Title: Practitioner Credentialing Policy	Policy Number: **QI-025**
Department: Quality Improvement	Effective Date: 05/08/15
CEO Approved: *Robert Franco* for	Revised: 01/14/2020

I. PURPOSE

The Credentialing Program of Gold Coast Health Plan (GCHP) ensures that GCHP practitioners meet professional standards for the delivery of quality care. It enables GCHP to maintain a network of practitioners to serve its Members who deliver safe, consistent, high-quality care.

The Credentialing Program involves assessment, evaluation, and monitoring of a practitioner's ability to deliver quality care to GCHP Members. It requires that all practitioners maintain compliance with the GCHP credentialing requirements, which include requirements promulgated by Centers for Medicare and Medicaid Services (CMS), the Department of Health Care Services (DHCS) or designee, the National Committee for Quality Assurance (NCQA), and other applicable regulatory agency requirements and/or standards.

The GCHP Credentialing and Recredentialing standards are reviewed by the GCHP Credentialing/Peer Review Committee (C/PRC).

II. POLICY

This Practitioner Credentialing Policy is one aspect of GCHP's Quality Improvement Program. Through this policy, GCHP ensures that licensed practitioners who seek to participate in GCHP's Network undergo a credentialing process prior to providing care to GCHP Members, except as set forth in Section VII.C.7., Exemption from Credentialing Process. This Credentialing Policy requires that practitioners meet basic qualifications before delivering care to members and that the qualifications of said practitioners are verified on an ongoing basis. In addition, this policy assures a consistent, rigorous, and fair process for evaluating and credentialing practitioners.

III. DEFINITIONS

Attestation: A signed statement by a practitioner confirming the validity, correctness and completeness of a credentialing application and the representations therein.

Board Certified: A practitioner that has satisfied the requirements/standards of a nationally recognized specialty board and received the board's specialist certification.

Board-Certified Consultant: A practitioner external to an organization who holds certification from American Board of Medical Specialties (ABMS), American Osteopathic

Association (AOA), or other specialty board and acts in an advisory capacity to the organization.

Clinical Privileges: A practitioner is authorized by a health care organization to provide defined patient care services, based on the practitioner's license, education, training, experience, competence and ability.

Commission: the Ventura County Medi-Cal Managed Care Commission, the governing body for Gold Coast Health Plan.

Council for Affordable Quality Healthcare (CAQH): A multi-stakeholder collaboration that manages the Universal Credentialing DataSource, designed to make the credentialing process easier for providers by gathering data in a single repository that may be accessed by participating health plans and other healthcare organizations.

Clean Practitioner: A practitioner who fully meets the standards, guidelines, and criteria for credentialing. Also referred to as a Type I Practitioner.

Credentialing Process: Includes both the credentialing and recredentialing of independently licensed practitioners to evaluate and verify the practitioner's professional licensure, education, certification, or other qualifications and to monitor the competency and quality of medical services provided. Initial credentialing is conducted prior to a practitioner providing care to GCHP members; recredentialing is conducted within three (3) years of the initial credentialing process.

Credentials/Peer Review Committee (C/PRC): A subcommittee of the Quality Improvement Committee (QIC) that is responsible for decision-making related to the credentialing and recredentialing of healthcare practitioners and organizational providers.

Credentials Verification Organization (CVO): an organization that contracts with a health plan to verify primary source documentation of credentials of practitioner applicants who desire to join the plan's network.

Delegated Credentialing: Occurs when the credentialing functions of a managed care organization have been outsourced or contracted to be performed by another capable organization. The delegating organization is responsible for ensuring that the delegate performs the activities in accordance with regulatory and accreditation requirements including the delegating organization's approved policy for credentialing.

Facility-based Practitioner: A practitioner who renders services to Members only as a result of the Member being directed to a hospital, freestanding facility, or other inpatient setting.

Examples of this type of practitioner are hospitalists, pathologists, radiologists, anesthesiologists, neonatologists, and emergency room physicians.

Free-Standing Facilities: A health care facility that is physically, organizationally, and financially separate from a hospital and whose primary purpose is to provide immediate or short-term medical care on an outpatient basis. Examples of this type of facility include but are not limited to Mammography centers, urgent care centers, and surgical centers. GCHP assesses these facilities as Organization Providers. GCHP assesses these facilities as Organization Providers pursuant to Policy QI-005.

Gold Coast Health Plan (GCHP): An independent public entity governed by the Ventura County Medi-Cal Managed Care Commission (the Commission).

Independent Relationship: An independent relationship exists when GCHP directs its Members to see a specific practitioner or group of practitioners, including all practitioners whom a Member may select as a primary care practitioner. An independent relationship is not synonymous with an independent contract.

Locum Tenens: A Latin phrase that means *"to hold the place of, to substitute for."* In layman's terms, it means a temporary and/or covering practitioner.

Member: An individual residing in Ventura County and enrolled in GCHP.

National Practitioner Data Bank (NPDB): A federally-mandated agency that is the repository of information about settled malpractice suits and adverse acts, sanctions or restrictions against the practice privileges of a physician.

Network Practitioner: Credentialed practitioner who has entered into a contractual agreement with GCHP to provide healthcare services to its Members and follow all established plan policies and procedures.

Peer Review: Evaluation or review of colleague performance by professionals with similar types and degrees of expertise (*e.g.*, evaluation of a physician's credentials and practice by another physician).

Practitioner: A licensed or certified professional who provides medical care or behavioral healthcare services.

Primary Source Verification: Verification of credentialing information directly from the entity (*e.g.*, state licensing board) that conferred or issued the original credential.

Organizational Provider: An institution or organization that provides services, such as a hospital, residential treatment center, home health agency, or rehabilitation facility.

Provisional Credentialing: A process that provides a managed care organization with the ability to add practitioners to its network prior to completing the full credentialing process.

Quality Improvement Committee (QIC): The committee responsible for the monitoring and evaluation of the overall effectiveness of quality improvement activities at GCHP. Although credentialing decisions are not made by this committee, the C/PRC is a subcommittee that reports to the QIC.

Type I Practitioners: Practitioners whose Verification File fully meet the Minimum Requirements for credentialing (as set forth in Section VI.A.-D.) and the Additional Criteria in Sections VI.A. (which incorporates by reference the Quality of Care Criteria in Section VI.E,) as applicable. Also referred to as a "clean file."

Type II Practitioners: Practitioners whose Verification File does not meet the GCHP Additional Criteria for credentialing and/or the Quality of Care Criteria as set forth in Section VI. and whose Verification File requires further review by the C/PRC.

Verification File: A practitioner's complete credentialing application with all documents gathered during the credentialing/recredentialing process, including primary source verification, quality improvement data, and other information furnished to GCHP.

IV. AUTHORITY AND RESPONSIBILITY FOR CREDENTIALING

A. Overview:

GCHP has designated the QIC to oversee all Quality Improvement Program Policies and Procedures and make recommendations to the Commission. GCHP's Commission has delegated credentialing functions to GCHP's C/PRC, with leadership of and oversight by the GCHP Chief Medical Officer (CMO) or his/her designee. The C/PRC is responsible for administering and operating the Credentialing Program and for approving or denying a practitioner's credentials. A summary report of each C/PRC meeting will be made to the QIC and, subsequently, to GCHP's Commission by the CMO or his/her designee. Each Member of the C/PRC is responsible for maintaining objectivity in the credentialing process.

B. Composition of the Credentialing/Peer Review Committee:

The CMO is responsible for the oversight and operation of the Credentialing Program. The CMO either serves as Chairperson of the C/PRC or may appoint a Chairperson, with equal qualifications.

The C/PRC is a peer-review body that includes participating practitioners who span a range of specialties, including primary care (*i.e.*, family practice, internal medicine, pediatrics, general medicine, geriatrics, etc.) and specialty care. It consists of eight voting members who serve two-year terms which may be renewed (there are no term limits). Members are nominated by the CMO and approved by the Commission.

C. Responsibilities/Duties of CMO:

The CMO is responsible for:

1. Overseeing the clinical quality of care, *i.e.*, the review of complaints and grievances, the review and assessment of potential quality issues submitted to the Quality Improvement department, compliance with medical records reviews required by DHCS, and all other ongoing performance monitoring.
2. Recommending new members to be appointed to the C/PRC.
3. Referring significant quality of care issues to the C/PRC for review.
4. Assuring of the completeness of credentialing files.
5. Coordinating and following up on clinical quality of care recommendations by the C/PRC and QIC.
6. Reviewing the list of practitioners to be presented for review prior to the C/PRC meeting to determine if any of the candidates have clinical quality of care issues that may require review by the C/PRC. Classifying credentialing files as Type I or Type II.
7. Reviewing and approving files designated as Type I (clean files).
8. Approving a practitioner who fully meets the established criteria as a provisional practitioner between C/PRC meetings.
9. Presenting candidates for initial credentialing and recredentialing to the C/PRC.
10. Ensuring that proceedings of the C/PRC are recorded in the minutes of the Committee.
11. Communicating with practitioners regarding their credentialing status.
12. Assuring the fairness of the credentialing process and facilitating the appeal and fair hearing process.
13. Ensuring the confidentiality of records of peer review proceedings.

14. Reporting to the QIC, Commission, and other appropriate authorities as required by law.

The C/PRC reviews and evaluates the qualifications of each practitioner applying to become a contracted Network Practitioner or seeking recredentialing as a contracted Network Practitioner. The C/PRC has authority to:

1. Review and ratify Type I Credentialing and Recredentialing practitioner list. Type I files will be presented to the C/PRC on a list of Type 1 files as one group for approval. The CMO or designee will sign each file, and the list will be documented in the minutes of the C/PRC.
2. Receive, review, and act on Type II practitioners applying for Credentialing or Recredentialing.
3. Review the quality of care findings resulting from GCHP's credentialing and quality monitoring and improvement activities.
4. Act as the final decision maker in regard to the initial and subsequent credentialing of practitioners based on clinical competency and/or professional conduct.
5. Review the Credentialing and Recredentialing policy and procedures annually.
6. Establish, implement, and make recommendations regarding policies and procedures.
7. Perform other related responsibilities.

D. Quorum of the C/PRC:

A quorum (half plus one voting member) is satisfactory for the valid transaction of business by the C/PRC, which meets at least quarterly and/or as deemed necessary by the Chairperson. The C/PRC may meet and take action in a forum other than a face-to-face meeting, such as a teleconference or web conference (with audio). Any action taken must be with a quorum present, and all proceedings must be recorded and minutes presented to the C/PRC at its next regularly scheduled meeting. Voting members include only the C/PRC Physicians. The C/PRC Chair votes only when there is a tie vote, in order to break the tie. If during a meeting, a quorum is no longer met, the voting must cease. All meetings must be conducted in accordance with the Brown Act.

E. Committee Minutes and Reports:

Complete and accurate minutes will be prepared and maintained for each meeting. Minutes will reflect the name of the Committee, the date and duration of the meeting, the members

present and absent, and the names of guests or other representatives. The minutes will reflect decisions and recommendations, the status of activities in progress, and the implementation status of recommendations, when appropriate. Applicable reports and substantiating data will be appended for reporting purposes. The C/PRC will be responsible for reviewing minutes for accuracy. A summary report will be submitted to the QIC which in turn reports to the Commission.

1. For each practitioner discussed, the minutes will identify the specialty and a summary of the discussion regarding that practitioner, the C/PRC recommendation, and the rationale for recommendation.
2. Minutes will be securely retained electronically and manually in accordance with GCHP's Records Management Program Policy, ADM-005.

F. Confidentiality, Immunity and Release Policy:

All peer review records and proceedings are included in the quality improvement process of GCHP and are confidential and privileged in accordance with Section 1157 of the California Evidence Code. GCHP classifies all credentialing records that are part of the credentialing peer review process as confidential. The mechanisms in effect to ensure the confidentiality of information collected in this process are as follows:

1. GCHP will hold in confidence all data and information that it acquires in the exercise of its duties and functions as a peer review organization recognized under California Statutes Section 1157.
2. Access to such documents will be restricted to: 1) The practitioner being credentialed, solely pursuant to the description set forth in Section XIII. Practitioner's Rights, 2) C/PRC Members, 3) Commissioners, only if presented in closed session of a Commission meeting related to a C/PRC action and presented as confidential and privileged, 4) GCHP Credentialing staff and legal counsel, 5) the CVO, solely to the extent such information is necessary to conduct primary source verification, and 6) experts, witnesses, representatives of practitioner, or other participants in the Fair Hearing Process, as set forth in the Fair Hearing Policy, QI-028.
3. All C/PRC members, support staff, and other individuals who attend any Committee meetings will be required to sign a confidentiality of information agreement prior to attendance and annually thereafter in order to protect the peer review function. Any breach of confidentiality may be grounds for corrective action by the C/PRC.
4. Each C/PRC member will be immune, to the fullest extent provided by law, from liability to applicants for damages or other relief for any action taken or

statements or recommendations made within the scope of the C/PRC duties exercised.

5. All C/PRC members will comply with GCHP policies for conflicts of interest, Ethics and Conflict of Interest #1-4.

G. Conflict of Interest:

All voting C/PRC members are required to sign a Conflict of Interest agreement before becoming a member and on an annual basis. Committee members will reveal any associations, conflicts of interest or potential conflicts of interest with any credentialing applicant to the C/PRC Chair prior to the consideration of a candidate. No person may participate in the review and evaluation of any professional practitioner with whom he/she has been in a group practice, professional corporation, partnership, or similar entity whose primary activity is the practice of medicine or where judgment may be compromised. The Chair of the C/PRC will have the authority to excuse a voting member from the C/PRC when a conflict of interest exists.

H. Non-Discriminatory Practices:

GCHP conducts each C/PRC meeting in a non-discriminatory manner. No practitioner will be denied privileges with GCHP, have any corrective actions imposed, or have his/her privileges suspended or terminated solely on the basis of race, ethnic/national identity, age, gender, sexual orientation, or the type of patient that the practitioner treats or against particular practitioners that serve high-risk populations or specialize in conditions that require costly treatment.

A heterogeneous Committee will be maintained, and all C/PRC members responsible for credentialing decisions will annually sign a statement affirming that they do not discriminate in credentialing decisions. In order to monitor the credentialing and recredentialing processes for potentially discriminatory practices, quarterly audits of practitioner grievances/complaints will be conducted to determine if there are grievances/complaints alleging discrimination. The grievance/complaints reports are reported to the C/PRC.

V. THE CREDENTIALING PROGRAM

A. Scope of Credentialing:

Credentialing requirements apply to:

- Practitioners who are licensed, certified or registered by the State of California to practice independently (without direction or supervision).

- Practitioners who have an independent relationship with the organization.
- Practitioners who provide care to Members under the organization's medical benefits.

The criteria listed above apply to practitioners in the following settings:

- Individual or group practices
- Facilities
- Telemedicine

The scope of the Credentialing Program includes all practitioners of the types listed below.

B. Types of Practitioners to be Credentialed:

1. *Medical Practitioners*

- Doctor of Medicine (MD), including those anesthesiologists with pain management practices
- Doctor of Osteopathy (DO)
- Doctor of Podiatric Medicine (DPM)
- Doctor of Chiropractic (DC)
- Doctor of Dental Surgery (DDS), including oral surgeons
- Optometrists providing services covered under the medical benefits plan

This list includes telemedicine practitioners who have an independent relationship and who provide treatment services under the organization's medical benefit.

2. *Behavioral Healthcare and/or Substance Use Disorder Practitioners*

- Psychiatrists and other physicians, including addiction medicine specialists
- Doctoral or master's-level licensed psychologists
- Master's-level licensed clinical social workers (LCSW)
- Master's-level clinical nurse specialists or psychiatric nurse practitioners (CNS, PMHNP)
- Licensed marriage and family therapists
- Licensed professional clinical counselors
- Certified qualified autism service providers
- Other behavioral health specialists who are licensed, certified, or registered by the State to practice independently

3. ***Non-Physician Practitioners***

- Nurse Practitioners (NP, PNP, ANP)
- Certified Nurse Midwives (CNM)
- Clinical Nurse Specialist (CNS)
- Physician Assistants (PA)
- Acupuncturists
- Physical Therapists, where an independent relationship exists
- Occupational Therapists, where an independent relationship exists
- Speech - Language Therapists, where an independent relationship exists

C. Types of Practitioners Who Do Not Need to be Credentialed:

The following practitioners do not need to be credentialed:

- Practitioners who practice exclusively within an inpatient setting, or practitioners who provide care for GCHP Members only as a result of being directed to the hospital or another inpatient setting. Examples of this type of practitioner include, but are not limited to:
  - Pathologists
  - Radiologists
  - Anesthesiologists
  - Neonatologists
  - Emergency Room Physicians
  - Hospitalists
  - Pediatric Intensive Care Specialists
  - Other Intensive Care Specialists
- Covering practitioners (*e.g.*, locum tenens) who do not have an independent relationship with the organization.
- Practitioners who do not provide care for Members in a treatment setting (*e.g.*, board-certified consultants).
- Pharmacists who work for a pharmacy benefits management (PBM) organization to which the organization delegates utilization management (UM) functions.

D. File Audit

On an ongoing basis, the Credentialing Coordinator (the staff member responsible for administration and coordination for the C/PRC activities) or designee will review files at the

time of completion, prior to forwarding to the CMO or designee, to ensure accuracy and timeliness. This administrative file review will assess the:

1. Completeness of verification, method of verification, and source of required documentation
2. Timeliness of file completion
3. Compliance with GCHP Credentialing Policy Minimum Criteria

In addition to the administrative file review conducted by the Credentialing Coordinator prior to submission of files to the CMO and/or C/PRC, the GCHP Compliance Department will conduct at least one internal Annual Compliance Audit of the GCHP credentialing program and policies using the Industry Collaborative Effort (ICE) Tool or any other appropriate method, to ascertain compliance with GCHP Credentialing Policy criteria. The audit tool is based upon current NCQA, DHCS and GCHP standards and modified on an as-needed basis.

Lastly, for those organizations to which GCHP has delegated credentialing responsibilities, the Credentialing Coordinator conducts quarterly roster audits and reviews submitted delegate reports. The GCHP Compliance Department conducts pre-delegation audits for newly delegated entities and annual audits for existing delegates.

As set forth in Section XV. Delegated Credentialing, annual audits will be conducted on the credentialing files of the delegated entities. GCHP's Compliance Department will audit files completed during the past 12 months using either a random sampling methodology and/or a Roster Audit of the following types of practitioners:

- Medical doctors (MD), including psychiatrists, addiction medicine specialists, and anesthesiologists with pain management practices
- Osteopaths (DO)
- Podiatrists (DPM)
- Nurse Practitioners (NP, PNP, ANP)
- Physician Assistants (PA)
- Nurse midwives (CNM)
- Clinical Nurse Specialists (CNS, PMHNP)
- Doctor or master's level psychologists
- Master's level licensed clinical social workers

At a minimum, the files audited should result in a 90% rate of completeness, timeliness, and compliance with minimum criteria, regulatory, and contractual requirements. Results of the audits must be documented on a checklist. In the event any deficiencies are identified through the oversight process, corrective action plans are implemented based upon areas of non-compliance. If the delegate is unable to correct or does not comply with the corrective action plan within the required timeframe, GCHP will take action that may include imposing sanctions, de-delegation of the delegated function or termination of the contract or agreement. Focused audits may be performed to verify deficiencies have been corrected or if a quality issue is identified. The results of all audits are reported to the GCHP Compliance Committee, C/PRC, and QIC. The Compliance Committee, which supports GCHP's regulatory compliance functions, reports to the Commission.

VI. CRITERIA FOR CREDENTIALING

GCHP accepts professional practitioners into its network at its sole discretion based on the need for professional practitioners in certain specialties, geographic areas, or similar considerations.

Each professional practitioner must meet minimum standards for participation in the GCHP Network. These guidelines are intended to comply with standards of GCHP, DHCS or its designee, NCQA, or any other applicable regulatory and/or accreditation entities where applicable.

A. Minimum Professional Standards for Credentialing ("Minimum Requirements")

All health care practitioners within the scope of this Credentialing Policy who apply for initial credentialing must satisfy the following minimum standards detailed below. Refer to Section VIII. Primary Source Verification for validation/verification processes and sources for each requirement/credential.

1. Possess a current, valid, unencumbered, unrestricted, and non-probationary California license or registration, or certification, as applicable
    a) An exception to this requirement may be made in the following instances:
        i. For those applicants not previously participating in the GCHP provider network whose licensure action was related to substance abuse, physical impairment, or mental illness and who have demonstrated a minimum of two years of successful participation in a treatment and/or monitoring program with no

evidence of recidivism, recurrence or relapse since the institution of the treatment/monitoring. Should this exception be entertained, GCHP may request specific documentation from the treating physician and/or program as it deems appropriate. These applicants will be subject to Type II review.

ii. For applicants previously terminated from the GCHP network related to licensure action for substance abuse, and who have demonstrated a minimum of one (1) year of successful participation in a treatment and/or monitoring program with no evidence of recidivism since that time. Should this exception be entertained, GCHP may request specific documentation from the treating physician and/or program as it deems appropriate. These applicants will be subject to Type II review.

2. Possess a current, valid, and unrestricted DEA and/or CDS registration for prescribing controlled substances, if applicable to his/her specialty. It is not considered a restriction if a practitioner voluntarily limits the scope of his/her DEA/CDS license.
   a) Initial applicants who have no DEA/CDS certificate and have not applied for such certificate will be viewed as not meeting criteria and the credentialing process will not proceed.
   b) If the applicant can provide evidence that he/she has applied for a DEA/CDS certificate, the credentialing process may proceed if all of the following are met:
      i. It can be verified that this application is pending, and the provider fills out a DEA/CDS Form.
      ii. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the DEA/CDS certificate is obtained.
      iii. The applicant agrees to notify GCHP upon receipt of the required DEA/CDS certificate. GCHP will verify the DEA/CDS certification via standard sources.
      iv. The applicant agrees that failure to provide the appropriate DEA/CDS certification within a 90-day timeframe will result in termination from the network.
3. Not be currently suspended, terminated, or excluded from participation in Medicare or Medi-Cal/Medicaid.
4. Have relevant education in his/her practicing specialty, as evidenced by completion of medical residency and/or specialty training and satisfaction of applicable continuing education requirements. Board certification is required, with the following exceptions: 1) For physicians, new graduates

must become board-certified within two (2) years of first eligibility. 2) Board certification requirements may be waived upon review of the C/PRC if the physician has five years of verified relevant work history and/or has unrestricted, current active privileges in the specialty area. 3) Physicians may be "grand parented" if the practitioner was initially credentialed by GCHP prior to 05/08/15. If the physician had board certification, such certification is subject to verification.

5. Be enrolled in Medi-Cal
    a) Initial applicants who are not enrolled in Medi-Cal and have not applied for Medi-Cal enrollment will be viewed as not meeting criteria and the credentialing process will not proceed.
    b) If the applicant can provide evidence that he/she has applied for enrollment in Medi-Cal, the process may proceed if all of the following are met:
        i. It can be verified that the application is pending,
        ii. The applicant agrees to notify the C/PRC upon receipt of DHCS action on his/her enrollment application. C/PRC will verify via standard sources.
        iii. The applicant agrees that failure to provide the appropriate Medi-Cal enrollment within a 120-day timeframe will result in termination from the network, unless the applicant can show that the application review has been delayed.
6. Have a current and valid National Provider Identifier (NPI).
7. Have a current and valid California or federal identification card *i.e.*, Driver's License, Identification card, Passport, *etc.*
8. Application and required attachments do not contain any omissions (including any additional information requested by GCHP), or falsifications.
9. For physicians and non-physicians for which hospital privileges are required, the applicant must have unrestricted hospital privileges at a network hospital previously approved by the C/PRC, or if practicing solely in an outpatient setting, an appropriate admitting arrangement. Some clinical disciplines may function exclusively in the outpatient setting, and hospital privileges are not relevant to practitioners in such specialties (See Attachment B).
10. Have current and valid malpractice insurance in the amounts of $1 Million per incident and $3 Million per aggregate per year.
11. History of professional liability suits, arbitrations or settlements must be within established GCHP standards (See Attachment A).

Applicants who do not meet the above criteria will be notified of this failure to meet Minimum Requirements and their applications will not proceed through the credentialing or recredentialing process.

Additional Eligibility Criteria for All Applicants (Initial or Recredentialing).

If an applicant for initial participation or continued participation in GCHP's programs or networks does not meet one or more of the following criteria, the applicant's history must not raise a reasonable suspicion of future substandard professional conduct and/or competence. The C/PRC will consider the applicant's history on an individual basis with respect to the following additional criteria, if these additional criteria are not met by the applicant. Refer to Section VIII. Primary Source Verification for validation/verification processes and sources for each requirement/criterion.

1. Reasonable and documented explanations for gaps in work history. No gap in work history greater than six months in the past five years with the exception of those gaps related to parental leave or immigration where 12-month gaps will be acceptable and viewed as Type II. Other gaps in work history of six to 24 months will be reviewed by the Chair of the C/PRC and may be presented to the Committee if the gap raises concerns of future substandard professional conduct and competence. In the absence of this concern, the Chair of the C/PRC may approve work history gaps of up two years;
2. Satisfaction of GCHP standards for quality of care, as set forth in Section VI.E.
3. No physical or mental impairment, (including chemical dependency and substance abuse), that would affect the health care practitioner's ability to practice within the scope of his or her license or pose a risk or imminent harm to members.
4. No history of disciplinary actions or sanctions against the applicant's license, or DEA and/or CDS registration. NOTE: A history of an investigation that did NOT result in any sanction, reprimand, or other adverse action will be viewed as Type I.
5. No history of disciplinary actions, sanctions, or revocations of privileges taken by hospitals and other healthcare facilities or entities, Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPO), etc.
6. No history of sanctions against participating in Medicare and Medi-Cal.

7. No open indictments or convictions, or pleadings of guilty or no contest to a felony, and no open indictments or convictions to any offense involving moral turpitude, or fraud, gross misdemeanors reasonably related to the practice of medicine, or any other similar offense.
8. No other significant information, such as information related to boundary issues or sexual impropriety (including but not limited to convictions, judgments, or pleading of guilty or no contest to sexual misconduct, sexual assault, or sexual harassment) or illegal drug use (including but not limited to convictions, judgments, or pleading of guilty or no contest to possession of illegal substances) or any responses of "yes" to the Attestation section of the application.

B. Additional Minimum Requirements for Certain Specialty Medical Practitioners

1. ***CHDP, CPSP, HIV/AIDS***

For some physician specialties, there are additional credentialing pre-requisite requirements. For example:

- Pediatricians and family practice specialists who care for children must also be paneled by Children Health Disability Prevention Program (CHDP) to participate in the GCHP network.
- Obstetricians must be paneled by Comprehensive Perinatal Services Program (CPSP).
- HIV/AIDS specialist must document that they meet certain additional education and training requirements.

If the practitioner has been identified as an HIV/AIDS Specialist, the following additional criteria is verified prior to indicating this subspecialty in the practitioner listing. Practitioner must be:

- Credentialed as an "HIV Specialist" by the American Academy of HIV Medicine;
- Board certified, or has earned a Certificate of Added Qualification in the field of HIV Medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification or a Certificate of Added Qualification in the field of HIV Medicine;
- Board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications:

1. In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; AND;
2. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category one continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both of HIV infected patients including a minimum of five hours related to antiretroviral therapy per year; or meets the following qualifications:
   a) In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV: and;
   b) Has completed any of the following:
      i. In the immediately preceding 12 months has obtained board certification or recertification in the field of infectious diseases from a member board of the American Board of Medical Specialties;
      ii. In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category (1) continuing medical education in the prevention of HIV infection, combined with diagnosis treatment or both, of HIV-infected patients; or
      iii. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category (1) continuing medical education in the prevention of HIV infection combined with diagnosis.

2. ***Hospice and Palliative Care***

Each specialist must meet all criteria as described in Minimum Requirements in this policy. In order to be recognized as a specialist in Palliative Care, the following board certification requirements must also be met:

- American Board of Medical Specialties (ABMS) subspecialty certificate: Practitioners with a primary board certification from the American Board of Medical Specialties (ABMS) AND a subspecialty Certification in Hospice and Palliative Medicine

  OR

- American Osteopathic Association (AOA) Certificate of Added Qualification: Practitioners with an American Osteopathic Association (AOA) board certification in Family Medicine, Internal Medicine, Neurology and Psychiatry, or Rehabilitation Medicine AND a Certificate of Added Qualification in Hospice and Palliative Medicine

OR

- Practitioners without either ABMS or AOA Hospice and Palliative Care certificates: The C/PRC may waive the above requirements after review of at least 5 years of relevant work history

3. ***OB/GYN Provider PCP Designation***

The C/PRC determines if an Obstetrician and Gynecologist (OB/GYN) will be designated as a full-service Primary Care Provider. This applies to all Obstetricians and Gynecologist (OB/GYN) practitioners whether they are seeking a contract with GCHP, are currently contracted, or are contracted through a delegated group.

The practitioner must be able to substantiate his/her ability, and training in general medicine, as well as his/her ability to demonstrate on-going management of hypertension, diabetes, hyperlipidemia, gastrointestinal illness, cardiovascular disease, musculoskeletal disease, respiratory disease, renal disease, endocrinology and the majority of procedures outlined in the PCP scope of services.

Obstetrician and Gynecologist (OB/GYN) practitioners will need to attest to aforementioned criteria at a regularly scheduled meeting of the C/PRC for approval.

4. ***Optometrists and Ophthalmologists***

GCHP delegates, in its entirety, the credentialing of optometrists, ophthalmologists, and doctor of osteopath specializing in ophthalmology who provide vision care services and/or vision care materials to a subcontractor. GCHP will provide oversight of delegated credentialing functions, consistent with Section XV. Delegated Credentialing.

C. <u>Additional Minimum Requirements for Behavioral Health Care Practitioners</u>

GCHP delegates, in its entirety, the credentialing of behavioral health and substance use disorder providers who provide services to Members to a subcontractor. GCHP will provide oversight of delegated credentialing functions, consistent with Section XV.

D. <u>Additional Minimum Requirements for Non-Physician Practitioners</u>

1. ***Nurse Practitioners***

The required education/training will be, at a minimum, the completion of an education program leading to licensure as a Registered Nurse, and subsequent additional education leading to certification by the California Board of Registered Nursing (BRN) as a NP. Requirements include:

- California Registered Nursing license;
- Nurse Practitioner number, issued by the BRN;
- Nurse Practitioner Furnishing number issued by the BRN; and
- DEA number if prescribing controlled substances.

Nurse Practitioners must also submit a copy of any current Collaborative Agreement with a physician.

2. **Certified Nurse Midwives**

The required education/training will be, at a minimum, that required for licensure as a Registered Nurse with subsequent additional training for certification as a Certified Nurse Midwife by the appropriate licensing body. Requirements include:

- California Registered Nursing license;
- Nurse Midwife certification from the BRN or Medical Board of California (as applicable).
- Furnishing number issued by the BRN; and
- DEA number if prescribing controlled substances.

Certified Nurse Midwives must also submit a copy of any current Collaborative Agreement with physician.

3. ***Clinical Nurse* Specialist**

The required education/training will be, at a minimum, the completion of an education program leading to licensure as a Registered Nurse and subsequent additional education leading to certification as a Clinical Nurse Specialist. Minimum requirements include:

- California Registered Nursing license;
- Clinical Nurse Specialist certification number from the BRN.

4. ***Physician Assistants***

The required education/training will be, at a minimum, the completion of an education program leading to licensure as a Physician Assistant. Minimum requirements include:

- Physician Assistant license issued by the Physician Assistant Board of California;
- DEA number if prescribing controlled substances.

Physician assistants must also submit a copy of any current Delegation of Services Agreement.

5. ***Acupuncturists***

The required education/training will be, at minimum, the necessary curriculum requirements of a California Acupuncture Board-approved training program or a tutorial program approved by the Board. Minimum requirements include:

- Acupuncturist license issued by the California Acupuncture Board.

6. ***Physical Therapists***

The required education/training will be, at minimum, completion of a Master's degree and a professional education program that includes a clinical internship in physical therapy, in an accredited program approved by the Physical Therapy Board of California. Minimum requirements include:

- Licensure as physical therapist.

7. ***Occupational Therapists***

The required education/training will be, at minimum, completion of a Master's degree or equivalent in occupational therapy and supervised clinical practicum, as approved by an accredited program approved by the Occupational Therapy Board of California. Minimum requirements include:

- Licensure as an occupational therapist.

8. ***Speech-Language Therapists***

The required education/training will be, at minimum, completion of Master's degree or equivalent in speech-language pathology and supervised clinical practicum, as approved

by an accredited program approved by the Speech-Language Pathology & Audiology & Hearing Aid Dispensers Board of California. Minimum requirements include:

- Licensure as a speech-language pathologist.

E. Quality of Care Criteria

- Professional practitioner(s) practice patterns must reflect a general adherence to established practice standards and protocols as adopted by GCHP. The professional practitioner(s) practice must also align with the scope of practice for their license and/or certification, and with their education, training, experience, competency, and skills.
- Professional practitioner(s) must maintain satisfactory performance in the area of practice quality indicators (*i.e.,* clinical outcomes, performance measure outcomes, Member satisfaction, etc.) established by GCHP.

GCHP retains the right to approve/deny new practitioners based on quality issues, and to terminate individual practitioners for same. Termination of individual practitioners for quality of care considerations will be supported by documented records of noncompliance with specific expectations and requirements for practitioners. GCHP has a prescribed system of appeals and fair hearings which must be followed for denials based on medical disciplinary causes of action.

F. Business Administrative Criteria:

- Professional practitioner(s) area of specialty must fill a network need as determined by GCHP. GCHP reserves the right to deny participation or terminate a contract, on a case-by-case basis, if need does not exist for a particular specialty and if such action is deemed in the best interest of the network.
- If a practitioner is denied inclusion in the network or a practitioner's contract is terminated for business administrative criteria, it will not be considered a denial of credentialing for a quality reason. The practitioner will not have access to the credentialing appeal or fair hearing processes.

If GCHP terminates a contract with a practitioner for administrative reasons and not for medical disciplinary reasons, it may reinstate the practitioner within 30 calendar days of termination and is not required to perform initial credentialing. GCHP will perform initial credentialing if reinstatement is more than 30 calendar days after termination. In the event that the termination is found to be in error, the credentialing process will be determined on a case-by-case basis.

VII. INITIAL CREDENTIALING OF PRACTITIONERS

A. Process:

GCHP practitioners must be enrolled in the Medi-Cal Program to be credentialed by GCHP. In instances where GCHP elects to enroll providers, the Credentialing Coordinator or designee will assist Provider Network Operations and check the sources for Medicaid/Medicare sanctions listed in Table VII-A.

Each practitioner must submit a legible and completed application on either a GCHP or CAQH application form, which includes a signed and dated consent form, a signed attestation, and all other required documentation as outlined below. The attestations will include the following:

- Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation.
- A history of loss of license or felony conviction.
- A history of loss or limitation of privileges or disciplinary activity.
- A lack of present illegal drug use.
- The application's accuracy and completeness.

B. Application:

The application will be provided to the Credentialing Coordinator or designee of the GCHP CMO. Upon receipt of the application the Credentialing staff will:

- Prepare and send a letter to the applicant reviewing the application process. Included in the letter will be an Addendum to California Participating Physician Application, which indicates that the applicant will have the right to review certain information in the file and correct erroneous information received from third parties obtained in the credentialing process. The practitioner will also be informed of the process of submitting a request to review the file in writing to the Credentialing Coordinator or designee. References, recommendations, or other peer-review protected information is excluded from the right to review information. The right to correct erroneous information does not extend to information (inaccurate or false) submitted by the practitioner as part of the application process.
- If the application is incomplete, the Credentialing Coordinator or designated staff will request that the applicant provide the additional missing information required within 30 calendar days. If the required information is not received, GCHP staff will again inform the applicant that the application is incomplete and request the needed information within 15 calendar days. If the required information is not

received within 45 calendar days of the date of initial receipt of the application, GCHP will consider the application withdrawn. If an application has been withdrawn and the applicant wishes to apply to be credentialed, a new application must be submitted to GCHP.

C. Initial Credentialing Actions

1. *Failure to Meet Minimum Requirements – Administrative Action*

If an application for initial credentialing does not meet the Minimum Requirements in Sections VI.A.- VI.D., it will be denied on an administrative basis and not proceed to a review by the C/PRC, except as set forth below. Such administrative denial will not be considered a denial for a medical disciplinary reason. The practitioner will not have access to the GCHP fair hearing or appeal processes.

2. *New Applicants – Type I Review*

Any practitioner meeting the Minimum Requirements and the Additional Criteria in Sections VI.A – VI.D. will be noted as "meets all standards" and be assigned a designation of Type I, provided the practitioner submits a complete application and required attachments. Type I applicants will be approved by the CMO or designee and the approval will be ratified by the C/PRC.

3. *New Applicants – Type II Review*

In the unique circumstance of those providers whose education and training cannot be verified because the institution has closed, the applicant may be submitted for Type II review.

Practitioners who satisfy the Minimum Requirements in Sections VI.A.-D, as applicable, but do not satisfy the Additional Criteria in Section VI.A or the Quality of Care Criteria in Section VI.E. will be assigned as Type II and will be individually reviewed by the C/PRC.

If any one of the following issues are identified for a practitioner who is initially applying to be a provider for GCHP, the Credentialing Coordinator will forward the credentialing file to the CMO or designee for review. Action on the application will not be taken until the conclusion of the legal proceedings pertaining to:

- A pending felony charge;
- A pending criminal charge involving any criminal activity related to the practitioner's practice;

- Any pending action by the licensing board of the practitioner that could result in revocation or limitation of the practitioner's license to practice; or
- Any pending criminal charge relating to a sex offense.

4. ***Credentialing Actions – Committee Decisions***

When a new credentials file is complete and has been verified, it will be presented to the C/PRC as a Type I or Type II file.

Type I applications are approved by the CMO and presented to the C/PRC as a group for ratification of the CMO's action.

Type II files will be considered and acted on individually by the C/PRC.

Factors to be considered by the C/PRC for Type II files include but are not limited to:

- Past history of actions taken by a licensing body;
- Past history of actions taken by a medical facility related to practitioner's privileges;
- Past history of medical malpractice claims, judgments, and/or payments;
- Past history of suspension or exclusion from federal or state health care programs,
- Past history of criminal charges, if any;
- Any limitations that affect the ability of the practitioner to perform any of the position's essential functions, with or without accommodation,
- Present illegal drug use, or
- Personal issues affecting the practitioner's ability to treat GCHP Members;

These factors will be taken into account as a whole for use by the C/PRC in determining if a practitioner will be credentialed and to determine the services that the practitioner may provide to Members.
Note: A practitioner will receive one of the following designations from the Committee:

	Approved
	Pended
	Denied
	Special Conditions
	Restricted
	Other

5. ***Communication of Credentialing Decision***

The Credentialing Coordinator will send a letter to the applicant, informing him or her of the credentialing decision within 60 days of approval or denial of the application.

6. ***Provisional Credentialing***

GCHP CMO or designee can, on an as needed basis and when in the interest of Members, make practitioners available to see members prior to completion of the entire initial credentialing process. In this case, GCHP will provisionally credential practitioners who are applying to the organization for the first time. The following is verified in the provisional credentialing process:

- Current, valid license unencumbered, unrestricted, and non-probationary license to practice in California
- Past five years of malpractice claims or settlements from the malpractice carrier or NPDB that is in compliance with the standards in Attachment A.
- Must not be currently suspended, terminated, or excluded from participation in Medicare or Medi-Cal/Medicaid.
- Current and signed application with attestation.

A practitioner may only be provisionally credentialed once. A practitioner must meet the criteria above to be eligible for provisional credentialing. All required Primary Source Verification, application, signature, and documentation requirements outlined in Section VII.A. must be satisfied prior to presentation of provider's file to the CMO.

The CMO will review and act on the file of a practitioner that has been provisionally credentialed within the 60-calendar day period after his/her approval of the provisional credentialing. If the practitioner is designated as a Type 1 in accordance with the procedures set forth above, the CMO will approve credentialing of the practitioner. The practitioner's name will be included in the list of Type 1 practitioners for ratification as a group at the next C/PRC meeting. If the practitioner's file is classified as a Type II file, the file will be presented to the C/PRC for individual review at the next scheduled meeting. If the C/PRC is not scheduled to meet before the end of the 60-day period, then appropriate action will be taken to expedite the review.

7. ***Exemption from Credentialing Process***

At times, there may be a need for GCHP to enter into a Letter of Agreement (LOA) with a physician or other provider for certain out-of-network services for a single patient, because such services are either not available or not accessible within the network. In these cases, a practitioner will not be credentialed but must satisfy the criteria for provisional credentialing described in Section VII.C.6. Full credentialing must take place before GCHP enters into a network participation agreement with any such practitioner.

VIII. PRIMARY SOURCE VERIFICATION:

The GCHP credentialing staff, along with the CVO, will conduct primary source verification as required by the most current and applicable DHCS, NCQA, and other GCHP adopted guidelines. GCHP accepts letters, telephone calls, faxes, computer printouts, and/or online viewing of information as acceptable sources of verification with appropriate reference documentation (*i.e.*, the name of the person who provided verification, the date of the call, and the verifier's name). The information must be accurate and current.

Verbal verifications documented in credentialing files are dated and signed by the credentialing staff or the CVO employee who receives the information (noting source and date). Written verifications are received in the form of letters or documented review of latest cumulative reports released by primary sources. Internet verifications may be obtained from any CMS, DHCS, NCQA, and/or GCHP-approved website source. Each practitioner credentialing file will include copies of all applicable verified credentials documents, signed and dated by the CVO.

To meet verification standards, all credentials must be valid at the time of the C/PRC's decision per Table VII-A below and the specific time limits as set forth by DHCS, NCQA, GCHP and any other applicable regulatory and/or accreditation entities.

All verifications, attestations, and information released will be less than 180 days old at the time of the credentialing decision, with the exception of work history, which will be less than 365 days old at the time of the credentialing decision. For written verification, the 180-day limit begins with the date on the written verification from the entity that verified that particular credential. Unless otherwise stated, all verification timeframes in this policy are 180 days prior to the decision.

The following table shows the acceptable sources for those credentials that require primary source verification.

Table VII-A

Primary Source Information:	Acceptable Sources:
• **Credential: License, Certification, or Registration** • **Verification Time Limit: 180 calendar days*** -Must confirm that practitioners hold a valid, current state license, certification, or registration, which must be in effect at the time of the C/PRC's decision; -License, certification, or registration, as applicable, must be verified in each state where practitioners provide care for plan Members; -All restrictions on license or practice will be documented in the credentialing file. Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable). *Satisfaction of applicable continuing education requirements is verified by the State agency responsible for licensing, registration or certification. GCHP relies on licensure, certification, or registration being in good standing as proof of completion of required continuing education.	• A copy of a valid and current state license, certification, or registration from the state licensing or certification agency. • If the plan uses the Internet to verify state licensure or certification, the website must be that of the appropriate state licensing agency.
• **Credential: DEA or CDS Certificate** • **Verification Time Limit: Prior to the credentialing decision** -Must be effective at the time of the credentialing decision; -Must be verified in each state in which the practitioner cares for plan Members.	• A copy of the DEA or CDS certificate • Documented visual inspection of the original certificate • Confirmation from the DEA or CDS Agency • Confirmation from the National Technical Information Service (NTIS) database

Primary Source Information:	Acceptable Sources:
Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable) Note: Eligible practitioners whose DEA or CDS certification is pending upon initial application for certification must complete a DEA/CDS Form.	• Confirmation from the American Medical Association (AMA) Physician Master File (DEA only) • Confirmation from the American Osteopathic Association Official Osteopathic Physician Profile Report or Physician Master File (DEA only).
• **Credential: Education and Training** • **Verification Time Limit: Prior to the credentialing decision** The organization must verify the highest of the three levels of education and training obtained by the practitioner. 1. Graduation from medical or professional school 2. Medical residency and/or specialty training 3. Board certification (Required for physicians with exception of practitioners who were grand parented) 4. Satisfaction of any applicable continuing education requirements is verified through possession of a current state license Note: If a practitioner's education has not changed during the recredentialing cycle, the previous education verification will stand and not be re-verified. Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)	• The primary source • State licensing agency, specialty board or registry, if it performs primary-source verification. At least annually, GCHP must obtain written confirmation from the source that it performs primary source verification. • Printout from state licensing agency, specialty board or registry, website: The plan may use a dated printout of the licensing agency's website in lieu of a letter or other written notice as long as the site states that the agency verifies education and training with primary sources and indicates that this information is current; or provides evidence of a state statute that requires the licensing board to obtain verification of education and training directly from the institution. • Sealed transcripts: If a practitioner submits transcripts to the organization that are in the institution's sealed envelope with an unbroken institution seal, if the organization provides evidence that it inspected the contents of the envelope and confirmed that transcript shows that the practitioner completed (graduated from) the appropriate training program.

Primary Source Information:	Acceptable Sources:
	• Note: If the practitioner states that education and training were completed through the AMA's Fifth Pathway program, the organization must confirm it through primary-source verification from the AMA *Other acceptable verification sources for physicians (MD, DO)* Medical School Graduation • AMA Physician Master File • American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File • Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986. Completion of Residency Training • AMA Physician Master File American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File• Federation Credentials Verification Services (FCVS) for closed residency programs. • NCQA only recognizes residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) *For Other Healthcare Professionals* • Additional sources for primary verification of education for behavioral health and non-physician practitioners are described in Section VI. B. – D.

• **Credential: Board Certification** • **Verification Time Limit: 180 calendar days*** Board certification - required for GCHP physicians with exception of practitioners who were grand parented. Refer to VI.A.4. Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)	*For all practitioners* • The primary source (appropriate specialty board) (See Attachment D.) • The state licensing agency if it primary source verifies board certification. *For physicians* • ABMS or its member boards, or an official ABMS Display Agent, where a dated certificate of primary-source authenticity has been provided. • AMA Physician Master File. • AOA Official Osteopathic Physician Profile Report or AOA Physician Master File. • Boards in the United States that are not members of the ABMS or AOA if the organization documents within its policies and procedures which specialty boards it accepts and obtains annual written confirmation from the board that the board performs primary source verification of completion of education and training. For Other Healthcare Professionals • Registry that performs primary source verification of board status if the organization obtains annual written confirmation that the registry performs primary source verification of board certification status. • Additional sources for primary verification for behavioral health and non-physician practitioners are described in Section VI. B. – D.

Primary Source Information:	Acceptable Sources:
• **Credential: Hospital Privileges** • **Type of Privileging: Full, Active (or equivalent status).** • **Verification Time Limit: 180 calendar days** Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable). Note: Specialties who require hospital privileges and currently do not hold valid privileges at a GCHP contracted hospital, are required to complete Hospital Coverage Agreement Form.	Contact the hospital(s) identified on the practitioner's application and use the hospital roster, fax, or other mode to confirm privileges
• **Credentials: National Provider Identifier, Medi-Cal Enrollment**	Verify NPI in the PPI Registry Public Search at https://npiregistry.cms.hhs.gov/ Verify Medi-Cal Enrollment at the CHHS Open Data website
• **Credential: State and Federal Sanction Information - Medicaid and Medicare Sanctions, Restrictions on Licensure or Limitations on Scope of Practice, Exclusions and Limitations related to Fraud and Abuse** • **Verification Time Limit: 180 calendar days** The appropriate sources must be queried for sanctions and limitations prior to presenting a practitioner to the Committee for review and a decision. Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable).	**Sources for Sanctions or Limitations on Licensure:** NPDB is an acceptable source for all practitioner types listed below. *Physicians:* • Appropriate state agencies • Federation of State Medical Boards (FSMB) *Chiropractors:* • State Board of Chiropractic Examiners. • Federation of Chiropractic Licensing Boards' Chiropractic Information Network-Board Action Databank (CIN-BAD). *Oral Surgeons:*

Primary Source Information:	Acceptable Sources:
	• State Board of Dental Examiners or State Medical Board. *Podiatrists:* • State Board of Podiatric Examiners. • Federation of Podiatric Medical Boards *Other Health Care Professionals:* • Appropriate state agency • State licensure or certification board **Sources for Medicare/Medicaid Sanctions** • Medi-Cal agency or intermediary • Medicare intermediary • AMA Physician Master File • Federal Employees Health Benefits Plan (FEHB) Program department record, published by the Office of Personnel Management, Office of the Inspector General • Federation of State Medical Boards (FSMB) • List of Excluded Individuals and Entities (maintained by OIG), available over the Internet • Centers for Medicare and Medicaid Services, Medicare Exclusion Database • List of Suspended and Ineligible Providers, Medi-Cal, State Department of Health Care Services website • NPDB

The following information must also be received and verified, but primary source verification is not required:

A. Work History
Verification Time Limit*: 365 calendar days*

Employment dates. The organization obtains a minimum of the most recent five years of work history as a health professional through the practitioner's application or CV. If the practitioner has fewer than five years of work history, the time frame starts at the initial licensure date.

The application or CV includes the beginning and ending month and year for each position of employment experience, unless the practitioner has had continuous employment for five years or more with no gap. In such a case, providing the year meets the intent of this factor.

Gaps in work history. The organization documents its review of the practitioner's work history and any gaps on the application, CV, checklist or other identified documentation methods (*i.e.*, signature or initials of staff who reviewed the history and the date of review).

If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing. The organization documents a verbal clarification in the practitioner's credentialing file. If the gap in employment exceeds one year, the practitioner clarifies the gap in writing.

B. Malpractice Coverage
Verification time limit: *180 calendar days*

GCHP must obtain a copy of the Liability Insurance Coverage face sheet that shows medical malpractice coverage and/or professional liability coverage *of* $1 million per occurrence and $3 million annual aggregate.

C. Malpractice History
Verification time limit: *180 calendar days*

GCHP must obtain confirmation of the past seven (7) years of malpractice settlements from the malpractice carrier or query the NPDB. The five-year period may include residency or fellowship years. The organization is not required *to* obtain confirmation from the carrier for practitioners who had a hospital insurance policy during a residency or fellowship.

- **D. History of Suspension or Curtailment of Clinical Privileges**

GCHP must obtain information about suspensions or curtailment of clinical privileges during the past seven (7) years from the practitioner via the GCHP or CAQH application and from the NPDB.

IX. RECREDENTIALING: PRACTITIONERS

A. Process:

GCHP re-credentials all practitioners within three years of their last credentialing or recredentialing date. The intent of the process is to identify any changes that may affect a practitioner's ability to perform the services that he/she is under contract to provide.

GCHP practitioners must be enrolled in the Medi-Cal Program to be recredentialed by GCHP. In instances where GCHP elects to enroll providers, the credentialing coordinator or designee will assist Provider Network Operations and check the sources for Medicaid/Medicare sanctions listed in Table VII-A.

Each practitioner must submit a legible and completed application on either a GCHP or CAQH application form, which includes a signed and dated consent form, a signed attestation, and all other required documentation as outlined below. The attestations will include the following:

- Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation.
- A history of loss of license or felony conviction.
- A history of loss or limitation of privileges or disciplinary activity.
- A lack of present illegal drug use.
- The application's accuracy and completeness.

B. Application

All application requirements detailed in Section VII are applicable to the recredentialing process. All verification timeframes detailed in Table: VII-A are applicable to the recredentialing process.

Each practitioner must complete and sign the GCHP or CAQH Recredentialing Application that includes the professional questions and attestation that the information given is correct and gives GCHP the right to verify the information. The following information is obtained

and verified according to the standards and utilizing the sources listed under Initial Credentialing:

- State license, registration, or certification
- DEA/CDS certificate (if applicable)
- Additional Education (if applicable)
- Board certification
- Hospital affiliations/status of clinical privileges, including history of suspension/curtailment
- Malpractice coverage
- Malpractice claims
- Sanction information, including Medicare/Medi-Cal sanctions, entries into the NPDB, and sanctions or limitations on license or DEA certificate
- Documentation showing Medi-Cal enrollment and NPI

The recredentialing process will include performance-monitoring information. Sources of such information may include one or more of the following:

- Member grievances/complaints
- Member and Practitioner/Provider satisfaction surveys
- Utilization Management
- Risk Management
- Quality improvement activities, performance quality measures, potential quality issues, quality deficiencies, and/or trending patterns
- Medical Record Keeping Practice/Treatment Assessments during recredentialing

Upon receipt of the application the Credentialing staff will:

- Prepare and send a letter to the applicant reviewing the application process. Included in the letter will be an Addendum to California Participating Physician Application, which indicates that the applicant will have the right to review certain information in the file and correct erroneous information received from third parties obtained in the recredentialing process. The practitioner will also be informed of the process of submitting a request to review the file in writing to the Credentialing Coordinator or designee. References, recommendations, or other peer-review protected information is excluded from the right to review information. The right to correct erroneous information does not extend to information (inaccurate or false) submitted by the practitioner as part of the application process.

- If the application is incomplete, the Credentialing Coordinator or designated staff will request that the applicant provide the additional missing information required within 30 calendar days. If the required information is not received, GCHP staff will again inform the applicant that the application is incomplete and request the needed information within 15 calendar days. If the required information is not received within 45 calendar days of the date of initial receipt of the application, the CMO will send a formal letter to the practitioner reflecting:
    - The number of times and specific dates the Credentialing staff has reached out to the practitioner and his/her designee (as applicable);
    - The provider's contractual requirements regarding recredentialing;
    - That the provider has five business days in which to respond and that failure to respond will result in administrative denial of the application for recredentialing and contract termination.

Provider Network Operations will be notified when a practitioner has failed to respond to the recredentialing efforts.

C. Credentialing Actions

1. *Failure to Meet Minimum Requirements – Administrative Action*

If an application for initial or recredentialing does not meet the Minimum Requirements in Sections VI.A.- VI.D., it will be denied on an administrative basis and not proceed to a review by the C/PRC, except as set forth below. Such administrative denial will not be considered a denial for a medical disciplinary reason. The practitioner will not have access to the GCHP fair hearing or appeal processes.

2. *Currently Participating Applicants (Recredentialing) – Type I Review*

Any practitioner meeting the Minimum Requirements in Sections VI.A. – VI.D. as applicable and the Additional Criteria in Section VI.A., will be noted as "meets all standards" and be assigned a designation of Type I, provided the practitioner submits a complete application and required attachments. Type I applicants will be reviewed and approved by the CMO and submitted to the C/PRC as a group for ratification.

3. *Currently Participating Practitioners – Type II Review*

Practitioners who satisfy the Minimum Requirements in Sections VI.A. – VI.D., as applicable, but do not satisfy the Additional Criteria in Section VI.A will be assigned as Type II and will be individually reviewed by the C/PRC.

In addition, GCHP may identify quality of care issues that require C/PRC review. All practitioners with identified quality of care issues will be individually reviewed and considered by the C/PRC.

4. *Credentialing Actions – Suspensions and Pending Practitioners' Files*

Each practitioner's credentialing/recredentialing file is reviewed by Credentialing Coordinator or designee for completeness and accuracy based on Minimum, Additional, and Quality of Care Criteria prior to presentation to the CMO. Any file identified with exceptions or potential exceptions is referred to the CMO or designee to evaluate and request additional information, as needed. If further information is needed, either the Credentialing Coordinator or CMO or designee will gather the additional information for the credentials file and for presentation to the C/PRC.

A. If any one of the following issues are identified, Credentialing staff will forward the credentialing file or active practitioner file to the CMO or designee for review and, if verified, may be cause for immediate denial of an application, or summary suspension as a practitioner for GCHP for up to 14 calendar days:
   - A restriction, imposition of probation, suspension, or a revocation of the practitioner's license to practice medicine in the State of California;
   - A sanction, debarment, or exclusion that disallows participation in the Medicare and Medicaid programs;
   - A condition that is identified that would suggest that care by the practitioner would present a danger to a Member;
   - Any verified evidence that the practitioner lied or made a misstatement on the application;
   - Loss of DEA or CDS certification, if applicable;
   - Loss of NPI or Medi-Cal provider number;
   - No current malpractice coverage;
   - Malpractice claims history no longer satisfies GCHP standards;
   - Suspension or loss of privileges at any hospital (if applicable).

C. If any of the following issues are identified for a practitioner who is being considered for recredentialing the committee may, but is not required to, temporarily extend the practitioners credentials until the practitioner has had due legal process or has had the opportunity to complete a Corrective Action Plan, or the practitioner may be suspended because of the seriousness of the accusation:

- A pending felony charge;
- A pending criminal charge involving any criminal activity related to the practitioner's practice;
- Any pending action by the licensing board of the practitioner that could result in revocation or limitation of the practitioner's license to practice;
- Any pending criminal charge relating to a sex offense; or
- Suspension or loss of hospital privileges (if applicable)

D. Recredentialing Actions

When a re-credentials file is complete, it will be presented to the C/PRC as a Type I or Type II file. Type I applications are approved by the CMO and presented to the C/PRC as a group for ratification of the CMO's action.

Type II files will be considered and acted on individually by the C/PRC. Factors to be considered by the C/PRC:

- Past history of actions taken by a licensing body;
- Past history of actions taken by a medical facility related to practitioner's privileges;
- Past history of medical malpractice claims, judgments, and/or payments;
- Past history of suspension or exclusion from federal or state health care programs,
- Past history of criminal charges, if any;
- Personal issues affecting the practitioner's ability to treat Plan Members;
- History of grievances and complaints by Plan Members (for recredentialing);
- Reviews submitted to the C/PRC by the QIC (for recredentialing);
- Peer review issues referred to the C/PRC and verified and rated as significant Potential Quality Issues (for recredentialing);
- History of the practitioner failing to abide by the policies of GCHP, including failing to meet the standard quality indicators such as HEDIS® Metrics and access requirements (for recredentialing).

These factors will be taken into account as a whole for use by the C/PRC in determining if a practitioner will be credentialed or re-credentialed and to determine the services that the practitioner may provide to Plan Members.

A practitioner will receive one of the following designations from the Committee:

	Approved
	Pended

	Denied
	Special Conditions
	Restricted
	Other

E. Communication of Credentialing Decision

If an applicant's recredentialing application is denied, the Credentialing Coordinator will send a letter to the applicant, informing him or her of the denial within 60 days of such decision. The Credentialing Coordinator will also notify Provider Network Operations of any denials of recredentialing applications.

X. ONGOING MONITORING

GCHP Credentialing staff monitors practitioner sanctions, and grievances/complaints and quality issues between credentialing cycles and takes appropriate action(s) against practitioners when it identifies occurrences of poor quality. GCHP staff reviews information within 30 calendar days of its release by the reporting entity listed on Attachment D. If the reporting entity does not publish sanction information on a set schedule, staff will implement the following:

- Document that the reporting entity does not release information on a set schedule
- Queries for this information at least every six months

If the reporting entity does not release sanction information reports, GCHP staff conducts individual queries of credentialed practitioners every 12–18 months.

GCHP acts on important quality and safety issues in a timely manner by reporting such occurrences at C/PRC meetings or as needed. These practitioners will be identified as Type II when they are presented to the C/PRC. If an occurrence requires urgent attention, the CMO or designee will address it immediately, issuing appropriate action(s) to ensure quality and safety for GCHP members. The C/PRC will be engaged, as appropriate. If the CMO determines that there is an immediate danger to the provision of care by a practitioner, the CMO or designee may summarily suspend the practitioner for a period of 14 days.

On an ongoing monitoring basis, GCHP collects and takes appropriate intervention and/or action by:

- Collecting and reviewing Medicare and Medicaid sanctions per one of the acceptable sources for primary source verification in Table VII-A. All practitioners must maintain good standing in the Medicare or Medicaid/Medi-Cal programs. Any practitioner terminated from the Medicare or Medicaid/Medi-Cal programs may not participate in the GCHP provider network.

- Collecting and reviewing grievances/complaints: The CMO or designee will review a report of Member complaints/grievances quarterly and at year end. If an unusually large number of grievances, as defined in the criteria below, are filed against a practitioner, the CMO or designee will review copies of the actual grievance documentation and will make a determination as to whether the grievance materials should be submitted to the C/PRC at the next regularly scheduled meeting.
    - Criteria for Referral Physicians with no linked Members
        - If three or more grievances are filed against any GCHP Physician with no linked Members in any given year, the practitioner will be presented to the C/PRC as noted above for their consideration.

    - Criteria for Primary Care Physicians with linked Members:
        - During any quarter, if the rate of grievances filed against any Primary Care Physician is greater than a rate of three (3) grievances per 1,200 Member months per year annualized, then the practitioner will be presented to the C/PRC as noted above for their consideration. Member's complaints and Potential Quality Issues (PQIs) will also be reviewed at the time of recredentialing and issues addressed between recredentialing cycles will be part of the recredentialing review process.

- Collecting and reviewing information from identified adverse events:
    - GCHP staff monitors for adverse events at least every six months to determine if there is evidence of poor quality that could affect the health and safety of Members. Depending on the nature of the adverse event, GCHP will implement actions and/or interventions based on its policies and procedures when instances of poor quality are identified.

- Medical Board of California Monitoring:

- Medical Board of California: The "Hot Sheet" website report is run monthly. This report is a summary of disciplinary matters for the Medical Board of California, the Physician Assistant Committee, Board of Podiatric Medicine, and the Board of Psychology. The practitioners on the report are matched against GCHP's Provider Network Database by the Credentialing Coordinator or designee. If a match is found the information is reviewed by the CMO or designee, and when appropriate, submitted to the C/PRC for follow-up review and recommendations. Any practitioners matched on the report that are in delegated networks are sent to the GCHP Compliance Department for follow up with the delegated entity.

- Verify that State License Renewal occurs with no restrictions at license renewal date: Reports of expired license are run monthly by the Credentialing Coordinator or designee. Staff will verify at the State licensure Board website that the license of each practitioner on the report has been renewed and is free of any sanctions or limitations. If a license is found not to have been renewed or has sanctions or limitations placed against it, the information will be reviewed by the CMO or designee and, when appropriate, submitted to C/PRC for review and recommendations.

- HIV/AIDs Specialist Board Certification Status
  - HIV/AIDs Specialist Board Certification status will be run monthly by the Credentialing Coordinator or designee. Staff will verify at the following website that the credential is current: www.aahivm.org. If a certification has been found not to have been renewed or has sanctions or limitations placed against it, the information will be reviewed by the CMO or designee, and when appropriate, submitted to C/PRC for review.

- Potential Quality Issues (PQIs):
  - Refer to Potential Quality Issue Investigation and Resolution Policy, QI-023.

XI. REPORTING TO MEDICAL BOARD OF CALIFORNIA (MBC) AND NATIONAL PRACTITIONER DATA BANK (NPDB)

A. 805 Reports to Medical Board of California - Actions Requiring Reports

An 805 Report is filed with the MBC whenever any of the following actions taken by GCHP and/or its C/PRC involving a physician, podiatrist or other allied practitioner become final:

- The practitioner's application for GCHP Provider status is denied or rejected for a medical disciplinary cause or reason;
- The practitioner's GCHP Provider status is terminated or revoked for a medical disciplinary cause or reason;
- Restrictions are imposed or voluntarily accepted on the practitioner's authority to provide care to GCHP Members for a cumulative total of 30 calendar days or more for any 12-month period, for a medical disciplinary cause or reason;
- The practitioner resigns or takes a leave of absence from GCHP Provider status following notice of an impending investigation based on information indicating a medical disciplinary cause or reason; or
- A summary suspension remains in effect in excess of fourteen (14) days.

B. Timeframe for filing an 805 Report

An 805 report is filed within the timeframe noted below as follows:

- Resignation or Leave of Absence:
  - Within 15 days after the effective date of resignation or leave of absence.
- Denial, Termination or Restriction:
  - Within 15 days after the conclusion of all of the proceedings under Fair Hearing Policy QI-028 if a denial, termination or restriction results from such proceedings.
- Summary Suspension:
  - Within 15 days following the imposition of summary suspension, if the summary suspension remains in effect for a period in excess of fourteen (14) days.

C. 805.1 Reports to the Medical Board of California

An 805.1 report will be filed with the Medical Board of California (MBC) when a final decision or recommendation has been made by the C/PRC, subsequent to completion of the fair hearing process.

If the decision or recommendation of the C/PRC is made for any one of the following four reasons, the 805.1 report must be submitted to the MBC before the fair hearing process:

1. Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, to the extent or in such a manner as to be dangerous or injurious to any person or to the public

2. The use of, or prescribing for or administering to himself or herself of any controlled substance, any dangerous drug (as specified), or alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, any other person, or the public, or to the extent that the licentiate's ability to practice safely is impaired by that use
3. Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated of prescribing, dispensing, or furnishing of controlled substances without a good faith effort or prior examination of the patient and the medical reason therefore (note that in no event will a physician or surgeon who is lawfully treating intractable pain be reported for excessive prescribing, and if a report is made, the licensing board must promptly review any such report to ensure these standards are properly applied); and
4. Sexual misconduct with one or more patients during a course of treatment or an examination.

These practitioners will be identified as Type II Review when they are presented to the C/PRC. The proposed action must be given to the practitioner within 15 days after the C/PRC makes the recommendation or final decision.

D. NPDB Reports - Actions Requiring Reports:

An NPDP Report is filed whenever any of the following actions, taken by the C/PRC, involving a Physician, Podiatrist or other licensed clinical practitioner become final:

1. An Action that is based on the practitioner's professional competence or professional conduct which adversely affects or could adversely affect the health or welfare of a patient when that action adversely affects the practitioner's authority to provide care to GCHP Members for more than thirty (30) calendar days;

2. Acceptance of the practitioner's surrender or restriction of authority to provide care to GCHP Members while under investigation for possible professional incompetence or improper professional conduct or in return for not conducting an investigation or professional review action.

E. Timeframe for filing an NPDB Report

An NPDB Report is filed within 15 calendar days from the date the adverse action was taken or authority to provide care to GCHP Members is voluntarily surrendered.

F. Additional Reports

An NPDB Report is filed when any revision is made to a previously reported adverse action.

XII. FAIR HEARING RIGHTS

Except in the event of a summary suspension in effect less than thirty one (31) calendar days or a surrender or restriction of authority to provide care to GCHP Members as provided below, an NPDB Report is filed after the GCHP Provider has had the opportunity to either waive or exhaust his/her Fair Hearing rights, if applicable, in accordance with Fair Hearing Policy QI-028**.**

XIII. PRACTITIONER RIGHTS

A. To Review Information Submitted in Support of Credentialing Application

GCHP notifies providers of their right to review information obtained from outside sources to support their credentialing application, such as information from malpractice insurance carriers or state licensing boards. GCHP is not required to make available references, recommendations, or other peer-review protected information, if applicable. GCHP is not required to reveal the source of information if the information was not obtained to meet credentialing verification requirements or if federal or State law prohibits disclosure.

B. To Correct Erroneous Information

Practitioners have the right to correct erroneous information received from third parties and obtained by GCHP during the credentialing process within 15 calendar days of notification of discrepancy between the information submitted by the Practitioner and that obtained by GCHP. Practitioners may submit in writing to the Credentialing Department any corrections or an explanation of discrepancies by mail, fax, or email. Practitioners are notified of this right to correct erroneous information from third parties during the credentialing process email and/or letter.

C. To Be Informed of Application Status

GCHP notifies a practitioner of his/her application status upon request. The process allows for phone calls, emails, letters, or faxes from practitioners. If either the credentialing staff or another department receives a request, it will be responded to within 72 hours of receipt. If another department receives a request, it will be routed to the Credentialing Department

within 10 business days for follow-up and resolution by the Credentialing staff within 72 hours of initial receipt.

The Credentialing Department staff will advise the practitioner, once key information is verified, of the following information via phone or in writing:

- The date the application was received
- The status of the application – pending for additional information, etc.
- The date the application is tentatively scheduled to be presented to the C/PRC

Prior to disclosing any confidential practitioner information via phone, the following must be verified by the Credentialing staff and confirmed by the practitioner or designee listed on Credentialing Application (*i.e.,* practitioner's credentialing coordinator, office manager or any authorized person designated by practitioner):

- Practitioner's full name
- Practitioner's primary office location
- Practitioner date of birth
- The name, city and state of the schools from which the practitioner graduated

Practitioners are notified of the above rights via fax, email and/or mailed letter provided at the time of initial credentialing and recredentialing.

XIV. FILE RETENTION

Credentialing files will be retained for at least ten years, as set forth in the GCHP Records Management Program Policy ADM-005. Credentialing files are considered protected and confidential. Each practitioner has an electronic file in the QI directory and/or with the CVO. File cabinets containing practitioner files will be locked and/or secured at all times. Staff utilizing practitioner files will ensure file will be secured, as practical or business appropriate, after normal business hours.

XV. DELEGATED CREDENTIALING

Delegation is the formal process by which a managed care organization (MCO) such as GCHP, gives another entity (*e.g.,* an Independent Practice Association (IPA), hospital, medical group) the authority to perform credentialing functions on its behalf. If any functions are delegated, the MCO, *i.e.,* GCHP, (i) is responsible and accountable for assuring that the same standards of participation are maintained throughout its provider network; (ii)

retains the right to approve, suspend, or terminate all practitioners and sites of care; and (iii) ensures that a consistent and equitable process is used throughout its network by requiring:

- That the delegated entity adheres to at least the same criteria, policies, and procedures. GCHP will evaluate the delegated entity's capacity to perform the delegated activities prior to delegation;
- A mutually agreed upon document, which may be a contract, exhibit, letter, memorandum of understanding, or other document, which clearly defines the performance expectations for GCHP and the delegated entity. This document will define GCHP's and the delegate's specific duties, responsibilities, activities, reporting requirements, and identify how GCHP will monitor and evaluate the delegate's performance. This mutually agreed upon document will also specify the remedies available to GCHP, including (but not limited to) revocation of the delegation if the delegate does not fulfill its obligations;
- GCHP staff to audit the delegate's files on an annual basis to evaluate whether the delegated entity's activities are being conducted in accordance with GCHP expectations and NCQA standards. The only exception to the oversight requirements is when GCHP delegates to an entity that is NCQA Certified for Credentialing or NCQA accredited. GCHP does not need to conduct an annual file audit or evaluation, however, credentialing policies and procedures will be reviewed as applicable to delegated functions;
- If monitoring reveals deficiencies in the delegate's credentialing and recredentialing processes, GCHP will work with the delegate to set priorities and correct the problems. If serious problems cannot be corrected, GCHP will revoke the delegation arrangement;
- That GCHP retains the right, based on quality issues, to approve, to suspend or terminate practitioners;
- Functions performed by vendors that do not involve decision-making (*i.e.* data collection as may be performed by a CVO) are not delegated functions, as defined in this section.

XVI. ATTACHMENTS:

Attachment A	Malpractice Case History Thresholds
Attachment B	Practitioner Types and Physician Specialties Not Requiring Hospital Privileges
Attachment C	Hospital Coverage Agreement Form

XVII. REFERENCES:

1. National Committee for Quality Assurance “Standards and Guidelines for the Accreditation of Health Plans” Credentialing and Recredentialing Standards
2. MC Policy Letter 02-003, Credentialing & Re-Credentialing: Time Line Change, New Primary Source Verification Requirements and Verification of Credentials of Non-Physician Practitioners
3. MMCD APL 16-012 Provider Credentialing and Recredentialing (Supersedes PL 02-003)
4. MMCD APL 17-019 Provider Credentialing/Recredentialing and Screening/ Enrollment Provider Credentialing / Recredentialing and Screening / Enrollment (Supersedes APL 16-012)
5. MMCD APL 19-004 Provider Credentialing/Recredentialing and Screening / Enrollment (Supersedes APL 17-019)
6. Policy QI-016 Contract Compliance Monitoring Site Audits and Medical Records Review
7. Title 42 Code of Federal Regulations § 438.214
8. GCHP Credentialing for Organizational Providers, QI-005
9. GCHP Fair Hearing Policy, QI-028
10. GCHP Potential Quality Issue Investigation and Resolution Policy, QI-023
11. GCHP Records Management Program Policy ADM-005

ATTACHMENT A

MALPRACTICE CASE HISTORY THRESHOLDS

A. <u>Initial Credentialing:</u>

- A minimum of the past seven (7) years of malpractice case history is reviewed.
- Practitioners with ONE OR MORE malpractice cases will be individually reviewed and considered by the C/PRC. Cases will be reviewed based on volume, disposition and award settlement.

B. <u>Recredentialing:</u>

The practitioner's malpractice case history is reviewed since the last C/PRC review. If no new cases are identified since the last review, malpractice history will be reviewed as meeting criteria for Type I review. If new malpractice history is present, then a minimum of last five years of malpractice history is evaluated and criteria consistent with initial credentialing is used.

ATTACHMENT B

PRACTITIONER TYPES AND PHYSICIAN SPECIALTIES NOT REQUIRING HOSPITAL PRIVILEGES

Hospital Privilege requirements apply in general to physician providers, and thus the following provider types are excluded from this requirement. These practice types include:

1. Chiropractors
2. Podiatrists
3. Optometrists
4. Non-physician behavioral health providers (Including but not limited to: Psychologists, Social Workers, Nurse Practitioners working in behavioral health)
5. Medical Therapists, *e.g.* physical therapists, speech/language therapists, and occupational therapists, who are within the scope of credentialing

In addition, there are several physician specialty types whose practices are primarily limited to the outpatient arena and thus are exempted from the requirement for hospital privileges. These specialties are:

1. Addiction Medicine
2. Allergy & Immunology
3. Dermatology
4. Genetics
5. Occupational Medicine
6. Physical Medicine & Rehabilitation
7. Psychiatry
8. Public Health and General Preventive Health
9. Rheumatology
10. Radiation Oncology practicing at a Center for Improvement in Healthcare Quality (CIHQ), The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (NIAHO) or Healthcare Facilities Accreditation Program (HFAP)-approved facility
11. Ophthalmology
12. Neuromusculoskeletal Medicine & Osteopathic Manipulative Medicine
13. Primary Care physicians whose patients are admitted to a participating hospital with an established hospitalist program
14. Physicians in any specialty who have been credentialed to participate solely as a Telemedicine Provider (note: if such a physician later applies to

participate as an office-based physician, the hospital privilege requirement may apply)

15. Anesthesiologists practicing solely in an outpatient setting
16. Radiologists practicing solely in an outpatient setting.
17. Pathologists practicing solely in an outpatient setting.

All other MD and DO provider types within the scope of the credentialing program, and dentists who practice as Oral Surgeons are required to have hospital privileges or appropriate admitting arrangements. This includes all PCP providers (family physicians, pediatricians, internists, & general practitioners) and Specialty Providers including but not limited to those specifically exempted by the listings above. CMO will determine, with committee input, if there are additional specialties exempted.

ATTACHMENT C: HOSPITAL COVERAGE AGREEMENT FORM

Hospital Coverage Agreement Form

Complete this form if you do not participate in a Gold Coast Health Plan network-participating hospital, but have arrangements with a hospitalist group or physician that can admit your Gold Coast Health Plan patients to a Gold Coast Health Plan Network-participating hospital in which they have active privileges. This physician or hospitalist group must participate in the Gold Coast Health Plan network, and practice in the same or similar specialty field as you do.

Hospital coverage arrangement statement

I, _____(the referring physician), practice in the specialty

of_____. I confirm that if any of my patients should require admission to the hospital, they will be admitted

To_____,
(Gold Coast Health Plan-participating hospital name)

By_____,
(Gold Coast Health Plan-participating admitting hospitalist group or physician name)

who agrees to admit my patients and provide care appropriate to my specialty.

***Note**: The provider must have active privileges at the hospital noted above; temporary or pending privileges are not acceptable.*

Attestation

By signing below, I am attesting that:

1. The above information is correct and current.
2. The admitting hospitalist group or physician is aware of this arrangement.
3. I will notify Gold Coast Health Plan of any change in my hospital coverage arrangement within five (5) calendar days of the change.

Print name: _____
(Referring physician)

Signature: _____
(Referring physician)

Date: _____

Attachment D

Ongoing Monitoring Website Information

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Report Frequency
Medical Board of California 2005 Evergreen Street, Suite 1200 Sacramento, CA 95815 PH:(916) 263-2382 or (800) 633-2322 Enforcement Central File Room PH: (916) 263-2525 FAX: (916) 263-2420 805's Discipline Coord. (916) 263-2449	MD	**www.mbc.ca.gov** **All communications for disciplinary actions will be done by e-mail to subscribers.** **Link to subscribe for actions:** **http://www.mbc.ca.gov/Subscribers/** **Link for all Disciplinary Actions/License Alerts distributed:** **http://www.mbc.ca.gov/Publications/Disciplinary_Actions/** **Enforcement Public Document Search (Search by Name or Lic:** **http://www2.mbc.ca.gov/PDL/Search.aspx**	Bi-Monthly subscribers will be sent information regarding Accusations. Decisions will be sent on a daily basis as the decisions become final
Osteopathic Medical Board of CA 1300 National Drive, Suite #150 Sacramento, CA 95834-1991 (916) 928-8390 Office (916) 928-8392 Fax E-mail: osteopathic@dca.ca.gov Enforcement/Disciplines (916)-928-8390 Ext. 6	DO	**www.ombc.ca.gov** **Direct Link To Enforcement Actions:** **http://www.ombc.ca.gov/consumers/enforce_action.shtml** **Subscribe to e-mail Alerts** **http://www.ombc.ca.gov/consumers/enforce_action.shtml**	Quarterly via the Website E-Mail Distribution list.
Medical Board of California Board of Podiatric Medicine 2005 Evergreen Street, Ste. 1300 Sacramento, CA 95815-3831 PH: (916) 263-2647 Fax:(916) 263-2651	DPM	**www.bpm.ca.gov** **Direct Link to Enforcement Resources:** **http://www.bpm.ca.gov/consumers/index.shtml**	Board of Podiatric Medicine: Changes to viewing information. On the website go to

Email: BPM@dca.ca.gov Enforcement Program Central File Room Medical Board of California 2005 Evergreen Street, Suite 1200 Sacramento, CA 95815 FAX: (916) 263-2420		**Subscribers list** **http://www.mbc.ca.gov/Subscribers/**	recent Disciplinary Actions, separated into categories, Decisions, Accusations filed, etc. History not available only current accusations and decisions latest one year from effective date. You can subscribe to actions related to licenses.
Acupuncture Board 1747 N. Market Blvd Suite 180 Sacramento, CA 95834 PH: (916) 515-5200 Fax: (916) 928-2204 Email: acupuncture@dca.ca.gov To order copies of actions send to Attn of Consumer Protection Program	LAC/AC	**www.acupuncture.ca.gov** **Direct Link to Disciplinary Actions:** **www.acupuncture.ca.gov/consumers/board_actions.shtml** **Sign up for subscribers list for disciplinary actions:** **https://www.dca.ca.gov/webapps/acupuncture/subscribe.php**	Monthly running report listed Alpha Newer actions highlighted with date in blue. Note: Board meetings are held quarterly.

Board of Behavioral Sciences 1625 N Market Blvd., Suite S-200 Sacramento, CA 95834 PH: (916) 574-7830 Fax: (916) 574-8625 E-Mail: BBSWebmaster@bbs.ca.gov	Licensee Licensed Clinical Social Workers (LCSW) Licensed Marriage and Family Therapists (LMFT) Licensed Professional Clinical Counselors (LPCC) Licensed Educational Psychologists (LEP)	**www.bbs.ca.gov** **Sign up for subscribers list for disciplinary actions.** **https://www.dca.ca.gov/webapps/bbs/subscribe.php**	**Via Subscriptions Only** Information must be obtained via subscription.
CA Board of Chiropractic Examiners Board of Chiropractic Examiners 901 P Street, Suite 142A Sacramento, CA 95814 PH (916) 263-5355 FAX (916) 327-0039 Email: chiro.info@dca.ca.gov	DC	**www.chiro.ca.gov** **Monthly Reports** **http://www.chiro.ca.gov/enforcement/actions.shtml**	Monthly
Dental Board of California 2005 Evergreen Street, Suite 1550 Sacramento, CA 95815 PH: (916) 263-2300 PH: (877)729-7789 Toll Free Fax #: (916) 263-2140 Email: dentalboard@dca.ca.gov Enforcement Unit PH: 916-274-6326	DDS, DMD	**www.dbc.ca.gov** **Direct Link to Disciplinary Actions:** **http://www.dbc.ca.gov/consumers/hotsheets.shtml**	Monthly
California Board of Occupational Therapy (CBOT) 2005 Evergreen St. Suite 2250 Sacramento, CA 95815 PH: (916) 263-2294 Fax: (916) 263-2701	OT, OTA	**www.bot.ca.gov** **Direct Link To Enforcement Actions:** **http://www.bot.ca.gov/consumers/disciplinary_action.shtml**	Update as needed (whenever they have an update). Depends on when there is an OT placed on probation or revoked. Listed Alpha by type of action.

Email: cbot@dca.ca.gov Email: EnfPrg@dca.ca.gov		**Sign up for subscribers list for disciplinary actions:** **https://www.dca.ca.gov/webapps/bot/subscribe.php**	
California State Board of Optometry 2450 Del Paso Road, Suite 105 Sacramento, CA 95834 PH:(916) 575-7170 Fax (916) 575-7292 Email: optometry@dca.ca.gov	OD	**www.optometry.ca.gov** **Direct Link To Enforcement Actions:** **http://www.optometry.ca.gov/consumers/disciplinary.shtml**	Listed by year, in Alpha Order by type of Action Website will be updated as actions are adopted. Recommend monthly review. The Board typically adopts formal disciplinary actions during regularly scheduled quarterly meetings.
Physical Therapy Board of California 2005 Evergreen St. Suite 1350 Sacramento, CA 95815 PH: (916) 561-8200 Fax: (916) 263-2560	PT	**www.ptb.ca.gov** **Sign up for subscribers list for disciplinary actions:** **https://www.dca.ca.gov/webapps/ptbc/interested_parties.php**	**None** – This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners.
Physician Assistant Board (PAB) 2005 Evergreen Street Suite 1100 Sacramento, CA 95815 PH: (916) 561-8780 FAX(916) 263-2671 Email: pacommittee@mbc.ca.gov	PA/PAC	www.pac.ca.gov **Direct Link to Enforcement Actions:** **www.pac.ca.gov/forms_pubs/disciplinaryactions.shtml**	Monthly
Board of Psychology 1625 North Market Blvd, Suite N-215 Sacramento, CA 95834 bopmail@dca.ca.gov	PhD, PsyD	**www.psychboard.ca.gov** **Sign up for subscribers list for disciplinary actions:**	**Via Subscriptions Only** Information must be obtained via subscription.

Office Main Line (916)-574-7720 **Toll Free Number: 1-866-503-3221.**		**https://www.dca.ca.gov/webapps/psychboard/subscribe.php**	
CA Board of Registered Nursing 1747 North Market Blvd, Suite 150 Sacramento, CA 95834 Mailing Address: Board of Registered Nursing P.O. Box 944210 Sacramento, CA 94244-2100 Phone: (916) 322-3350 FAX (916) 574-7693. Email: enforcement_brn@dca.ca.gov	Certified Nurse Midwife (CNM) Certified Nurse Anesthetist (CRNA) Clinical Nurse Specialist (CNS) Critical Care Nurse (CCRN) Nurse Practitioner (NP) Registered Nurse (RN) Psychiatric Mental Health Nursing (PMHN) Public Health Nurse (PHN)	**www.rn.ca.gov** **Unlicensed Practice/Nurse Imposter Citations:** **http://www.rn.ca.gov/enforcement/unlicprac.shtml**	**None** – This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners.
National Council of State Board of Nursing (BCSBN) 111 East Wacker Drive, Suite 2900 Chicago, IL 60601-4277 Phone: (312) 525-3600 Fax: **(**312) 279-1032 Email: info@ncsbn.org	Additional information for RN/LVN/NP/ CNM	**www.nursys.com** To subscribe for daily, weekly or monthly (depending on how often you want to be updated) updates on license status, expirations and disciplinary actions. **https://www.nursys.com/EN/ENDefault.aspx**	
Speech-Language Pathology & Audiology Board 2005 Evergreen Street, Suite 2100 Sacramento, CA 95815	SP, AU	**http://www.speechandhearing.ca.gov/** **Direct Link to Accusations Pending and Disciplinary Actions:**	**Quarterly** Disciplinary Actions are listed by fiscal year. Pending Actions are listed alphabetically by first name.

Email: speechandhearing@dca.ca.gov Main Phone Line: (916) 263-2666 Main Fax Line: (916) 263-2668		**http://www.speechandhearing.ca.gov/consumers/enforcement.shtml**	
Site Name, Address and Phone Numbers	**Service**	**Website**	**Report Frequency**
HHS Officer of Inspector General Office of Investigations Health Care Administrative Sanctions Room N2-01-26 7500 Security Blvd. Baltimore, MD 21244-1850	OIG - List of Excluded Individuals and Entities (LEIE) excluded from Federal Health Care Programs: Medicare /Medicaid sanction & exclusions	**www.oig.hhs.gov** **Direct Link for individuals:** **http://exclusions.oig.hhs.gov/** **Direct Link to exclusion database** **http://oig.hhs.gov/exclusions/exclusions_list.asp**	**Monthly**
CMS.gov **Centers for Medicare & Medicaid Services**	Medicare Opt-Out Affidavits	**https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/OptOutAffidavits.html** For a listing of all physicians and practitioners that are currently opted out of Medicare: **https://data.cms.gov/dataset/Opt-Out-Affidavits/7yuw-754z**	
CMS.gov **Centers for Medicare & Medicaid Services**	Medicare Enrolled Providers	This link will provide information regarding Providers enrolled with Medicare CMS.gov.	
Department of Health Care Services (DHCS) **Medi-Cal Provider Suspended and Ineligible List** Office of Investigations Health Care Administrative Sanctions Room N2-01-26	Medi-Cal Reports exclusions and reinstatements from the State Medi-Cal Program	**www.medi-cal.ca.gov** **Direct Link to Suspended and Ineligible Provider List**:	**Monthly**

7500 Security Blvd. Baltimore, MD 21244-1850		**http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp**	
SAM (System for Award Management) formerly known as Excluded Parties List System (EPLS)	Individuals and Organizations debarred from participating in government contracts or receiving government benefits or financial assistance	**https://www.sam.gov/portal/SAM/#1** SAM Registration **https://uscontractorregistration.com/** Note: The SAM website has a user guide: Link to SAM User Guide- v1.8.3 of 350:	**Monthly**
DEA Office of Diversion Control **800-882-9539** **deadiversionwebmaster@usdoj.gov**	**DEA Verification**	**www.deadiversion.usdoj.gov/** **Direct Link to Validation Form** **https://www.deadiversion.usdoj.gov/webforms/validateLogin.jsp**	**NA**
The Licensed Facility Information System (LFIS) The Automated Licensing Information and Report Tracking System (ALIRTS) Contains license and utilization data information of healthcare facilities in California. The Licensed Facility Information system (LFIS) is maintained by the Office of Statewide Health Planning and Development to collect and display licensing and other basic information about California's hospitals, long-term care facilities, primary care and specialty clinics, home health agencies and hospices.	**Organizational Providers License Verification:** Hospitals Long-term care facilities Home Health Agencies Hospices Primary care and Specialty clinics	**www.alirts.oshpd.ca.gov/Default.aspx** **Direct Link:** **www.alirts.oshpd.ca.gov/LFIS/LFISHome.aspx**	
The California Department of Public Health (CDPH)	**Organizational Providers**	http://www.cdph.ca.gov/Pages/DEFAULT.aspx	

General Information (916) 558-1784	**License Verification:** Hospitals Surgery Centers Home Health Agencies Hospices Dialysis Centers Others	Licensed Facility Report http://hfcis.cdph.ca.gov/Reports/GenerateReport.aspx?rpt=FacilityListing Health Facilities Search http://hfcis.cdph.ca.gov/search.aspx	
National Plan and Provider Enumeration System (NPPES) NPI Enumerator PO Box 6059 Fargo, ND 58108-6059 800-465-3203 customerservice@npienumerator.com The Centers for Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers. The NPI Registry enables you to search for a provider's NPPES information. All information produced by the NPI Registry is provided in accordance with the NPPES Data Dissemination Notice. Information in the NPI Registry is updated daily. You may run simple queries to retrieve this read-only data.	**Organizational Providers and Practitioners Numbers for the following:** • NPI • Medicare Medi-Cal	https://nppes.cms.hhs.gov/NPPES/Welcome.do Search NPI Records https://npiregistry.cms.hhs.gov/ **Search the NPI Registry** • Search for an **Individual** **Provider** • Search for an **Organizational Provider**	
Social Security Death Master File (DMF). National Technical Information Services (NTIS) is the only	**Subscription to the Limited Access**	**Social Security Death Master File (DMF) Website** https://www.ssdmf.com/FolderID/1/SessionID/%7B17B93F37-71E0-	

authorized official distributor of the Death Master file on the web. Final Rule Establishing Certification Program for Access to Death Master File in Effect The National Technical Information Service (NTIS) established a certification program for subscribers to the Limited Access Death Master File (LADMF) through a Final Rule (FR), pursuant to Section 203 of the Bipartisan Budget Act of 2013 (Pub. L. 113-67) which also requires NTIS to recoup the cost of the certification program through processing fees. The FR was published in the Federal Register Wednesday, June 1, 2016, and became effective Monday, November 28, 2016. The FR may be reviewed at **https://www.gpo.gov/fdsys/pkg/FR-2016-06-01/html/2016-12479.htm**.	**Death Master File (LADMF)**	433B-B3F2-B9BA03D721A6%7D/PageVars/Library/InfoManage/Guide.htm **National Technical Information Services (NTIS)** https://classic.ntis.gov/products/ssa-dmf/#	
Board Certification, Address and Phone Numbers	**Practitioner**	**Website**	**Verification Type**
Nursing Board Certification for Nurse Practitioners/ Advance Practice Nurses **- American Academy of Nurse Practitioners Certification Board (AANPCB) (1/2017) (Formerly the American Academy of Nurse Practitioners Certification Program**	NP	AANPCB - www.aanpcert.org/ ANCC - **www.nursecredentialing.org** ncc - **www.nccwebsite.org**	**Board Certification**

(AANPCP) - **American Nurses Credentialing Center** (ANCC) **- National Certification Corporation for the Obstetrics, Gynecology and Neonatal Nursing Specialties** (ncc) **- Pediatric Nursing Certification Board** (PNCB) **- American Association of Critical-Care Nurses** (AACN)		PNCB - **www.pncb.org** AACN - **www.aacn.org**	
National Commission on Certification of PA's (NCCPA)	PAC	**http://www.nccpa.net/**	**Board Certification**
American Midwifery Certification Board (amcb) 849 International Drive, Suite 120 Linthicum, MD 21090 Phone 410-694-9424	CNM and CM	**http://www.amcbmidwife.org/**	**Board Certification** Informational only to verify board certification needed
American Board of Professional Psychology (ABPP) 600 Market Street Suite 201 Chapel Hill, NC 27516 Phone 919-537-8031 email: office@abpp.org	PhD, PsyD	**http://www.abpp.org/**	**Board Certification** Informational only to verify board certification if needed
Three specialty certifying boards are currently approved under California law for DPMs: – **American Board of Foot and Ankle Surgery** (formerly The American Board of Podiatric Surgery 7/1/14) (Also includes the following certifications: Foot Surgery and	DPM	• American Board of Foot and Ankle Surgery. https://www.abfas.org/	**Board Certification**

Reconstruction Rear foot/Ankle Surgery (RRA)). – **The American Board of Podiatric Medicine** (Conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine – **American Board of Multiple Specialties in Podiatry.** (Includes Certification for Primary Care, Foot and ankle Surgery, diabetic wound care and limb salvage		• The American Board of Podiatric Medicine conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine. https://www.abpmed.org/ • American Board of Multiple Specialties in Podiatry. http://abmsp.org/	
Commission on Dietetic Registration **312-899-0040 Ext. 4891**	RD	**https://www.cdrnet.org**	**None** – This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners.

Revision History:

Review Date	Revised Date	Approved By
03/19/15		**PRC**
05/18/15		**DHCS**
05/05/15		**Ruth Watson (Interim CEO)**
01/19/2016		**DHCS (Default)**
01/20/2016		**Dale Villani, CEO**
	03/09/2017	**Credentialing & Peer Review Committee**
5/10/2017		**DHCS (Default)**
5/15/2017		**Dale Villani, CEO**
	02/22/2019	**Kimberly Timmerman, QI Director**
	06/27/2019	**Credentials/Peer Review Committee**
	12/5/2019	**Credentials/Peer Review Committee**
8/18/2020		**DHCS**
8/20/2020		**Robert Franco, Interim Compliance Officer**