of active doula experience in either a paid or volunteer capacity within the previous seven years.	✔ Initial Assessment ✔ New Contract Assessment ✔ Revalidation (36-months)

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
NON-LICENSED PROVIDERS

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APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Attestation Instance

	• Attestation to skills in prenatal, labor, and postpartum care as demonstrated by the following:
	  • Three written client testimonial letters, or professional letters of recommendation from any of the following: a physician, licensed behavioral health provider, nurse practitioner, nurse midwife, licensed midwife, enrolled doula, or community-based organization.
	  • Letters must be written within the last seven years. One letter must be from either a licensed Provider, a community-based organization, or an enrolled doula. "Enrolled doula" means a doula enrolled either through DHCS or through a MCP (Managed Care Plan).
	
	Source: Attestation Form – Faxed, digital, electronic, scanned or photocopied signatures will be accepted. Stamped signatures or font print will not be accepted on the attestation form.
	
	Exceptions: None	

Attestation Form Attestation Form to be completed by a prospective provider who is requesting network participation with KHS pursuant to APL 22-029 Dyadic Care Services and Family Therapy Benefit, or any superseding APL, and/or when providing psychiatric and psychological service as outlined in the DHCS NSMHS Provider Manual. ***Practitioner Type:*** ☒ *Non-Licensed Provider* • **Associate Clinical Social Worker** • **Associate Marriage/Family Therapist** • **Associate Clinical Counselor** • **Associate Psychology Assistant**	**Requirement (LIP):** MD/DO Psychiatrist, Licensed Clinical Social Works, Licensed Marriage/Family Therapist, Licensed Clinical Counselor and Licensed Psychologist will be credentialed pursuant to established criteria under Policy and Procedure 4.01-P Credentialing Attachment A-Practitioner Provider Specific Credentialing Criteria. **Requirement (Supervised Associate):** Associate Clinical Social Works, Associate Marriage/Family Therapist, Associate Clinical Counselor and Associate Psychology Assistant, when there is no state-level enrollment pathway, Credentialing Staff will conduct an assessment to validate the Supervised Associate meets the requirements outlined in the DHCS APL 22-029 Dyadic Care Services and Family Therapy Benefit and/or when providing psychiatric and psychological service as outlined in the DHCS NSMHS Provider Manual. **Criteria**: Including but not limited to: 1) Must have a valid NPI Number through the NPPES Registry 2) Holds an active associate registration number by the California Board of Behavioral Sciences 3) Has a signed supervision-related form by a KHS credentialed and qualified licensed supervisor (i.e. LCSW, LMFT, LPCC AND LEP) 4) Is supervised by a qualified licensed supervisor (i.e., LCSW, LMFT, LPCC, LEP, MD-Psychiatrist or Psychologist) whose license is not restricted or on probation. 5) Adheres to their scope of practice described in the applicable California Business and Professions Code and/or Title 16 CCR.	✔ Initial Assessment ✔ New Contract Assessment ✔ Revalidation (36-months)

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
NON-LICENSED PROVIDERS

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Attestation Instance
	6) Supervising Providers and Supervisee should have no current or pending state sanctions, restriction on license/certification, limitations to scope of practice, including probation by the California Board of Behavioral Sciences. **Primary Source**: applicable state or certifying agency via verbal, written or internet/electronic method. Copies of certificates will be accepted when there is no primary source validation abilities. **Exceptions**: None	
Certifying Agency ***Practitioner Type:*** ☒ *Non-Licensed Provider* • **Associate Clinical Social Worker** • **Associate Marriage/Family Therapist** • **Associate Clinical Counselor** • **Associate Psychology Assistant**	**Requirement:** Current and valid professional licensure or certificate **Primary Source**: applicable state or certifying agency via verbal, written or internet/electronic method. Copies of certificates will be accepted when there is no primary source validation abilities. **Criteria**: 1) Associates should have no current or pending state sanctions, restriction on license/certification, limitations to scope of practice, including probation by the California Board of Behavioral Sciences **Exceptions**: None	✔ Initial Assessment ✔ New Contract Assessment ✔ Revalidation (36-months)
NPI Number ***Practitioner Type:*** ☒ *Non-Licensed Provider, when applicable*	**Requirement:** A current valid NPI number. **Primary Source**: NPPES Registry **Exceptions**: Atypical Providers who may not require NPI Number, example Qualified Autism Service Professionals or Paraprofessionals, Community Healthcare Workers.	✔ ✔ Initial Assessment ✔ New Contract Assessment ✔ Revalidation (36-months)
Sanction Information: Medicare, Medi-Cal, OIG/LEIE Database, DHCS Restricted Provider List and EPLS/SAM ***Practitioner Type:*** ☒ *Non-Licensed Provider*	**Requirement:** Eligibility in good standing to provide services to Medicare and Medi-Cal beneficiaries. KHS will query the required state and federal databases to ensure there are no providers who have been sanctioned, restricted, terminated or debarred from any state or federal agency/registry. **Primary Source**: OIG-Office of the Inspector General LEIE Database, CMS Medicare Opt Out Affidavit, DHCS Medi-Cal Suspended/Ineligible List, DHCS Restricted Provider List (RPD) and the SAM-System for Award Management Database. **Exceptions**: None.	✔ Initial Assessment ✔ New Contract Assessment ✔ Revalidation (36-months)

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
NON-LICENSED PROVIDERS

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Attestation Instance
DHCS Medi-Cal Fee-For-Service Proof of enrollment or applicable alternate enrollment process, when applicable ***Practitioner Type:*** ☒ *Non-Licensed Provider, when there is a state-level pathway*	**Requirement:** Proof of Medi-Cal Fee-for-Service screening, enrollment and approval with the Department of Health Care Services (DHCS) as defined by the DHCS All Plan Letter 22-013 and/or within the established process outlined in KHS Policy & Procedure 4.43-P "Medi-Cal Enrollment Policy" for those practitioner and provider types where there is a state pathway for enrollment. **Primary Source**: CHHS Portal for Enrolled Medi-Cal Fee For Service Provider; Copy of welcome/approval letter from DHCS; DHCS Medi-Cal Ordering, Referring & Prescribing (ORP) Portal; Other health plan attestation of enrollment at KHS discretion. **Exceptions:** When there is no state pathway or KHS, at their discretion, choses to screen and enroll at the plan level or other Managed Care health plan approval.	✔ Initial Assessment ✔ New Contract Assessment ✔ Revalidation (36-months)
Death Master File, when there is no state-level pathway for FFS Enrollment ***Practitioner Type:*** ☒ *Non-Licensed Provider*	**Requirement:** Verification from the Death Master File data source confirming Social Security Number is valid and is not of a deceased person.	✔ Initial Assessment ✔ New Contract Assessment
Sanction Information: ***Medicare Opt-Out, Medi-Cal Suspended & Ineligible, OIG/LEIE Database, DHCS Restricted Provider List and SAM-EPLS Database*** ***Practitioner Type:*** ☒ *Non-Licensed Provider*	**Requirement:** Eligibility in good standing to provide services to Medicare and Medi-Cal beneficiaries. KHS will query the required state and federal databases to ensure there are no providers who have been sanctioned, restricted, terminated or debarred from any state or federal agency/registry. **Primary Source**: NPDB, OIG-Office of the Inspector General LEIE Database, CMS Medicare Opt Out Affidavit, DHCS Medi-Cal Suspended/Ineligible List, DHCS Restricted Provider List (RPD) and the SAM-System for Award Management Database. **Exceptions**: None.	✔ Initial Assessment ✔ New Contract Assessment ✔ Revalidation (36-months) ✔ Monthly Monitoring
Contract: Provider Service Agreement ☒ All Contract Providers	**Requirement:** Signed contract between KHS and the provider to provide health care services to KFHC Members.	✔ Initial Assessment ✔ New Contract Assessment