5. CREDENTIALING AND REcredentialing

A. Credentialing Standards

1. Credentialing Policies

APPLIES TO:

A. This policy applies to all IEHP Medicare DualChoice Providers contracted under IEHPs Direct Network.

POLICY:

A. IEHP has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent Practitioners to provide care to its Members.

B. IEHP notifies Practitioners about their right to review information submitted to support their credentialing application.

C. IEHP has a process that describes how primary source information is received, dated and stored; how modified information is tracked and dated from its initial verification; the staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate; the security controls in place to protect the information from unauthorized modification; and how the organization audits the processes and procedures.

D. IEHP’s recredentialing policies and procedures require information from quality improvement activities and Member complaints in the recredentialing decision making process.

E. IEHP policies and procedures must ensure that it only contracts with Physicians who have not opted out.

F. IEHP prohibits employment or contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation (Practitioners or entities found on Office of Inspector General (OIG) Report).

G. IEHP does not contract with practitioners who are precluded from receiving payment for Medicare Advantage (MA) items and services Part D drugs furnished or prescribed to Medicare beneficiaries.

PURPOSE:

A. IEHP promulgates credentialing and recredentialing decision guidelines for Practitioners directly contracted with IEHP and Practitioners credentialed and contracted by IEHPs Delegates, to perform these activities.

B. IEHP is required to adhere to all procedural and reporting requirements under state and federal laws and regulations regarding the credentialing and recredentialing process, including the confidentiality of Practitioner information obtained during the credentialing
5. CREDENTIALING AND REcredentialing

A. Credentialing Standards

1. Credentialing Policies

C. IEHP will use procedures consistent with Department of Health Care Services (DHCS) for all of Medi-Cal. DHCS can modify these rules at any time and is required to notify Centers for Medicare & Medicaid Services (CMS) within ninety (90) days prior of any such change.

D. IEHP must demonstrate a rigorous process to select and evaluate Practitioners.

DEFINITION:

A. Verification Time Limit (VTL): National Committee for Quality Assurance (NCQA) counts back from the decision date to the verification date to assess timeliness of verification.

B. Verbal Verification - Requires a dated, signed document naming the person at the primary source who verified the information, his/her title, the date and time of verification and include what was verified verbally.

C. Automated Verification - Requires there be a mechanism to identify the name of the entity verifying the information, the date of the verification, the source, and the report date, if applicable.

D. Written Verification - Requires a letter or documented review of cumulative reports. IEHP must use the latest cumulative report, as well as periodic updates released by the primary source. The date on which the report was queried, and the volume used must be noted.

E. Using the Internet for Primary Source Verification (PSV): PSV on documents that are printed/processed from an internet site (e.g. BreEZe, National Practitioner Data Bank (NPDB) etc.), the data source date (as of date, release date) must be queried within the timeframe. The date of the query must be verified prior to the Credentialing Decision. If there is no data source date, the verifier must document the review date on the verification or the checklist. Verification must be from a National Committee for Quality Assurance (NCQA) approved and appropriate state-licensing agency.

F. PSV Documentation Methodology: The organization may use an electronic signature or unique electronic identifier of staff to document verifications (to replace the dating and initialing of each verification) if it can demonstrate that the electronic signature or unique identifier can only be entered by the signatory. The system must identify the individual verifying the information and the date of verification.

PROCEDURES:

A. IEHP has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent Practitioners to provide care to its Members that includes Practitioner Credentialing Guidelines that specify:

1. The types of Practitioners it credentials and recredentials. Credentialing requirements
5. CREDENTIALING AND RECREREDENTIALING

A. Credentialing Standards
   1. Credentialing Policies

apply to:

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

b. Practitioners who have an independent relationship with the organization.
   1) An independent relationship exists when the organization directs its Members to see a specific Practitioner or group of Practitioners, including all Practitioners whom Member can select as Primary Care Providers.

c. Practitioners who provide care to Members under the organization’s medical benefits.

d. The criteria listed above apply to Practitioners in the following settings:
   1) Individual or group practices;
   2) Facilities; and
   3) Telemedicine.

e. IEHP is required to contract with and credential all Practitioners defined as a PCPs, Specialists, Non-Physician Practitioners, and Physician Admitters, including employed Physicians participating on the Provider Panel and published in external directories who provide care to Members. At minimum, they include:
   1) Doctor of Medicine (M.D.)
   2) Doctor of Osteopathic Medicine (D.O.)
   3) Doctor of Podiatric Medicine (D.P.M.)
   4) Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.), who provide medical services only
   5) Occupational Therapists (O.T.)
   6) Physical Therapy (P.T.)
   7) Physician Assistants (P.A.) or Physician Assistants Certified (P.A.-C)
   8) Certified Nurse Midwives (C.N.M.)
   9) Nurse Practitioners (N.P.)
   10) Speech Pathologists (S.P.)
   11) Audiologists (Au.)
   12) Registered Dieticians (R.D.) and Nutritionists
   13) Chiropractors (D.C.)
   14) Psychiatrists (M.D.)
5. CREDENTIALING AND RECREREDENTIALING

A. Credentialing Standards
   1. Credentialing Policies

15) Licensed Marriage and Family Therapists (L.M.F.T.)
16) Licensed Clinical Social Workers (L.C.S.W.)
17) Psychologists (Ph.D., Psy.D.)
18) Doctor of Chiropractic (D.C.)
19) Licensed Acupuncturists (L.Ac.)
20) Optometrists (O.D.)
21) Other Behavioral healthcare Practitioners
   - Addiction Medicine Specialists
   - Master Level Clinical Nurses
   - Licensed Clinical Social Workers
   - Marriage Family Therapists

22) IEHP does not require covering Practitioners and locum tenens that do not have an independent relationship with IEHP to be credentialed.

23) IEHP does not require Practitioners that are Hospital-based and that do not see Members on a referral basis to be credentialed.

2. Listed below are the sources used by IEHP to verify credentialing information of each of the following criterion listed below. All verification sources must be included in policy to ensure compliance.

   a. State license to practice all Practitioners must be licensed by the State of California by the appropriate state licensing agency. The following license verifications must be obtained by the licensing board or their designated licensing and enforcement systems. The following licensures may be verified through BreEZe Online services or directly with the licensing board via phone or mail:

   1) Medical Board of California (M.D.)
   2) Osteopathic Medical Board of California (D.O.)
   3) Board of Podiatric Medicine (D.P.M.)
   4) Board of Behavioral Sciences (L.M.F.T., L.C.S.W., M.F.C.C)
   5) Board of Psychology (Ph.D., Psy.D.)
   6) Dental Board of California (D.D.S., D.M.D.)

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1 Medicare Managed Care Manual, Chapter 6 “Relationships with Providers”, Chapter 6 § 60.3
2 NCQA, 2020 HP Standards and Guidelines, CR 1, Element A, Factor 1
5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards
   1. Credentialing Policies

   7) California Board of Occupational Therapy (O.T.)
   8) California State Board of Optometry (O.D.)
   9) Physical Therapy Board of California (P.T.)
  10) Physician Assistant Committee (P.A., P.A.-C)
  11) California Board of Registered Nursing (C.N.M., N.P.)
  12) California Board of Chiropractic Examiners (D.C.)
  13) Speech-Language Pathology & Audiology Board (S.P., Au)
  14) Acupuncture Board (L.Ac.)

b. Drug Enforcement Administration (DEA) or Controlled Dangerous Substance (CDS) certificate, if applicable (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date). All Practitioners who are qualified to write prescriptions, except non-prescribing Practitioners, must have a valid and current DEA certificate verified through one (1) of the following sources:

   1) A photocopy of the current DEA certificate, with date stamped and initialed by the reviewer to show receipt and review prior to the credentialing decision;
   2) A query of the National Technical Information Service (NTIS) database, with date stamped and initialed by the reviewer to show receipt and review prior to the credentialing decision;
   3) IEHP may credential a Practitioner whose DEA certificate is pending or pending a DEA with a California address, by obtaining written documentation that the Practitioner with a valid DEA certificate will write all prescriptions requiring a DEA number for the prescribing Practitioner until the Practitioner has a valid DEA certificate; or
   4) If a Practitioner does not have a DEA or CDS certificate, IEHP must have a documented process to require an explanation why the Practitioner does not prescribe medications and to provide arrangements for the Practitioner’s patients who need prescriptions requiring DEA certification.

c. Education and Training (VTL: Prior to the Credentialing Decision) IEHP may use any of the following to verify education and training:

   1) The primary source from the Medical School or through a clearinghouse;
   2) The state licensing agency or specialty board if the state agency and specialty board, respectively, perform primary source verification. The organization obtains, at least annually, written confirmation of this fact, uses a printed, dated screenshot of the state licensing agency’s or specialty board’s website displaying the statement that it performs primary source verification of
5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards
   1. Credentialing Policies

Practitioner education and training information or provides evidence of a state statute requiring licensing to obtain verification of education and training directly from the institution;

3) Sealed transcripts if the organization provides evidence that it inspected the contents of the envelope and confirmed that Practitioner completed (graduated from) the appropriate training program; or

4) Below are acceptable sources for Physicians (M.D., D.O.) to verify graduation from Medical School:
   - American Medical Association (AMA) Physician Master File.
   - Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986.

Below are acceptable sources for Physicians (M.D., D.O.) to verify completion of residency training:
   - Primary source from the institution or clearinghouse where the postgraduate medical training was completed.
   - AMA Physician Master File.
   - AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
   - Federation Credentials Verification Service (FCVS) for closed residency programs.
     - NCQA only recognizes residency programs accredited by the Accredited Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) (in the United States) or by the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada.

d. Board Certification (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date). Below are the acceptable sources to verify board certification:
   1) For all Practitioner types
      - The primary source (appropriate specialty board).
      - The state licensing agency if the primary source verifies board certification.
5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards
   1. Credentialing Policies

   2) For Physicians (M.D., D.O.)
      - American Board of Medical Specialties (ABMS) or its member boards, or an official ABMS Display Agency, 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 specialties it accepts and obtains annual written confirmation from the boards that the boards performs primary source verification of completion of education and training.

   3) For other health care professionals
      - Registry that performs primary source verification of board that the registry performs primary source verification of board certification status.

   4) For Podiatrists (D.P.M.)
      - American Board of Foot and Ankle Surgery (formerly The American Board of Podiatric Surgery).
      - The American Board of Podiatric Medicine.
      - American Board of Multiple Specialties in Podiatry.

   5) For Nurse Practitioners (N.P.)
      - American Association of Nurse Practitioners (AANP).
      - 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).

   6) For Physician Assistants (P.A.-C).
      - National Commission of Certification of P.A.’s (NCCPA).

   7) For Certified Nurse Midwives (C.N.M.).
      - American Midwifery Certification Board (AMCB).
5. CREDENTIALING AND RECREREDENTIALING

A. Credentialing Standards
   1. Credentialing Policies

8) For Psychologists (Ph.D., Psy.D.).
   - American Board of Professional Psychology (ABPP).

e. Work history (VTL: one hundred-eighty (180) calendar days prior to Credentialing
decision date) IEHP must obtain a minimum of the most recent five (5) years of
work history as a health professional through the application, Curriculum Vitae
(CV) or work history summary/attachment, providing it has adequate information.

f. Malpractice Claim History. A history of professional liability claims that resulted
in settlement or judgment paid on behalf of the Practitioner. (VTL: one hundred-
eighty (180) calendar days prior to Credentialing decision date). IEHP will obtain
confirmation of the past five (5) years of malpractice settlements through one of the
following sources:

1) Malpractice Insurance Carrier;

2) National Practitioner Data Bank Query; or

3) Evidence of Continuous Query (formerly Proactive Disclosure Services (PDS).
   Continuous Query must be reviewed within one hundred-eighty (180) calendar
days of the initial credentialing decision. Evidence must be documented in the
file or on checklist.

g. Current Malpractice Insurance Coverage. IEHP requires that a copy of the
insurance face sheet or Certificate of Insurance (COI) or written verification from
the insurance carrier directly, be obtained in conjunction of collecting information
on the application. (VTL: Must be evidence that the Practitioner has current and
adequate malpractice coverage prior to the Credentialing Committee date and
remain valid and current throughout the Practitioner’s participation with IEHP).

1) For Practitioners with federal tort coverage, the Practitioner must submit a
   copy of the federal tort letter or an attestation from the Practitioner of federal
tort coverage.

h. Hospital Admitting Privileges: IEHP must verify that Practitioners have clinical
privileges in good standing. Practitioner must indicate their current Hospital
affiliation or admitting privileges at a participating hospital. Verification that all
clinical privileges are in good standing to perform functions for which the
Practitioner is contracted, to include verification of admitting privileges, must be
confirmed with the Hospital, in writing, via approved website or verbally.

1) If a published Hospital directory is used, the list must include the necessary
   information and be accompanied by a dated letter from the Hospital attesting
   that the Practitioner is in “good standing.”
5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards
   1. Credentialing Policies

   2) If the practitioner does not have clinical privileges, IEHP must have a written statement delineating the inpatient coverage arrangement documented in the provider’s file. (See Policy 5B, “Hospital Privileges”).

   3) Allied Health Professionals (Non-physicians i.e. Chiropractors, Optometrists) will not have Hospital privileges and documentation in the file is not required for these types of Practitioners.

   4) Advanced Practice Practitioners (Physician Assistants (PA), Nurse Practitioners (NP), Nurse Midwives (NM)) may not have Hospital privileges. However, if they provide IEHP their Hospital privileges, IEHP will be responsible for verifying if those privileges are active and ensure they are in good standing.

   5) Specialists (MDs, DOs and DPMs) may not have Hospital privileges. Documentation must be noted in the file as to the reason for not having privileges (e.g. A note stating that they do not admit as they only see patients in an outpatient setting is sufficient).

i. State Sanctions and Restrictions on Licensure and Limitation on Scope of Practice. State sanctions, restrictions on licensure or limitations on scope of practice (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision).

   1) Verification sources for sanctions or limitations on licensure include:
      • Chiropractors: State Board of Chiropractic Examiners, Chiropractic Information Network/Board Action Databank (CIN-BAD), NPDB.
      • Oral Surgeons: State Board of Dental Examiners, or State Medical Board, NPDB.
      • Physicians: Appropriate state board agencies, Federation of State Medical Boards (FSMB), NPDB.
      • Podiatrists: State Board of Podiatric Examiners, Federation of Podiatric Medical Boards, NPDB.
      • Non-physician Healthcare Professionals: State licensure or certification board, appropriate state agency, NPDB.
      • For practitioners screened using the Continuous Query (formerly Proactive Disclosure Service (PDS))
        o Evidence of current enrollment must be provided.
        o Report must be reviewed within one hundred eighty (180) calendar days of the initial credentialing decision.
        o Evidence of review must be documented in the file or on checklist.
5. CREDENTIALING AND RECREREDENTIALING

A. Credentialing Standards
   1. Credentialing Policies

j. Medicare/Medicaid Sanctions. Verification Sources for Medicare/Medicaid Sanctions:
   1) OIG must be the one (1) of the verification sources for Medicare sanctions, to ensure compliance with CMS. ³
      • Date of query and staff initials must be evident on a checklist or the OIG page must be in the file.
   2) The Medi-Cal Suspended and Ineligible list must be one (1) of the verification source for Medicaid sanctions, to ensure compliance with DHCS. ⁴
      • Date of query and staff initials must be evidence on a checklist, or the report page must be in the file.
   3) NPDB
   4) FSMB
   5) Federal Employees Health Benefits Program (FEHB) Program Department Record, published by the Office of Personnel Management, OIG.
   6) List of Excluded Individuals and Entities (maintained by OIG).
   7) Medicare Exclusions Database
   8) State Medicaid Agency or intermediary and the Medicare intermediary.
   9) For practitioners screened using the Continuous Query (formerly Proactive Disclosure Service (PDS))

k. National Provider Identifier (NPI) Number: Practitioners must hold and maintain a valid and active individual National Provider Identification Number (NPI) that can be verified through the NPPES website.
   1) Group NPI Numbers may be requested by IEHP, in addition to the mandatory individual NPI number. ⁵ ⁶

3. IEHP verifies that the following are within the prescribed time limits, for all credentialing applications, before Practitioners can provide care to Members. IEHP does not allow provisional credentialing. Policies must define the criteria required to reach a credentialing decision and must be designed to assess the Practitioner’s ability to deliver

³ Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004 Supersedes APL 17-019, “Provider Credentialing / Recredentialing and Screening / Enrollment”
⁴ Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004 Supersedes APL 17-019, “Provider Credentialing / Recredentialing and Screening / Enrollment”
⁵ NCQA, 2020 HP Standards and Guidelines, CR 1, Element A, Factor 2
⁶ Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004 Supersedes APL 17-019, “Provider Credentialing / Recredentialing and Screening / Enrollment”
5. CREDENTIALING AND RECRE CREDENTIALING

A. Credentialing Standards
   1. Credentialing Policies

Care. This criterion is used to determine which Practitioners may participate in its network, which may include, but are not limited to:

g. Provider must submit an application or reapplication that includes the following:
   1) Reasons for inability to perform the essential functions of the position;
   2) Lack of present illegal drug use;
   3) History of loss of license and felony convictions;
   4) History of loss or limitation of privileges or disciplinary actions;
   5) Current Malpractice Insurance coverage; and
   6) Current and signed attestation confirming the correctness and completeness of the application.

h. All Primary Care Provider (PCP) and Urgent Care Providers must meet the Facility Site Review (FSR)/Medical Record Review (MRR) Guidelines (See Policy 6A, “Facility Site Review and Medical Records Review Survey Requirements and Monitoring”). 7
   1) Providers at a site without an active participating PCP must still have an FSR/MRR completed and passed to be considered a Non-Par Provider in the network. No PCPs or Non-Par Providers will be able to provide services at sites without completing an FSR/MRR
   2) All PCPs must pass a required initial facility review performed by IEHP prior to receiving IEHP enrollment and treating Members.
   - IEHP has ninety (90) days from the submission of all required credentialing information to complete the facility site review.

i. Advanced Practice Practitioners are allowed to increase only one (1) supervising PCPs enrollment capacity per location with a maximum of two (2) unique locations allowed. Advanced Practice Practitioners must be practicing at a site assigned to their supervising Physician.

j. Practice within IEHP’s service area

k. Education and Training. Practitioners must be board certified in the specialty and/or subspecialty they are credentialed and contracted for, if applicable.
   1) If the Practitioner is not board certified in the subspecialty in which he/she is applying, there must be evidence of verification of residency and training in the subspecialty (e.g. Fellowship in Cardiology, Rheumatology, Pediatric Endocrinology, etc.), as relevant to the credentialed specialty, and meet the

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7 Medicare Managed Care Manual, Chapter 6 “Relationships with Providers”, Chapter 6 § 60.3
5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

1. Credentialing Policies

   training requirements as set forth by ABMS or AOA.

   • Practitioners who do not meet graduate medical training requirements as
     set forth by ABMS or AOA for the Provider’s requested subspecialty, will
     be subject to review by the IEHP Credentialing Subcommittee for review.
     Further review may be completed by the IEHP Peer Review
     Subcommittee.

1. Effective January 1, 2017, IEHP Credentialing guidelines require Providers to meet
   the internship and residency requirements to be a Pediatric, Internal Medicine,
   Family Practice, or Public Health and General Preventive Medicine Provider in
   order to be credentialed as a Primary Care Provider in IEHP’s network.

   1) Existing Providers who do not meet this requirement are grandfathered into the
      network, however if the Provider chooses to terminate, the Provider may not
      reapply or be reinstated as a Primary Care Provider.

   m. IEHP specific specialty requirements: Medical Doctors (M.D.) and Doctor of
      Osteopathic (D.O.) must meet the education and training requirements set forth by
      the American Board of Medical Specialties (ABMS) or American Osteopathic
      Association (AOA) and additional criterion set by IEHP and noted below, if
      applicable. All IEHP specific specialty requirements are subject for review by the
      IEHP Medical Director or Chief Medical Officer. Further review may be completed
      by the Peer Review Subcommittee who will either approve or deny.

      IEHP will consider all relevant information including practice site demographics,
      Provider training, experience and practice capacity issues before granting any such
      change.

      1) Bariatric Surgery requirements effective January 1, 2019: Meet the education
         and training requirements for General Surgery; and one (1) of the following
         criteria:

         • Completion of an accredited bariatric surgery fellowship;

         • Documentation of didactic training in bariatric surgery (IEHP
           recommends the American Society for Metabolic and Bariatric Surgery
           Course). This information will be verified through:

           o Bariatric training certificate and/or supporting letter from supervising
             bariatric surgeon, which will be verified by Credentialing. Supporting
             letter will include the minimum criteria:

             ▪ Supervising bariatric surgeon qualifications;

             ▪ Supervising bariatric surgeon relationship with applicant;
5. CREDENTIALING AND RECRECREDENTIALING

A. Credentialing Standards

1. Credentialing Policies

- Duration of relationship of supervising bariatric surgeon with applicant; and
- Assessment of applicant’s competency to perform bariatric surgery by supervising bariatric surgeon.
  - Attestation of bariatric surgery case volume signed by applicant (See Attachment, “Bariatric Surgeon Case Volume Attestation” in Section 5) to include the following:
    - Indicate volume of:
      1) proctored cases; and
      2) cases where applicant was the primary surgeon.
    - IEHP requires a minimum of fifteen (15) cases where applicant was the primary surgeon.

- Current or past “Regular or Senior Member” of American Society for Metabolic and Bariatric Surgery (ASMBS). Verification of membership will be obtained by the Credentialing Department; or
- IEHP recommends applicant actively participates with the MBSAQIP (Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program) or an equivalent regional or national quality improvement program.
  - Supportive documentation of participation with program is to be submitted with Credentialing application.  

2) Family Practice Providers with Obstetrics (OB) services, must meet the education and training requirements for Family Practice, set forth by ABMS or AOA and provide the following:

- Family Practice 1: Family Practice that includes Outpatient OB services must:
  - Provide a copy of a signed agreement that states Member transfers will take place within the first twenty-eight (28) weeks of gestation and a protocol for identifying and transferring high risk Members with a contracted and credentialed OB.

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5. CREDENTIALING AND RECredentialing

A. Credentialing Standards
   1. Credentialing Policies

   - The OB must be within the same network as the Family Practice Provider and hold admitting privileges to the IEHP contracted Hospital linked with that IPA network.

   - Family Practice 2: Family Practice that includes full OB services and delivery must:
     - Have and maintain full delivery privileges at an IEHP contracted Hospital.
     - Provide a written agreement for an available OB backup Provider is required.
     - The OB Provider must be credentialed, contracted and hold admitting privileges to the IEHP Hospital linked with the Family Practice Provider; and
     - Provide a protocol for identifying and transferring high risk Members and stated types of deliveries performed (i.e. low-risk, cesarean section, etc).

   3) Obstetrics/Gynecology (OB/GYN) Providers who would like to participate as a Primary Care Provider only, will provide outpatient well woman services only with no Hospital or surgical privileges, must provide the following information for consideration:

     - Documentation of primary care practice in the United States;
     - Twenty-five (25) Continuing Medical Education (CME) units for most recent three (3) year period, of which must be in primary care related areas;
     - Applicants must provide two (2) letters of recommendation from a Physician coworker (i.e. Primary Care Providers with work experience associated with the applicant in the preceding twenty-four (24) months); and
     - The Physician coworkers must hold an active board certification in a Primary Care Specialty (i.e. board certified in Internal Medicine, Family Practice or Pediatrics).

     - In lieu of having full hospital delivery privileges, provide a written agreement with an OB Provider, that includes a protocol for identifying and transferring high risk Members, stated types of deliveries performed (i.e. low-risk, cesarean section etc.), must be available for consultations, as needed and that the OB will provide prenatal care after twenty-eight (28)
5. CREDENTIALING AND RECREREDENTIALING

A. Credentialing Standards

1. Credentialing Policies

weeks gestation including delivery (See Attachment, “Patient Transfer Agreement” in Section 5).

- The Agreement must include back-up Physician’s full delivery privileges at IEHP network Hospital, in the same network as the non-admitting OB Provider.

- The OB Provider must be credentialed and contracted within the same network.

These OB/GYNs provide outpatient well woman services only with no Hospital or surgical privileges. This exception must be reviewed and approved by IEHP Medical Director or Chief Medical Officer. Further review may be completed by the Peer Review Subcommittee who will either approve or deny.

4) Pediatric Providers may practice outside of scope (with expanding age ranges to all ages) and will be processed with a secondary specialty of General Practice, for review and approval by the IEHP Medical Director or Chief Medical Officer. Further review may be completed by the IEHP Peer Review Subcommittee who will either approve or deny. The following documents are required for consideration:

- PCPs that have Member assigned ages 0-19 must enroll in the Vaccines for Children (VFC) Program.

- Provide documentation of primary care practice in the United States for the past five (5) years which includes a mix of pediatric and adult patients (See Attachment, “IEHP Addendum E” in Section 5);

- Provide evidence of twenty-five (25) CME units in Adult Primary Care completed within the last three (3) years; and

- Applicants must provide two (2) letters of recommendation from a Physician coworker (i.e., Primary Care Providers with work experience associated with the applicant in the preceding twenty-four (24) months). The Physician coworkers must hold an active board certification in Internal Medicine or Family Practice.

5) General Preventive Medicine PCPs must complete the following, in addition to meeting the education requirements set by ABMS or AOA:

- Twelve (12) month internship; and

- Nine (9) months direct patient care experience (during or after residency).

6) Specialties not recognized by either board (ABMS or AOA) are subject to
5. CREDENTIALING AND REcredentialing

A. Credentialing Standards
   1. Credentialing Policies

Medical Director or Chief Medical Officer Review. Further review may be
completed by the Credentialing Subcommittee or Peer Review Subcommittee,
who will either approve or deny.

7) Urgent Care Providers must:
   - Meet the education and training requirements set forth by ABMS or AOA
     for at least one (1) of the following Specialty boards:
     - American Board of Pediatrics;
     - American Board of Family Practice;
     - American Board of Internal Medicine;
     - American Board of Obstetrics and Gynecology;
     - American Board of Emergency Medicine;
     - Osteopathic Board of Pediatrics;
     - Osteopathic Board of Family Physicians;
     - Osteopathic Board of Internal Medicine;
     - Osteopathic Board of Obstetrics and Gynecology;
     - Osteopathic Board of Emergency Medicine; or
     - If the Practitioner is board certified or eligible in a specialty and/or
       subspecialty recognized by the American Board of Medical
       Specialties or American Osteopathic Association not referenced
       above, then those Providers are subject to Medical Director or Chief
       Medical Officer Review. Further review may be completed by the
       Peer Review Subcommittee, who will either approve or deny. For
       their review and consideration, the following documents must be
       submitted:
         - Provide evidence of twenty-five (25) CME units in Pediatric
           Primary Care completed within the last three (3) years if the
           Provider is requesting to treat Pediatric patients;
         - Provide evidence of twenty-five (25) CME units in Adult
           Primary Care completed within the last three (3) years if the
           Provider is requesting to treat Adult patients; and
         - Applicants must provide two (2) letters of recommendation
           from a Physician coworker (i.e., Primary Care Providers with
           work experience associated with the applicant in the preceding
           twenty-four (24) months). The Physician coworkers must hold
5. CREDENTIALING AND REcredentialing

A. Credentialing Standards
   1. Credentialing Policies

   an active board certification in Pediatrics, Family Practice or
   Internal Medicine.

   n. Practice Parameter expansion(s) or reduction(s): Providers are required to submit a
      request that includes a detailed explanation when requesting a change in practice
      parameters such as an expansion or reduction in Member age range or specialty
      care privileges (i.e. addition of specialty). All Practice Parameter expansions and
      reductions are subject for review by the IEHP Medical Director or Chief Medical
      Officer. Further review may be completed by the Peer Review Subcommittee who
      will either approve or deny.

      IEHP will consider all relevant information including practice site demographics,
      Provider training, experience and practice capacity issues before granting any such
      change. At a minimum, Provider’s written request must include:

      1) Documentation of any relevant training (e.g., Continuing Medical Education,
         postgraduate/residency training, etc.); and
      2) Practical experience relating to the request (e.g., years in clinical practice,
         direct care experience with the relevant membership, etc.).

   o. A current and valid, unencumbered license to practice medicine in California.

   p. Current and valid DEA registered in California

   q. NPI: Must confirm Provider has an active Individual NPI with a Primary address
      must be registered to an address in California.

      1) Group NPI may be submitted to IEHP in conjunction to the Individual NPI.
      2) Telehealth Providers are not required to have an NPI registered with a primary
         address in California.

   r. Malpractice Insurance Coverage. Must have current and adequate malpractice
      insurance coverage that meets the following criteria:

      1) Minimum $1 million per claim/$3 million per aggregate.
      2) Coverage for the specialty the Provider is being credentialed and contracted
         for.
      3) Coverage for all locations the Provider will be treating IEHP patients.

   s. Appropriate admitting privileges or arrangements to IEHPs contracted Hospitals, if
      applicable See Policy 5B, “Hospital Privileges”.

      1) Providers are not required to maintain Hospital admitting privileges if they are
         only practicing at an Urgent Care.

   t. Adverse History Guidelines: IEHP must carefully review the oversight process for
      the Delegates’ review of all Practitioners with evidence of adverse history are
5. CREDENTIALING AND REcredentialing

A. Credentialing Standards
   1. Credentialing Policies

   presented to Credentialing Committee for review and documented in the meeting minutes, that may include, but is not limited to Providers who have:

   1) Restrictions on licensure
   2) Restrictions on DEA
   3) Loss of Clinical privileges or negative privilege actions
   4) Absence of Sanctions

   • Medi-Cal Suspended & Ineligible List Providers are deemed suspended and ineligible from Medi-Cal will be terminated or not be credentialed and contracted with for Medi-Cal line of business. IEHP does not allow Medi-Cal Suspended & Ineligible List Providers to participate in the IEHP network.

   • Providers Excluded/Sanctioned by Medicare or Medicaid (OIG). IEHP prohibits employment or contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation (Practitioners found on OIG report). Providers identified on the OIG report, will not be credentialed or contacted, and terminated from our network if they are existing Providers.

   • Medicare Opt-Out Providers who are identified on the Medicare Opt-Out will not be contracted for Medicare line of business. IEHP does not allow Medicare Opt-Out Providers to participate in the IEHP network.

   • Preclusions List: Providers identified on the preclusions list will be terminated or not be credentialed and contracted.

   5) Other negative actions may include, but are not limited to:

   • Use of illegal drugs
   • Criminal history
   • Engaged in any unprofessional conduct or unacceptable business practices.

   6) Appropriate Malpractice History: For Practitioners with a history of malpractice suits or decisions, the following criteria warrants full Credentialing Subcommittee Review of the history and should be applied in making credentialing and recredentialing decisions:

   • Number of claims - any claims within the prior seven (7) years.
   • Results of cases - any settlements within the prior seven (7) years.

      1. Settlements with a minimum payout of $30,000 or more.
5. CREDENTIALING AND REcredentialing

A. Credentialing Standards

1. Credentialing Policies

2. Settlements resulting in major permanent injury or death.
   - Trends in cases - Practitioners with multiple malpractice claims in a similar area (e.g., missed diagnosis, negative surgical outcomes, etc.).
   - Higher than average grievance rate or trend in grievances.

7) Lower than average grievance rate

8) Absence of grievance trend

u. Patient Age ranges

1) Patient age ranges for Primary Care Providers (PCP) must be specifically delineated as part of the Delegated credentialing process. Age range for Medicare DualChoice Cal-MediConnect line of business is twenty-one (21) and above.

2) Guidelines for age ranges for non-physician Practitioners which include Nurse Practitioners (NPs), Physician Assistants (PAs), Certified Nurse Midwives (CNMs), Physical Therapists (PT), Occupational Therapists (OT), Speech/Language Therapists (S/LT), Opticians, Optometrists (OD), Chiropractors (DC), Dieticians and Nutritionists are as applicable to the training and certification of the non-physician Practitioner.

v. Patient age ranges for specialty Physicians are specific to the specialty involved, training, and education of the Physician. IEHP requires a completed Attachment I: Statement of Agreement by Supervising Provider, for all Advanced Practitioner and Supervising Physician arrangements, to ensure arrangements are documented appropriately, which will be collected at the time of credentialing, recredentialing and upon relationship change.

IEHP must ensure the appropriate documentation for all Advanced Practice Practitioners (i.e. Physician Assistants (PAs), Nurse Practitioners (NPs), and Certified Nurse Midwives (CNMs) between the Advanced Practice Practitioner and Supervising Physician are present at each site. Therefore, sites must ensure these documents are readily available at the time of audit and are readily available upon request.

1) Physician Assistants are required to have a Practice Agreement or Delegation of Services Agreement and Supervising Physician Form (See Attachment, “Delegation of Services Agreement and Supervising Physician Form” in Section 5). This agreement must define specific services identified in practice protocols or specifically authorized by the supervising Physician, and
   - Both the Physician and PA must attest to, date and sign the document;
5. CREDENTIALING AND REcredentialing

A. Credentialing Standards
1. Credentialing Policies

- PAs must be practicing at a site assigned to their supervising Physician;
- An original or copy must be readily accessible at all practice sites in which the PA works; and
- The agreement must be reviewed, dated and signed annually; and provided to IEHP, upon request.

2) Nurse Practitioners and Nurse Midwives are required to have Standardized Procedures. Standardized Procedures must be on-site site specific and:

- Reference textbooks and other written sources to meet the requirements of Title 16, CCR § 1474 (3), must include:
  - Book (specify edition) or article title, page numbers and sections.
- NP and/or NM must be practicing at a site assigned to their supervising Physician; and
- Standardized Procedures must be signed by both the Practitioner and the supervising Physician, initially and annually; and provided to IEHP, upon request. At minimum, the Delegate must collect and submit to IEHP:
  - Table of Contents of the Standardized Procedures used, between the NP and/or CNM and supervising Physician, that references the textbook or written sources to meet the requirements of the Board of Registered Nursing.
  - Evidence that the Standards of Care established by the sources were reviewed and authorized by the nurse Practitioner, Physician and administrator in the practice setting (i.e. signature page that includes all parties involved).
  - Standardized Procedures written using the Physician Assistants Delegation of Services Agreement and Supervising Physician Form format and/or verbiage is not accepted by IEHP.  

4. All Practitioners who do not meet the criterion set forth above, must be reviewed by the IEHP Credentialing Subcommittee and/or IEHP Peer Review Subcommittee. IEHP’s Credentialing Subcommittee will review, discuss and document their findings in the respective Subcommittee minutes. At a minimum:

a. The Credentialing Committee must receive and review the credentials of the Practitioners who do not meet IEHP’s established criteria for the Practitioners

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9 NCQA, 2020 HP Standards and Guidelines, CR 1, Element A, Factor 3
10 Medicare Managed Care Manual, Chapter 6 “Relationships with Providers”, Chapter 6 § 60.3
11 Title 16, California Code of Regulations (CCR) § 1474 (3)
5. CREDENTIALING AND RECREREDENTIALING

A. Credentialing Standards
   1. Credentialing Policies

   applying directly to IEHP to provide advice and expertise for credentialing decisions.

   b. If retrospective review by IEHP’s Credentialing Department reveals that a Practitioner approved by a Delegate does not meet the above requirements, IEHP can submit the Practitioner to IEHPs Peer Review Subcommittee for review. 12

5. IEHP utilizes a clean file process. All Practitioners who meet the criterion set forth above, are determined as “clean” and may be submitted to the IEHP Medical Director for sign-off. The sign-off date is the Committee date and evidence of the IEHP Medical Director signature will be documented in the Practitioners file or on a list of all Practitioners who meet the established criteria.

   a. The IEHP Medical Director, who is responsible for oversight of the credentialing process, has been identified as the individual with the authority to determine that a file is “clean” and to sign off on it as complete, clean and approved. 13

6. IEHP’s credentialing and recredentialing decisions are not based solely on the applicant’s race, ethnic/national identity, gender, age, sexual orientation or patient in which the Practitioner specializes and describes the steps for monitoring and preventing discriminatory practices during the credentialing/credentialing process.

IEHP’s procedures for monitoring and preventing discriminatory credentialing decisions may include, but are not limited to:

   a. Monitoring: Periodic audits of Practitioner complaints to determine if there are complaints alleging discrimination are conducted annually.

   b. Preventing: Maintaining a heterogeneous Credentialing Committee membership and requiring those responsible for credentialing decisions to sign an affirmative statement on, which is included on the sign-in sheet, to make decisions in a non-discriminatory manner. 14

7. Practitioners are notified verbally or in writing, when credentialing information obtained from other sources varies substantially from that provided. The Credentialing Specialist notifies the Practitioners by fax or email, within ten (10) business days, of any information obtained during the credentialing process that varies substantially from the information provided by the Practitioner that includes but is not limited to:

   a. Actions on license.

   b. Malpractice history.

   c. Board certification, education and training.

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12 NCQA, 2020 HP Standards and Guidelines, CR 1, Element A, Factor 4
13 NCQA, 2020 HP Standards and Guidelines, CR 1, Element A, Factor 5
14 NCQA, 2020 HP Standards and Guidelines, CR 1, Element A, Factor 6
5. CREDENTIALING AND REcredentialing

A. Credentialing Standards
   1. Credentialing Policies
      
      d. Any incomplete or blank sections on the application
      
       IEHP is not required to reveal the source of the information if the law prohibits the disclosure. The notification to the Practitioner includes the following:
      
      a. Identification of the discrepancy;
      b. Identification of the source of the discrepancy;
      c. Informs the Practitioner that the Practitioner has ten (10) business days to submit the missing and/or corrected information;
      d. The format for submitting the correction;
      e. The person to whom the corrections must be submitted; and
      f. Where to submit the information
      
      The Practitioner has ten (10) business days from the receipt of the notification to correct the erroneous information and is responsible for submitting additional or corrected information including any other supporting or pertinent information in writing, to the IEHP Credentialing Specialist.

      a. Upon receipt, the Credentialing Specialist stamps the document with the date received, to include the name of the reviewer, and verifies the information is correct. If it’s correct, the document is included in the Practitioner’s credentialing file for review and approval.

      b. For Credentialing files: If the requested information is not received within ten (10) business days, the Provider is notified that their credentialing process is ceased due to non-compliance to credentialing or recredentialing.

      c. For Recredentialing files: If the requested information is not received within ten (10) business days, the Provider Services Representatives (PSRs) and Contracts Managers (CMs) are notified that the Provider has outstanding items and are approaching their recredentialing due dates. Failure to provide all recredentialing documents timely may result in an administrative termination.  

     8. Practitioners are notified of their credentialing and recredentialing decisions within sixty (60) calendar days of the Committee’s decision or Medical Director sign off.

     9. IEHP’s Medical Director’s overall responsibility and participation in the credentialing program includes, but is not limited to:
        a. Possession of a current license to practice in the state of California;

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15 NCQA, 2020 HP Standards and Guidelines, CR 1, Element A, Factor 7
16 NCQA, 2020 HP Standards and Guidelines, CR 1, Element A, Factor 8
5. CREDENTIALING AND RECredentialing

A. Credentialing Standards
   1. Credentialing Policies

   b. His/her role in implementation, development and coordination in the functions of the Credentialing Program;
   c. Oversight of the Credentialing Program, policies and procedures;
   d. Membership, attendance and/or chairmanship at all Credentialing Committee meetings; and
   e. Description of the reporting structure and responsibilities for Medical Director/physician designee, Committee and Board of Directors for final recommendation for participation, as applicable.  

10. The information obtained in the credentialing process is kept confidential and IEHP mechanisms to ensure confidentiality of the information collected during the credentialing process includes, but is not limited to:
   a. Confidentiality statements are signed by the Committees and Credentialing staff
   b. Practitioners files (hard copies) are maintains in locked file cabinets and are only accessible by authorized personnel; and
   c. Security for database systems is maintained through passwords or other means to limit access to Practitioner information to authorized staff only. 

11. All information provided by IEHP for Member materials and Practitioner directories is consistent with the information obtained during the credentialing and recredentialing process, regarding Practitioner education, training, certification and designated specialty. Information collected and verified during the credentialing and recredentialing process and requests received in between cycles, is entered and maintained by the Credentialing Department to ensure consistency.  

B. IEHP notifies Practitioners of their rights to review information submitted to support their credentialing application, correct erroneous information, and receive the status of their credentialing and recredentialing application, upon request, through the Provider Manual, and Provider application.

   1. Practitioners may review information submitted to support their credentialing application that are obtained from outside sources (e.g. malpractice insurance carriers, state licensing boards) to support their credentialing application.

   a. IEHP is not required to make available:
       1) References.
       2) Recommendations.

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17 NCQA, 2020 HP Standards and Guidelines, CR 1, Element A, Factor 9
18 NCQA, 2020 HP Standards and Guidelines, CR 1, Element A, Factor 10
19 NCQA, 2020 HP Standards and Guidelines, CR 1, Element A, Factor 12
5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards
   1. Credentialing Policies

   3) Peer-Review protected information.

2. Practitioners have the right to correct erroneous information (submitted by another source) and must clearly state:
   a. Practitioners have fifteen (15) business days of notification of discrepancy from the date the Credentialing Department provides notice to correct any erroneous information. Erroneous information may include substantial variation in information on:
      1) Actions on a license
      2) Adverse history
         - Malpractice Claim History
         - Criminal History
         - Sanction History
         - Clinical Privileges History
      3) Board Certification
      4) Education and Training
         - Insufficient years of training in desired specialty
   b. Practitioners must submit their corrections in writing.
   c. Practitioners must send their written requests via confidential fax, email or letter to the Credentialing Department:
      P.O. Box 1800
      Rancho Cucamonga, CA 91729-1800
      Fax: (909) 890-5756
      E-mail: credentialing@iehp.org.

IEHP is not required to reveal the source of information that was not obtained to meet the verification requirements or if federal or state law prohibits disclosure.

IEHP documents receipt of corrected information in the Practitioner’s credentialing file.

3. Practitioners have the right to be informed, upon request, of the status of their credentialing or recredentialing application. Following receipt of the Practitioner’s request, the Practitioner will be contacted by the Credentialing Department with their status.20

C. Upon receipt of a credentialing, recredentialing or Provider profile, the Credentialing Team

20 NCQA, 2020 HP Standards and Guidelines, CR 1, Element B, Factors 1-3
5. CREDENTIALING AND REcredentialing

A. Credentialing Standards

1. Credentialing Policies

Member will begin and conduct the primary source verification process.

1. All primary source verifications are:
   a. Received through the verification sources identified in this policy
   b. Stored in the Practitioners file, which is then saved in the Credentialing Drive (N:Drive)
   c. Reviewed and verified by Credentialing. The Credentialing Team Member will identify their review of the verification with a stamp that includes their name, time and date that they completed their review, which can only be accessed by the reviewer.
   d. Tracked in the Network Development Database (NDDB) and the file checklist

2. When the Credentialing Team Member identifies any discrepancies, they are responsible for obtaining clarification from the verification source and notifying the Practitioner of any discrepancies, as identified in the Practitioner’s Right to Review.
   a. If the clarification requires modifications, to include deletions, the Credentialing Team Member will notate on the primary source verification, the following information:
      1) When the information was modified
      2) How the information was modified
      3) Credentialing Team Member Name, who made the modification
      4) Why the information was modified
      5) Who they confirmed the information with (IEHP requirement)

3. Only Team Members in Credentialing are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate
   a. Credentialing Team Members are allowed to:
      1) Access all Practitioner files in Credentialing and in NDDB
      2) Modify verifications due to clarifications from the Provider or verification source on the file and in NDDB.
      3) Delete notations made by the reviewer in error
         • Credentialing is not allowed to delete or remove any pages submitted by the Provider or delegated entity
   b. Quality Assurance (QA) for Credentialing, Team Members are allowed to:
      1) Access Practitioner files in the Credentialing, Recredentialing and Delegated review process and in NDDB
5. CREDENTIALING AND RECREREDENTIALING

A. Credentialing Standards

1. Credentialing Policies

2) Modify their auditing tool in NDDB based on clarifications from Credentialing

3) Delete notations in error by the QA Team

c. Health Care Informatics (HCI) Team Members who focus on the Network Development Data Base, and hold modifying and deleting rights, are allowed to:

1) Access all Practitioner records in NDDB

2) Modify inaccurate information entered by Credentialing, upon request of the Credentialing Department

3) Delete erroneous information entered by Credentialing, upon request of the Credentialing Department.

4. The security controls in place to protect the information from unauthorized modifications, include but are not limited to:

a. The physical access to the credentialing information, to protect the accuracy of information gathered from primary source and NCQA-approved sources, are limited to the Credentialing Department.

b. The prevention of authorized access, changes to and release of credentialing information is conducted through:

1) Information Technology (IT) Department, who allows only the Credentialing Team access to the N:Drive, which is the drive where the credentialing files are stored

2) Health Care Informatics (HCI) Department is responsible for allowing only the Credentialing Department rights to add, modify and delete any information related to primary source verifications

c. Our electronic systems include password-protections for all users, which is monitored by our IT Department. This process includes but is not limited to:

1) Use of strong passwords

2) Avoiding written-down passwords

3) Use of different passwords for different accounts

4) Change of passwords periodically

5) The changing of withdrawing passwords, including alerting appropriate staff who oversee the computer security to:

- Change passwords when appropriate
- Disable or remove passwords or employees who leave the organization.

Upon notification:
5. CREDENTIALING AND RECREREDENTIALING

A. Credentialing Standards

1. Credentialing Policies

   o IT will terminate the Team Member’s access
   o Credentialing will terminate the team member’s access to the National Practitioner Data Bank (NPDB)

6) IEHP does not contract with any external entity to outsource the storage of credentialing information. If IEHP chooses to do so, IEHP will ensure the contract describes how the contracted entity ensures the security of the stored information.

5. Credentialing will be responsible for including audit checks in our processes to identify and assess any risks to the processes specified in this policy. These audit checks will include, but are not limited to:

   a. For primary source verifications received, dated and stored. All verifications must be received, dated and stored, by the Credentialing Team Member. This will be conducted for all primary source verifications.
      1) Does not have to be by the same Credentialing Team Member

   b. For modifying information and how its tracked and dated from its initial verification, the modification must be based on a clarification conducted by the Credentialing Team Member and documented in the Practitioner’s file. This will be conducted for all primary source verifications.
      1) The Credentialing Team Member can then update the modification in NDDB, based on the information verified.

   c. For staff who are authorized to review, modify and delete information, and circumstances when modifications or deletion is appropriate, semi-annually, Credentialing will send a request to:
      1) IT (Help Desk) to request for a list of Team Members who have access to N:Drive, to review the Level of staff who are authorized to access, modify and delete practitioner credentialing files.
         • Any modifications and deletions will be communicated to IT, from the Credentialing Manager
      2) HCI (Network Development Team) to request for a list of Team Members who have Credentialing access to add, modify and delete credentialing information in NDDB, to review the level of staff who are authorized access, modify and delete practitioner credentialing files.
         • Any modifications and deletions will be communicated to HCI, from the Credentialing Manager

   d. For the security controls in place to protect the information from unauthorized modification, the Credentialing Supervisor will confirm with IT that the Team
5. CREDENTIALING AND REcredentialing

A. Credentialing Standards

1. Credentialing Policies

Member’s access has been terminated and be responsible for terminating the Team member’s access from the National Practitioner Data Bank.

1) Confirmation of the Team Member’s Access will be completed through the Request to IT above

2) Confirmation of the Team Member’s access to NPDB can be verified upon request by logging into NPDB and verifying the authorized users. 21

D. IEHP collects information from quality improvement activities and Member complaints for all Practitioner files undergoing the recredentialing process, to be included in the recredentialing decision making process. 22 23

E. During the IEHP credentialing, recredentialing, and ongoing monitoring process, Providers are reviewed to ensure that they it only contracts with Physicians who have not opted out, by verifying our Practitioners are not included on the Medicare Opt-Out Report. IEHP does not allow Medicare Opt-Out Providers to participate in the IEHP network for Medicare lines of business. 24

F. IEHP prohibits employment or contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation (Practitioners found on OIG report). Providers identified on the OIG report, will not be credentialed or contacted, and terminated from our network if they are existing Providers. 25

G. IEHP does not contract with Practitioners who are precluded from receiving payment for Medicare Advantage (MA) items and services Part D drugs furnished or prescribed to Medicare beneficiaries. IEHP does not allow Practitioners identified on the preclusions list to participate in the IEHP network.

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\text{Chief Approval:} & \text{Signature on File} \\
\hline
\text{Original Effective Date:} & \text{January 1, 2020} \\
\hline
\text{Chief Title:} & \text{Chief Operating Officer} \\
\text{Revision Date:} & \\
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\end{array}
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21 NCQA, 2020 HP Standards and Guidelines, CR 1, Element C, Factors 1-5.
22 Medicare Managed Care Manual, Chapter 6 “Relationships with Providers”, Chapter 6 § 60.3.
23 Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004 Supersedes APL 17-019, “Provider Credentialing / Recredentialing and Screening / Enrollment”.
24 Medicare Managed Care Manual, Chapter 6 “Relationships with Providers”, Chapter 6 § 60.2.
25 Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004 Supersedes APL 17-019, “Provider Credentialing / Recredentialing and Screening / Enrollment”.

IEHP Provider Policy and Procedure Manual 01/20 Medicare DualChoice MA_05A1 Page 28 of 28
5. CREDENTIALING AND RECRECREDENTIALING

A. Credentialing Standards
   2. Credentialing Committee

APPLIES TO:

A. This policy applies to all IEHP Medicare DualChoice Providers contracted under IEHPs Direct Network.

POLICY:

A. IEHP designates the Credentialing Subcommittee who uses a peer-review process to make recommendations regarding credentialing decision. Activities of the Subcommittee are reported to Quality Management (QM) Committee on a quarterly basis or more frequently for issues of a more serious nature.

B. IEHPs Credentialing Subcommittee reviews the credentials for Providers who do not meet established thresholds and give thoughtful consideration of the credentialing information. IEHPs Credentialing Subcommittee obtains meaningful advice and expertise from participating Practitioners when it makes credentialing decisions.

C. IEHPs Credentialing Subcommittee ensures files that meet established criteria are reviewed and approved by a medical director or designated Physician.

PURPOSE:

A. IEHP designates the Credentialing Subcommittee who uses a peer-review process to make recommendations regarding credentialing decisions.

B. IEHP obtains meaningful advice and expertise from participating Practitioners when it makes credentialing decisions.

C. Assessment of Timeliness. In accordance to National Committee for Quality Assurance (NCQA) guidelines, IEHP uses the Credentialing Subcommittee or medical director decision date to assess timeliness in the file review elements if a review board or governing body reviews decisions made by the Credentialing Subcommittee or Medical Director.

D. Providing care to Members. IEHP does not permit Practitioners to provide care to its Members before they are credentialed.

PROCEDURES:

A. The Credentialing Subcommittee is structured to provide review of Practitioners applying for participation with IEHP and to ensure compliance with IEHP requirements.
   1. IEHP uses participating Practitioners to provide advice and expertise for credentialing decisions. IEHPs voting rights are restricted to the appointed Subcommittee Members, who are Physicians only.
5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards
   2. Credentialing Committee

   a. IEHP Medical Director or designee as Chairperson;
      1) IEHP’s Medical Director is directly responsible for the credentialing process,
         Credentialing policies and procedures, and has overall responsibility and
         participation in the credentialing process.
   b. Chief Medical Officer;
   c. At least four (4) multidisciplinary participating PCPs or specialty Physician
      representative of network Practitioners;
      1) Any other specialty not represented by Subcommittee membership including
         vision and behavioral health serves on an ad hoc basis for related issues.
         • Prospective appointed Physician Members of the Subcommittee are subject
           to verification of licensure, Drug Enforcement Agency (DEA) and
           malpractice history prior to participating on the Subcommittee.
         • Prospective Physician Members not providing requested information to
           perform verification in a timely manner, or who do not meet IEHP’s
           requirements upon verification may not participate on the Subcommittee.
         • The full term for practicing primary care and specialists Subcommittee
           voting Members is two (2) years, with replacements selected from network
           Practitioners.
           o The determination of whether any Practitioner Member may serve
              additional terms is at the sole discretion of the Chief Medical Officer
              and Medical Director, with approval of the Subcommittee.
           o The initial term(s) of Subcommittee Members are staggered to ensure
              consistent Subcommittee operations.
   d. IEHPs non-physician staff on the Subcommittee do not have voting rights and
      consists of the following:
      1) Director of Provider Relations;
      2) Director of Quality Management;
      3) Credentialing Manager;
         • Credentialing ensures the timeframe for notifying applicants of their
           credentialing decisions for both credentialing and recredentialing, does not
           exceed sixty (60) calendar days from the committee’s decision.
      4) Quality Manager; and
      5) Other IEHP staff, as necessary
         • IEHP staff attend as permanent Members of the Credentialing
5. CREDENTIALING AND REcredentialing

A. Credentialing Standards

2. Credentialing Committee

Subcommittee.

6) Provider Services Administrative Assistant
   • Acts as secretary to the Credentialing Subcommittee

B. IEHPs Credentialing Subcommittee reviews the credentials for Providers who do not meet established thresholds and give thoughtful consideration of the credentialing information. IEHPs Credentialing Subcommittee obtains meaningful advice and expertise from participating Practitioners when it makes credentialing decisions.

1. The committee’s discussion must be documented within its meeting minutes. The Credentialing decision date is used to determine the timeliness requirements for credentialing.

   a. Credentialing Subcommittee meetings and decision making may take place in form of real-time virtual meetings (e.g. through video conferencing or web conferencing with audio). Meetings may not be conducted only through email.

   b. Voting cannot occur unless there is a quorum of voting Members present. For decision purposes a quorum can be composed of one of the following:

      1) The Chairperson, (who is the IEHP Medical Director or designee), Chief Medical Officer, and three (3) appointed Subcommittee Members; or

      2) The Chairperson (who is the IEHP Medical Director or designee), or Chief Medical Officer and two (2) appointed Subcommittee Members.

   c. Credentialing Subcommittee decisions cannot be based on applicant’s race, ethnic/national identity gender, age, or sexual orientation, or on type of procedure or patient (i.e. Medicaid) in which the Practitioner specializes. Policies and procedures must describe specific steps that the organization prevent and monitor discriminatory practices. This does not preclude the organization from including in its network Practitioners who meet certain demographic or specialty needs (i.e. meeting cultural needs of the Members).

   d. In-depth minutes are recorded at each meeting by a Provider Services Administrative Assistant, with review by the Credentialing Manager and IEHP Medical Director.

      1) Minutes include all activities addressed in Subcommittee meetings, including credentialing and recredentialing decisions, and other business related to credentialing and recredentialing of Practitioners including thoughtful discussion and consideration of all Practitioners being credentialed and recredentialied before a credentialing decision is determined.

      2) Minutes are dated, signed and reflect the responsible person for follow-up actions.

      3) Credentialing minutes are stored in a confidential and secure location with
5. CREDENTIALING AND RECredentialing

A. Credentialing Standards

2. Credentialing Committee

access only to authorized staff.

e. Updates of activities including minutes and appropriate reports are submitted to Quality Management (QM) Committee on a quarterly basis, or more frequently as needed.

f. The Credentialing Subcommittee meets monthly with additional meetings as needed.

C. Ensures that files that meet established criteria are reviewed and approved by a medical director or designated Physician. IEHP implemented a process to designate a Medical Director or other designated Physician review and approval of clean files submits all Practitioner files, and then provides a list to the Credentialing Subcommittee for review as a repository.

1. IEHP’s Medical Director is directly responsible for the credentialing process. Credentialing policies and procedures and has overall responsibility and participation in the credentialing process.

2. Evidence of the medical director’s or equally qualified Physician’s review will be present on a list or file of the Practitioners who meet the established criteria.

3. IEHP’s Medical Director reviews, analyzes, and recommends any changes to the IEHP Credentialing and Recredentialing Program policies and procedures on an annual basis, or as deemed necessary.

REFERENCE:

A. NCQA, 2019 HP Standards and Guidelines, Credentialing and Recredentialing (CR) 2.
5. CREDENTIALING AND REcredentialing

A. Credentialing Standards

3. Credentialing Verification

APPLIES TO:

A. This policy applies to all IEHP Medicare DualChoice Providers.

POLICY:

A. IEHP verifies that the following are within the prescribed time limits: License to Practice, Drug Enforcement Administration (DEA), education and training, board certification, work history and malpractice history.

B. IEHP verifies the following sanction information for credentialing: State sanctions, restrictions on licensure or limitations on scope of practice, Medicare and Medicaid sanctions.

C. IEHP ensures applications for credentialing and recredentialing include reasons for inability to perform the essential functions of the position, lack of present illegal drug use, history of loss of license and felony convictions, history of loss or limitation of privileges or disciplinary actions, current malpractice insurance coverage, and a current and signed attestation confirm the correctness and completeness of the application.

D. IEHP verifies that Practitioners must have clinical privileges in good standing. Practitioner must indicate their current hospital affiliation or admitting privileges at a participating hospital.

E. IEHP monitors its credentialing files to ensure that it only contracts with Practitioners who have not opted out.

F. IEHP includes information from the quality improvement activities and Member complaints in the recredentialing decision-making process.

G. IEHP confirms all Practitioners maintain an active individual NPI number registered through the CMS National Plan and Provider Enumeration System (NPPES).

H. IEHP ensures all Primary Care Provider’s (PCP) and Urgent Care’s (UC) are informed that they must pass an on-site site review conducted by IEHP. (See Policy 6A, “Site Review and Medical Record Review Survey Requirements and Monitoring”).

I. IEHP must obtain Social Security Numbers for all new and existing Practitioners participating Providers, to ensure all Practitioners are included in IEHP’s screening of the Death Master File.

J. IEHP monitors its Provider network and ensures their Providers are not included in the Centers Medicare & Medicaid Services (CMS) Preclusions List.
5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards
   3. Credentialing Verification

K. IEHP must ensure all Practitioners are within the appropriate age range guidelines, as appropriate to ensure compliance with IEHP guidelines. (See Policy 5A1, Credentialing Policies”.)

L. IEHP must obtain appropriate documentation to expand or limit their practice parameters for IEHP review and approval.

M. IEHP must ensure and obtain the appropriate documentation for all Mid-Level Practitioners (i.e. Physician Assistants (PAs), Nurse Practitioners (NPs), and Nurse Midwives (NMs) between the Mid-Level and Supervising Physician, provide them to IEHP, and ensure these documents are readily available upon request. (See Policy 6F, “Facility Site Review – Non-Physician Practitioner Requirements”).

N. IEHP must ensure and obtain the appropriate documentation for all Mid-Level Practitioners (i.e. Physician Assistants (PAs), Nurse Practitioners (NPs), and Nurse Midwives (NMs)) between the Mid-Level and Supervising Physician, provide them to IEHP, and ensure these documents are readily available upon request.

PURPOSE:

A. IEHP conducts timely verification of information to ensure that Practitioners have the legal authority and relevant training and experience to provide quality care.

B. Pencils are not an acceptable writing instrument for credentialing documentation.

DEFINITION:

A. Verification Time Limit (VTL): National Committee for Quality Assurance (NCQA) counts back from the decision date to the verification date to assess timeliness of verification.

B. Each file contains evidence of verification, defined by NCQA as “Appropriate documentation.” IEHP documents verification in the credentialing files using any of the following methods or a combination:
   1. Credentialing documents signed (or initialed) and dated by the verifier.
   2. A checklist that includes for each verification:
      a. The source used.
      b. The date of verification.
      c. The signature or initials of the person who verified the information.
      d. The report date, if applicable.
   3. A checklist with a single signature and a date for all the verifications that has a statement
5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards
   3. Credentialing Verification

   confirming that the signatory verified all the credentials on that date and that includes for each verification.

   a. The source used.
   b. The report date, if applicable.
   c. If the checklist does not include checklist requirements listed above appropriate credentialing information must be included.

C. Verbal Verification - Requires a dated, signed document naming the person at the primary source who verified the information, his/her title, the date and time of verification and include what was verified verbally.

D. Automated Verification - Requires there be a mechanism to identify the name of the entity verifying the information, the date of the verification, the source, and the report date, if applicable.

E. Written Verification - Requires a letter or documented review of cumulative reports. IEHP must use the latest cumulative report, as well as periodic updates released by the primary source. The date on which the report was queried, and the volume used must be noted.

F. Using the Internet for Primary Source Verification (PSV): PSV on documents that are printed/processed from an internet site (e.g. BreEZer, National Practitioner Data Bank (NPDB) etc.), the data source date (as of date, release date) must be queried within the timeframe. The date of the query must be verified prior to the Credentialing Decision. If there is no data source date, the verifier must document the review date on the verification or the checklist. Verification must be from an NCQA approved and appropriate state-licensing agency.

G. PSV Documentation Methodology. The organization may use an electronic signature or unique electronic identifier of staff to document verifications (to replace the dating and initialing of each verification) if it can demonstrate that the electronic signature or unique identifier can only be entered by the signatory. The system must identify the individual verifying the information and the date of verification.

H. NPPES – CMS National Plan and Provider Enumeration System.

I. CMS Preclusions List – List of prescribers and individuals or entities who fall within any of the following categories: (1) Are currently revoked from Medicare, are under an active re-enrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program.

J. Death Master File (DMF) contains information about persons who had Social Security numbers and whose deaths were reported to the Social Security Administration from 1962 to the present; or persons who died before 1962, but whose Social Security accounts were still active in 1962.

PROCEDURES:
5. CREDENTIALING AND REcredentialing

A. Credentialing Standards

3. Credentialing Verification

A. IEHP verifies that the following are within the prescribed time limits:

1. A current and valid license to practice in California (Verification Time Limit (VTL): one hundred-eighty (180) calendar days prior to Credentialing decision date).
   a. Must be valid, current, and unencumbered at the time of committee and remain valid and current throughout the Practitioner’s participation with IEHP.
      1) For web queries, the data source data – e.g. release date or as of date is used to assess timeliness of verification.
      2) All Practitioners must be licensed by the State of California by the appropriate state licensing agency. The following license verifications must be obtained by the licensing board or their designated licensing and enforcement systems. The following licensures may be verified through BreEZe Online services online or directly with the licensing board via phone or mail:
         • Medical Board of California (M.D.)
         • Osteopathic Medical Board of California (D.O.)
         • Board of Podiatric Medicine (D.P.M.)
         • Board of Behavioral Sciences (L.M.F.T., L.C.S.W., M.F.C.C)
         • Board of Psychology (Ph.D., Psy.D.)
         • Dental Board of California (D.D.S., D.M.D.)
         • California Board of Occupational Therapy (O.T.)
         • California State Board of Optometry (O.D.)
         • Physical Therapy Board of California (P.T.)
         • Physician Assistant Committee (P.A., P.A.-C)
         • California Board of Registered Nursing (C.N.M., N.P.)
         • California Board of Chiropractic Examiners (D.C.)
         • Speech-Language Pathology & Audiology Board (S.P., Au)
         • Acupuncture Board (L.Ac.)
      3) Failure to maintain a valid and current license at all times, will result in an administrative termination of the Practitioner.

2. A valid DEA or Controlled Dangerous Substances (CDS) certificate, if applicable (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date). All Practitioners who are qualified to write prescriptions, except non-prescribing Practitioners, must have a valid and current DEA certificate.
5. CREDENTIALING AND REcredentialing

A. Credentialing Standards

3. Credentialing Verification

a. Must be valid and current at the time of committee and remain valid and current throughout the Practitioner’s participation with IEHP).

b. Verification may be in the form of:

1) A photocopy of the current DEA certificate, with date stamped and initialed by the reviewer to show receipt and review prior to the credentialing decision;

2) A query of the National Technical Information Service (NTIS) database, with date stamped and initialed by the reviewer to show receipt and review prior to the credentialing decision.

c. Any Practitioner with a DEA with an “EXEMPT” Fee or status, the DEA is only valid at the exempting institution and any affiliate Hospital or Clinic rotations within the scope of training. IEHP must confirm the Practitioner’s practice and exempting institutions relationship and document their findings in the Provider file, if the address on the DEA does not match the Providers practice location. If a Practitioner is practicing outside of the exempting institution and/or its affiliates, the Practitioner must obtain a “Paid” status DEA.

d. IEHP may credential a Practitioner whose DEA certificate is pending or pending a DEA with a California address, if IEHP obtains written documentation from the Provider of their arrangements with another Practitioner who will write all prescriptions requiring a DEA number for the prescribing Practitioner until the Practitioner has a valid DEA certificate.

e. If a Practitioner does not have a DEA or CDS certificate, IEHP must obtain an explanation to why the Practitioner does not prescribe medications and to provide arrangements for the Practitioner’s patients who need prescriptions requiring DEA certification.

f. Failure to maintain an active DEA, may result in an administrative termination of the Practitioner.

3. Education and training (VTL: Prior to the Credentialing Decision) All Practitioners must have completed appropriate education and training for practice in the U.S. or a residency program recognized by NCQA, in the designated specialty or subspecialty they request to be credentialed and contracted. IEHP verifies the highest of the following three levels of education and training obtained by the Practitioner, as appropriate.

If the Practitioner is not board certified in the specialty or sub-specialty in which he/she is applying, there must be evidence of verification of residency and training in the subspecialty (e.g. Fellowships in Cardiology, Rheumatology, Pediatric Endocrinology etc.), as relevant to the credentialed specialty.

IEHP may use any of the following to verify education and training:

a. The primary source from the Medical School or through a clearinghouse.
5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards
   3. Credentialing Verification

   b. The state licensing agency or specialty board if the state agency and specialty board, respectively, perform primary source verification. The organization obtains, at least annually, written confirmation of this fact, uses a printed, dated screenshot of the state licensing agency’s or specialty board’s website displaying the statement that it performs primary source verification of Practitioner education and training information or provides evidence of a state statute requiring licensing to obtain verification of education and training directly from the institution.

c. Sealed transcripts if the organization provides evidence that it inspected the contents of the envelope and confirmed that Practitioner completed (graduated from) the appropriate training program.

d. Below are acceptable sources for physicians (M.D., D.O.) to verify graduation from Medical School:

   1) AMA Physician Master File.
   3) Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986.

   Below are acceptable sources for physicians (M.D., D.O.) to verify completion of residency training:

   1) Primary source from the institution or clearinghouse where the postgraduate medical training was completed.
   2) AMA Physician Master File.
   3) AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
   4) FCVS for closed residency programs.

   • NCQA only recognizes residency programs accredited by the Accredited Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) (in the United States) or by the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada.

   4. Board certification status, if applicable (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date).

   a. IEHP verifies current certification status of Practitioners who state that they are board certified.

      1) IEHP must document the expiration date of the board certification within the
5. CREDENTIALING AND RECredentialing

A. Credentialing Standards

3. Credentialing Verification

credential file.

- If a Practitioner has a “lifetime” certification status and there is no expiration date for certification, the organization verifies that the board certification is current and documents the date of verification.

2) If board certification has expired it may be used as verification of education and training.

3) Verification must be performed through a letter directly from the board or an online query of the appropriate board as long as the board states that they verify education and training with primary sources, is an acceptable source by NCQA, and indicate that this information is correct. Below are the acceptable sources to verify board certification:

- For all Practitioner types
  - The primary source (appropriate specialty board).
  - The state licensing agency if the primary source verifies board certification.

- For Physicians (M.D., D.O.)
  - ABMS or its Member boards, or an official ABMS Display Agency, 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 specialties it accepts and obtains annual written confirmation from the boards that the boards performs primary source verification of completion of education and training.

- For other health care professionals
  - Registry that performs primary source verification of board that the registry performs primary source verification of board certification status.

- For Podiatrists (D.P.M.)
  - American Board of Foot and Ankle Surgery (formerly The American Board of Podiatric Surgery).
5. CREDENTIALING AND RECredentialING

A. Credentialing Standards

3. Credentialing Verification

- The American Board of Podiatric Medicine.
- American Board of Multiple Specialties in Podiatry.
- For Nurse Practitioners (N.P.)
  - American Association of Nurse Practitioners (AANP).
  - 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).
- For Physician Assistants (P.A.-C).
  - National Commission of Certification of P.A.’s (NCCPA).
- For Certified Nurse Midwives (C.N.M.).
  - American Midwifery Certification Board (AMCB).
- For Psychologists (Ph.D., Psy.D.).
  - American Board of Professional Psychology (ABPP).

4) If IEHP is unable to verify the board certification, the Practitioner is notified and given the right to review and correct erroneous information. In addition, further review of the Providers attestation may be required for correction.

5. Work history (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date) IEHP must obtain a minimum of the most recent five (5) years of work history as a health professional through the application, Curriculum Vitae (CV) or work history summary/attachment, providing it has adequate information.

a. IEHP must document review of work history on the application, CV, or checklist that includes the signature or initials of staff who reviewed work history and the date of review. Documentation of work history must meet the following:

  1) Must include the beginning and ending month and year for each work experience.

  2) The month and year do not need to be provided if the Practitioner has had continuous employment at the same site for five (5) years or more. The year to year documentation at that site meets the intent.

  3) If the Practitioner completed education and went to straight into practice, this will be counted as continuous work history.
5. CREDENTIALING AND REcredentialing

A. Credentialing Standards

3. Credentialing Verification

4) If the Practitioner has practiced fewer than five (5) years from the date of credentialing. The work history starts at the time of initial licensure.

5) IEHP must review for any gaps in work history. If a work history gap of six (6) months to one (1) year is identified, IEHP must obtain an explanation from the Practitioner. Verification may be obtained verbally or in writing or in writing for gaps of six (6) months to one (1) year.

6) Any gap in work history that exceeds one (1) year must be clarified in writing from the Practitioner. The explanation of the gap needs to be sufficient to ascertain that the gap did not occur as a result of adverse and/or reportable situations, occurrences or activities.

6. A history of professional liability claims that resulted in settlement or judgment paid on behalf of the Practitioner. (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date)

a. IEHP will obtain confirmation of the past five (5) years of malpractice settlements through one of the following sources:

1) Malpractice Insurance Carrier

2) National Practitioner Data Bank Query

3) Evidence of Continuous Query (formerly Proactive Disclosure Services (PDS). Continuous Query must be reviewed within one hundred-eighty (180) calendar days of the initial credentialing decision. Evidence must be documented in the file or on checklist.

b. A minimum the five (5) years claim history must be reviewed for initial credentialing and all claim history activities after the previous credentialing decision date, will be reviewed for recredentialing.

c. The five (5) year period may include residency and fellowship years. IEHP is not required to obtain confirmation from the carrier for Practitioners who had a hospital insurance policy during a residency and fellowship.

B. IEHP will verify the following sanction information for credentialing:

1. State sanctions, restrictions on licensure or limitations on scope of practice (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision). IEHP uses OIG Compliance Now, a sanction screening service to monitor its Provider network for restrictions on licensure or limitation on scope of practice:

a. During the credentialing or recredentialing process, the Credentialing Specialist or designee will submit the Provider to OIG Compliance Now for screening. The results are reviewed by the Credentialing Specialists and included in the Provider file.

1) If a Practitioner is not identified on any reports, the OIG Compliance Now
5. CREDENTIALING AND RECredentialing

A. Credentialing Standards

3. Credentialing Verification

Findings are included in the Provider file and date stamped by the reviewer, to ensure that findings were reviewed within the one hundred eighty (180) calendar-day timeframe.

2) If a Practitioner is identified by their respective licensing board with an action, the Credentialing Specialist obtains and reviews the action(s) identified. The Credentialing Specialist then:

- Verification sources for sanctions or limitations on licensure include:
  - Chiropractors: State Board of Chiropractic Examiners CIN-BAD, NPDB.
  - Oral Surgeons: State Board of Dental Examiners, or State Medical Board, NPDB.
  - Physicians: Appropriate state board agencies, FSMB, NPDB.
  - Podiatrists: State Board of Podiatric Examiners, Federation of Podiatric Medical Boards, NPDB.
  - Non-physician Healthcare Professionals: State licensure or certification board, appropriate state agency, NPDB.
  - For Practitioner’s screened using the Continuous Query (formerly Proactive Disclosure Service (PDS))
    - Evidence of current enrollment must be provided.
    - Report must be reviewed within one hundred eighty (180) calendar days of the initial credentialing decision.
    - Evidence of review must be documented in the file or on checklist.

3) The Credentialing Specialist includes the OIG compliance NOW findings in the Provider file and date stamps their review, to ensure the findings were reviewed within one hundred eighty (180) calendar-days of the IEHP Subcommittee decision.

- If the Practitioner is new to the IEHP network, Credentialing will prepare the file as a Level II for the next scheduled IEHP Credentialing Subcommittee for review and decision.
- If the Practitioner is an existing Provider, the Credentialing Specialist will confirm if this licensure action was reviewed by IEHP Credentialing Subcommittee previously.
  - If so, the Credentialing Specialist will document in the Provider’s file when the Provider’s licensure actions were reviewed and discussed by the IEHP Credentialing Subcommittee.
5. CREDENTIALING AND REcredentialing

A. Credentialing Standards

3. Credentialing Verification

   o If not, the Credentialing Specialist will obtain prepare the Practitioner’s file as a Level II, for the next scheduled IEHP Credentialing Subcommittee meeting, for review and discussion.

2. Medicare and Medicaid sanctions. (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision). IEHP uses OIG Compliance Now, a sanction screening service to monitor its Provider network and ensures their Providers are reviewed for Medicare and Medicaid sanctions.

   a. During the credentialing or recredentialing process, the Credentialing Specialist or designee will submit the Provider to OIG Compliance Now for screening. The results are reviewed by the Credentialing Specialists and included in the Provider file.

      1) The document will identify when the Provider was screened, and if the Provider was identified on any of the ongoing monitoring of sanctions review required by IEHP, to include but is not limited to the HHS-OIG Exclusions List and/or Medi-Cal Suspended & Ineligible List.

         • If a Practitioner is not identified on any reports, the OIG Compliance Now findings are included in the Provider file and date stamped by the reviewer, to ensure that findings were reviewed within the one hundred eighty (180) calendar-day timeframe.

         • If a Practitioner is identified on the report for the HHS-OIG Exclusions List and/or Medi-Cal Suspended & Ineligible List, the Credentialing Specialist obtains and reviews the information.

   o Verification Sources for Medicare/Medicaid Sanctions:

      • OIG must be the verification source for Medicare sanctions, to ensure compliance with CMS.

         ▪ Date of query and staff initials must be evident on a checklist or the OIG page must be in the file.

      • The Medi-Cal Suspended and Ineligible list must be the verification source for Medicaid sanctions, to ensure compliance with DHCS.

         ▪ Date of query and staff initials must be evidence on a checklist, or the report page must be in the file.

      • NPDB

      • Federation of State Medical Boards (FSMB)

      • FEHB Program Department Record, published by the Office of Personnel Management, OIG.
5. CREDENTIALING AND RECREREDENTIALING

A. Credentialing Standards

3. Credentialing Verification

- List of Excluded Individuals and Entities (maintained by OIG).
- Medicare Exclusions Database.
- State Medicaid Agency or intermediary and the Medicare intermediary.
- Continuous Query (formerly Proactive Disclosure Service (PDS))

2) The OIG compliance Now findings are included in the Provider file and date stamped by the review, to ensure the findings were reviewed within one hundred eighty (180) calendar-days of the IEHP Subcommittee decision.

- If the Practitioner is new to the IEHP network, Credentialing will notify the Practitioner that their credentialing is closed due to IEHP not allowing Practitioners identified on the HHS-OIG Exclusions List and/or Medi-Cal Suspended & Ineligible List to participate in the IEHP network.

- If the Practitioner is an existing Provider, the Credentialing Specialist will send the Provider a notification to terminate due to IEHP not allowing Practitioners identified on the HHS-OIG Exclusions List and/or Medi-Cal Suspended & Ineligible List to participate in the IEHP network.

  o The Credentialing Specialist will prepare these documents for the Peer Review Subcommittee review and discussion for Providers identified through IEHPs ongoing monitoring of sanctions process for the HHS-OIG Exclusions List and/or Medi-Cal Suspended & Ineligible List review.

C. IEHP applications for credentialing and recredentialing must include the following:

1. Reasons for inability to perform the essential functions of the position.
2. Lack of present illegal drug use.
   a. IEHPs application may use alternative language or general language that may not be exclusive to present use or only illegal substances
3. History of loss of license and felony convictions
   a. At initial credentialing, the Practitioner must attest to any loss of license or felony convictions since their initial licensure.
   b. At recredentialing, the Practitioners may attest to any loss of licensure or felony convictions since their last credentialing cycle.
4. History of loss or limitation of privileges or disciplinary actions
   a. At initial credentialing, the Practitioner must attest to any loss or limitation of privileges since their initial licensure.
5. CREDENTIALING AND REcredentialing

A. Credentialing Standards

3. Credentialing Verification

b. At recredentialing, the Practitioners may attest to any loss or limitation of privileges since their last credentialing cycle.

5. Current malpractice insurance coverage. IEHP requires that a copy of the insurance face sheet or Certificate of Insurance (COI) or written verification from the insurance carrier directly be obtained in conjunction of collecting information on the application.

(VTL: Must be evidence that the Practitioner has current and adequate malpractice coverage prior to the Credentialing Committee date and remain valid and current throughout the Practitioner’s participation with IEHP).

a. All Practitioners must have current and adequate malpractice insurance coverage that is current and:

1) Meets IEHP’s standard of $1 million/$3 million, as well as IEHPs standards. Professional Liability Insurance coverage and amounts of coverage must be verified with the insurance carrier or through the Practitioner via a copy of the policy and the signed attestation completed by the Practitioner. The copy of the Practitioner’s certificate must be initialed, and date stamped to show receipt prior to the credentialing decision and to show it was effective at the time of the credentialing decision.

2) Must include coverage for the specialty the Practitioner is being credentialed for and for all locations the Practitioner will be treating IEHP patients.
   - If the specialty coverage and/or the locations are not identified on the malpractice insurance certificate, the coverage must be verified with the insurance carrier and documented in the Practitioner’s file.

3) For Practitioners with federal tort coverage, the Practitioner must submit a copy of the federal tort letter or an attestation from the Practitioner of federal tort coverage.

4) There must be evidence that the Practitioner has current and adequate malpractice coverage prior to the Credentialing Committee approval date.
   - Failure to maintain current malpractice coverage for the specialty the Provider is being credentialed for and for all locations the Practitioner will be treating IEHP patients, will result in an administrative termination of the Practitioner.

6. Current and signed attestation confirm the correctness and completeness of the application. Attestation must be:

a. Signed and dated within the timeframe and must include all elements to be compliant.

1) The one hundred eighty (180) calendar day timeframe is based on the date the Practitioner signed the application.
5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards
   3. Credentialing Verification

   - If the signature or attestation exceeds one hundred eighty (180) calendar days the Practitioner must only attest that the information on the application remains correct and complete, be re-signing and re-dating the attestation. Practitioner does not need to complete another application.

   b. Signed with a full signature, if the attestation needs to be re-signed by the Practitioner; dating and initialing is not acceptable.

   c. If the attestation is not signed and/or dated, within the appropriate time frame, all application elements are non-compliant (except current malpractice coverage since IEHP requires a face sheet is obtained).

      1) If a question is answered incorrectly, IEHP is responsible for notifying the Practitioner to have them review the question.

         - If the Provider chooses to change their response, the Provider may initial and date next to the change.

         - If the Provider chooses not to change their response, the IEHP will document their attempt to have the Practitioner review their response and that the provider chose not to change their response.

   d. When reviewing the CAQH application, IEHP must review attestation questions in addition to the form that contains the generated date and the last updated (attestation date).

      1) If the generated date on the form is older than 180 calendar date, but there is a current attestation date, the IEHP may accept the application.

D. IEHP must verify that Practitioners must have clinical privileges in good standing. Practitioner must indicate their current hospital affiliation or admitting privileges at a participating hospital. Verification that all clinical privileges are in good standing to perform functions for which the Practitioner is contracted, to include verification of admitting privileges, must be:

   1. Confirmed with the Hospital, in writing, via approved website or verbally, and must include:

      a. The date of appointment;

      b. Scope of privileges, restrictions (if any i.e. restricted, unrestricted) and recommendations.

      c. Confirmation Provider has admitting privileges in the specialty the Provider is credentialed and contracted for.

      d. If a published Hospital directory is used, the list must include the necessary information and be accompanied by a dated letter from the Hospital attesting that the Practitioner is in “good standing.”
5. CREDENTIALING AND RECredentialing

A. Credentialing Standards
   3. Credentialing Verification

   e. Practitioner must meet the requirements for Hospital Privileges as required by IEHP. (See Policy 5B, “Hospital Privileges”), i.e. if an admittor or hospitalist arrangement is used, a written agreement that meets IEHP admittor requirements, confirming coverage for all inpatient work covering the entire age range of the Practitioner must be included in the Practitioner’s credentialing file.

      1) These arrangements must be provided to IEHP for all Practitioners participating in the IEHP network, via Provider application, admittor report or attachment.

      2) If the Provider utilizes an admittor or hospitalist arrangement, IEHP will document these arrangements in the Provider file, to include when the Provider was notified. Documentation must include:

          • The date the Practitioner was notified
          • Name(s) of the admittor and/or hospitalist, admitting on behalf of the Provider
          • Name(s) of the Hospital, affiliated with the inpatient coverage arrangements

2. If the Practitioner does not have clinical privileges, the IEHP must have a written statement delineating the inpatient coverage arrangement documented in the Providers file. (See Policy 5B, “Hospital Privileges”).

3. Allied Health Professionals (Non-physicians i.e. Chiropractors, Optometrists) will not have hospital privileges and documentation in the file is not required for these types of Practitioners.

4. Mid-Level Practitioners (Physician Assistants (PA), Nurse Practitioners (NP), Nurse Midwives (NM)) may not have hospital privileges. However, if the Mid-Level provides IEHP their hospital privileges, IEHP will be responsible for verifying if those privileges are active and ensure they are in good standing.

5. Specialists (MDs, DOs and DPMs) may not have hospital privileges, documentation must be noted in the file as to the reason for not having privileges. (e.g. A note stating that they do not admit as they only see patients in an outpatient setting is sufficient).

   a. These arrangements must be provided to IEHP for all Practitioners participating in the IEHP network, via Provider application, admittor report or attachment.

      1) These arrangements are subject to IEHP review and approval.

      2) IEHP may request for inpatient coverage arrangements for the Practitioner, if IEHP identified that specialty as a specialty that requires hospital admitting arrangements.

6. Certified Nurse Midwives (CNMs) may provide care of mothers and newborns through the maternity cycle of pregnancy, labor, birth and delivery services only after they are
5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

3. Credentialing Verification

fully credentialed and approved by the same Provider network. CNM Providers must meet the following criteria:

a. In lieu of having full hospital delivery privileges, provide a written agreement with an OB Provider, that includes a protocol for identifying and transferring high risk Members, stated types of deliveries performed (i.e. low-risk, cesarean section etc.), must be available for consultations, as needed.

1) The Agreement must include back-up physician’s full delivery privileges at IEHP network hospital, in the same network as the CNM Provider.

2) The OB Provider must be credentialed and contracted within the same practice and network.

7. Family Practice including outpatient Obstetrics (OB) services (FP-1) Must provide a copy of a signed agreement that states:

a. Member transfers will take place within the first twenty-eight (28) weeks of gestation and a protocol for identifying and transferring high risk Members with a contracted and credentialed OB.

1) The OB must be contracted and credentialed by the same network as the Family Practice Provider and must hold admitting privileges to the IEHP hospital linked to IEHPs Direct Network.

8. Family Practice including full Obstetrics services and delivery (FP-2). Providers that fulfill these requirements may be referred to and see Ob/Gyn Members within IEHPs Direct Network, and must have:

a. Full delivery privileges at an IEHP network hospital; and

1) Provide a written agreement for an available OB back up Provider is required. The OB Provider must be credentialed, contracted and hold admitting privileges to the IEHP hospital linked with the Family Practice Provider; and

2) Provide a protocol for identifying and transferring high risk Members and stated types of deliveries performed (i.e. low-risk, cesarean section, etc.).

9. Obstetrics/Gynecology (OB/GYN) Providers who would like to participate as a Primary Care Physician only, will provide outpatient well woman services only with no hospital or surgical privileges, must provide the following information for consideration:

a. In lieu of obtaining or maintaining full hospital delivery privileges, the Practitioners must provide a written agreement with OB that includes:

1) A protocol for identifying and transferring high risk Members, stated types of deliveries performed (i.e. low-risk, cesarean section etc.);
5. CREDENTIALING AND RECredentialing

A. Credentialing Standards
   3. Credentialing Verification

   2) Must be available for consultations, as needed and that the OB will provide prenatal care after twenty-eight (28) weeks gestation including delivery.

   3) The agreement must include back-up physician’s full delivery privileges at IEHP network hospital, in the same network as the non-admitting OB Provider.

   • The OB Provider must be credentialed and contracted within the same network.

10. Urgent Care Providers are not required to maintain hospital privileges if they are exclusively practicing at an Urgent Care.

E. IEHP monitors its credentialing files to ensure that it only contracts with Practitioners who have not opted out. IEHP. IEHP uses OIG Compliance Now, a sanction screening service to monitor its Provider network and ensures their Providers are reviewed to ensure they have not opted out of Medicare.

1. During the credentialing or recredentialing process, the Credentialing Specialist or designee will submit the Provider to OIG Compliance Now for screening. The results are reviewed by the Credentialing Specialists and included in the Provider file.

   a. The document will identify when the Provider was screened, and if the Provider was identified on any of the ongoing monitoring of sanctions review required by IEHP, to include but is not limited to the Medicare Opt-Out Report.

   1) If a Practitioner is not identified on any reports, the OIG Compliance Now findings are included in the Provider file and date stamped by the reviewer, to ensure that findings were reviewed within the one hundred eighty (180) calendar-day timeframe.

   2) If a Practitioner is identified on the report for Medicare Opt-out, the Credentialing Specialist reviews the information via hard copies, electronic or one (1) of the CMS.gov Opt-Out sites. The OIG compliance Now findings are included in the Provider file and date stamped by the review, to ensure the findings were reviewed within 180 calendar-days of the IEHP Subcommittee decision.

   • The Credentialing Specialist will include these findings in the Provider’s file and prepare these documents for Credentialing Subcommittee review and discussion.

   • Certain healthcare Providers categories cannot opt-out of Medicare. These include Chiropractors, physical therapists and occupational therapists in independent practice.

F. IEHP includes information from the quality improvement activities and Member complaints in the recredentialing decision-making process. (Verification Time Limit: Last recredentialing cycle to present).
5. CREDENTIALING AND REcredentialING

A. Credentialing Standards
   3. Credentialing Verification

1. Quality activities include, but are not limited to:
   a. Adverse events
   b. Medical record review
   c. Data from Quality Improvement Activities
   d. Performance Information, may include but is not limited to:
      1) Utilization Management Data
      2) Enrollee satisfaction surveys
      3) Other activities of the organization
   e. Not all quality activities need to be present

2. Grievance/complaints

G. IEHP must ensure all Practitioners hold and maintain a valid and active National Provider Identifier (NPI) Practitioners individual NPI number, and the information provided must be:

   1. Verified through the NPPES website;
   2. Active while in the IEHP network;
   3. Current at all times (i.e. Primary Practice Address must be registered to an address within California).
   4. Practitioners that have a group NPI number may submit that information to IEHP, in addition to the mandatory individual NPI number.

H. All Primary Care Provider’s (PCP) and Urgent Care’s (UC) are informed that they must pass an on-site site review conducted by IEHP. (See Policy 6A, “Site Review and Medical Record Review Survey Requirements and Monitoring”). All PCPs and UCs must pass an IEHP facility on-site review at the time of initials credentialing and every three (3) years thereafter, for Medi-Cal Programs.

I. IEHP must obtain and provide IEHP with Social Security Numbers for all new and existing Practitioners participating Providers, to ensure all Practitioners are included in IEHP’s screening of the Social Security Administration’s Death Master File (SSADMF).

   1. All Provider applications for participation in the IEHP network, must include the Providers full Social Security Number (SSN).
      a. Submissions without SSN will be ceased and not processed by IEHP.
   2. Existing Providers without SSNs will be notified. Providers are required to provide all missing SSNs to IEHP.
      a. Providers who do not provide the requested information will be placed on a
5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

3. Credentialing Verification

Corrective Action Plan (CAP), until all missing SSNs are submitted.

3. If a Practitioner confirms that his/her SSN is correctly stated on the SSADMF, but is clearly not deceased, IEHP must request for:
   a. A copy of the Social Security Card;
   b. A photo ID;
   c. A signed attestation from the Practitioner confirming they are who they say they are; and
   d. The Provider to contact the Social Security Administration’s Death Master File (SSADMF) to correct the issue.

4. If a Practitioner’s SSN is correctly stated but the name and Date of Birth (DOB) does not, the IEHP must request for:
   a. A copy of the Social Security Card;
   b. A photo ID;
   c. A signed attestation from the Practitioner confirming they are who they say they are; and
   d. The Provider to contact the Social Security Administration’s Death Master File (SSADMF) to correct the issue.

J. IEHP uses OIG Compliance Now, a sanction screening service to monitor its Provider network and ensures their Providers are not included in the Centers of Medicare & Medicaid Services (CMS) Preclusions List.

1. During the credentialing or recredentialing process, the Credentialing Specialist or designee will submit the Provider to OIG Compliance Now for screening. The results are reviewed by the Credentialing Specialists and included in the Provider file.
   a. The document will identify when the Provider was screened, and if the Provider was identified on any of the ongoing monitoring of sanctions review required by IEHP, to include but is not limited to the Centers of Medicare and Medicaid Services (CMS) Preclusions List.

   1) If a Practitioner is not identified on any reports, the OIG Compliance Now findings are included in the Provider file and date stamped by the reviewer, to ensure that findings were reviewed within the 180 calendar-day timeframe.

   2) If a Practitioner is identified on the report for the (CMS) Preclusions List, the Credentialing Specialist reviews the information the (CMS) Preclusions List provided by IEHPs Compliance Department. The OIG compliance Now findings are included in the Provider file and date stamped by the review, to ensure the findings were reviewed within 180 calendar-days of the IEHP.
5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

3. Credentialing Verification

Subcommittee decision.

- If the Practitioner is new to the IEHP network, Credentialing will notify the Practitioner that their credentialing is closed due to IEHP not allowing Practitioners identified on the Centers of Medicaid and Medicaid Services (CMS) Preclusions List to participate in the IEHP network.

- If the Practitioner is an existing Provider, the Credentialing Specialist will send the Provider a notification to terminate due to IEHP not allowing Practitioners identified on the CMS Preclusions List to participate in the IEHP network.
  - The Credentialing Specialist will include these findings in the Provider’s file and prepare these documents for the Peer Review Subcommittee review and discussion for Providers identified through IEHP's ongoing monitoring of sanctions process for the CMS Preclusions List.

2. On a monthly basis, the Credentialing Specialist or designee will submit a file on the 5th day of each month, prepared by Health Care Informatics (HCI) containing a list of credentialed Providers to be screened by OIG Compliance Now. The results are reviewed by the Credentialing Specialists within thirty (30) days of release.

   a. If a Practitioner is identified on the screening list with a sanction or action, the Credentialing Specialist uses the monthly sanction tracking log as a reference to track the following information:
      1) Report Month & Year
      2) Publication Date
      3) Review Date
      4) Reviewer
      5) Name of Identified Provider
      6) Type of Sanction or action identified
      7) Tracking log is updated to reflect sanction information, by Credentialing Specialist.

   b. If there are no new Practitioners identified, the Credentialing Specialist notes are documented in the tracking log as “none reported” for the month.

K. IEHP must ensure all Practitioners are within the appropriate age range guidelines, as appropriate. Medicare DualChoice Member age ranges are ages 21 and above.

   1. Specialists Member age ranges are specific to the specialty involved, training, and
5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

3. Credentialing Verification

education of the physician.

2. Non-Physician Practitioners which include Nurse Practitioners (NPs), Physician Assistants (PAs), Certified Nurse Midwives (CNMs), Physical Therapists (PT), Occupational Therapists (OT), Speech/Language Therapists (S/LT), Opticians, Optometrists (OD), Chiropractors (DC), Dieticians and Nutritionists are as applicable to the training and certification of the non-physician Practitioner.

L. IEHP must obtain appropriate documentation to expand or limit their practice parameters for IEHP review and approval. Practitioners may practice outside of scope with approval from IEHP, by undergoing the Provide Privilege Adjustment process in this policy.

1. Primary Care Physicians age range expansions.

a. For PCP’s who have Pediatric age ranges assigned and would like to expand their age range to reflect all ages, will be processed with a secondary specialty of General Practice, must provide the following information for review and consideration:
   1) Provide documentation of primary care practice in the United States for the past five (5) years which includes a mix of pediatric and adult patients. (See Attachment, “IEHP Addendum E” in Section 5);
   2) Provide evidence of twenty-five (25) CME units in Adult Primary Care completed within the last three (3) years;
   3) Applicants must provide two (2) letters of recommendation from a physician coworker (i.e., Primary Care Providers with work experience associated with the applicant in the preceding twenty-four (24) months). The physician coworkers must hold an active board certification in Internal Medicine or Family Practice;
   4) PCPs that have Members assigned ages (0-14) must enroll in the Vaccines for Children (VFC) Program;
   5) Malpractice coverage for the age range Provider is requesting for that overs all locations the Provider will be treating IEHP Members; and
   6) Pass a Medical Record Chart Audit for Adult Members

2. Provider Privilege Adjustment. Practitioners who request a change in practice parameters (i.e. reduction of Member age range, additional specialty) must submit a detailed explanation that includes the following, for review and consideration:
   a. Practice site demographics;
   b. Practical experience relating to the request (years in clinical practice, direct care experience with the relevant membership, etc.);
5. CREDENTIALING AND RECREREDENTIALING

A. Credentialing Standards
   3. Credentialing Verification

   c. Practice capacity; and
   d. Relevant training in the specialty, if applicable (e.g. Continuing Medical Education (CME), Post-graduate training, etc.)

M. IEHP must ensure and obtain the appropriate documentation for all Mid-Level Practitioners (i.e. Physician Assistants (PAs), Nurse Practitioners (NPs), and Nurse Midwives (NMs)) between the Mid-Level and Supervising Physician, provide them to IEHP, and ensure these documents are readily available upon request. (See Policy 6F, “Facility Site Review – Non-Physician Practitioner Requirements”).

1. Physician Assistants (PAs) may act as an agent of the supervising physician in which they have an agreement. (See Attachment, “Delegation of Services Agreement and Supervising Physician Form”, in Section 5). Physician Assistants and Supervising Physicians must have the following documents current, in place, and readily available on-site subject for review:

   a. Delegation of Services Agreement and Supervising Physician Form. (See Attachment, “Delegation of Services Agreement and Supervising Physician Form” in Section 5), This agreement must define specific services identified in practice protocols or specifically authorized by the supervising physician, and

      1) Both the Physician and PA must attest to, date and sign the document;
      2) PAs must be practicing at a site assigned to their supervising physician;
      3) An original or copy must be readily accessible at all practice sites in which the PA works; and
      4) The agreement must be reviewed, dated and signed annually; and provided to IEHP, upon request.

      • The Delegation of Services Agreement authorizes a PA to provide or perform the following activities as long as there is documentation evidencing the activity was actually performed:

         o Physician examinations, including interscholastic athletic program examinations;
         o Order durable medical equipment (DME) and make arrangements with regard to home health services or personal care services, as applicable. For home health and/or personal care services, after consultation with the supervising physician, the PA may approve, sign, modify or add to the plan of treatment of care.
         o Routine visual screenings, which includes non-invasive, non-pharmacological, simple testing for visual acuity, visual field defects, color blindness and depth perception.
5. CREDENTIALING AND RECredentialing

A. Credentialing Standards
   3. Credentialing Verification

b. Nurse Practitioners (NPs) and Nurse Midwives (NMs) may perform the following procedures if a standardized procedure is in place:
   1) To diagnose mental and physical conditions, to use drugs in or upon human beings, to sever or penetrate the tissue of human beings and to use other methods in the treatment of diseases, injuries, deformities or other physical or mental conditions.
   2) Standardized Procedures must be on-site site specific and
      • Reference textbooks and other written sources to meet the requirements of Title 16, CCR § 1474 (3), must include:
         o Book (specify edition) or article title, page numbers and sections.
      • NP and/or NM must be practicing at a site assigned to their supervising physician; and
      • Standardized Procedures must be signed by both the Practitioner and the supervising physician, initially and annually; and provided to IEHP, upon request. At minimum, the Delegate must collect and submit to IEHP:
         o Table of Contents of the Standardized Procedures used, between the NP and/or CNM and supervising physician, that references the textbook or written sources to meet the requirements of the Board of Registered Nursing.
         o Evidence that the Standards of Care established by the sources were reviewed and authorized by the nurse Practitioner, physician and administrator in the practice setting (i.e. signature page that includes all parties involved)
      • Standardized Procedures written using the Physician Assistants Delegation of Services Agreement and Supervising Physician Form format and/or verbiage is not accepted by IEHP.

REFERENCES:

A. NCQA, 2019 HP Standard and Guidelines, Credentialing and Recredentialing (CR) 3.
B. Medicare Managed Care Manual, Chapter 6 § 60.3
C. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004 supersedes APL 17-019, “Provider Credentialing/Recredentialing and Screening/Enrollment”.
D. DMHC TAG - Quality Management
F. California Code of Regulations (CCR) 1379, 1399.540 and 1474.
5. CREDENTIALING AND RECREREDENTIALING

A. Credentialing Standards
   3. Credentialing Verification

G. Board of Registered Nursing, Title 16, California Code of Regulations (CCR) section 1474
H. Medical Board of California, Title 16, CCR Section 1379.
5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

4. Recredentialing Cycle Length

APPLIES TO:

A. This policy applies to all IEHP Medicare DualChoice Providers contracted under IEHPs Direct network.

POLICY:

A. IEHP is responsible for formally recredentialing its contracted Practitioners (i.e. Primary Care Physicians (PCPs), Non-Physician Practitioners, Specialists, and Admitting Physicians) at least every thirty-six (36) months from their last credentialing decision date.

PURPOSE:

A. IEHP conducts timely recredentialing.

PROCEDURES:

A. The length of the recredentialing cycle is within the required thirty-six (36) month time frame. The thirty-six (36) month recredentialing cycle begins on the date of the previous credentialing decision. The thirty-six (36) month cycle is counted to the month, not to the day.

All written and verbal communications regarding recredentialing applications are documented within the Credentialing database, by the person who made the attempt (i.e. Credentialing Specialist, Provider Services Representative etc.), to ensure all attempts are documented and readily available for those providers terminated due to non-compliance to recredentialing.

1. Four (4) months prior to the recredentialing due date, the Credentialing Department generates and sends out the recredentialing applications to the respective providers via email or fax to the Practitioners credentialing contact or Practitioner directly, for review and signature.

   a. The practitioner is provided a due date within fourteen (14) calendar days to return the completed recredentialing application to the Credentialing Department.

      1) If the practitioner does not submit the application within the designated timeframe, the Credentialing Specialist will make at least three (3) separate attempts to follow-up with the practitioner’s office. During this time, the Credentialing Specialist must obtain the following information:

         • Confirm the best contact for the recredentialing application
         • Best communication method (i.e. e-mail, fax, phone call etc.)
         • Confirmation of receipt of recredentialing application
         • Next follow-up date
         • Anticipated date of completion and submission to IEHP
5. CREDENTIALING AND REcredentialing

A. Credentialing Standards

4. Recredentialing Cycle Length

2. Three (3) months prior to the recredentialing due date, the Credentialing Department will notify the Provider Services and Contracts Department of the practitioners who have not submitted their recredentialing applications.

a. The Provider Services Representatives (PSRs) are responsible for at least three (3) separate attempts, via phone, email, and office visit, to follow up on the recredentialing application with the practitioner. During this time, the PSRs are responsible for:

1) Remind the Practitioner:
   - Their recredentialing application is past due;
   - If their application is not submitted to credentialing@iehp.org, by the 20th of the month prior their recredentialing application is due, their file will be recommended for termination due to non-compliance to recredentialing; and
   - After termination and the provider wants to continue participation in the IEHP Direct Network, the provider must undergo the initial credentialing process, regardless if the termination date was less than thirty (30) calendar days.

2) Obtain the next follow-up date and/or anticipated date of completion and submission to IEHP

3) Collecting and forwarding the recredentialing application to credentialing@iehp.org

3. Two (2) months prior to the recredentialing due date, the Credentialing Department will notify the Provider Services and Contacts Department of the Practitioners who have not submitted their recredentialing applications. During this time, the PSRs are responsible for:

a. Notifying the Contracts Managers (CMs) and Credentialing Specialists of their attempts to obtain the Provider’s recredentialing application.

b. If the recredentialing application is not received by the 20th of the month prior to the provider’s recredentialing due date, the PSRs will coordinate with the CMs, to send a request to terminate the practitioner due to non-compliance to recredentialing, with an effective date of the 1st of the following month, their recredentialing application is due.

1) The CMs are responsible for sending a request to terminate the respective practitioner(s) due to non-compliance to recredentialing, with an effective date of the 1st of the month following their recredentialing due date, to allow members at least thirty (30) days advance notice of their provider termination and ensure the practitioner does not see patients beyond their approved credentialing cycle.
5. CREDENTIALING AND RECRECREDENTIALING

A. Credentialing Standards

4. Recredentialing Cycle Length

2) The Credentialing Specialist will send the termination letter due to non-compliance to recredentialing, via FEDEX and include the respective CMs and PSRs.

4. If the recredentialing application is received after the termination letter is sent to the provider, the provider is notified by recipient that the provider was terminated due to non-compliance to recredentialing. If the provider would like to continue their participation with the IEHP network, the provider must undergo the initial credentialing process and submit their application to contracts@iehp.org to initiate the process.

B. IEHP may extend a practitioner’s recredentialing cycle time frame (beyond the thirty-six (36) months) if the Practitioner is:

1. On active military assignment
2. On medical leave (e.g. maternity leave)
3. On sabbatical

If the Credentialing Department is made aware of any of the reasons above, Credentialing must obtain written documentation from the Practitioner’s office that includes an anticipated date of return. The Credentialing Department must recredential the practitioner within sixty (60) calendar-days of the Practitioners return to practice.

Failure to meet the allocated time frame above, will result in the administrative termination of the Practitioner due to non-compliance to recredentialing.

C. If IEHP terminates a Practitioner for administrative reasons (e.g. the Practitioner failed to provide complete credentialing information) and not for quality reasons, IEHP may reinstate the Practitioner within thirty (30) calendar days of termination and is not required to perform initial credentialing. IEHP will consider and review these requests on a case by case basis.

IEHP must perform initial credentialing if reinstatement is more than thirty (30) days after termination.

REFERENCES:

A. NCQA, 2019 HP Standards and Guidelines, Credentialing and Recredentialing (CR) 4.
B. Medicare Managed Care Manual Chapter 6 – Relationships with Providers § 60.3.
5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

5. Ongoing Monitoring and Interventions

APPLIES TO:

A. This policy applies to all IEHP Medicare DualChoice Providers contracted under IEHPs Direct Network.

POLICY:

A. IEHP conducts ongoing monitoring of Practitioner sanctions, complaints and quality issues between recredentialing cycles and takes appropriate action against Practitioners when it identifies occurrences of poor quality, on a monthly basis.

B. IEHP maintains a documented process for monitoring whether network physicians have opted out of participating in the Medicare Program.

C. IEHP will verify that their contracted Providers have not been terminated as Medi-Cal Providers or have not been placed on the Suspended and Ineligible Provider List.

D. IEHP maintains a documented process for monitoring whether its Practitioners are included in the Centers for Medicare & Medicaid Services (CMS) Preclusions List, to ensure compliance with the 2019 Medicare Program Final Rule.

E. IEHP that subscribe to a sanctions alert service must have a documented process and evidence for the screening and notification process.

F. IEHP will notify the respective Delegates of any findings and the actions decided by the Credentialing Committee regarding the Practitioners identified through the ongoing monitoring of sanctions, complaints, and quality issues between recredentialing cycles.

G. IEHP verifies and ensures Practitioners maintain an active licensure status, Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate, etc., and remedies if the license or certification expires or status changes during the Practitioner’s participation with IEHP regardless of its outside the recredentialing cycle.

PURPOSE:

A. IEHP identifies and when appropriate, acts on important quality and safety issues in a timely manner during the interval between formal credentialing.

DEFINITION:

A. Adverse event – An injury that occurs while a Member is receiving healthcare service from a Practitioner.
5. CREDENTIALING AND RECRECREDENTIALING

A. Credentialing Standards

5. Ongoing Monitoring and Interventions

PROCEDURES:

A. IEHP utilizes OIG Compliance Now, as a contracted vendor to conduct the Ongoing Monitoring of Sanctions screenings for IEHP’s credentialed and contracted Practitioners. All reports will be reviewed within thirty (30) calendar days of its release. New findings are presented to the next scheduled Peer Review Subcommittee, for review and discussion.

1. On a monthly basis, the Credentialing Specialist(s) or designee will submit a file on the fifth (5th) of each month, prepared by Health Care Informatics (HCI) containing a list of credentialed Providers, to submit to OIG Compliance NOW for screening. The sanction screening services provides screening across various Federal and State agencies, to include those required by IEHP, as noted in this policy.

2. All reviews for Ongoing Monitoring of Sanctions are tracked in a Sanctions Log maintained by the Credentialing Department. This log will include the following information:
   a. Name of Institution or Agency issuing the Sanction
   b. Date Publication was released
   c. Date report was reviewed
   d. Providers identified
   e. Description of the Sanction or finding
   f. Name of person reviewing the report

3. All findings are referred to the following Departments and people and is included in the next scheduled Peer Review Subcommittee Meeting:
   a. IEHP Peer Review Chairperson/Medical Director
      1) Responsible for reviewing the sanction in preparation for the upcoming Peer Review Subcommittee discussion.
      2) Notifying the following Departments or people if additional information regarding the Provider, is needed or helpful prior or during the Peer Review Subcommittee meeting:
         • Credentialing, may include but is not limited to:
            o Licensure status
            o DEA status
            o Education and Training
            o Hospital Affiliations or arrangements
            o Practice Locations
5. CREDENTIALING AND REcredentialing

A. Credentialing Standards

5. Ongoing Monitoring and Interventions

- Mid-Level under his/her supervision (if applicable)
- Membership counts
- National Practitioner Data Bank history
- Malpractice Claim History
- Delegated IPA affiliations

- Quality Assurance Nurse
  - Facility Site Review/Medical Record Audit Status (if applicable)
  - Quality Improvement activities
  - Grievance History
  - Narcotics Audits (if needed, will work with Pharmacy to coordinate)

b. Deputy Chief Medical Officer
c. Chief Operating Officer
d. Director of Provider Services
e. Director of Quality Management
f. Director of Grievance and Appeals
g. Credentialing Manager
h. Credentialing Specialist

1) Responsible for the Peer Review Subcommittee packet compilation and coordination with the Provider Services Administrative Assistant for Distribution to the Peer Review Subcommittee.
i. Quality Assurance Nurse

1) Responsible for collecting Quality Improvement activities, grievance history and summarizing licensure and/or action findings for the Peer Review Subcommittee committee packet.

4. The Peer Review Subcommittee meets the 4th Wednesday of every other month and reviews the all Practitioners identified on through the Ongoing Monitoring of Sanctions Process, Practitioners escalated from the Medical Director(s) for PQIs, Practitioners escalated from the Grievance Trend Committee, and any new Provider(s) requesting for participation through one (1) or more of our Delegated IPA networks with adverse history. The Peer Review Subcommittee will review each of the Providers and give thoughtful consideration to the information collected and presented for review. The Peer Review Subcommittee obtains meaningful advice from participating practitioners during their decision process. All discussions and actions will be documented in the Peer Review Subcommittee.
5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

5. Ongoing Monitoring and Interventions

Subcommittee meeting minutes and will be reviewed and approved at the following Peer Review Subcommittee.

5. IEHP will provide evidence of ongoing monitoring and appropriate interventions by:

a. IEHP ensures OIG Compliance Now collects and reviews information from the following sources for Medicare and Medicaid sanctions.

1) List of Excluded Individuals and Entities (maintained by OIG) as the verification source for Medicare Sanctions, and review the report on a monthly basis, within thirty (30) days of its release.

2) If a Practitioner is identified, the Credentialing Specialist will review the OIG Exclusions Report and confirm the findings.

- Practitioners identified on the HHS-Office of Inspector General (OIG) Exclusions Report will be administratively terminated for all lines of business, without appeal rights due to IEHP prohibiting employment of contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation.
  - Members will be reassigned to new Practitioners.
  - The Provider will be presented to Peer Review Subcommittee as an administrative termination, for further review and discussion. Peer Review Subcommittee discussion will include Quality Management (QM) and Grievance Department findings to include any additional prior quality of care issues and Member complaints for the Provider.

6. IEHP ensures OIG Compliance Now collects and reviews information BreEZe Online Services or directly from the licensing Board via phone, email or mail, for reviewing sanctions or limitations on licensure. The verifications must be verified through:

a. Physicians.

1) Medical Board of California (M.D.)

- Subscription for email notifications of accusations, licensure suspensions, restrictions, or surrenders, distributed by the Medical Board of California.

2) Osteopathic Medical Board of California (D.O.)

- Distribution list from J. Corey Sparks, Lead Enforcement Analyst, Corey.Sparks@dca.ca.gov Phone: (916) 925-8393 Fax: (916) 928-8392.

b. Chiropractors.

1) California Board of Chiropractic Examiners (D.C.)

c. Oral Surgeons.
5. CREDENTIALING AND REcredentialing

A. Credentialing Standards

5. Ongoing Monitoring and Interventions

1) Dental Board of California (D.D.S., D.M.D.)

d. Podiatrists

1) Board of Podiatric Medicine (D.P.M.)

e. Nonphysician healthcare Practitioners.

1) Board of Behavioral Sciences (L.M.F.T., L.C.S.W., M.F.C.C)

- Subscriber list to obtain enforcement actions.

2) Board of Psychology (Ph.D., Psy.D.)

- Subscriber list to obtain enforcement actions.

3) California Board of Occupational Therapy (O.T.)

- Monthly Hot Sheet List of disciplinary actions via email to Enfpгр.Enfprg@dca.ca.gov.

4) California State Board of Optometry (O.D.)

5) Physical Therapy Board of California (P.T.)

6) Physician Assistant Committee (P.A., P.A.-C)

7) California Board of Registered Nursing (C.N.M., N.P.)

8) Speech-Language Pathology & Audiology Board (S.P., Au)

9) Acupuncture Board (L.Ac.)

3. IEHPs Grievance and Appeals Department is responsible for collecting and reviewing complaints and will:

a. Investigate Practitioner-specific Member complaints upon their receipt and evaluates the Practitioner’s history of complaints, if applicable.

b. Evaluates the history of complaints for all Practitioner’s history of complaints at least every six (6) months.

c. Quality or collecting and reviewing complaints received by Delegates must be forwarded to IEHP, since they are not delegated for these activities.

d. Policy and evidence may be found in the Grievance and Appeals Department.

4. IEHPs Quality Management Department is responsible for collecting and reviewing information from identified adverse events and will:

a. Monitoring for adverse events occurs every six (6) months.

b. Quality/collection and reviewing adverse events received by Delegates must be forwarded to IEHP, since they are not delegated for these activities.
5. CREDENTIALING AND RECREREDENTIALING

A. Credentialing Standards

5. Ongoing Monitoring and Interventions

c. Policy and evidence may be found in the Quality Department

5. IEHP will implement appropriate interventions when it identifies instances of poor quality related for factors 1-4 may be found in the Quality Management, Grievance and Appeals, and/or Credentialing Department and documented in the Peer Review Subcommittee minutes. This process will determine if there is evidence of poor quality that could affect the health and safety of its Members and implement the appropriate policy based on action/intervention.

a. At minimum, Providers identified through ongoing monitoring for licensure actions, sanctions, adverse history, grievances and/or complaints, must be fully discussed and reviewed by the Peer Review Subcommittee. The reason for review must be considered and documented in the meeting minutes.

1) Interventions can be identified in one of the following:
   - Committee minutes
   - Practitioner files
   - Delegate file binders

B. IEHP ensures and monitors whether network physicians have opted out of participating in the Medicare Program through the Ongoing Monitoring process with OIG Compliance Now, and ensures they are conducting their screenings for Medicare Opt Out, using one of the CMS.gov Opt-Out sites.

1. IEHP must review the Opt-Out Report from one of the CMS.gov sites most current list available and within thirty (30) calendar days of its release.

   Certain healthcare Providers categories cannot opt-out of Medicare. These include Chiropractors, physical therapists and occupational therapists in independent practice.

a. If a Practitioner is identified on the report for Medicare Opt-out, the Credentialing Specialist reviews the information via hard copies, electronic or one (1) of the CMS.gov Opt-Out sites, to confirm the finding.

1) Practitioners identified on the Medicare Opt Out Report will be administratively terminated for Medicare lines of business. IEHP does not allow Providers who have opted out of Medicare to participate in the IEHP network for Medicare lines of business.

   - Members will be reassigned to new Practitioners.

2) The Credentialing Specialist will include these findings in the Provider’s file and prepare these documents for Peer Review Subcommittee as an administrative termination, for further review an discussion. Peer Review Subcommittee discussion will include Quality Management (QM) and Grievance and Appeals Department findings to include any additional prior
5. CREDENTIALING AND RE CREDENTIALING

A. Credentialing Standards
5. Ongoing Monitoring and Interventions

quality of care issues and Member complaints for the Provider.

C. IEHP ensures OIG Compliance Now collects and reviews the Medi-Cal Suspended and Ineligible List, published monthly by the Department of Health Care Services (DHCS), as the verification source for Medicaid Sanctions. Delegate must review the Suspended & Ineligible List on a monthly basis, within thirty (30) days of its release.

1. If a Practitioner is identified, the Credentialing Specialist will review the Medi-Cal Suspended and Ineligible List and confirm the findings.
   a. Providers identified on the Medi-Cal Suspended and Ineligible List will be automatically terminated for all lines of business, without appeal rights.
      1) All Members assigned to the suspended Practitioner will be reassigned to new Practitioners.
      2) The Suspended Practitioner will be presented to the Peer Review Subcommittee as an administrative termination and for further review and discussion. Peer Review Subcommittee discussion will include Quality Management (QM) and Grievance and Appeals Department findings to include any additional prior quality of care issues and Member complaints for the Provider.

D. IEHP ensures OIG Compliance Now screens whether IEHP’s Practitioners are included in the Centers for Medicare & Medicaid Services (CMS) Preclusions List, to ensure compliance with the 2019 Medicare Program Final Rule. In order for Providers (including entities) to receive payment from Medicare Plan (Part C and D), they must not be included in the Centers for Medicare & Medicaid Services (CMS) Preclusions List.

1. If a Practitioner is identified, the Credentialing Specialist will review the Centers for Medicare & Medicaid Services (CMS) Preclusions List and confirm the findings.
   a. Providers identified on the Centers for Medicare & Medicaid Services (CMS) Preclusions List will be automatically terminated for all lines of business, without appeal rights.
      1) All Members assigned to suspended Practitioners will be reassigned to new Practitioners.
      2) The Practitioner will be presented to the Peer Review Subcommittee as an administrative termination and for further review and discussion. Peer Review Subcommittee discussion will include Quality Management (QM) and Grievance and Appeals Department findings to include any additional prior quality of care issues and Member complaints for the Provider.

E. IEHP uses an outside company or sanctions alert service, OIG Compliance Now, for the ongoing monitoring or data collection and alert services, IEHP will ensure to:

1. Have evidence of its subscription to the sanctions alert service during the look back
A. Credentialing Standards

5. Ongoing Monitoring and Interventions

period.

2. On a monthly basis, the Credentialing Specialist(s) or designee will submit a file on the fifth (5th) of each month, prepared by Health Care Informatics (HCI) containing a list of credentialed Providers, to submit to OIG Compliance NOW for screening. The sanction screening services provides screening across various Federal and State agencies, to include those required by IEHP, as noted in this policy.

3. List of sanctions screened by the outside company can be made available upon request to IEHPs Compliance Department, through an attachment or contract with OIG Compliance Now.

4. OIG Compliance Now will notify IEHP of their findings via email to Credentscreening@iehp.org and cc’s Compliancescreening@iehp.org.

5. Upon receipt, the Credentialing Specialist will review the report within thirty (30) calendar days of their notification.
   a. If no reports were received for ongoing monitoring IEHP will document or note that no reports were received during the monthly look-back period.

F. IEHP is responsible for notifying the Practitioner’s respective Delegated networks of any findings and the actions decided by the Peer Review Subcommittee Committee within thirty (30) days of the decision, to include, but not limited to:

1. Date(s) of the Credentialing Committee the Practitioner was reviewed;
2. Date of the Credentialing Committee decision;
3. IEHPs Plan of action for the Practitioner;
4. Frequency of monitoring (if applicable); and
5. Any follow-ups scheduled
   a. All Practitioners identified through the ongoing monitoring will be presented to IEHP’s Peer Review Subcommittee for review and decision.
      1) IEHP reserves the right to approve, deny, terminate or otherwise limit Practitioner participation in the IEHP network for any reason including up to quality issues.
         • If a Provider is denied participation due to quality of care and an 805 was filed with the appropriate licensing agency and the National Practitioner Data Bank (NPDB) than the Provider is not eligible to reapply.
            o For administrative terminations or denials, he/she may reapply after one (1) year.
5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

5. Ongoing Monitoring and Interventions

- Practitioners can appeal adverse decisions by the IEHP Peer Review Subcommittee as delineated in IEHP’s Peer Review Process and Level I Review and Level II Appeal (See Attachments, “IEHP Peer Review Process and Level I Review” and “IEHP Peer Review Process and Level II Appeal” in Section 5).

G. On a monthly basis, IEHP will run a report of all licensures and DEA’s that have or will expire within thirty (30) days.

1. For all licensures, IEHP will verify the Practitioner’s licensure with the appropriate licensing agency and ensure that the practitioners’ licensure is valid and current.

   a. For all Practitioners whose licensures are not valid and current, IEHP will send a notification to the Provider terminating the practitioner administratively, for all lines of business, for not having a current and valid license to practice.

      1) The letter notification will:

         • Include a cc: to the Practitioners affiliated networks
         • A termination effective date, which will take effect the day after the licensure was no longer valid.
         • A current copy of the licensure verification as an enclosure

      2) All Members assigned to the Practitioner will be reassigned to other Practitioners.

      3) The Practitioner will be presented to the Peer Review Subcommittee as an administrative termination and for further review and discussion. Peer Review Subcommittee discussion will include Quality Management (QM) and Grievance and Appeals Department findings to include any additional prior quality of care issues and Member complaints for the Provider.

2. For all Practitioners with expired DEA certificates, IEHP will verify the DEA certificate through the DEA Number website, to ensure the Practitioners DEA certificate is valid and current.

   a. For all DEA certificates that are no longer valid, the Credentialing Specialist will reach out to the Practitioners office to obtain the Practitioners:

      b. New DEA Number

      c. The Practitioners prescribing arrangements until the Practitioner obtains a new DEA

      d. Written explanation for the Practitioner not having a DEA, which will be presented to the Peer Review Subcommittee for review and discussion.

      1) The Practitioner will be presented to the Peer Review Subcommittee for his/her
5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

5. Ongoing Monitoring and Interventions

DEA prescribing arrangements for further review and discussion. Peer Review Subcommittee discussion will include Quality Management (QM) and Grievance and Appeals Department findings to include any additional prior quality of care issues and Member complaints for the Provider.

3. Practitioners are responsible for notifying IEHP of any licensure and DEA changes within thirty (30) days of the change. The notification must include:
   a. Date the Practitioner was aware
   b. Type of change
   c. Effective date of the change

REFERENCES:

A. NCQA, 2019 HP Standards and Guidelines, Credentialing (CR) 5.
B. Medicare Managed Care Manual, Chapter 6 § 60.3
C. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004 supersedes APL 17-019, “Provider Credentialing/Recredentialing and Screening/Enrollment”.

INLAND EMPIRE HEALTH PLAN

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IEHP Provider Policy and Procedure Manual 01/20
Medicare DualChoice MA_05A5
Page 10 of 10
5. CREDENTIALING AND RECredentialing

A. Credentialing Standards

6. Notification to Authorities and Practitioner Appeal Rights

APPLIES TO:

A. This policy applies to all IEHP Medicare DualChoice providers.

POLICY:

A. IEHP must review participation of Practitioners whose conduct could adversely affect members’ health or welfare, specify the range of actions that may be taken to improve practitioner performance before termination, how the IEHP reports its actions to the appropriate authorities and makes the appeal process known to Practitioners.

A Practitioner’s status or participation in the IEHP network may be denied, reduced, suspended, or terminated for any lawful reason, including but not limited to, a lapse in basic qualifications such as licensure, insurance, or required medical staff privileges or admission coverage at an IEHP contracted Hospital; or a determination by IEHP based on information obtained during the credentialing process that the Practitioner cannot be relied upon to deliver the quality or efficiency of Member care required by IEHP.

B. IEHPs policies and procedures regarding suspension or termination of a participating Physician requires IEHP to ensure that the majority of the hearing panel members are peers of the affected physician.

PURPOSE:

A. If IEHP has taken action against a Practitioner for quality reasons reports the action to the appropriate authorities and offers the Practitioner a formal appeal process.

B. IEHP must use objective evidence and patient-care considerations when deciding on a course of action for dealing with a Practitioner who does not meet its quality standards.

C. If IEHP terminates or suspends a Practitioner for quality reasons, it must report to the appropriate authorities, including state licensing agencies, the National Practitioner Data Bank (NPDB), and Inland Empire Health Plan (IEHP).

D. Notification applies to Physicians and nonphysicians for suspensions and terminations for quality reasons.

E. IEHP must provide evidence that it followed its appeal process if it altered the conditions of a Practitioner’s participation based on quality of care or service reasons.

F. Practitioners must appeal directly to their contracted IPA for adverse credentialing decisions rendered by the Delegated IPA.

G. Reporting to Appropriate authorities is not applicable in the following circumstances:
5. Credentialing and Recredentialing

A. Credentialing Standards

6. Notification to Authorities and Practitioner Appeal Rights

1. If there are no instances of suspension, termination, restriction or revocation to report for quality reasons.

2. For automatic administrative terminations based on the Practitioners not meeting specific contractual obligations for participation in the network.

H. All credentialing records and proceeds are confidential and protected to the fullest extent allowed by Section 1157 of the California Evidence Code, and any other applicable law.

DEFINITION:

A. “Peer” is an appropriately trained and licensed Physician in a practice similar to that of the affected physician.

B. “Licentiate” means a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage family therapist, clinical social worker, professional clinical counselor, dentist, licensed midwife, or physicians assistant. Licentiate also includes a person authorized to practice medicine pursuant to California Code, Business and Professions Code Section 2113 or 2168.

C. “Agency” meets the relevant state licensing agency having regulatory jurisdiction over the licentiates.

1. The Medical Board of California is the agency for the following practitioner types:
   a. Physicians and Surgeons (MDs)
   b. Doctors of Podiatric Medicine (DPMs)
   c. Licensed Midwives (LMs)
   d. Physician Assistants (PAs)

D. “Staff privileges” means any arrangements under which a licentiate is allowed to practice in or provide care for patients in a health facility. Those arrangements shall include, but are not limited to, full staff privileges, active staff privileges, limited staff privileges, auxiliary staff privileges, provisional staff privileges, temporary staff privileges, courtesy staff privileges, locum tenens arrangements, and contractual arrangements to provide professional services, including, but not limited to, arrangements to provide outpatient services.

E. “Denial or termination of staff privileges, membership, or employment” includes failure or refusal to renew a contract or to renew, extend or reestablish any staff privileges, if the action is based on medical disciplinary cause or reason.

F. “Medical disciplinary cause or reason” means that aspect of a licentiate’s competence or professional conduct that is reasonably likely to be detrimental to the patient’s safety or to the delivery of patient care.
5. CREDENTIALING AND RECREREDENTIALING

A. Credentialing Standards

6. Notification to Authorities and Practitioner Appeal Rights

PROCEDURES:

A. IEHP must review participation of Practitioners whose conduct could adversely affect Members’ health or welfare, specify the range of actions that may be taken to improve Practitioner performance before termination, how the IEHP reports its actions to the appropriate authorities and makes the appeal process known to Practitioners.

A Practitioner’s status or participation in the IEHP network may be denied, reduced, suspended, or terminated for any lawful reason, including but not limited to, a lapse in basic qualifications such as licensure, insurance, or required medical staff privileges or admission coverage at an IEHP contracted Hospital; or a determination by IEHP based on information obtained during the credentialing process that the Practitioner cannot be relied upon to deliver the quality or efficiency of Member care required by IEHP. The IEHP Committee’s involved for these reviews, include but are not limited to, IEHPs Credentialing Subcommittee and IEHPs Peer Review Subcommittee.

IEHPs Credentialing Subcommittee is responsible for reviewing, approving and denying practitioners who are directly contracting with IEHP’s Direct network, as appointed by IEHPs Quality Management Committee.

IEHPs Peer Review Subcommittee is responsible for forming review member, Practitioner or Provider grievances and/or appeals, Practitioner-related quality of care and service issues, including Facility Site and Medical Record Reviews, Sanctioning and Provider appeals for adverse credentialing decisions. Other Peer Review matters such as Retrospective Practitioner Quality Reviews referred by the Grievance and Appeal Review Committee (GARC), may be reviewed and discussed, as directed by the IEHP Medical Director(s), IEHP Chief Medical Officer (CMO), and IEHPs Deputy Chief Medical Director. The Peer Review Subcommittee also performs the oversight of the credentialing activities of Delegates and that are delineated responsibilities for credentialing.

1. The range of actions available to IEHP, that they may take to improve the Practitioner performance before termination, to include, but not limited to:
   a. Profiling
   b. Corrective actions(s)
   c. Monitoring
   d. Medical Record Audit

2. Practitioners have the right to appeal any adverse credentialing decision that impacts their participation status with IEHP, in accordance with the appeals procedures provided herein. IEHP will:
   a. Provide written notification when a professional review action has been brought
5. CREDENTIALING AND REcredentialing

A. Credentialing Standards

6. Notification to Authorities and Practitioner Appeal Rights

against a Practitioner, including reasons for the action.

b. Allow Practitioners thirty (30) calendar days to request a hearing/appeal.

c. IEHP cannot have an attorney, if the practitioner does not have attorney representation, to ensure compliance with CA Business & Professions Code 809.3(c).

3. Practitioner Appeal Process. IEHP informs the affected Practitioner of its appeal process and includes the following information in the process and notification.

a. IEHP provides written notification, by FedEx delivery, return receipt requested, to any Practitioner denied participation within thirty (30) calendar days of the decision reached by the IEHP Subcommittee (Peer Review or Credentialing). The written notice will indicate the following:

1) A professional review action has been brought against the Practitioner

2) Reason(s) for the action may include a brief description of the factual basis for the proposed action that includes but is not limited to

- A lapse in basic qualifications such as licensure, insurance, or required medical staff privileges;
- A determination that the Practitioner cannot be relied upon to deliver the quality or efficiency of patient care desired by IEHP;
- A determination that the Practitioner cannot be relied upon to follow IEHP’s clinical or business guidelines or directives;
- Falsification of information provided to IEHP;
- Adverse malpractice history;
- Adverse events that have potential for or have caused injury or negative impact to Members; and/or
- Felony convictions.

3) A summary of the appeal rights and process is provided in the provider manual and is included as an enclosure with the credentialing decision letter. (See Attachment, “IEHP Peer Review Level I and Credentialing Appeal” in Section 5).

4) A statement that the Practitioner may request for an IEHP Peer Review Level I Appeal and Credentialing Appeal, conducted by the IEHP Subcommittee (Credentialing or Peer Review) who denied participation, is included in the decision letter, in accordance with this policy.

5) The Practitioner is notified that a request for an IEHP Peer Review Level I Appeal
5. CREDENTIALING AND REcredentialING

A. Credentialing Standards

6. Notification to Authorities and Practitioner Appeal Rights

and Credentialing Appeal, must be requested by the Practitioner in writing, addressed to the IEHP Committee Chairperson or Medical Director designee.

6) The practitioner is notified that the practitioner’s request for an IEHP Peer Review Level I Appeal and Credentialing Appeal, must be received within thirty (30) days of the date of receipt of the notice, by the Practitioner. The Practitioner’s written request must include:

- A clearly written explanation of the reason for the request; and
- A request to exercise the right to present the appeal orally, if so desired per below.

7) A summary of the Practitioner’s Rights at the appeal include the right to:

- Present additional written material for review by the IEHP Subcommittee (Peer Review or Credentialing);
- Present any information orally to the IEHP Subcommittee (Peer Review or Credentialing);
- Notification that the IEHP Peer Review Level I and Credentialing Appeal meeting takes place before the IEHP Peer Review or Credentialing Subcommittee.

   o The IEHP Peer Review Level I and Credentialing Appeal meeting is not a hearing and procedural rights associated with the formal peer review hearings do not apply for adverse credentialing decisions.

   ▪ At the IEHP Peer Review Level I and Credentialing Appeal meeting, Practitioners may not be represented by a licensed attorney; however, they have a right to be represented by a non-attorney representative of their choice.

8) Practitioners not requesting an appeal within the required timeframe and as specified above, waives his or her right to further appeals, and the decision of the IEHP Subcommittee is final.

- The decision will be adopted as the final action; and
- The action, if implemented, IEHP will report the final decision to the IEHP Governing Board, appropriate state licensing agency, and National Practitioner Data Bank, as required under the California Business and Professions Code subsection 805 and 45 of Federal Regulations, Part 60.

9) If an appeal is submitted in a timely manner, IEHP arranges for a review of the appeal to be conducted at the next scheduled meeting of the IEHP Subcommittee.
CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

6. Notification to Authorities and Practitioner Appeal Rights

(Peer Review or Credentialing) who made the decision to deny.

- Prior to the meeting, IEHP sends a written notice to the Practitioner to the Practitioner via FedEx, informing the Practitioner of the date, time and place of the meeting.

b. The IEHP Subcommittee (Peer Review or Credentialing) meets to complete its evaluation and renders a decision to uphold or overturn the denial, the Practitioner is provided written notification of the appeal decision, that contains specific reasons for the decision, in writing within thirty (30) calendar days of the decision.

1) If the appeal decision by the IEHP Subcommittee (Peer Review or Credentialing) is to overturn the original denial of the Practitioner’s participation in the IEHP network, the Practitioner is notified in writing within thirty (30) calendar days of the decision.

2) If the appeal decision by the IEHP Subcommittee (Peer Review or Credentialing) is to uphold the original denial of the Practitioner’s participation in the IEHP network, the Practitioner is notified in writing within thirty (30) calendar days of the decision. The written notice will include:

- The decision, including a brief description of the decision and the reasons for it;
- A statement that the Practitioner may request for an IEHP Peer Review Process and Level II Appeal, in accordance to this policy.
- A provided a copy of the IEHP Peer Review Process and Level II Appeal (See Attachment, “IEHP Peer Review Process and Level II Appeal” in Section 5);
- The practitioner is notified that a request for an IEHP Peer Review Process and Level II Appeal, must be requested by the Practitioner in writing, addressed to the IEHP Committee Chairperson or Medical Director designee.
- The Practitioner is notified that the Practitioner’s request for an IEHP Peer Review Process and Level II Appeal, must be received within thirty (30) days of the date of receipt of the notice.
- At the hearing, the Practitioner can be represented by an attorney or another person of the Practitioner’s choice. IEHP cannot have attorney, if the practitioner does not have attorney representation.

c. Practitioners not requesting an appeal within the required timeframe and as specified above, waives his or her right to further appeals, and/or the decision of the IEHP Subcommittee is final.
5. CREDENTIALING AND RECRECREDENTIALING

A. Credentialing Standards

6. Notification to Authorities and Practitioner Appeal Rights

1) The decision will be adopted as the final action; and

2) The action, if implemented, IEHP will report the final decision to the IEHP Governing Board, appropriate state licensing agency, and National Practitioner Data Bank, as required under the California Business and Professions Code subsection 805 and 45 of Federal Regulations, Part 60.

4. IEHP complies with the reporting requirements of the Medical Board of California, the Dental Board of California, the Osteopathic Medical Board of California, the Board of Podiatric Medicine, the California Board of Behavioral Sciences, the Board of Psychology, and the Physician Assistant Board, and other licensing agencies, and National Practitioners Data Bank (NPDB) as required by law. IEHP also complies with the reporting requirements of the California Business and Professions Code and the Federal Health Care Quality Improvement Act regarding adverse credentialing actions. Practitioners are notified of the report and its contents in accordance with law.

a. 805 Reports.

1) IEHP is not required to file a separate report with respect to action attributable to the same medical disciplinary cause or reason.

- If the Medical Board of California or a licensing agency of another state revokes or suspends, without a stay, the license of a Physician and Surgeon, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension.

- If the California Board of Podiatric Medicine or a licensing agency of another state revokes or suspends, without a stay, the license of a doctor of podiatric medicine, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension.

2) If an 805 is reported, it shall include the following information:

- The name of the licentiate involved;
- The license number of the licentiate involved;
- A description of the facts and circumstances of the medical disciplinary cause or reason;
- Any other relevant information deemed appropriate by the reporter.

3) IEHP must file an 805 report with the relevant agency within fifteen (15) days after the effective date on which any of the following occur as a result of an action of a peer review body:

- A licentiate’s application for staff privileges or membership is denied or
5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

6. Notification to Authorities and Practitioner Appeal Rights

rejected for medical disciplinary cause or reason.

- A licentiate’s membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason.

- Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of thirty (30) days or more for any twelve (12) month period, for a medical disciplinary cause or reason.

4) If a licentiate takes any action listed above, after receiving notice of a pending investigation initiated for a medical disciplinary cause or reason or after receiving notice that his or her application for membership or staff privileges is denied or will be denied for a medical disciplinary cause or reason, the chief of a staff or a medical or professional staff or other Chief Executive Officer, Medical Director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic where the licentiate is employed or has staff privileges or membership or where the licentiate applied for staff privileges or membership, or sought the renewal thereof, shall file an 805 report with the relevant agency within fifteen (15) days after the licentiate takes the action.

- Resigns or takes a leave of absence from membership, staff privileges or employment.

- Withdraws or abandons his or her application for staff privileges or membership.

- Withdraws or abandons his or her request for renewal of staff privileges or membership.

b. 805.01 Reports

1) IEHP must file an 805.01 within fifteen (15) days after a peer review body makes a final decision or recommendation of termination, suspension or restriction of staff privileges, membership or employment due to an investigation, for at least one (1) of the following reasons:

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

- The use of, or prescribing for or administering to him/herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, or any other persons, or the public, or to the extent
that such use impairs the ability of the licentiate to practice safely.

- Repeated acts of clearly excessive prescribing, furnishing or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefor.

- Sexual misconduct with one (1) or more patients during a course of treatment or an examination.

c. National Practitioner Data Bank (NPDB)
   1) Reports must be submitted to the NPDB within thirty (30) days of the action.

d. Health Plan Reporting
   1) Reports must be submitted to IEHP's Credentialing Manager, within thirty (30) days of the action.

B. IEHP's policies and procedures regarding suspension or termination of a participating Physician requires IEHP to ensure that the majority of the hearing panel members are peers of the affected Physician.

1. A Peer is an appropriately trained and licensed Physician in a practice similar to that of the affected Physician.

2. Panel members do not have to possess identical specialty training.

3. Policies and procedures do not always have to state the word “majority”, but at least 51% of the members must be peers.

REFERENCES:

A. NCQA, 2019 HP Standards and Guidelines, Credentialing and Recredentialing (CR) 6.

B. California Code, Business and Professions Code § 805, 805.01, 809.3(c).

C. Medicare Managed Care Manual, Chapter 6 § 60.4

D. California Evidence Code § 1157.
5. CREDENTIALING AND REcredentialing

A. Credentialing Standards

7. Assessment of Organizational Providers

APPLIES TO:

A. This policy applies to all organizational providers contracted for Medicare DualChoice of business with IEHP’s Direct Network.

POLICY:

A. IEHP has written policies and procedures for the initial and ongoing assessment of Providers with whom the plan contracts.

B. IEHP is responsible for the initial and on-going assessment of subcontracted Providers that render services to Members and IEHP is responsible for claims payment for those Health Care Delivery Organization Providers. IEHP retains oversight responsibilities for all subcontracted Providers.

C. IEHP includes in its assessment, but is not limited to: Hospitals, Home Health Agencies, Skilled Nursing Facilities, Free-Standing Surgical Centers, Behavioral Health Providers, Hospice, Clinical Laboratories, Comprehensive Outpatient Rehabilitation Facilities, Outpatient Physical Therapy Providers, Outpatient Speech Pathology Providers, Providers of End-stage Renal Disease Services (Dialysis), Outpatient Diabetics Self-Management Training providers, Portable X-Ray Supplier, Rural Health Clinics and Federally Qualified Health Centers (FQHC).

D. IEHP is responsible for the initial and ongoing assessment of behavioral healthcare facilities, providing mental health or substance abuse services in an inpatient setting. Residential Treatment Facilities and Ambulatory Behavioral Health Facilities are not covered by this policy as these are not a covered IEHP benefit.

E. IEHP must assess contracted medical health care providers, organizational providers, against the requirements and within the time frame.

F. IEHP assesses contracted behavioral healthcare providers against the requirements and within time frame.

PURPOSE:

A. IEHP evaluates the quality of organizational Providers with whom the plan contracts.

B. All Providers must adhere to all procedural and reporting requirements under state and federal laws and comply with the most recent NCQA, state and regulatory guidelines for subcontracted organizational Providers, as well as IEHP requirements.

C. IEHP audits organizations who are delegated the credentialing activities for the Assessment of Organizational Providers to ensure compliance with IEHP requirements on an annual basis,
5. CREDENTIALING AND RECRECREDENTIALING

A. Credentialing Standards

7. Assessment of Organizational Providers


D. IEHP reserves the right to perform facility site audits when quality of care issues arise and to deny contracted or subcontracted Providers participation in the IEHP network if IEHP requirements for participation are not met.

E. Contracted and/or subcontracted Provider’s failure to meet IEHP’s requirements may result in adverse action up to and including non-renewal or termination of the delegated entity contract or IEHP contract.

F. Contracting must notify IEHP’s Compliance Department by emailing compliance@iehp.org or fax (909) 477-8536 or via Compliance Hotline (866) 355-9038 within five (5) business days of discovering any of our Providers have been added to disciplinary or exclusionary lists.

PROCEDURES:

A. All Organizational Providers directly contracted with IEHP must meet the following requirements before IEHP contracts with a provider, and at least every thirty-six (36) months thereafter, it:

1. The following sources are used to confirm that providers are in good standing with state and federal requirements, that include, but are not limited to:

   a. State (Department of Health Care Services) regulatory body

      1) A copy of the license and expiration date.

      2) A current and unencumbered license; must also be appropriately licensed and no other negative license actions that may impact participation

      3) Physician-owned clinics are not required to be licensed by DHCS, but they must be accredited by an agency approved by the Medical Board. (If the physician-owned clinic is appropriately accredited, they would be compliant of the Knox-Keene Act of Title 28.)

      4) If a state license is not issued by the Department of Health Care Services, the facility should have a business license or certificate of occupancy.

      5) Licensure must be maintained throughout the duration of the subcontractors’ participation in the IEHP network.

   b. Federal Regulatory Bodies

      1) Review of OIG or Medicare/Medicaid Sanctions must be completed and documented on the spreadsheet or the file.
5. CREDENTIALING AND RECredentialing

A. Credentialing Standards

7. Assessment of Organizational Providers

- The monthly review of the OIG report as part of the “Ongoing Monitoring” qualifies as compliant for this section if the facilities are included on the OIG Report.
  - IEHP prohibits employment or contracting with practitioners (or entities that employ or contract with such practitioners) that are excluded/sanctioned from participation (practitioners or entities found on OIG Reports). A Provider is considered excluded, sanctioned, or ineligible, if the Provider is named by the appropriate State or Federal departments or agencies on exclusionary lists, including but not limited to the following: The Department of Health & Human Services (DHHS) Office of Inspector General (OIG) List of Excluded Individuals and Entities List (LEIE), General Services Administration (GSA) Excluded Parties Lists System (EPLS), CMS Preclusions List, California Department of Health Care Services (DHCS) Medi-Cal Suspended and Ineligible List, and California Department of Public Health (CDPH) Medi-Cal certification as applicable. IEHP reserves the right to terminate the contract for cause, with appropriate notice as defined in the IEHP Agreement.

  2) Must have no sanctions that may impact participation
  3) CMS signed participating agreement letter, if applicable.
  4) An attestation from a Provider to the organization regarding the provider’s regulatory status is not acceptable.

b. IEHP expects the Health Care Delivery Organizational Providers to maintain accreditation and license status in good standing and/or current at all times during participation in the IEHP network.

  1) The Health Care Delivery Organization Provider is responsible for providing IEHP with renewals of its license and accreditations within sixty (60) days following the expiration of the license and accreditation.

  2. IEHP accepts an accreditation report or a letter from the regulatory and accrediting bodies regarding the status of the provider as evidence that the provider has been reviewed and approved by an accrediting body.

  Accreditation and licensure must be maintained throughout the duration of the subcontractors’ participation in the IEHP network.

  a. The following are acceptable accrediting bodies by IEHP:
     1) Accreditation Association for Ambulatory Health Care (AAAHC)
     2) Accreditation Commission for Health Care Inc (ACHC)
5. CRE CREDENTIALING AND RECRE DENTIALING

A. Credentialing Standards

7. Assessment of Organizational Providers

3) American Association for Accreditation for Ambulatory Surgical Facilities (AAAASF)
4) American Association of Diabetes educators (AADE)
5) Clinical Laboratory Association Improvement (CLIA) Certificate or CLIA Waiver
6) College of American Pathology (CAP)
7) Commission for the Accreditation of Birth Centers (CABC)
8) Commission on Accreditation or Rehabilitation Facilities (CARF)
9) Commission on Office Laboratory Accreditation (COLA)
10) Continuing Care Accreditation Commission (CCAC)
11) Center for Improvement in Healthcare Quality (CIHQ)
12) Council on Accreditation (COA)
13) Community Health Accreditation Program (CHAP)
14) Det Norske Veritas National Integrated Accreditation of Healthcare Organization (DNVNIAC)
15) Federal Drug Administration (FDA) Certification
16) Healthcare Facilities Accreditation Program (HFAP) As of October 2015, the Healthcare Facilities Accreditation Program (HFAP) is no longer owned by the AOA, it is now managed by the Accredited Association for Ambulatory Healthcare Care, Inc. (AAAHC)
17) Indian Health Service (IHS)
18) The Institute for Medical Quality’s (IMQ’s) (CMS approved accrediting body verified by IEHP)
19) The Joint Commission (TJC)
20) An attestation from a provider to the organization regarding the providers regulatory status is not acceptable.

b. IEHP recognizes the following accreditations by Organizational Provider type:

1) Hospitals
   • The Joint Commission (TJC)
   • Healthcare Facilities Accreditation Program (HFAP) As of October 2015, the Healthcare Facilities Accreditation Program (HFAP) is no longer owned
5. CREDENTIALING AND RECRE CREDENTIALING

A. Credentialing Standards

7. Assessment of Organizational Providers

by the AOA, it is now managed by the Accredited Association for Ambulatory Health Care, Inc. (AAAHC)

- Det Norske Veritas National Integrated Accreditation of Healthcare Organization (DNVNIAHO)
- Center for Improvement in Healthcare Quality (CIHQ)

2) Home Health Agencies

- The Joint Commission (TJC)
- Community Health Accreditation Program (CHAP)
- Accreditation Commission for Health Care Inc (ACHC)

3) Skilled Nursing Facilities

- The Joint Commission (TJC)
- Commission on Accreditation or Rehabilitation Facilities (CARF)
- Continuing Care Accreditation Commission (CCAC)

4) Free-Standing Surgical Centers

- The Joint Commission (TJC)
- American Association for Accreditation for Ambulatory Surgical Facilities (AAAASF)
- Accreditation Association for Ambulatory Health Care (AAAHC)
- Healthcare Facilities Accreditation Program (HFAP) As of October 2015, the Healthcare Facilities Accreditation Program (HFAP) is no longer owned by the AOA, it is now managed by the Accredited Association for Ambulatory Health Care, Inc. (AAAHC)
- The Institute for Medical Quality’s (IMQ’s) (CMS approved accrediting body verified by IEHP)

5) Behavioral Health Providers (Intensive Programs and Inpatient Treatment Programs)

- The Joint Commission (TJC)
- Commission on Accreditation or Rehabilitation Facilities (CARF)
- Healthcare Facilities Accreditation Program (HFAP)
- Council on Accreditation (COA)

6) Hospice
5. CREDENTIALING AND RECredentialing

A. Credentialing Standards

7. Assessment of Organizational Providers

- The Joint Commission (TJC)
- Community Health Accreditation Program (CHAP)
- Accreditation Commission for Healthcare INC (ACHC) (CMS approved accrediting body verified by IEHP)

7) Clinical Laboratories

- The Joint Commission (TJC)
- Clinical Laboratory Association Improvement (CLIA) Certificate or CLIA Waiver
- Commission on Office Laboratory Accreditation (COLA)
- College of American Pathology (CAP)

8) Comprehensive Outpatient Rehabilitation Facilities

- The Joint Commission (TJC)
- Commission on Accreditation or Rehabilitation Facilities (CARF)

9) Outpatient Physical Therapy Providers

- American Association for Accreditation of Ambulatory Surgical Services (AAAASF)
- If no Accreditation, must be certified by Medicare (Must have Medicare Part A)

10) Outpatient Speech Pathology Providers

- American Association for Accreditation of Ambulatory Surgical Services (AAAASF)
- If no Accreditation, must be certified by Medicare (Must have Medicare Part A)

11) Providers of End-stage Renal Disease Services (Dialysis)

- The Joint Commission (TJC)
- If no Accreditation, must be certified by Medicare

12) Birth Centers

- Commission for the Accreditation of Birth Centers (CABC)

13) Congregate Living Health Facility

- The Joint Commission (TJC)
5. CREDENTIALING AND RECREREDENTIALING

A. Credentialing Standards

7. Assessment of Organizational Providers

14) Outpatient diabetes self-management training Providers
   - American Association of Diabetes educators (AADE)
   - Indian Health Service (IHS)

15) Portable X-Ray Supplier
   - Federal Drug Administration (FDA) Certification

16) Rural Health Clinics
   - The Joint Commission (TJC)
   - American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF)
   - If no Accreditation, must be certified by Medicare

17) Federally Qualified Health Centers
   - The Joint Commission (TJC)
   - If no Accreditation, must be certified by Medicare

3. Must conduct an onsite quality assessment if the Provider is not accredited. Policy must include:
   a. Onsite quality assessment criteria for each type of Provider.
   b. A process ensuring that the Providers credential their Practitioners.
   c. A CMS or state quality review in lieu of a site visit under the following circumstances (if IEHP chooses to substitute the site visit with a CMS or state quality review), if it meets the following requirements:
      1) The CMS or state review is no more than three (3) years old.
         - If the CMS or state review is older than three (3) years, IEHP’s Quality Management (QM) will assess the provider by conducting its own onsite quality review and present their findings for review and approval to the Credentialing Subcommittee.
      2) IEHP obtains a survey report or letter from CMS or the state, from either the provider or the agency, stating that the facility was reviewed and passed inspection.
         - The report meets IEHP’s quality assessment criteria or standards.
      3) IEHP is not required to conduct a site visit if the state or CMS has not conducted a site review of the provider and the provider is in a rural area, as defined by the U.S. Census Bureau.
5. CREDENTIALING AND RECRECREDENTIALING

A. Credentialing Standards

7. Assessment of Organizational Providers

B. The following organizational Providers types are contracted and IEHP is responsible for claims payment, therefore these Providers require an assessment, including, but not limited to:

1. Hospitals
2. Home Health Agencies
3. Skilled Nursing Facilities
4. Free-Standing Surgical Centers
5. Clinical Laboratories
6. Hospice
7. Comprehensive Outpatient Rehabilitation Facilities
8. Outpatient Physical Therapy Providers
9. Outpatient Speech Pathology Providers
10. Providers of End-stage Renal Disease Services (Dialysis)
11. Outpatient Diabetics Self-Management Training providers
12. Portable X-Ray Supplier
13. Rural Health Clinics
14. Federally Qualified Health Centers

C. IEHP’s delegation arrangements with Delegates, “carves out” behavioral healthcare services, therefore, IEHP is responsible for the initial and ongoing assessment for behavioral healthcare facilities providing mental health or substance abuse services in the following settings:

1. Inpatient

Behavioral Healthcare Facilities providing mental health or substances abuse services in Residential and Ambulatory settings are not covered as an IEHP benefit, therefore IEHP is not responsible for the initial and ongoing assessment.

D. IEHP must assess contracted medical health care providers, organizational providers, against the requirements and within the time frame. IEHP uses:

1. A comprehensive spreadsheet or log showing credentialing of Medical organizational providers, to calculate compliance and completion of the File Review.
2. IEHP has a tracking mechanism for ensuring that expirables and tri-annual reviews are compliant.

E. IEHP assesses contracted behavioral healthcare providers against the requirements and within time frame.
5. CREDENTIALING AND REcredentialing

A. Credentialing Standards

7. Assessment of Organizational Providers

1. IEHP use a comprehensive spreadsheet or log showing credentialing of Medical organizational providers, to calculate compliance and completion of the File Review.

F. If during the contract period, Contracting becomes aware of a change in the accreditation and/or CMS Site Survey, license, certification status, sanctions, fraudulent activity or other legal or remedial actions have been taken against any Provider, Contracting must:

1. Notify IEHP’s Compliance Department by emailing compliance@iehp.org or fax (909) 477-8536 or via Compliance Hotline (866) 355-9038 within five (5) days business of discovering any of our Providers have been added to disciplinary or exclusionary lists.

2. The Director of Provider Contracting informs the Provider in writing that it is in violation of its contract with IEHP and begins the cure process. Depending on the seriousness of the offense, IEHP:

   a. Reserves the right to temporarily suspend or terminate the contract for cause, with appropriate notice as defined in the IEHP Provider Agreement.

   b. May report the termination of the contract to regulatory agencies as per contractual requirements. Any services provided after the date of exclusion shall not be reimbursable or may be subject to recoupment.

REFERENCE:

A. NCQA, 2019 HP Standards and Guidelines, Credentialing and Recredentialing (CR) 7.
B. Medicare Managed Care Manual, Chapter 6 § 70.
C. Medi-Cal Law, Welfare and Institutions Code (W&I Code), § 14043.6 and 14123.
D. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004 supersedes APL 17-019, “Provider Credentialing/Recredentialing and Screening/Enrollment”.
E. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-022 Supersedes APL 16-017 and APL 15-017, “Provision of Certified Midwife and Alternative Birth Center Facility Services.”
F. Knox-Keene Act of Title 28

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IEHP Provider Policy and Procedure Manual 01/20
Medicare DualChoice

MA_05A7
Page 9 of 9
5. CREDENTIALING AND RECRECREDENTIALING

A. Credentialing Standards

8. Delegation of Credentialing

APPLIES TO:

A. This policy applies to all IEHP delegated relationships for the DualChoice Cal MediConnect Plan (Medicare – Medicaid) line of business.

POLICY:

A. IEHP ensures there is a delegation agreement in place for all delegation arrangements in place.
B. For new delegation agreements initiated, IEHP will evaluate the delegates capacity to meet National Committee for Quality Assurance (NCQA), state and regulatory requirements before delegation began.
C. For delegation arrangements in effect for 12 months or longer, IEHP will conduct oversight reviews of the Delegate’s Credentialing Activities.
D. If there are any opportunities for improvement identified during the review of delegated credentialing activities, IEHP will identify, notify and follow-up with the Delegate to ensure the opportunities have been addressed.

PURPOSE:

A. IEHP delegates credentialing activities to outside entities and remains responsible for credentialing and recredentialing its practitioners, even if it delegates all or part of these activities.
B. If the Delegated entities subdelegate their credentialing activities, IEHP will review the Delegates’ oversight process over their subdelegates.
C. IEHP verifies that Delegates perform the functions discussed in the Section 25 of the Provider Manual and what is outlined in the Delegation Agreement between IEHP and the Delegate.
D. IEHP reserves the right to rescind delegation of credentialing activities based on the outcome of monitoring activities or as determined by IEHP.
E. Within two (2) working days advanced notice to the Delegate, IEHP and any regulatory oversight agency has the right to examine the Delegates credentialing/recredentialing files or sites as needed to perform oversight of all Practitioners or to respond to a complaint or grievance.

DEFINITION:

A. Implementation Date: NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date.
B. IEHP does not accept accredited Health Plan audits for pre-delegation audit evaluations for
5. CREDENTIALING AND RECREREDENTIALING

A. Credentialing Standards

8. Delegation of Credentialing

delegation arrangements between IEHP and Delegated IPAs.

C. If a Management Services Organization (MSO) and a Delegated IPA are owned or under the same ownership, this is not considered delegation.

D. If an organization gives another organization the authority to perform certain functions on its behalf, this is considered delegation (e.g. Primary Source Verifications, collection of the application, etc.).

E. Ongoing monitoring or data collection and alert services are NOT seen as delegation. If the organization uses another organization for collecting data for ongoing monitoring or sanction monitoring and the organization then handles the review of information and intervention, it is not considered delegation.

F. If the information is gathered from a company website and the organization is pulling the queries for the Office of the Inspector General (OIG) or other types of queries, it is NOT considered delegation.

G. NCQA defines “annual” for this section as “a 12-month period, with a 2-month grace period”.

H. Delegate: If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.

1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered subdelegation, and the organization would be considered a subdelegate. The Delegate will be responsible for subdelegation oversight.
   a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.
   b. If information is gathered from a company website and the Delegate staff is pulling the queries for OIG or other types of queries, it is NOT considered delegation.

PROCEDURES:

A. IEHP will review all delegation agreements in place for all delegation and sub-delegation arrangements in place. The delegation agreement describes all delegated credentialing activities. The written delegation arrangement must ensure:

1. Delegation activities are mutually agreed upon before delegation begins, are in a dated, binding document or communication between IEHP and the delegated entity. There must be evidence that the document was agreed to by both IEHP and the delegate before the delegate began performing delegated activities. Evidence of the mutually agreed-upon document shall include:
5. CREDENTIALING AND RECREREDENTIALING

A. Credentialing Standards

8. Delegation of Credentialing

a. A signature and a date on an agreement, but it may also be found in a letter, meeting minutes or other form of communication.

b. The responsibilities of the organization and its delegates in terms specific to their relationship. At minimum, the document must state which entity (IEHP, the delegate or both) is responsible for the following tasks:

   1) Accepting applications and attestation;
   2) Collecting all data elements from NCQA approved sources;
   3) Collecting and evaluating ongoing monitoring and complaint information; and
   4) Making credentialing decisions.

c. To ensure that a consistent and equitable process is used throughout its network, the organization’s credentialing and recredentialing policies require a delegated entity to adhere to at least the same criteria as IEHP.

2. The written arrangement must be in a delegation agreement or an addendum thereto or other binding communication between IEHP and the Delegate. If the Delegate subdelegates an activity, the delegation agreement must specify which organization is responsible for the oversight of the subdelegate the credentialing activities and which credentialing activities are:

   a. Performed by the delegate, in detailed language.
   b. Not delegated but retained by the organization.

3. IEHP requires Delegates to submit credentialing activity reports even if the Delegate is accredited at least quarterly. Reports may include, but are not limited to:

   a. Lists of credentialed and recredentialed practitioners.
   b. Committee meeting minutes.
   c. Facilities credentialed.

4. The written arrangement describes IEHP’s process for monitoring and evaluating the Delegates performance.

5. IEHP reserves the right to approve, suspend, deny, terminate or otherwise limit individual Practitioners, Providers and sites’ participation in the IEHP network for any reason, including up to quality issues.

   a. If a Provider is denied participation due to quality of care and an 805 was filed with the appropriate licensing agency and the National Practitioner Data Bank (NPDB), then the Provider is not eligible to reapply.

   b. Administrative terminations or denials, he/she may reapply after one (1) year.

6. The delegation agreement specifies consequences if a Delegate fails to meet the terms of
5. CREDENTIALING AND RECRECREDENTIALING

A. Credentialing Standards

8. Delegation of Credentialing

the agreement and, at a minimum, circumstances that result in revocation of the agreement. The Delegate must comply with the remedies available to the Delegate if the it does not fulfill its obligations, as specified in policy 25D3, “Quality Management - Corrective Action Plan Requirements”.

B. For new delegation agreements initiated, delegation arrangements in effect within twelve (12) months of implementation, IEHP will evaluate the Delegates capacity to meet NCQA, state and regulatory requirements before delegation begins.

1. IEHP’s Pre-Delegation evaluation evaluates the delegate’s capacity to meet NCQA, state and federal regulatory requirements within twelve (12) months prior to implementing delegation. IEHP will conduct a Pre-Delegation evaluation under the following circumstances:

a. If the time between the pre-delegation evaluation and implementation exceeds twelve (12) months, IEHP must conduct another pre-delegation evaluation.

b. If IEHP amends the delegation agreement to include additional credentialing activities, IEHP must perform a pre-delegation evaluation for the additional activities.

c. If the Delegate changes Management Services Organizations (MSOs), IEHP must evaluate the new MSO prior to contracting.

d. MSO contracted with multiple Delegated IPAs process. When conducting the file review for multiple Delegated IPAs who are serviced by the same MSO, IEHP must determine whether all Delegated IPAs use the same Credentialing Committee.

1) If an MSO is contracted with multiple Delegated IPAs, has one set of policies and procedures and all the Delegated IPAs use the same Credentialing Committee, then IEHP will pull one file sample across all contracted Delegated IPAs and apply the same score for CR 3 (CR C3 & CR R3) and CR 4 for each Delegated IPA.

2) If the Delegated IPAs share the same committee, but have different organizational providers or different delegation agreements, a separate audit must be conducted.

3) If the MSO is contracted with multiple Delegated IPAs, has one set of policies and the Delegate has separate Credentialing Committee, IEHP will pull one file sample for each Delegate.

e. Delegated IPAs combining Credentialing Committee within the annual audit period.

1) If a Delegated IPA merges their credentialing committee with another at any time during the annual audit period, a separate file pull and audit must be conducted for the Delegated IPA. The Delegated IPA will be audited for the combined committee and will have one audit at the next annual audit.
5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

8. Delegation of Credentialing

f. New MSO.

1) If a Delegate has changed management companies and the files from the Delegated IPA were forwarded to the new MSO, the files may undergo recredentialing when appropriate.

2) If a Delegate has changed management companies and the files were NOT submitted to the new MSO, the practitioners must be initially credentialed by the new MSO within six (6) months of acquiring the Delegated IPA.

g. Delegated IPA purchased by another Delegated IPA.

1) If a Delegated IPA purchases another Delegated IPA and obtains the credentials files, they can continue with the current recredentialing process.

2. IEHP’s systematic method for conducting pre-delegation evaluations, especially if more than one (1) delegation is in effect, (See attachment, “Delegation Oversight Audit Preparation Instructions” in Section 25) includes the types of documents to be available at the time of the audit and standard forms to be completed and returned to IEHP prior to the audit. The audit can be conducted on-site or as a desk-top audit.

a. File Selection for Pre-Delegation Audits, the IEHP auditor will:

1) Obtain a spreadsheet of all credentialed practitioners from the Delegate and then select thirty (30) initial and thirty (30) recredentialing files for the specified audit time period, using the NCQA 8/30 file methodology. When using the 8/30 NCQA file methodology, IEHP uses the following method:

- After reviewing eight (8) files, if any of those eight (8) files are non-applicable for that element (e.g. Drug Enforcement Administration (DEA)), the IEHP auditor will review additional files to have a total denominator of eight (8).

- After reviewing eight (8) files, if one (1) or more of the elements are non-compliant, the IEHP auditor will review the remaining files for the element’s that are non-compliant. If the Delegated IPA has not initially credentialed or recredentialed at least thirty (30) files, IEHP will note that the file pull was exhausted.

b. If the organization is NCQA CR Accredited or Certified, IEHP must obtain a copy of the certification to ensure the delegate is certified to perform the activity being delegated by the organization.

1) The following are not part of the NCQA Certification/Accreditation review and are not eligible for automatic credit and must be reviewed as part of the delegation oversight process. Delegate must submit copies of the following policies and procedures and other non-file elements.
5. CREDENTIALING AND REcredentialing

A. Credentialing Standards

8. Delegation of Credentialing

- CR 1.A. – Practitioner Credentialing Guidelines. The Delegate specifies:
  - The types of Practitioners it credentials and recredentials.
  - The verification sources it uses.
  - The criteria for credentialing and recredentialing.
  - The process for making credentialing and recredentialing decisions.
  - The process for managing credentialing files that meet the organization’s established criteria.
  - The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner.
  - The process for notifying if information obtained during the organization’s credentialing process varies substantially from the information they provided to the organization.
  - The process for notifying Practitioners the credentialing and recredentialing decision within sixty (60) calendar days of the Committee’s decision.
  - The Medical Director or other designated Physician’s direct responsibility and participation in the credentialing program.
  - The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.

- CR 1.B. – Practitioner Rights. The Delegate specifies practitioners about their right to:
  - Review information submitted to support their credentialing application.
  - Correct erroneous information (submitted by another source).
  - Receive the status of their credentialing and recredentialing application, upon request.

- CR 1.C. – Performance Monitoring for Recredentialing (Centers for Medicare and Medicaid Services [CMS]/ Department of Health Care Services [DHCS])


- CR 1.E. – Medicare Exclusions/Sanction Policy (CMS/DHCS)

- CR 5.B. – Monitoring Medicare Opt-Out Reports (CMS)
5. CREDENTIALING AND REcredentialing

A. Credentialing Standards

8. Delegation of Credentialing

- CR 5.C. – Monitoring Medi-Cal Suspended and Ineligible Provider Reports (DHCS)
- CR 6.A. – Actions Against Practitioners
- CR 6.B. – Fair Hearing Panel Composition
- CR 7.A. – Assessment of Organizational Providers
  - Review and approval of Providers.
  - Medical Providers included in Delegates assessment.
  - Assessing Medical Providers.
  - Accreditation/Certification of Free-Standing Surgical Centers (FSSC)
- CR 8.A. – Delegation of Credentialing
  - Written Delegation Agreement.
  - Review of Delegate’s Credentialing activities, as applicable.
  - Opportunities for Improvement.
- CR 9.C. – Distribution of Findings (DMHC/DHCS)

2) Delegate submits the following information for File Review. Additional files will be requested if there is a deficiency or additional elements are required for the review.

INITIAL CREDENTIALING. Initial credentialing is only for those practitioners who are initiating a contracted with the Delegate. A recredentialing file that was placed into the initial credentialing file pull due to being out of recredentialing timeframe limit will not be included in the initial credentialing files. It must be included in the universe of recredentialing files. If the provider was terminated and the break in service was for more than thirty (30) days, and was initially credentialed, the file will be audited as an initial credentialing file.

- CR C3.A.2. – A valid DEA/CDS certificate (CMS)
  - Verification conducted within one hundred eighty (180) calendar days of Credentialing Committee decision.
- CR C3.A.5. – Work History (CMS)
5. CREDENTIALING AND RECREREDENTIALING

A. Credentialing Standards

8. Delegation of Credentialing

- Verification conducted within one hundred eighty (180) calendar days of Credentialing Committee decision.

- CR C3.B.3. – Medicare and Medicaid Sanctions (CMS/DHCS)
  - OIG must be the verification source. Date of query and staff initials must evident on checklist or report must be in file.

- CR C3.B.4. – Medi-Cal Sanction (DHCS)
  - Medi-Cal Suspended and Ineligible List must be the verification source. Date of query and staff initials must evident on checklist or report must be in file.

- CR C3.C.1-6. – Application and Attestation (CMS)
  - Verification of questions completed, and attestation signed within one hundred eighty (180) calendar days of Credentialing Committee decision.

- CR C3.D. – Hospital Admitting Privileges (CMS/DHCS)
  - Send Documentation of coverage. Verification of admitting privileges required by IEHP.

- CR C3.E. – Medicare Opt-Out review (CMS)
  - Evidence reviewed via checklist or other documentation that indicates review of information from the most recent CMS.gov Opt-Out sites.

RECREREDENTIALING. This applies to practitioners who have undergone initial credentialing and are due for recredentialing, thirty-six (36) months thereafter, at minimum. The thirty-six (36) months recredentialing cycle begins on the date of the previous credentialing decision.

- CR R3.A.2. – A valid DEA/CDS certificate (CMS)
  - Verification conducted within one hundred eighty (180) calendar days of Credentialing Committee decision.

- CR R3.B.3. – Medicare and Medicaid Sanctions (CMS/DHCS)
  - OIG must be the verification source. Date of query and staff initials must evident on checklist or report must be in file.

- CR R3.B.4. – Medi-Cal Sanction (DHCS)
  - Medi-Cal Suspended and Ineligible List must be the verification source. Date of query and staff initials must evident on checklist or report must be in file.
5. CREDENTIALING AND RECRECREDENTIALING

A. Credentialing Standards

8. Delegation of Credentialing

- CR R3.C.1-6. – Application and Attestation (CMS)
  - Verification of questions completed, and attestation signed within one hundred eighty (180) calendar days of Credentialing Committee decision.

- CR R3.D. – Hospital Admitting Privileges (CMS/DHCS)
  - Send Documentation of coverage. Verification of admitting privileges required by IEHP.

- CR R3.E. – Medicare Opt-Out review (CMS)
  - Evidence reviewed via checklist or other documentation that indicates review of information from the most recent CMS.gov Opt-Out sites.

  - Must include Quality Improvement (QI) Activities and Grievance/Complaints, via checklist, reports, form/sheet detailing the Delegate’s findings.

C. For delegation arrangements in effect for twelve (12) months or longer, IEHP will annually evaluate Delegates, including a review of policies and procedures and the documented process that ensure the Delegate’s:

1. Credentialing Committee or organization staff reviews the Delegate’s credentialing policies and procedures. At a minimum, IEHP will reviews the sections of the policies and procedures that apply to the delegated functions.
   a. Credentialing Committee of the Delegates’ staff annually reviews their subdelegate’s credentialing policies and procedures, e.g. audit tool, audit correspondence, audit summary documentation, committee meeting minutes, and email approval noted in their database or other methods.
   b. IEHP does not accept accredited Health Plan audits for annual delegation audit for delegation arrangements between IEHP and Delegated IPAs. IEHP will review for evidence that IEHP’s health plan audit was reviewed, e.g. audit tool, audit correspondence, committee minutes, email approval noted in their database or other methods indicating acceptance of review.
   c. If the Delegate subdelegates credentialing, IEHP will review the Delegates oversight for the credentialing and recredentialing files against NCQA, state and regulatory standards. IEHP bases its annual audit on the responsibilities of the Delegate described in the delegation agreement and provider manual that includes all the appropriate NCQA, state and regulatory standards.

2. The organization uses one of the following methods to audit the files:
5. CREDENTIALING AND REcredentialing

A. Credentialing Standards

8. Delegation of Credentialing

a. File Selection for Pre-Delegation Audits, the IEHP auditor will:

1) Generate a pull list from IEHP’s Network Development Data Base (NDDB) that includes a list of all credentialed and recredentialed providers submitted and added to the IEHP network by IPA, based on the look-back period. Then select thirty (30) initial and thirty (30) recredentialing files for the specified audit time period, using the NCQA 8/30 file methodology. When using the 8/30 NCQA file methodology, IEHP uses the following method:

- After reviewing eight (8) files if any of those eight (8) files are non-applicable for that element (e.g. DEA), the IEHP auditor will review additional files to have a total denominator of eight (8).

- After reviewing eight (8) files if one or more of the elements are non-compliant, review remaining files for the element’s that are non-compliant. If the Delegated IPA has not initially credentialled or recredentialled at least thirty (30) files, IEHP will note that the file pull was exhausted.

2) Obtain a spreadsheet or file of ten (10) initial and ten (10) recredential files from the Delegate. Additional files will be requested if there is a deficiency within the first eight (8) elements or additional elements are required for the review.

3. IEHP annually evaluates the Delegates performance against NCQA standards for delegated activities.

a. The audit must include all pieces of the credentialing process (e.g. policies and procedures, file audit, etc.) as outlined in the written delegation arrangement and Credentialing Audit Tool (See Attachment, “Credentialing DOA Audit Tool” in Section 25).

b. If the organization is NCQA CR Accredited or Certified, IEHP must obtain a copy of the certification to ensure the delegate is certified to perform the activity being delegated by the organization.

1) The following are not part of the NCQA Certification/Accreditation review, are not eligible for automatic credit and must be reviewed as part of the delegation oversight process. Delegate must submit copies of the following policies and procedures and other non-file elements.

- CR 1.A. – Practitioner Credentialing Guidelines. The Delegate specifies:
  - The types of Practitioners it credentials and recredentials.
  - The verification sources it uses.
  - The criteria for credentialing and recredentialing.
  - The process for making credentialing and recredentialing decisions.
5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

  8. Delegation of Credentialing

  o The process for managing credentialing files that meet the organization’s established criteria.
  o The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner.
  o The process for notifying if information obtained during the organization’s credentialing process varies substantially from the information they provided to the organization.
  o The process for notifying Practitioners the credentialing and recredentialing decision within sixty (60) calendar days of the Committee’s decision.
  o The Medical Director or other designated Physician’s direct responsibility and participation in the credentialing program.
  o The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.

  • CR 1.B. – Practitioner Rights. The Delegate specifies practitioners about their right to:
    o Review information submitted to support their credentialing application.
    o Correct erroneous information (submitted by another source).
    o Receive the status of their credentialing and recredentialing application, upon request.

  • CR 1.C. – Performance Monitoring for Recredentialing (CMS/DHCS)
  • CR 1.E. – Medicare Exclusions/Sanction Policy (CMS/DHCS)
  • CR 5.B. – Monitoring Medicare Opt-Out Reports (CMS)
  • CR 5.C. – Monitoring Medi-Cal Suspended and Ineligible Provider Reports (DHCS)
  • CR 6.A. – Actions Against Practitioners
  • CR 6.B. – Fair Hearing Panel Composition
  • CR 7.A. – Assessment of Organizational Providers
    o Review and approval of Providers.
    o Medical Providers included in Delegates assessment.
5. CREDENTIALING AND REcredentialing

A. Credentialing Standards

8. Delegation of Credentialing

- Assessing Medical Providers.
- Accreditation/Certification of Free-Standing Surgical Centers (FSSC)

- CR 8.A. – Delegation of Credentialing
  - Written Delegation Agreement.
  - Review of Delegate’s Credentialing activities, as applicable.
  - Opportunities for Improvement.

- CR 9.C. – Distribution of Findings (DMHC/DHCS)

C. Delegate submits the following information for File Review. Additional files will be requested if there is a deficiency or additional elements are required for the review.

INITIAL CREDENTIALING. Initial credentialing is only for those Practitioners who are initiating a contracted with the Delegate. A recredentialing file that was placed into the initial credentialing file pull due to being out of recredentialing timeframe limit will not be included in the initial credentialing files. It must be included in the universe of recredentialing files. If the Provider was terminated and the break in service was for more than thirty (30) days, and was initially credentialled, the file will be audited as an initial credentialing file.

1) CR C3.A.2. – A valid DEA/CDS certificate (CMS).
   - Verification conducted within one hundred eighty (180) calendar days of Credentialing Committee decision.

   - Verification conducted within one hundred eighty (180) calendar days of Credentialing Committee decision.

   - OIG must be the verification source. Date of query and staff initials must evident on checklist or report must be in file.

4) CR C3.B.4. – Medi-Cal Sanction (DHCS)
   - Medi-Cal Suspended and Ineligible List must be the verification source. Date of query and staff initials must evident on checklist or report must be in file.
5. CREDENTIALING AND REcredentialing

A. Credentialing Standards

8. Delegation of Credentialing

5) CR C3.C.1-6. – Application and Attestation (CMS)
   • Verification of questions completed, and attestation signed within 180 calendar days of Credentialing Committee decision.

6) CR C3.D. – Hospital Admitting Privileges (CMS/DHCS)
   • Send Documentation of coverage. Verification of admitting privileges required by IEHP.

7) CR C3.E. – Medicare Opt-Out review (CMS)
   • Evidence reviewed via checklist or other documentation that indicates review of information from the most recent CMS.gov Opt-Out sites.

REcredentialing. This applies to practitioners who have undergone initial credentialing and are due for recredentialing, thirty-six (36) months thereafter, at minimum. The thirty-six (36) months recredentialing cycle begins on the date of the previous credentialing decision.

8) CR R3.A.2. – A valid DEA/CDS certificate (CMS)
   • Verification conducted within one hundred eighty (180) calendar days of Credentialing Committee decision.

9) CR R3.B.3. – Medicare and Medicaid Sanctions (CMS/DHCS)
   • OIG must be the verification source. Date of query and staff initials must evident on checklist or report must be in file.

10) CR R3.B.4. – Medi-Cal Sanction (DHCS)
    • Medi-Cal Suspended and Ineligible List must be the verification source. Date of query and staff initials must evident on checklist or report must be in file.

11) CR R3.C.1-6. – Application and Attestation (CMS)
    • Verification of questions completed, and attestation signed within one hundred eighty (180) calendar days of Credentialing Committee decision.

12) CR R3.D. – Hospital Admitting Privileges (CMS/DHCS)
    • Send Documentation of coverage. Verification of admitting privileges required by IEHP.

13) CR R3.E. – Medicare Opt-Out review (CMS)
    • Evidence reviewed via checklist or other documentation that indicates review of information from the most recent CMS.gov Opt-Out sites.

5. CREDENTIALING AND RECredentialing

A. Credentialing Standards

8. Delegation of Credentialing

- Must include QI Activities and Grievance/Complaints, via checklist, reports, form/sheet detailing the Delegate’s findings.

4. IEHP evaluates regular reports, at minimum quarterly, of the credentialing activities delegated to the Delegate, to include reporting of the names or files of Practitioners or Providers processed by the delegate. The Quality or Credentialing Committee minutes may be assessed for this information.

a. Delegated Reporting to IEHP. Delegates must submit the following Practitioner credentialing information to IEHP:

1) Provider Additions. Delegates must submit a provider profile, contract (with appropriate addendums) and W-9 via Secure File Transfer Portal (SFTP) for review for all Practitioners the Delegate would like to participate in the IEHP network. The Provider Additions must be submitted after the Credentialing is complete and contract is signed with the Delegate. The following must be present to be considered for review. The addition request must include the following:

- For Primary Care Physicians (PCPs), Specialists (SCPs) and Urgent Care Practitioners, the Delegate must submit the following:
  - Provider Profile (See Table below, “Provider Profile”) or spreadsheet (See attachment, “Credentialing Activities Report,” in Section 25);
  - Contract 1st and signature pages, and any applicable addendums to show the provider’s affiliation with that contract;
  - W-9 for all TIN’s utilized by the Provider;
  - Delegation of Services Agreement (applicable to PAs only) Attachment I is required if the document does not clearly document the Supervising Physician and Mid-Level affiliated with the document;
  - Supervising Physician Form (applicable to PAs only); Attachment I is required if the document does not clearly document the Supervising Physician and Mid-Level affiliated with the document);
  - Standardized Procedures (applicable to NPs and CNMs only) Attachment I is required if the document does not clearly document the Supervising Physician and Mid-Level affiliated with the document;
  - Hospitalist Group;
5. CREDENTIALING AND RECREREDENTIALING

A. Credentialing Standards

8. Delegation of Credentialing

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2) Credentialing and recredentialing activities via spreadsheet. It is only acceptable to receive only receive lists of credentialed and recredentialed practitioners from NCQA-accredited or NCQA-certified delegates.

- Delegates that are not NCQA-accredited or NCQA-certified need to
5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards
8. Delegation of Credentialing

demonstrate that it collects data from the delegate, evaluates that data, and takes corrective action if needed and follow-up on deficiencies.

- If no performance issues are identified, reporting could be limited to lists of credentialed and recredentialed practitioners.

D. For delegation arrangements that have been in effect for more than twelve (12) months, at least once in each of the past two (2) years, the Delegate must follow up on opportunities for improvement.

1. Findings from the Delegates pre-delegation evaluation, annual evaluations, file audits, or ongoing reports can be sources for identifying areas of improvement for which it takes actions.

2. The Delegate can use an accredited Health Plans’ audit to look for opportunities of improvement.

   a. If the Delegate sees that the accredited Health Plan found opportunities for improvement, the Delegate reviews the following:

      1) The corrective action plan (CAP) from the subdelegated entity.

      2) Reviews to see if the audit and CAP were reviewed and approved, i.e. committee minutes, email approval or other method indicating acceptance of review of the CAP.

REFERENCES:

A. NCQA, 2019 HP Standards and Guidelines, Credentialing (CR) 8.

5. CREDENTIALING AND REcredentialing

A. Credentialing Standards

9. Identification of HIV/AIDS Specialists

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal-MediConnect Plan (Medicare – Medicaid) Providers contracted under IEHPs Direct Network.

POLICY:

A. IEHP identifies HIV/AIDS Specialists during the credentialing and recredentialing process, and annually thereafter.

B. For those Providers who are identified as an HIV/AIDS Specialists, IEHP reconfirms the Provider is appropriately qualified and continues to meet the definition of an HIV/AIDS Specialist, on annual basis.

C. The department(s) responsible for authorizing standing referrals are notified of the Practitioners who are qualified HIV/AIDS Specialists.

PURPOSE:

A. IEHP must have a written and documented process to identify and reconfirm the appropriately qualified Physicians within IEHP who meet the definition and requirements of an HIV/AIDS Specialist on an annual basis.

DEFINITION:

A. “AIDS” means Acquired Immunodeficiency Syndrome.

B. “Category 1 continuing medical education” means:
   1. For Physicians, continuing medical education as qualifying for category 1 credit by the Medical Board of California;
   2. For Nurse Practitioners (NPs), continuing medical education contact hours recognized by the California Board of Registered Nursing; and
   3. For Physician Assistants (PAs), continuing medical education units approved by the American Association of Physician Assistants.

C. “HIV” means the Human Immunodeficiency Virus.

PROCEDURES:

A. IEHP identifies HIV/AIDS Specialists during the credentialing and recredentialing process, and annually thereafter. All credentialing and recredentialing applications include an HIV/AIDS form for all Practitioners to review and complete if they would like to be identified as an HIV/AIDS Specialist Provider. (See Attachment, “Verification of Qualifications for HIV/AIDS Physician Specialists,” in Section 5).
5. CREDENTIALING AND RECREREDENTIALING

A. Credentialing Standards

9. Identification of HIV/AIDS Specialists

1. All Physicians who complete the form and indicate “Yes, I do wish to be designated as an HIV/AIDS Specialist based on the criteria below,” Credentialing will obtain the documents to support the criterion the Practitioner identified on the form.

   a. For all Physicians who indicated “Yes, I do wish to be designated as an HIV/AIDS Specialist based on the criteria below,” and met the criterion set forth in this policy will be designated as an HIV/AIDS Specialist.

      1) If the Physician indicated “Yes, I do wish to be designated as an HIV/AIDS Specialist based on the criteria below,” and does not include the supporting documentation, the Credentialing Specialist will make a minimum of three (3) attempts to collect this information from the Physician, which will be documented in the Practitioners file.

         • If the Credentialing Specialist is unable to obtain the information from the Practitioner, the Physician will then be notified that they will not be listed in IEHP’s network, as an HIV/AIDS Specialist due to not meeting the HIV/AIDS Specialist criterion as noted in this policy.

   b. For all Physicians who indicated “No, I do not wish to be designated as an HIV/AIDS Specialist” or do not complete a form at all, they will not be identified as an HIV/AIDS Specialist in the IEHP network.

B. IEHP identifies and verifies the appropriately qualified Physicians who meet the definition of an HIV/AIDS Specialist. An “HIV/AIDS Specialist” is a Physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the State of California, who meets any one of the four (4) criterion below:

1. Is credentialed as an HIV Specialist by the American Academy of HIV Medicine (AAHIVM);

   a. IEHP will verify the Physician’s credentials on the American Academy of HIV Medicine website https://aahivm.org/.

2. Is board certified, or has earned Certificate of Added Qualifications, 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 Qualifications, in the field of HIV medicine; or

   a. IEHP will verify the Physicians board certification(s) using the sources in Policy 05A1, “Credentialing Standards – Credentialing Policies”

3. Is board certified in the field of Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:

   a. In the immediately preceding twelve (12) months has clinical managed medical care to a minimum of twenty-five (25) patients who are infected with HIV; and

   b. In the immediately preceding twelve (12) months has successfully completed a
5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

9. Identification of HIV/AIDS Specialists

minimum of fifteen (15) hours of category 1 continuous medical education (CME) in the prevention of HIV infection, combined with diagnosis, treatment, or both, of the HIV-infected patients, including a minimum of five (5) hours related to antiretroviral therapy per year.

1) IEHP will verify the Physicians board certification(s) using the sources in Policy 05A1, “Credentialing Standards – Credentialing Policies”; and

2) IEHP will request for copies of those Continuing Medical Education (CME) credits and verify:
   • The appropriate number of CMEs hours in the HIV Medicine or antiretroviral therapy, were completed;

4. Meets the following qualifications:
   a. In the immediately preceding twenty-four (24) months has clinically managed medical care to a minimum of twenty (20) patients who are infected with HIV; and
   b. Has completed any of the following:
      1) In the immediately preceding twelve (12) months has obtained board certification or recertification in the field of infectious disease from a member board of the American Board of Medical Specialties; or
      2) In the immediately preceding twelve (12) months has successfully completed a minimum of thirty (30) hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment of both, of HIV-infected patients.
         • IEHP will verify the Physicians board certification(s) using the sources in Policy 05A1, “Credentialing Standards – Credentialing Policies”; and
         • IEHP will request for copies of those Continuing Medical Education (CME) credits and verify:
            • The appropriate number of CMEs hours in the Prevention of HIV Infection, combined with diagnosis, treatment of both of HIV-infected patients, were completed;
      3) In the immediately preceding twelve (12) months has successfully completed a minimum of fifteen (15) hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competence Examination administered by the American Academy of HIV Medicine.
         4) IEHP will request for copies of those CME credits and verify:
            • The appropriate number of CMEs hours in the Prevention of HIV Infection,
5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

9. Identification of HIV/AIDS Specialists

combined with diagnosis, treatment of both of HIV-infected patients, were completed;

5) IEHP will request for a copy of the Exam Verification of the HIV Medicine Competence Examination administered by the American Academy of HIV Medicine.

C. On an annual basis, IEHP send a blast fax to all Direct Network Providers, to confirm which Providers would lie to be listed as HIV/AIDS Specialist Providers, ensure IEHP identifies or reconfirms the appropriately qualified Physician who meet the definition of an HIV/AIDS Specialist, on annual basis.

1. The annual screening is faxed to all Direct Primary Care Physicians (PCPs) and Specialists.

2. The blast fax is sent by IEHPs Provider Services Administration Team and then the list of Providers is provided to the Credentialing Department track the Physician responses.

3. The annual screening is completed within twelve (12) months of the prior year’s annual screening.

4. For Physicians currently listed in the network as an HIV/AIDS Specialist, the Credentialing Department will reconfirm if the Provider still meets the criterion to be listed as a HIV/AIDS Specialist.

D. The list of identified qualifying Physicians is provided to the department responsible for authorizing standing referrals through our Network Development Data Base in real time and is available upon request to the Credentialing Department.

REFERENCES:

A. California Health & Safety Code § 1374.16.

B. DMHC TAG (QM – 004).

C. DHCS MMCD All-Plan Letter 02001, “Medi-Cal HIV/AIDS Home and Community Based Services Waiver Program”.

INLAND EMPIRE HEALTH PLAN

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IEHP Provider Policy and Procedure Manual 01/20
Medicare DualChoice

MA_05A9
5. CREDENTIALING AND RECREREDENTIALING

B. Hospital Privileges

**APPLIES TO:**

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Providers.

**POLICY:**

A. IEHP requires its Delegated IPAs to ensure that all of their contracted and subcontracted Practitioners have privileges at a designated IEHP contracted Hospital. The contracted Hospital must be within a fifteen (15) mile radius or thirty (30) minute drive via private or public transportation of the Member’s residence, when applicable. In rural areas, or in specific situations, IEHP may approve Primary Care Physicians (PCP) links to Hospitals outside of these standards.

B. If the Delegate utilizes a Hospitalist Group, Hospitalist Admitter, or Admitter for Hospital admissions, the Delegate must forward copies of the Delegates/Hospitalist contract’s front and signature pages, National Provider Identifier (NPI) and W-9, as the contract is executed and/or amended. The contract should be signed by both parties and must include the age range, phone number, fax number, and Hospitals when the Hospitalist group will be treating patients.

C. IEHP requires its Delegates to ensure that all of their contracted and subcontracted Specialist Practitioners (in the appropriate specialties) must have a formal inpatient coverage arrangement at an IEHP contracted Hospital, with a specialist within the same practice and specialty. If the Practitioner does not have clinical admitting privileges, the delegate must obtain a written statement delineating the inpatient coverage arrangement, which must be documented in the Provider’s file.

D. Practitioners who provide care of mothers and newborns through the maternity cycle of pregnancy, labor, birth and delivery services (i.e. Certified Nurse Midwives, Obstetrics/Gynecology [OB/GYN], Family Practice 1, Family Practice 2 Providers) must have appropriate hospital arrangements in place.

E. The Provider Services Coordinator (PSC) emails all Delegated IPAs on the 15th of each month for verification of all Admitters to ensure accurate information is obtained. Any changes from the Delegated IPAs must be submitted by the 25th of every month via the Secure File Transfer Protocol (SFTP) sever. On the last day of the month all network Hospitals are emailed the final Admitter list for that month. It includes Admitters name, phone number and fax number for each Provider who utilizes a Hospital Admitter. If Hospitals find discrepancies, they are emailed back to the Credentialing Coordinator who verifies with the individual IPA’s credentialing contact.

**PURPOSE:**

A. No enrollment is given to any PCP until appropriate and complete arrangements for Hospital admissions are in place and verified by IEHP.
5. CREDENTIALING AND RECRECREDENTIALING

B. Hospital Privileges

B. In the event it is discovered that a PCP with assigned enrollment does not have privileges at the designated IEHP contracted Hospital, and the Delegated IPA has not made arrangements with other Practitioners to provide admitting and inpatient care services for that Practitioner, IEHP may freeze the membership of the PCP and/or transfer these Members immediately. The Delegated IPA may request to unfreeze or open the Provider’s panel once they provide appropriate arrangements with other Practitioners to provide admitting inpatient care services for that Practitioner.

C. IEHP and its Delegated IPAs must have established processes for outpatient and inpatient Utilization Management.

D. Utilizing on-call Hospital Practitioners without a contract is not an acceptable arrangement.

DEFINITIONS:

A. Hospitalists are Physicians who primary professional focus is the general medical care of hospitalized patients. Their activities include patient care, teaching, research and leadership related to hospital medicine.

PROCEDURES:

A. IEHP requires its Delegated IPAs to ensure that all of their contracted and subcontracted Practitioners have privileges at a designated IEHP contracted Hospital. The contracted Hospital must be within a fifteen (15) mile radius or thirty (30) minute drive via private or public transportation of the Member’s residence, when applicable. In rural areas, or in specific situations, IEHP may approve PCP links to Hospitals outside of these standards.

1. Providers who have their own privileges will be linked to those Hospital(s) they have privileges, if they meet the mileage and time standard set forth in this policy.
   a. Delegated IPAs must communicate these arrangements via provider profile upon initial submission.

2. Providers who do not have their own privileges yet have a Hospitalist Group arrangement at a Hospital and the respective network, will be linked to those Hospital(s) they have hospital admitting arrangements, if they meet the mileage and time standard set forth in this policy.
   a. IEHP or the Delegate network must use this arrangement for all Primary Care Physicians linked to this Hospital.
   b. The Hospitalist Group can only be used to cover the same age ranges as the non-admitting Physician.
   c. These arrangements must be communicated to the Physician and documented in the credentialing file.
5. CREDENTIALING AND RECREDENTIALING

B. Hospital Privileges

d. These arrangements will appear on the Admitter Reports thereafter for review and maintenance by IEHP and its respective Delegates.

3. Providers who do not have their own privileges yet have a Hospitalist Admitter arrangement at a Hospital and the respective network will be linked to those Hospital(s) they have hospital admitting arrangements, if they meet the mileage and time standard set forth in this policy.

a. IEHP or the Delegate network must use this arrangement for all Primary Care Physicians linked to this hospital.

b. The Hospitalist Admitter can only be used to cover the same age ranges as the non-admitting Physician.

c. These arrangements must be communicated to the Physician and documented in the credentialing file.

d. These arrangements will appear on the Admitter Reports thereafter for review and maintenance by IEHP and its respective Delegates.

4. Providers who do not have their own privileges yet have an Admitter arrangement at a Hospital and the respective network, with a Physician who is part of the same practice and specialty with the non-admitting Physician will be linked to those Hospital(s) they have hospital admitting arrangements, if they meet the mileage and time standard set forth in this policy.

a. These arrangements must be communicated to the Physician and documented in the credentialing file.

b. These arrangements will appear on the Admitter Reports thereafter for review and maintenance by IEHP and its respective Delegates.

B. If the Delegate utilizes a Hospitalist Group, Hospitalist Admitter, or Admitter for Hospital admissions, the Delegate must forward copies of the Delegates/Hospitalist contract’s front and signature pages, NPI and W-9, as the contract is executed and/or amended. The contract should be signed by both parties and must include the age range, phone number, fax number, and Hospitals when the Hospitalist group will be treating patients.

1. A written verification in the form of a signed agreement or letter from the admitting Practitioner that such arrangements are in place is required. This agreement must include the following information:

   a. Type of Agreement (i.e. Hospitalist Agreement);

   b. Delegates’ Name;

   c. Hospitalist or Admitter Name;

   d. Age Range;

   e. Hospitals affiliated with the Agreement;
5. CREDENTIALING AND REcredentialing

B. Hospital Privileges

f. Hospitalist or Admitter Phone Number; and

g. Hospitalist or Admitter Fax Number.

In addition, the IPA must provide the following:

h. NPI; and

i. W-9.

2. The agreement must stipulate a minimum of thirty (30) days advance notice of intent to terminate by either party. Notice of termination must be submitted to IEHP within five (5) days of the Delegate’s knowledge of pending termination.

a. This agreement must be signed and dated by the non-admitting Practitioner and the admitting Practitioner.

b. The agreement must also specify that bills for services rendered are submitted to and paid by the Delegate.

c. Upon receipt of the written admitting arrangements, IEHP verifies:

1) The non-admitting Practitioner’s specialty is completely covered by the admitting Practitioner’s specialty. (For example, a Family Practice Provider may admit patients for another Family Practice Provider or have an Internal Medicine and Pediatric Provider collectively cover admissions for a Family Practice Provider).

2) The admitting Practitioner(s) have admitting privileges to Hospitals they are admitting to, in place and in good standing, and confirms that the Provider has admitting privileges in their respective specialties and are within the same IPA network.

C. IEHP and its Delegates must ensure that all of their contracted and subcontracted Specialist Practitioners (in the appropriate specialties) (See Attachment, “Hospital Admitting Privileges Reference by Specialty” in Section 5) must have a formal inpatient coverage arrangement at an IEHP contracted Hospital, with a specialist within the same practice and specialty. If the Practitioner does not have clinical admitting privileges, IEHP and its Delegates must obtain a written statement delineating the inpatient coverage arrangement which must be documented in the Provider’s file.

1. All Specialists who are using another Physician to admit on his/her behalf, the hospital admitting arrangement will be added to the Hospitalist Admitter Report for review and maintenance by the Delegates on a monthly basis, thereafter.

2. The Admitting Physician used for Specialists must be within the same practice and specialty as the non-admitting Physician.

D. Practitioners who provide care of mothers and newborns through the maternity cycle of pregnancy, labor, birth and delivery services (i.e. Certified Nurse Midwives,
5. CREDENTIALING AND RECREREDENTIALING

B. Hospital Privileges

Obstetrics/Gynecology, Family Practice 1, Family Practice 2 Providers) must have the following arrangements in place:

1. Certified Nurse Midwives (CNM) Providers must meet the following criteria:
   a. In lieu of having full hospital delivery privileges, provide a written agreement with an OB Provider, that includes a protocol for identifying and transferring high risk Members, stated types of deliveries performed (i.e. low-risk, cesarean section etc.), must be available for consultations, as needed.
      1) The Agreement must include back-up Physician’s full delivery privileges at IEHP network hospital, in the same network as the CNM Provider.
         • The OB Provider must be credentialed and contracted within the same practice and network.

2. Family Practice 1: Family Practice that includes Outpatient OB services must:
   a. Provide a copy of a signed agreement that states member transfers will take place within the first twenty-eight (28) weeks of gestation and a protocol for identifying and transferring high risk Members with a contracted and credentialed OB.
   b. The OB must be within the same network as the Family Practice Provider and hold admitting privileges to the IEHP contracted Hospital linked with that Delegated IPA network.

3. Family Practice 2: Family Practice that includes full OB services and delivery must:
   a. Have and maintain full delivery privileges at an IEHP contracted Hospital.
   b. Provide a written agreement for an available OB back up Provider is required.
      1) The OB Provider must be credentialed, contracted and hold admitting privileges to the IEHP Hospital linked with the Family Practice Provider; and
      2) Provide a protocol for identifying and transferring high risk Members and stated types of deliveries performed (i.e. low-risk, cesarean section, etc).

4. OB/GYN Providers who would like to participate as a Primary Care Physician only, will provide outpatient well woman services only with no Hospital or surgical privileges, must provide the following information for consideration:
   a. In lieu of having full Hospital delivery privileges, provide a written agreement with an OB Provider, that includes a protocol for identifying and transferring high risk Members, stated types of deliveries performed (i.e. low-risk, cesarean section etc), must be available for consultations as needed and that the OB will provide prenatal care after twenty-eight (28) weeks gestation including delivery (See Attachment, “Patient Transfer Agreement” in Section 5).
5. CREDENTIALING AND RECREREDENTIALING

B. Hospital Privileges

1) The Agreement must include back-up Physician’s full delivery privileges at IEHP network Hospital, in the same network as the non-admitting OB Provider.

2) The OB Provider must be credentialed and contracted within the same network.

These OB/GYNs provide outpatient well woman services only with no Hospital or surgical privileges. This exception must be reviewed and approved by IEHP Medical Director or Chief Medical Officer. Further review may be completed by the Peer Review Subcommittee who will either approve or deny.

5. Obstetrics/Gynecology (OB/GYN) Specialists must provide have full delivery privileges at an IEHP network hospital or have an arrangement with a Obstetrics/Gynecology Specialist practicing within their same practice, credentialed and contracted with IEHP, who will admit patients on their behalf. This arrangement must be documented in the provider’s credentialing application.

E. IEHP emails all Delegated IPAs on the 15th of each month for verification of all inpatient admittter arrangements to ensure accurate information is obtained. Any changes from the Delegated IPAs must be submitted by the 25th of every month via the Secure File Transfer Protocol (SFTP) sever. On the last day of the month all network Hospitals are emailed the final Admitter list for that month. It includes Admitters name, phone number and fax number for each Provider who utilizes a Hospital Admitter. If Hospitals find discrepancies, they are emailed back to the Credentialing Specialist who verifies with the individual IPA’s credentialing contact. IEHP and its Delegated IPAs are responsible for reviewing the Admitter reports and:

1. Ensuring all providers are listed with the correct Admitting Provider. If there are changes, the Delegated IPAs are responsible for notifying the Provider of the changes and of their current admittter arrangements for each respective Hospital.

2. For the Admitting Providers, the Delegated IPA confirms admitting privileges to the Hospitals they are admitting to are in place and in good standing.

   a. The Delegated IPA is responsible for providing a replacement. If not, the provider will be terminated from the Delegated IPA’s network for not having hospital admitting arrangements;

   b. Ensuring all admitting Providers and non-admitting Providers are active with the Delegated IPA or IEHP; and

   c. Failure of the IPA to respond by the 25th day of each respective month will result in noncompliance and may result in a corrective action plan on monthly delegation reporting.
REFERENCES:

A. Title 28, California Code of Regulations § 1300.51 (d)(H).
B. American Society of Hospital Medicine, 2007.
5. CREDENTIALING AND REcredentialing

Attachments

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<tr>
<th>DESCRIPTION</th>
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<tr>
<td>Bariatric Surgeon Case Volume Attestation</td>
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<tr>
<td>Delegation of Services Agreement and Supervising Physician Form</td>
<td>5A1, 5A3</td>
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<td>Hospital Admitting Privileges Reference by Specialty</td>
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<td>IEHP Peer Review Process and Level II Appeal</td>
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<td>IEHP Addendum E</td>
<td>5A1, 5A3</td>
</tr>
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<td>Patient Transfer Agreement</td>
<td>5A1, 5B</td>
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<tr>
<td>Verification of Qualifications for HIV/AIDS Physician Specialists</td>
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I, ________________________________ (Print: Provider Name), attest that the information reported below accurately reflects the volume of bariatric surgery cases in which I was both proctored and served as a primary surgeon. I do hereby attest that this information is true, accurate, and complete to the best of my knowledge.

I understand Inland Empire Health Plan (IEHP) reserves the right to require me to provide clinical documentation verifying the attested bariatric surgery cases below, which I agree to provide upon IEHP’s request.

1. _______ Volume of applicant’s proctored cases

2. _______ Volume of cases where applicant was primary surgeon
   * IEHP requires a minimum of fifteen (15) cases where the applicant was the primary surgeon

__________________________________________  _______________________
PROVIDER’S SIGNATURE                     DATE
Delegation of Services Agreements – Change in Regulations

Recently, Title 16, Division 13.8, Article 4, section 1399.540 has been amended to include several requirements for the delegation of medical services to a physician assistant. There are four specific changes with this amendment:

Background:

The Delegation of Services Agreement (DSA) is a document used by supervising physicians and physician assistants to meet requirements of Section 1399.540. The DSA is the foundation of the relationship between a supervising physician and the physician assistant, and specifies the names of the supervising physicians and what types of medical services the physician assistant is allowed to perform, how they are performed, how the patient charts will be reviewed and countersigned, and what type of medications the physician assistant will transmit on behalf of the supervising physician.

Regulatory Requirements:

1) A physician assistant may provide medical services, which are delegated in writing by a supervising physician who is responsible for patients, cared for by the physician assistant. The physician assistant may only provide services which he or she is competent to perform, which are consistent with their education, training and experience, and which are delegated by the supervising physician.

2) The delegation of services agreement is the name of the document, which delegates the medical services. More than one supervising physician may sign the delegation of services agreement only if each supervising physician has delegated the same medical services. A physician assistant may provide medical services pursuant to more than one delegation of services agreement.

3) The Physician Assistant Board or their representative may require proof or demonstration of competence from any physician assistant for any medical services performed.

4) If a physician assistant determines a task, procedure or diagnostic problem exceeds his or her level of competence, and then the physician assistant shall either consult with a physician or refer such cases to a physician.

Q: What if a physician assistant works for more than one supervising physician at a hospital or clinic? Do we need to have separate DSAs for each supervising physician?

A: The Board has had questions regarding how the DSA would be written if a physician assistant works for more than one supervising physician at a hospital or clinic. If the duties and medical services performed are consistent with each supervising physician, then one DSA can be written to include several supervising physicians. Each supervising physician must sign and date the DSA, along with the signature of the physician assistant.
Q: What if a physician assistant works for one supervising physician who is an ob-gyn, and also works for an ortho supervising physician, and both are at the same clinic or hospital?

A: If the duties and medical services provided by the physician assistant differ from one supervising physician to another, then it is recommended that a separate DSA be written for each supervising physician. However, one DSA could be used, but it would need to be separated with which duties are allowed under each supervising physician. Again, signatures and dates from all parties must be included on the DSA.

Q: What if the physician assistant works at several different clinics – can one DSA be written?

A: A separate DSA should be made for each hospital or clinic, regardless of how many supervising physicians the physician assistant works with. Alternatively, a physician assistant may have a DSA that specifies what services can be provided at a specific site.

Q: How long should I retain my DSA?

A: You should retain the DSA as long as it is valid. Additionally, it is recommended that you keep a copy of your DSA for at least one to three years after it is no longer the current DSA in case you need to reference the document. However, there is no legal requirement to retain the DSA once it is no longer valid and current.
Title 16, Section 1399.540 of the Physician Assistant Regulations states, in part, “A physician assistant may only provide those medical services which he or she is competent to perform and which are consistent with the physician assistant’s education, training, and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant. b) The writing which delegates the medical services shall be known as a delegation of services agreement. A delegation of services agreement shall be signed and dated by the physician assistant and each supervising physician. A delegation of services agreement may be signed by more than one supervising physician only if the same medical services have been delegated by each supervising physician. A physician assistant may provide medical services pursuant to more than one delegation of services agreement.”

The following two sample documents are attached to assist you with meeting this legal requirement:

1) Delegation of Services Agreement (DSA) Between Supervising Physician and Physician Assistant; and
2) Supervising Physician’s Responsibility for Supervision of Physician Assistant Agreement.

These are sample documents. They are for your convenience, information, and use. Please feel free to duplicate or modify them as appropriate and consistent with law.

If you choose not to use the sample documents, please be aware that you are still required by law to execute a DSA with your supervising physician. The DSA must be signed and dated by you and your supervising physician. The original or a copy of this document should be maintained at all practice sites where the physician assistant practices, and should be readily accessible. It is recommended that you retain prior DSAs for one to three years after the DSA is no longer current or valid.

While every practicing physician assistant is required to have a DSA, you are not required to submit it to the Physician Assistant Board. If requested, you must make a copy of your DSA available to any authorized agent of the Medical Board of California, the Osteopathic Medical Board of California, or the Physician Assistant Board who may request it.

Failure to have a current DSA constitutes a violation of the Physician Assistant Regulations and is grounds for disciplinary action against a physician assistant’s license. In addition, failure by the physician assistant and supervising physician to comply with the supervision requirements specified in the Physician Assistant Regulations and in the Delegation of Services Agreement is ground for disciplinary action.

THE ATTACHED DOCUMENTS DO NOT NEED TO BE RETURNED TO THE PHYSICIAN ASSISTANT BOARD
DELEGATION OF SERVICES AGREEMENT BETWEEN SUPERVISING PHYSICIAN
AND PHYSICIAN ASSISTANT (Title 16, CCR, Section 1399.540)

PHYSICIAN ASSISTANT______________________________________________________________
(Name)

Physician assistant, graduated from the ________________________________________________
(Name of PA Training Program) on _________________________________.
(Date)

He/she took (or is to take) the licensing examination for physician assistants recognized by the State of California
(e.g., Physician Assistant National Certifying Examination or a specialty examination given by the State of California)
on _________________________________.
(Date)

He/she was first granted licensure by the Physician Assistant Board on ________________________, which expires
on ________________________, unless renewed.      (Date)

SUPERVISION REQUIRED. The physician assistant named above (hereinafter referred to as PA) will be supervised
in accordance with the written supervisor guidelines required by Section 3502 of the Business and Professions Code
and Section 1399.545 of the Physician Assistant Regulations. The written supervisor guidelines are incorporated
with the attached document entitled, "Supervising Physician's Responsibility for Supervision of Physician Assistants."

AUTHORIZED SERVICES. The PA is authorized by the physician whose name and signature appear below to
perform all the tasks set forth in subsections (a), (d), (e), (f), and (g) of Section 1399.541 of the Physician Assistant
Regulations, when acting under the supervision of the herein named physician. (In lieu of listing specific lab
procedures, etc. the PA and supervising physician may state as follows: "Those procedures specified in the practice
protocols or which the supervising physician specifically authorizes.")

The PA is authorized to perform the following laboratory and screening procedures:
________________________________________________________________________________________
________________________________________________________________________________________

The PA is authorized to assist in the performance of the following laboratory and screening procedures:
________________________________________________________________________________________
________________________________________________________________________________________

The PA is authorized to perform the following therapeutic procedures:
________________________________________________________________________________________
________________________________________________________________________________________

The PA is authorized to assist in the performance of the following therapeutic procedures:
________________________________________________________________________________________
________________________________________________________________________________________

The PA is authorized to function as my agent per bylaws and/or rules and regulations of (name of hospital):
________________________________________________________________________________________
________________________________________________________________________________________

a) The PA is authorized to write and sign drug orders for Schedule: II, III, IV, V without advance approval (circle
authorized Schedule(s)). The PA has taken and passed the drug course approved by the Board on _________
(attach certificate).       DEA #:______________________________. Date

or

b) The PA is authorized to write and sign drug orders for Schedule: II, III, IV, V with advance patient specific approval
(circle authorized Schedule(s)).      DEA #:______________________________.
CONSULTATION REQUIREMENTS. The PA is required to always and immediately seek consultation on the following types of patients and situations (e.g., patient's failure to respond to therapy; physician assistant's uncertainty of diagnosis; patient's desire to see physician; any conditions which the physician assistant feels exceeds his/her ability to manage, etc.)

(List Types of Patients and Situations)

MEDICAL DEVICES AND PHYSICIAN’S PRESCRIPTIONS. The PA may transmit by telephone to a pharmacist, and orally or in writing on a patient's medical record or a written prescription drug order, the supervising physician’s prescription in accordance with Section 3502.1 of the Business and Professions Code.

The supervising physician authorizes the delegation and use of the drug order form under the established practice protocols and drug formulary. YES NO

The PA may also enter a drug order on the medical record of a patient at ______________________________ in accordance with the Physician Assistant Regulations and other applicable laws and regulations.

Any medication handed to a patient by the PA shall be authorized by the supervising physician's prescription and be prepackaged and labeled in accordance with Sections 4076 of the Business and Professions Code.

PRACTICE SITE. All approved tasks may be performed for care of patients in this office or clinic located at ______________________________ and, in ______________________________ hospital(s) and ______________________________ skilled nursing facility (facilities) for care of patients admitted to those institutions by physician(s) ________________________________.

EMERGENCY TRANSPORT AND BACKUP. In a medical emergency, telephone the 911 operator to summon an ambulance.

The ________________________________ emergency room at ________________________________ is to be notified that a patient with an emergency problem is being transported to them for immediate admission. Give the name of the admitting physician. Tell the ambulance crew where to take the patient and brief them on known and suspected health condition of the patient.

Notify ________________________________ at ________________________________ immediately (or within ________________ minutes).

PHYSICIAN ASSISTANT DECLARATION
My signature below signifies that I fully understand the foregoing Delegation of Services Agreement, having received a copy of it for my possession and guidance, and agree to comply with its terms without reservations.

______________________________________________________________________________________________

Date Physician’s Signature (Required)

______________________________________________________________________________________________

Date Physician Assistant’s Signature (Required)

______________________________________________________________________________________________

Physician Assistant’s Printed Name

SAMPLE ONLY

2 of 2
SUPERVISOR ____________________________, M.D./D.O. is licensed to practice in California as a physician and surgeon with medical license number _________________. Hereinafter, the above named physician shall be referred to as the supervising physician.

SUPERVISION REQUIRED. The physician assistant (PA) named in the attached Delegation of Services Agreement will be supervised by the supervising physician in accordance with these guidelines, set forth as required by Section 3502 of the Business and Professions Code and Section 1399.545 of the Physician Assistant Regulations, which have been read by the physician whose signature appears below.

The physician shall review, countersign, and date within seven (7) days the medical record of any patient cared for by the physician assistant for whom the physician's prescription for Schedule II medications was transmitted or carried out.

REPORTING OF PHYSICIAN ASSISTANT SUPERVISION. Each time the physician assistant provides care for a patient and enters his or her name, signature, initials, or computer code on a patient's record, chart or written order, the physician assistant shall also enter the name of his or her supervising physician who is responsible for the patient. When the physician assistant transmits an oral order, he or she shall also state the name of the supervising physician responsible for the patient.

MEDICAL RECORD REVIEW. One or more of the following mechanisms, as indicated below, by a check mark (x), shall be utilized by the supervising physician to partially fulfill his/her obligation to adequately supervise the actions of the physician assistant named _________________________________________________________.

______ Examination of the patient by a supervising physician the same day as care is given by the PA.

______ The supervising physician shall review, audit, and countersign every medical record written by the PA within __________ days of the encounter.

______ The physician shall audit the medical records of at least 5% of patients seen by the PA under any protocols which shall be adopted by the supervising physician and the physician assistant. The physician shall select for review those cases which by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

______ Other mechanisms approved in advance by the Physician Assistant Board may be used. Written documentation of those mechanisms is located at ________________________________________________.

______ INTERIM APPROVAL. For physician assistants operating under interim approval, the supervising physician shall review, sign, and date the medical records of all patients cared for by the physician assistant within seven (7) days if the physician was on the premises when the physician assistant diagnosed or treated the patient. If the physician was not on the premises at that time, he or she shall review, sign, and date such medical records within 48 hours of the time the medical services were provided.

BACK UP PROCEDURES: In the event this supervising physician is not available when needed, the following physician(s) has (have) agreed to be a consultant(s) and/or to receive referrals:

___________________________________________________________ Phone: _________________________

(Printed Name and Specialty) (Printed Name and Specialty)

PROTOCOLS NOTE: This document does not meet the regulation requirement to serve as a protocol. Protocols, if adopted by the supervising physician, must fully comply with the requirements authorized in Section 3502 (c) (1) of the Business and Professions Code.

_________________  ____________________________ ______________________
Date                                                                   Physician's Signature

THIS DOCUMENT IS NOT TO BE RETURNED TO THE BOARD
SAMPLE ONLY

1 of 1
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1 of 7
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Addendum E
General Practice Providers & Obstetrics/Gynecology PCP’s only
Primary Care Experience – Attestation

Please indicate below the age of the patients for whom you have provided primary care services to in the last five (5) years. In order for a category to apply, it must represent at least 20% of your average practice and your must be familiar with and routinely follow standard preventative services, such as CHDP and the American Academy of Patients (AAP), both for Pediatrics only, and the United States Preventative Task Force (USPTF). Please check all those that apply:

- Pediatrics (0 to 18 years of age)
- Pediatrics (0 to 21 years of age)
- Adults (14 years of age and above)
- Adults (18 years of age and above)
- Adults (21 years of age and above)
- Ob/Gyn PCP (14 years and above, restricted to females)
- If you desire age limits different from above, please specify:

__________________________________________________________________________
__________________________________________________________________________

NOTE: If your desire age limits different from above, you will not receive member auto-assignment.

I attest to the fact that all of the information submitted by me in this document is true and correct to the best of my knowledge and belief. I fully understand that any significant misstatement or omission from this attestation may constitute cause for denial of participation or dismissal from participation with Inland Empire Health Plan (IEHP).

Physician’s Name: _____________________________________________________________________
Physician’s Signature: ____________________________ Date: ________________
(Stamped signature is not acceptable)
INLAND EMPIRE HEALTH PLAN

PEER REVIEW (LEVEL I) AND CREDENTIALING APPEAL

Denial, Reduction, Suspension or Termination of Practitioner Status

(Adopted April 14, 1997)

(Amended January 2019)
INLAND EMPIRE HEALTH PLAN

PEER REVIEW (LEVEL I) AND CREDENTIALING APPEAL
Denial, Reduction, Suspension or Termination of Practitioner Status

Purpose:

A. To provide:
   1. A mechanism for peer review of IEHP Providers of Service (Practitioners)
   2. A process for Practitioner to request review of negative peer review recommendations, decisions, and actions, for any reason related to quality of care issues, non-quality of care issues, and/or credentialing requirements, including, but not limited to, denial, reduction, suspension or termination of Practitioner status, as requested by the Inland Empire Health Plan (IEHP) Peer Review Subcommittee, the IEHP Quality Management (QM) Committee, the IEHP Credentialing Subcommittee, of the IEHP Medical Director, and
   3. A mechanism for appropriate action.

Scope:

A. The following policies and procedures apply to all Practitioners participating or requesting participation as a Provider for IEHP, including, but not limited to, the following licentiates: Physicians (MD), Osteopathic Physician (DO), Podiatrists (DPM), Pharmacists (Pharm D or RPh), Oral Surgeons (DDS or DMD), Optometrists (OD), Chiropractors (DC), Audiologists, Clinical Psychologists, (PhD), Nurse Practitioners (NP), Physician Assistants (PA), Certified Nurse Midwives (CNM), Physical Therapists (PT), Occupational Therapists (OT), and Speech/Language Therapists (S/LT), psychiatrists, psychologists, master level clinical nurses, Licensed Clinical Social Workers (LCSW), Marriage, Family and Child Counselors (MFCC/LMFT) and other behavioral health professionals licensed to provide behavioral health services in the state of California.

Policy:

A. A Provider’s status or participation may be denied, reduced, suspended or terminated for any lawful reason, including, but not limited to, a lapse in basic qualifications such as licensure, insurance, or required medical staff privileges or admission coverage at an IEHP contracted hospital; a determination by IEHP that the Practitioner cannot be relied upon to deliver the quality or efficiency of patient care required by IEHP; a determination by IEHP that the Practitioner cannot be relied upon to follow IEHP’s clinical or business guidelines or directives; or a change in IEHP’s business needs.

B. A Practitioner may request review of any initial adverse recommendation, decision or action by IEHP that is based on quality of care issues, non-quality of care issues, and/or credentialing requirements, and impacts his or her participation status with IEHP, including denial, reduction, suspension, or termination of his or her participation status with IEHP, in accordance with the Level I Review procedures, as provided herein.
Procedure:

A. Issues raised about either an applicant or a participating Practitioner’s credentialing packet or performance as a Practitioner shall be considered initially by the IEHP Medical Director, who shall have the discretion to investigate and to determine the necessary and appropriate response and intervention as delegated to the IEHP Medical Director as a member of the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee. His/her options shall include, but not be limited to, maintaining a record of the matter without further investigation or action; investigating the matter personally and making a report and recommendation to the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee, as warranted; or referring the matter to the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee for investigation and the preparation of a report and recommendation to the IEHP Medical Director.

B. In instances where there may be an imminent danger to the health of any individual, the IEHP Medical Director and/or the IEHP Peer Review Subcommittee may summarily restrict or suspend the participating Practitioner’s privilege to provide patient care services, effective immediately upon written notice to the Practitioner. The notice shall be in the same format as described in Section 3 herein, pending consideration and action by the IEHP Peer Review Subcommittee. The IEHP Peer Review Subcommittee may continue to enforce the reduction or suspension pending further action.

C. If an unfavorable recommendation, decision or action is made or taken by the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee for a reason relating to quality of care issues, non-quality of care issues, and/or credentialing requirements, the Practitioner shall be entitled to a Level I Review. The Practitioner shall be sent a written notice, by Fedex, with a return receipt, of the recommendation or decision and shall be afforded thirty (30) days in which to respond in writing to request a Level I Review. A copy of the “IEHP Peer Review Level I and Credentialing Appeal” document shall be provided with the notice. The notice will state:

1. The action which has been proposed against the Practitioner;
2. A brief description of the factual basis for the proposed action;
3. That the Practitioner has the right to request that a Level I Review be conducted by the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee;
4. That a Level I Review must be requested by the Practitioner in writing, addressed to the IEHP Medical Director within thirty (30) days of the date of receipt of the notice by the Practitioner. The Practitioner’s written request for a Level I Review must state the reasons for the request clearly, and if the Practitioner wishes to exercise the right to present information orally at the Level I Review meeting as provided in Section 4b below, the Practitioner shall so indicate in the written request for Level I Review;
5. A brief summary of the Practitioner’s rights at the Level I Review, as set forth in Section 4 below;
6. That the Level I Review shall take place before the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee; and
7. That the action, if implemented, must be reported to the Medical Board of California under California Business and Professions Code Section 805 or 809 as applicable, National Practitioner Data Bank (NPDB), and/or under any other applicable federal or state law.

D. A Practitioner’s rights at the Level I Review include:

1. Right to present any additional written material for review by the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee.

   Right to present any information orally to the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee in person at the time of the meeting for the Level I Review.

   If the Level I Review is not requested by the Practitioner within the time and in the manner specified, all administrative Level I Review rights of the Practitioner shall be deemed waived, and the decision made by the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee shall be final.

E. If Level I Review is requested within the time and in the manner specified, the IEHP Medical Director shall arrange for the review to be conducted at the next scheduled meeting of the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee, and the Practitioner shall be sent a written notice via FedEx stating the date, time, and place of the Level I Review meeting. The Practitioner’s written response to the notice of action or proposed action shall be summarized in or attached to a report to the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee which shall be written by the IEHP Medical Director, as a member of the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee.

F. As provided in this “IEHP Peer Review Level I and Credentialing Appeal”, the Level I Review shall include an opportunity for the Practitioner to present information and arguments in writing and/or orally. However, the Level I Review meeting is not a hearing, and the procedural rights associated with formal peer review hearings do not apply in Level I Review. At a Level I Review meeting, Practitioners may not be represented by a licensed attorney; however, they have a right to be represented by a non-attorney representative of their choice. The IEHP Peer Review Subcommittee and IEHP Credentialing Subcommittee shall have the discretion to prescribe such additional procedural elements as it deems appropriate to the circumstances. When the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee is satisfied that sufficient information and arguments have been presented in this review process, it shall recommend or take such action as it deems appropriate and send written notice via FedEx to the Practitioner.

G. In cases where the decision by the IEHP Peer Review Subcommittee or Credentialing Subcommittee for the Level I Review will result in the denial, suspension, reduction or termination of the Practitioner’s participation status with IEHP, the written notice will include the following:

1. The Level I Review decision, including a brief description of the proposed recommendation, decision or action and the reasons for it;

2. That the action, if implemented, must be reported to the Medical Board of California under Business and Professions Code Section 805 or 809 as applicable, National Practitioner Data Bank (NPDB), or under any other applicable federal or state law;
3. That the Practitioner may request a Level II Appeal hearing for adverse peer review decisions
4. That a Level II Appeal hearing must be requested in writing, within thirty (30) days of receipt of the notice by the Practitioner and the request must include a statement of the grounds for requesting a Level II Appeal;
5. A brief summary of the Practitioner’s rights with respect to the Level II Appeal hearing;
6. A statement that the Practitioner is required to exhaust the administrative remedies of the Level II Appeal hearing prior to seeking judicial review of the recommendations, decisions or actions of the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee; and
7. The Level II Appeal proceeding shall take place before a Hearing Officer, selected by the IEHP Medical Director in accordance with the procedures set forth in the Level II Appeal document, and the final action shall be taken by the Peer Review Subcommittee.

Request for a Level II Appeal

A. The Practitioner shall have thirty (30) days following the date of receipt of a notice of an adverse recommendation, decision or action resulting from a Level I Review to request a formal Level II Appeal. The request must be submitted in writing, directed to the IEHP Medical Director, and must be received at IEHP within the prescribed period. If the Practitioner does not request a formal Level II Appeal within the time and in the manner prescribed, they shall be deemed to have accepted the recommendation, decision, or action involved, and shall be deemed to have waived all administrative appellate review rights, and the recommendation, decision, or action may be adopted by the Peer Review Subcommittee or IEHP Credentialing Subcommittee as IEHP’s final action.

Reporting

A. IEHP shall comply with the reporting requirements of the Medical Board of California (MBOC) as required by law. IEHP shall comply with the reporting requirements of the California Business and Professions Code, the Federal Health Care Quality Improvement Act, and the National Practitioner Data Bank (NPDB) regarding adverse credentialing and peer review actions. The Practitioner will be notified of the reports and its contents.
B. MBOC requires reports whenever: a licentiate’s application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason; a licentiate’s membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason; restrictions are imposed or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of thirty (30) days or more for any 12-month period, for a medical disciplinary cause or reason; and/or a licentiate’s resignation or leave of absence from membership, staff, or employment following notice of impending investigation based on information indicating medical disciplinary cause or reason.
C. MBOC requires an 805 report whenever a peer review body makes a final decision or recommendation regarding the disciplinary action, resulting in a final proposed action to be taken against a licentiate based on the peer review body’s determination, following formal investigation
of the licentiate that any of the facts listed below have occurred, regardless of whether a hearing is held pursuant to Section 809:

D. IEHP complies with all reporting requirements of the Medical Board of California, the Dental Board of California, the Osteopathic Medical Board of California, the Board of Podiatric Medicine, the California Board of Behavioral Sciences, the Board of Psychology, and the Physician Assistant Board, and other licensing agencies, and National Practitioners Data Bank (NPDB) as required by law. IEHP also complies with the reporting requirements of the California Business and Professions Code and the Federal Health Care Quality Improvement Act regarding adverse credentialing decisions. IEHP notifies the Practitioner of such reporting and its contents in writing.

1. Actions that are reported to the Medical Board of California, the Dental Board of California, the Osteopathic Medical Board of California, the Board of Podiatric Medicine, the California Board of Behavioral Sciences, the Board of Psychology, and the Physician Assistant Board, and other licensing agencies, and National Practitioners Data Bank (NPDB) as required by law, as applicable, include a decision to deny or reject a Practitioner’s application for staff privileges or membership for a medical disciplinary cause or reason; a decision to terminate or revoke a Practitioner’s membership, staff privileges or employment for a medical disciplinary cause or reason; restrictions imposed or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of thirty (30) days or more for any twelve (12) month period, for a medical disciplinary cause or reasons; and/or a Practitioner’s resignation or leave of absence from membership, staff, or employment following notice of impending investigation based on information indicating medical disciplinary cause or reason.

2. An 805.01 will be filed, if a recommendation or final decision based on any of the following:
   a. Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury or to one or more patients in such a manner as to be dangerous or injurious to any person or the public
   b. The use of, or prescribing for or administering to him/herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, or any other persons, or the public, or to the extent that such impairs the ability of the licentiate to practice safely
   c. Repeated acts of clearly excessive prescribing, furnishing or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without good faith effort prior examination of the patient and medical reason therefore.
   d. Sexual misconduct with one or more patients during a course of treatment or an examination.

Confidentiality
A. All credentialing and peer review records and proceedings shall be confidential and protected to the fullest extent allowed by Section 1157 of the California Evidence Code, and any other applicable law.
INLAND EMPIRE HEALTH PLAN

PEER REVIEW PROCESS AND LEVEL II APPEAL

Reduction, Suspension or Termination of Practitioner Status

(Adopted April 14, 1997)

(Amended January 2019)
INLAND EMPIRE HEALTH PLAN

PEER REVIEW PROCESS AND LEVEL II APPEAL
Reduction, Suspension or Termination of Practitioner Status

Purpose:
A. To provide:
   1) A mechanism for peer review of IEHP Providers of Service (Practitioners);
   2) A process for Practitioners (as defined below under section B, “Scope”) to appeal negative peer review recommendations, decisions and actions for any reason related to quality of care, non-quality of care, and/or other professional conduct issues including, but not limited to, denial, reduction, suspension or termination of practitioner status, as requested by the Inland Empire Health Plan (IEHP) Peer Review Subcommittee, the IEHP Quality Management (QM) Committee, or the IEHP Chief Medical Officer; and
   3) A mechanism for appropriate final action.

Scope:
A. The following policies and procedures apply to all health care professionals participating or requesting participation as a Practitioner for IEHP (Practitioners), including, but not limited to, the following licentiates: Physicians (MD), Osteopathic Physician (DO), Podiatrists (DPM), Pharmacists (Pharm D or RPh), Oral Surgeons (DDS or DMD), Optometrists (OD), Chiropractors (DC), Audiologists, Clinical Psychologists, (PhD), Nurse Practitioners (NP), Physician Assistants (PA), Certified Nurse Midwives (CNM), Physical Therapists (PT), Occupational Therapists (OT), and Speech/Language Therapists (S/LT), psychiatrists, psychologists, master level clinical nurses, Licensed Clinical Social Workers (LCSW), Marriage, Family and Child Counselors (MFCC/MFT) and other behavioral health professionals licensed to provide behavioral health services in the state of California.

Policy:
A. A Practitioner’s status or participation may be denied, reduced, suspended or terminated for any lawful reason, including, but not limited to, a lapse in basic qualifications such as licensure, insurance, or required medical staff privileges or admission coverage at an IEHP contracted hospital; a determination by IEHP that the Practitioner cannot be relied upon to deliver the quality or efficiency of patient care required by IEHP; a determination by IEHP that the Practitioner cannot be relied upon to follow IEHP’s clinical or business guidelines or directives; or a change in IEHP’s business needs.

B. A Practitioner may appeal any adverse peer review Level I Review recommendation, decision or action by IEHP that is based on quality of care, non-quality of care, and/or other professional conduct issues and impacts his or her participation status with IEHP, including denial, reduction, suspension, or termination of participation status with IEHP, in accordance with the Level II Appeal procedures, as provided herein. A Practitioner may not appeal a recommendation, decision or action based on reasons unrelated to quality of care, non-quality of care, and/or other professional conduct issues. For example, there is no right to appeal if any application is denied or not processed because the applicant fails to provide requested information, additionally Level II Appeal procedures are not available for initial adverse
credentialing decisions upheld by the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee.

Procedure:

A. Final Authority
IEHP, as a health care service plan, is defined as a peer review body under applicable law. Certain peer review functions have been delegated to the IEHP Peer Review Subcommittee and the IEHP Credentialing Subcommittee. The IEHP Peer Review Subcommittee serves as the final level of review and is the final authority in credentialing and peer review decisions. The IEHP Peer Review Subcommittee has delegated the hearing of any Level II Appeal to a Judicial Hearing Committee (JHC).

B. Judicial Hearing Committee
Whenever a Level II Appeal is required pursuant to this document “Peer Review Process and Level II Appeal” the Chief Medical Officer shall appoint a JHC consisting of at least three (3) physician Providers, and alternates as appropriate. The physician Providers selected to serve on the JHC shall be physicians from within the IEHP network who shall gain no direct financial benefit from the outcome and are neither in direct economic competition nor professionally associated (including in a referral relationship) with the subject of the hearing. None of the JHC members may have acted as an accuser, investigator, fact-finder or initial decision maker, or otherwise actively participated in consideration of the matter that forms the subject of the appeal prior to the recommendation or action. JHC members also should not have participated in the care of the patients (if any) whose care forms the subject of the appeal. Where feasible, the JHC shall include at least one member who practices in the same specialty as the Practitioner who requested the hearing. The Chief Medical Officer shall designate a Chairperson who shall handle pre-hearing matters and preside until a hearing officer, as described in the Hearing Officer Section 4, is appointed. The JHC shall make findings of fact, and issue a recommended decision for action by the Peer Review Subcommittee.

C. Request for a Level II Appeal
Notice of the right to a Level II Appeal shall be sent as provided in Level I Review, Section 9 (Request for a Level II Appeal). The Practitioner shall have thirty (30) days following the date of receipt of a notice of an adverse recommendation, decision or action resulting from a Level I Review to request a formal Level II Appeal. The request must be submitted in writing, directed to the IEHP Chief Medical Officer, and must be received at IEHP within the prescribed period. If the Practitioner does not request a formal hearing within the time and in the manner prescribed, the Practitioner shall be deemed to have accepted the recommendation, decision, or action involved, and shall be deemed to have waived all administrative appellate review rights, and the recommendation, decision, or action may be forwarded to the Peer Review Subcommittee.

D. Hearing Officer
1. Selection
The Peer Review Subcommittee or its designee shall appoint a hearing officer to preside at the JHC hearing. The hearing officer shall be an attorney at law who has been admitted to practice before the courts of this State for at least five (5) years prior to appointment, and who is qualified by knowledge and experience to preside over a quasi-judicial peer
review hearing. The hearing officer shall gain no direct financial benefit from the outcome of the hearing. The hearing officer must not act as a prosecuting officer, or as an advocate for IEHP, Peer Review Subcommittee, the body whose action prompted the hearing, or the Practitioner. If requested by the JHC, the hearing officer may participate in the deliberations of the JHC and be legal advisor to it, but he/she shall not be entitled to vote. The hearing officer may be a hearing officer for either Riverside or San Bernardino counties, provided he or she meets the other criteria established by this subsection. The hearing officer will be sent a letter of appointment by the Peer Review Subcommittee.

The Practitioner shall have the right to a reasonable opportunity to voir dire any JHC member and the hearing officer, and the right to challenge the impartiality of any JHC member and the hearing officer. Such challenges to the impartiality of any JHC member or the hearing officer shall be ruled on by the hearing officer.

2. Duties
The duties of the hearing officer shall be to preside over the hearing, including any pre-hearing and/or post-hearing procedural matters; to rule on the challenges to the impartiality of JHC members and/or the hearing officer; to rule on requests for access to information and/or relevancy; rule on requests for continuances; to rule on evidentiary and burden of proof issues; to prepare the written report and recommendation of the JHC; and to perform such other functions as may be necessary or appropriate to facilitate completion of a fair hearing process as expeditiously as possible.

E. Scheduling of Appeal/Notice of Hearing
Upon the selection of the JHC, the Level II Appeal shall be scheduled at a time and place mutually agreeable to the Practitioner and to IEHP. The Practitioner shall be given notice of the time, place and date of the hearing. IEHP shall make its best efforts to ensure that the date of the commencement of the hearing shall be not less than thirty (30) days nor more than sixty (60) days from the date that IEHP receives the request for a Level II Appeal. The time frames set forth herein may be shortened or extended for a reasonable time by mutual written agreement of the parties (or by the Chairperson of the JHC if the hearing officer has not been appointed yet) upon a showing of good cause in accordance with Section 11 below. The peer review process shall be completed within a reasonable time after the Practitioner receives notice of a final proposed action or an immediate suspension or restriction of clinical privileges, unless the JHC issues a written decision that the Practitioner failed to comply with the discovery provision herein, or consented to the delay in the proceedings.

F. Notice of Charges
A Notice of Charges shall be sent to the Practitioner along with the Notice of Hearing, further specifying, as appropriate, the acts or omissions with which the Practitioner is charged. This Notice of Hearing also shall provide a list of the patient records, if any, which are to be discussed at the hearing, if that information has not been provided previously.

Witness lists (see Section D.8) shall be amended as soon as possible when additional witnesses are reasonably known or anticipated. A failure by either party to comply with this requirement, shall be good cause to postpone the hearing.

G. Discovery:
   Rights of Discovery and Copying
The Practitioner may inspect and copy (at his/her own expense) any documentary information relevant to the charges that the IEHP Peer Review Subcommittee has in its possession or under its control, as soon as practicable after the receipt of the Practitioner’s request for a Level II Appeal. The IEHP Peer Review Subcommittee shall have the right to inspect and copy (at its own expense) any documentary information relevant to the charges that the Practitioner has in his/her possession or control, as soon as practicable after the Practitioner’s receipt of the IEHP Peer Review Subcommittee’s request for such documents.

This right of discovery and copying does not create or imply an obligation to modify or create documents in order to satisfy a request for information. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable Practitioners, other than the Practitioner under review. Failure to comply with reasonable discovery requests at least ten (10) days prior to the Level II Appeal hearing shall be good cause for a continuance of the Level II Appeal hearing.

1. **Limits on Discovery**

   The Hearing Officer, upon the request of either side, may impose safeguards including, but not necessarily limited to, the denial of a discovery request. The Hearing Officer when ruling upon requests for access to information and determining the relevancy thereof shall, among other factors, consider the following:
   
   a. Whether the information sought may be introduced to support or defend the charges;
   
   b. Whether the information is “exculpatory” in that it would dispute or cast doubt upon the charges or “inculpatory” in that it would prove or help support the charges and/or recommendation;
   
   c. The burden on the party of producing the requested information; and
   
   d. Other discovery requests the party has previously made or has previously resisted.

H. **Pre-Hearing Witness List and Document Exchange**

   At least (10) working days prior to Level II appeal hearing, the parties shall exchange lists of the names of witnesses expected to be called at the hearing and copies of all documentation expected to be introduced in the evidence at the hearing. A failure to comply with this rule shall be good cause for the hearing officer to grant a continuance. Repeated failures to comply shall be good cause for the hearing officer to limit introduction of any documents or witnesses not provided or disclosed to the other side in a timely manner.

I. **Representation**

   Level II Appeals are provided for the purpose of addressing issues of professional conduct or competence in health care. Practitioner is required to notify IEHP if they intend to be represented by legal counsel. Accordingly, neither the Practitioner nor the peer review body whose decision prompted the hearing may be represented by an attorney at the hearing unless a majority of the JHC members, in their discretion, permit both sides to be so represented. In no case may the IEHP Peer Review Subcommittee be represented by an attorney if the Practitioner is not so represented. The foregoing shall not be deemed to deprive any party of its right to the assistance of an attorney for the purpose of preparing for the hearing. When attorneys are not allowed in the hearing, the Practitioner and the IEHP Peer Review Subcommittee each may be represented at the hearing by a licensed Practitioner who is not an attorney.
J. **Failure to Appear**

Failure, without good cause, of the Practitioner to appear and proceed at the Level II Appeal shall be deemed to constitute voluntary acceptance of the recommendation or action involved and it shall thereupon become the final action of the IEHP Peer Review Subcommittee.

K. **Postponements and Extensions**

After a timely request for a hearing has been received as described above, postponements and extensions of time beyond the times expressly permitted in this Level II Appeal Process may be effected upon written agreement of the parties or granted by the hearing officer (or the Chairperson of the JHC if the hearing officer has not been appointed yet) on a showing of good cause and subject to the hearing officer’s discretion to assure that the hearing proceeds and is completed in a reasonably expeditious manner under the circumstances.

L. **Record of the Hearing**

A record of the Level II Appeal shall be produced by using a certified court reporter to record the hearing (an audio tape recording of the proceedings may be made in addition). The Practitioner shall be entitled to receive a copy of the transcript upon paying his or her share of the court reporter’s fees, and the reasonable cost for preparing the transcript. Oral evidence shall be taken under oath administered by the court reporter.

M. **Rights of the Parties**

Both parties shall have the following rights, which shall be exercised in an efficient and expeditious manner and within reasonable limitations imposed by the hearing officer:

1. To be provided with all of the information made available to the JHC;
2. To have a record made of the proceedings as provided herein;
3. To call, examine and cross-examine witnesses;
4. To present and rebut evidence determined by the hearing officer to be relevant; and
5. To submit a written statement at the close of the hearing.

The Practitioner may be called by the IEHP Peer Review Subcommittee’s representative and examined as if under cross-examination. The JHC may interrogate the witnesses, or call additional witnesses, as the JHC deems appropriate. Each party has the right to submit a written statement at the close of the Level II Appeal. The JHC may request such a statement to be filed following the conclusion of the presentation of oral testimony.

N. **Rules of Evidence**

Rules relating to the examination of witnesses and the presentation of evidence in courts of law shall not apply in any hearing conducted herein. Any relevant evidence, including hearsay, shall be admitted by the hearing officer if it is evidence upon which responsible persons are accustomed to rely in the conduct of serious affairs. A Practitioner shall not be permitted to introduce information not produced upon request of the peer review body during the underlying peer review, application, or other credentialing process, unless the Practitioner establishes that the information could not have been produced previously in the exercise of reasonable diligence.

O. **Basis of Recommended Decision**

The recommended decision of the JHC shall be based on, but may not be limited to, the evidence produced at the hearing and any written statements submitted to the JHC.
P. **Burden of Going Forward and Burden of Proof**

In all Level II Appeals, the IEHP Peer Review Subcommittee shall have the burden of initially presenting evidence to support its recommendation, decision or action.

1. If the IEHP Peer Review Subcommittee’s recommendation is to deny initial IEHP affiliation, the Practitioner shall bear the burden of persuading the JHC, by a preponderance of the evidence, that he/she is sufficiently qualified to be awarded such affiliation in accordance with the professional standards of IEHP. This burden requires the production of information that allows for an adequate evaluation and resolution of reasonable doubts concerning the Practitioner’s qualifications, subject to the IEHP Peer Review Subcommittee’s right to object to the production of certain evidence as provided herein. A Practitioner shall not be permitted to introduce information not produced upon request of the peer review body during the application process, unless the initial applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

2. If the IEHP Peer Review Subcommittee’s action involves the termination of existing IEHP participation; or the suspension, reduction or limitation of privileges to perform patient care services, the IEHP Peer Review Subcommittee shall have the burden of persuading the JHC, by a preponderance of the evidence that its action is reasonable and warranted. The term “reasonable and warranted” means within the range of reasonable and warranted alternatives available, and not necessarily that the action is the only measure or the best measure that could be taken in the opinion of the JHC.

Q. **Preparation of Recommended Findings of Fact, Recommended Conclusions of Law and Recommended Decision**

Within a reasonable time after the final adjournment of the Level II Appeal hearing, the JHC shall issue a decision that shall include finding of fact and conclusions of law articulating the connection between the evidence produced at the hearing and the result. A copy shall be sent to the IEHP Chief Medical Officer, the Practitioner involved, and the IEHP Chief Executive Officer. Final action shall be taken by the Peer Review Subcommittee, as provided below.

There shall be no right of further appeal to the Peer Review Subcommittee following a formal Level II Appeal. The Practitioner shall receive a written decision of the Peer Review Subcommittee, including a statement of the basis for the decision, which shall be sent via FedEx. The notice shall contain a statement that there is no right of appeal the final decision of the Peer Review Subcommittee.

R. **Reports**

IEHP shall comply with the reporting requirements of the California Business and Professions Code, the Federal Health Care Quality Improvement Act, the National Practitioner Data Bank (NPDB), and any other applicable law regarding adverse peer review actions.

IEHP shall comply with the reports required by MBOC whenever a peer review body makes a final decision or recommendation regarding the disciplinary action, resulting in a final proposed action to be taken against a licentiate based on the peer review body’s determination, following formal investigation of the licentiate that any of the facts listed below have occurred, regardless of whether a hearing is held pursuant to Section 809.

MBOC requires reports whenever: a licentiate’s application for staff privileges or membership
is denied or rejected for a medical disciplinary cause or reason; a licentiate’s membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason; restrictions are imposed or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of thirty (30) days or more for any 12-month period, for a medical disciplinary cause or reason; and/or a licentiate’s resignation or leave of absence from membership, staff, or employment following notice of impending investigation based on information indicating medical disciplinary cause or reason.

MBOC requires an 805 report whenever a peer review body makes a final decision or recommendation regarding the disciplinary action, resulting in a final proposed action to be taken against a licentiate based on the peer review body’s determination, following formal investigation of the licentiate that any of the facts listed below have occurred, regardless of whether a hearing is held pursuant to Section 809:

IEHP complies with all reporting requirements of the Medical Board of California, the Dental Board of California, the Osteopathic Medical Board of California, the Board of Podiatric Medicine, the California Board of Behavioral Sciences, the Board of Psychology, and the Physician Assistant Board, and other licensing agencies, and National Practitioners Data Bank (NPDB) as required by law. IEHP also complies with the reporting requirements of the California Business and Professions Code and the Federal Health Care Quality Improvement Act regarding adverse credentialing decisions. IEHP notifies the Practitioner of such reporting and its contents in writing.

1. Actions that are reported to the Medical Board of California, the Dental Board of California, the Osteopathic Medical Board of California, the Board of Podiatric Medicine, the California Board of Behavioral Sciences, the Board of Psychology, and the Physician Assistant Board, and other licensing agencies, and National Practitioners Data Bank (NPDB) as required by law, as applicable, include a decision to deny or reject a Practitioner’s application for staff privileges or membership for a medical disciplinary cause or reason; a decision to terminate or revoke a Practitioner’s membership, staff privileges or employment for a medical disciplinary cause or reason; restrictions imposed or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of thirty (30) days or more for any twelve (12) month period, for a medical disciplinary cause or reasons; and/or a Practitioner’s resignation or leave of absence from membership, staff, or employment following notice of impending investigation based on information indicating medical disciplinary cause or reason.

2. An 805.01 will be filed, if a recommendation or final decision based on any of the following:
   a. Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury or to one or more patients in such a manner as to be dangerous or injurious to any person or the public.
   b. The use of, or prescribing for or administering to him/herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, or any other persons, or the public, or to the extent that such impair the ability of the licentiate to practice safely.
c. Repeated acts of clearly excessive prescribing, furnishing or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without good faith effort prior examination of the patient and medical reason therefore.

d. Sexual misconduct with one or more patients during a course of treatment or an examination.

S. Confidentiality
All peer review records and proceedings held pursuant to this procedure shall be confidential and protected to the fullest extent allowed by Section 1157 of the California Evidence Code, and any other applicable State and/or Federal law.

T. Privileges and Immunities
All activities conducted pursuant to this Level II Appeal Process are in reliance on the privileges and immunities afforded by the Federal Health Care Quality Improvement Act (42 USC Section 11101, et seq.) California Business and Professions Code Section 805, et seq. and the California Civil Code Sections 43.7, 43.8 and 47(b)(4) and (c).

U. Severability
This document and the various parts, sections and clauses thereof are hereby declared to be severable. If any part, sentence, paragraph, section or clause is adjudged unconstitutional or invalid, such unconstitutionality or invalidity shall affect only that part, sentence, paragraph, section or clause of this document, or person or entity; and shall not affect or impair any of the remaining provisions, parts, sentences, paragraphs, sections or clauses of this document, or its application to other persons or entities.

V. Applicability
This document shall be applicable to all peer review Level II Appeals, and shall be controlling.

W. Costs of Hearing
1. The costs associated only with the conduct of the Level II Appeal hearing, excluding the costs listed in subsection 23.b below, shall be divided equally between the Practitioner and IEHP. Such costs shall include, but not be limited to, the costs of the certified shorthand reporter and rental of a hearing room, if applicable.

2. The costs to be divided between the practitioner and the IEHP shall not include the costs, fees, and any other charges associated with legal representation of either party; the cost of the JHC, if any; the costs of discovery; the costs of preparation for the hearing; mileage costs for either party or witnesses; witness fees; or the costs of obtaining copies of the hearing transcripts or tapes. Except for the costs of the hearing officer and JHC, which shall be borne by IEHP, each party shall bear its own costs for these items individually.

X. Exhaustion of Administrative Remedies
1. A Practitioner shall be required to exhaust the administrative remedies herein prior to seeking judicial review of the actions of the IEHP Peer Review Subcommittee.
PATIENT TRANSFER AGREEMENT

BETWEEN

<TRANSFERING PROVIDER>

AND

<RECEIVING PROVIDER>
Attachment 05 – Patient Transfer Agreement

PATIENT TRANSFER AGREEMENT

This Patient Transfer Agreement (the “Agreement”) is made and entered into by and between <TRANSFERING PROVIDER>, the transferring provider, hereinafter referred to as “TRANSFEROR”, and <RECEIVING PROVIDER>, the receiving provider, hereinafter referred to as “RECEIVER”. (In general, both individually referred to as “Party” and collectively referred to as “Parties”.)

RECITALS

WHEREAS, TRANSFEROR and RECEIVER share a mutual desire to ensure the continuity of care and treatment appropriate to the needs of each patient in their respective institutions; and

WHEREAS, the purpose of this agreement is to define procedures and policies pertaining to:

1. The transfer of patients from TRANSFEROR to RECEIVER,
2. The provision of medical care by RECEIVER, and
3. The exchange and joint review of patient medical records between TRANSFEROR and RECEIVER.

NOW, THEREFORE, in consideration of their mutual agreements and promises, the Parties hereto agree as follows:

TERMS

1. PROCEDURES AND POLICIES.

TRANSFEROR and RECEIVER mutually agree on the procedures and policies as outlined in Exhibit A and Attachment 1 that are attached hereto and fully incorporated herein.

2. TERM.

The term of this Agreement shall be for a period of _______ year(s) from the date the last party signs this Agreement.

3. TERMINATION.

3.1 This Agreement may be terminated by either Party at any time and for any reason upon at least ninety (90) days prior written notice and by ensuring the continuity of care to patients who already are involved in the transfer process. This Agreement shall automatically terminate upon the occurrence of any of the following:
   a. either Party has its license revoked or suspended;
   b. either Party is destroyed to such an extent that the patient care provided by such institution cannot be carried out adequately;
   c. either Party no longer is able to provide the services for which this Agreement is sought;
   d. either Party is in default under any of the terms of this Agreement.

3.2 The rights and remedies of TRANSFEROR provided in this section shall not be exclusive and are in addition to any other rights and remedies provided by law or this Agreement.

4. INSURANCE.

Each Party shall maintain general and professional liability insurance with limits of at least $1,000,000
per occurrence and $3,000,000 in the aggregate. Certificates of insurance shall be made available upon request unless self-insured for the required coverage amounts.

5. **HOLD HARMLESS/INDEMNIFICATION.**

In connection with the obligations imposed by this Agreement, TRANSFEROR and RECEIVER shall each indemnify, defend, and hold harmless the other, including its officers, directors, agents, and employees, from and against any and all loss, damage, liability, or expense (including without limitation, reasonable attorney’s fees), of any kind arising by reason of the acts or omissions of the respective Party’s officers, directors, agents, employees, contractors, agents and shareholders acting alone or in collusion with others, in breach of this Agreement or applicable law. Each Party shall promptly notify the other Party hereto of any claims or demands which arise and for which indemnification is sought. The terms of this Section shall survive the termination of this Agreement.

6. **INDEPENDENT CONTRACTORS.**

The Parties are independent contractors who shall have no liability or objection for the acts or omissions of the other.

7. **NONEXCLUSIVE.**

Nothing in this Agreement shall be construed as limiting the rights of either Party to affiliate or contract with any other hospital or health care provider while this Agreement is in effect.

8. **PATIENT REFERRALS.**

This Agreement does not require either TRANSFEROR or RECEIVER to refer patients or enter into any other arrangement for the provision of any item or service offered for which Medicare or Medicaid payments may be made.

9. **NON-DISCRIMINATION REGARDING PATIENTS.**

Neither Party shall differentiate or discriminate in the treatment of any patient because of the patient’s race, color, national origin, ancestry, religion, health status, sex, marital status, age, the source or amount of payment available, or the ability of the patients to pay for medical services.

10. **ASSIGNMENT.**

This Agreement may not be assigned by either Party without the prior written consent of the other Party.

11. **ENTIRE AGREEMENT.**

This Agreement contains the entire understanding between the undersigned Parties and supersedes any and all prior agreements or understandings, whether oral or written, relating to the subject matter of this Agreement. This Agreement may not be amended, changed or modified except by written agreement executed by both Parties hereto.

12. **JURISDICTION/VENUE.**

This Agreement shall be governed by, and construed in accordance with, the laws of the State of
California. The Parties agree and consent to the exclusive jurisdiction of the courts of the State of California for all purposes regarding this Agreement and further agree and consent that venue of any action brought hereunder shall be exclusively in either the County of San Bernardino or the County of Riverside.

13. **THIRD PARTY BENEFICIARY.**

The Parties do not intend to confer any rights, privileges or benefits upon any other individual(s) or entity(ies), not signatories to this Agreement, arising out of this Agreement. The Parties agree that nothing in this Agreement shall be construed or interpreted to confer any such rights, privileges or benefits upon any individual or entity not a signatory to this Agreement.

14. **FORCE MAJEURE.**

If either Party is unable to comply with any provision of this Agreement due to causes beyond its reasonable control, and which could not have been reasonably anticipated, such as acts of God, acts of war, civil disorders, or other similar acts, such Party shall not be held liable for such failure to comply.

15. **NOTICE.**

All correspondences and notices required or contemplated by this Agreement shall be delivered to the respective Parties at the addresses set forth below and are deemed submitted one day after their deposit in the United States mail, postage prepaid:

**TRANSFEROR**

Name: ____________________________
Address: ____________________________
Address: ____________________________
Address: ____________________________
Attention: ____________________________

**RECEIVER**

Name: ____________________________
Address: ____________________________
Address: ____________________________
Address: ____________________________
Attention: ____________________________

16. **RECORDS AND DOCUMENTS.**

The Parties shall make available, upon written request by any duly authorized Federal, State or County agency, a copy of this Agreement and such books, documents and records as are necessary. All such books, documents and records shall be maintained for at least five years following termination of this Agreement.

17. **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA).**

The Parties in this Agreement are subject to all relevant requirements contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-91, enacted August 21, 1996, and the laws and regulations promulgated subsequent thereto. The Parties hereto agree to cooperate in accordance with the terms and intent of this Agreement for implementation of relevant law(s) and/or regulation(s) promulgated under HIPAA. The Parties further agree that it shall be in compliance, and shall remain in compliance with the
requirements of HIPAA, and the laws and regulations promulgated subsequent hereto, as may be amended from time to time.

IN WITNESS WHEREOF, the Parties hereto have signed this Agreement as set forth below.

**TRANSFEROR**

By ________________________________

Print Name and Title

Date ________________________________

**RECEIVER**

By ________________________________

Print Name and Title

Date ________________________________
EXHIBIT A

SCOPE OF WORK

A. Definition:

RECEIVER will provide (initial appropriate boxes by each Party)

____  ____ high risk obstetrical consultation

____  ____ routine obstetrical consultation

on RECEIVER’S premises, and perform deliveries for patients enrolled in the Medi-Cal program (including the Comprehensive Prenatal Services Program (CPSP)). If high risk obstetrics are provided, upon diagnosis of high risk medical conditions (see Attachment 1), TRANSFEROR will refer patient to RECEIVER for consultation. Pending RECEIVER’S recommendations, RECEIVER will assume care for the high risk patient or may transfer the patient back to TRANSFEROR with recommendation for follow-up care. If RECEIVER does not provide high risk obstetric care, those patients will be referred to other high risk accepting obstetricians with an existing written agreement with TRANSFEROR. Uncomplicated obstetrical patients with Inland Empire Health Plan (IEHP) coverage will be transferred to RECEIVER at 28 weeks gestation for continued care and delivery based on the individual case involved. Uncomplicated obstetrical patients with other coverage will be transferred by 32 weeks for continued care and delivery based on the individual case involved.

B. Responsibilities:

1. Upon request by TRANSFEROR, RECEIVER will accept transfer of the patient for consultation and assume responsibility for the care of the patient if indicated.

2. The Prenatal Care Coordinator (PCC) will maintain the overall Comprehensive Care Plan. The PCC is the CPSP provider that bills the initial combined assessment or any of the initial assessment procedures using the Individualized Care Plan. This provider will inform the patient that they are the case coordinator for all CPSP services. Each provider will bill only for the services that the provider directly renders. There will be no duplicate billing of the services, and service limits as specified in regulation for an individual patient will not be exceeded.

3. Prior to transfer for continuing prenatal care to RECEIVER the patient will be given a copy of her prenatal records and instructed to bring those records to every prenatal visit where the records will be updated. The patient will be instructed to bring these records to the accepting obstetric provider and/or hospital at the time of labor and delivery. Uncomplicated postpartum patients will be referred back to TRANSFEROR for follow-up services of the patient and the newborn. Additionally, TRANSFEROR will transmit via facsimile or electronic transmission, a copy of the patient’s prenatal record to RECEIVER at the time of transfer.

4. Patient will be delivered at the hospital where RECEIVER has admitting privileges. RECEIVER shall provide to TRANSFEROR and IEHP a list of hospitals where RECEIVER has admitting privileges.

5. A copy of the discharge summary for both the mother and the newborn will be forwarded to TRANSFEROR by RECEIVER. This information will be used to provide the patient with necessary information and appropriate referrals. TRANSFEROR will follow up with patients after delivery to ensure they receive postpartum services, family planning, well baby care, and Women, Infant, Children (WIC) information. The patient will be instructed to return to TRANSFEROR for the two week newborn exam and six to eight week postpartum examination for the mother.

6. RECEIVER will deliver patients and provide complete delivery information and outcome to TRANSFEROR and arrange for back-up delivery coverage in case of absences.
C. The flow of patient information:

1. TRANSFEROR will provide information and education related to antepartum and postpartum care for patient enrolled in Medi-Cal programs including CPSP and eligible for pregnancy related services. TRANSFEROR will provide information, education and referrals for family planning and well child care in the postpartum period.

2. TRANSFEROR will maintain malpractice insurance to cover the care provided by the TRANSFEROR. The TRANSFEROR may bill Medi-Cal on a fee for service basis (CPSP) or bill the managed care plan for the code “01” daily encounter visit with balance billing to Medi-Cal for the managed care differential (code 18).

3. RECEIVER will provide malpractice insurance coverage to render services under this Agreement. RECEIVER will bill Medi-Cal directly for their care and delivery of those patients enrolled in the Medi-Cal program.

4. All ante-partum and postpartum care will be performed according to protocols approved by the Chief of Medical Services for TRANSFEROR based on the discipline-specific standards set by the American College of Obstetrics and Gynecology.

5. In performing their duties under the agreement, both parties shall comply with the California Medi-Cal program requirements, the Comprehensive Prenatal Services Program (CPSP) requirements (California Code of Regulations, Title 22, Section 51179) when applicable, and the policies and procedures of the managed care plans, including any applicable credentialing requirements.
Attachment 1

High Risk Conditions

This includes all the high risk conditions in which the TRANSFEROR will transfer patients to RECEIVER but not limited to the following list:

Medical history and conditions:

- Drug/alcohol use
- Proteinuria (>=2+ by catheter sample, unexplained by urinary tract infection)
- Complicated pyelonephritis
- Severe systemic disease that adversely affects pregnancy

Obstetric history and conditions:

- Blood pressure elevation (diastolic>=90 or more than 2 visits), no proteinuria
- Suspected fetal growth restriction
- Fetal abnormality suspected by ultrasonography
- Fetal demise
- Gestational Diabetes Mellitus
- Active herpes outbreak on or after 36 weeks
- Hydramnios by ultrasonography
- Hyperemesis gravidarum
- Multiple gestation
- Oligohydramnios by ultrasonography
- Preterm labor, threatened
- Premature rupture of membranes
- Vaginal bleeding >= 14 weeks

Examination and laboratory findings:

- Abnormal MSAFP
- Pap HGSIL, ASCUS-cannot rule out HGSIL, AGUS
- Anemia (Hct <28%) not responsive to iron therapy
- Condylomata (extensive, covering labia and vaginal opening)
- HIV
- CDE (Rh) or other blood group isoimmunization (excluding ABO, Lewis)