



Policy #: 500-2010-H  
Title: Provider Credentialing Policy  
Dept.: Provider Services  
Signature of CEO: \_\_\_\_\_  
Effective Date: 9/1999  
Revision Date: 1/2008

## **I. PURPOSE**

To ensure that participating providers and physician executives meet basic qualifications before providing services to CenCal Health Members.

## **II. POLICY**

The Provider Credentialing Policy is one aspect of CenCal Health's Quality Assessment and Improvement Program. This policy governs the credentialing of providers who are Medical Doctors (MDs), Doctors of Osteopathy (DOs), Doctors of Podiatric Medicine (DPMs), Doctors of Chiropractic (DCs), and doctoral level Psychologists (PhD, PsyD), who desire to participate with CenCal Health as Primary Care Providers (PCPs), or Referral Specialists as individuals, members of a group or community clinic, or County employees. This policy also defines the credentialing of physicians and physician executives who serve in an administrative capacity for CenCal Health, and who make decisions regarding Utilization Management, Case Management, Quality Improvement, Member Satisfaction, Peer Review, Pharmacy & Therapeutics, or other decisions affecting clinical care or services for members of CenCal Health programs. Through this policy, CenCal Health ensures that participating providers and physician executives meet basic qualifications before delivering care to members and verifies the qualifications of said providers on an ongoing basis.

## **III. DEFINITIONS**

*American Board of Medical Specialties (ABMS)*- An NCQA-approved source for verification of board certification.

*American Medical Association (AMA) Physician Master File*- An NCQA-approved source for verification of various MD credentials, including, but not limited to: medical license, DEA certificate, education and training, board certification, sanction activity.

*American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report/Physician Master File*- An NCQA-approved source for verification of various DO credentials, including, but not limited to: medical license, DEA certificate, education and training, board certification, sanction activity.

*Chiropractic Information Network-Board Action Databank (CIN-BAD)*- Official Actions Database which is a comprehensive repository of information on actions taken by official bodies with regard to individual chiropractors. It is maintained by the Federation of Chiropractic Licensing Boards as a service to its member boards, to the health care community, and to the general public.

*Credentials Committee*- A committee delegated responsibility by the Board of Directors to review provider credentialing files and to make final decisions regarding each provider's participation in CenCal Health's provider network.

*Complete Application* 1) All blanks on the application form are filled in and necessary additional explanations provided; 2) all requested attachments have been submitted; 3) verification of the information is complete; and 4) all information necessary to properly evaluate the applicant's qualifications has been received and is consistent with the information provided in the application.

*Credentialing*- A part of CenCal Health's Quality Assessment and Improvement Program which verifies credentials with the issuer of the credential or other recognized monitoring organization, in order to evaluate a provider's qualifications, affiliations, competency, and to monitor the quality of medical services provided.

*Credentialing software*- NetworksPro © is a PC Windows© based software designed for the collection of provider credentials necessary to generate provider profiles and performance reports.

*Credentialing Specialist*- A CenCal Health employee responsible for carrying out the verification process; tracking, updating, reporting, and gathering of information pertaining to CenCal Health's Credentialing and Recredentialing Standards, based on those of NCQA; and some of the procedures of this policy.

*Directors*- Refers to the Medical Director and the Director of Provider Services who are delegated authority in this policy to monitor the credentialing process and its outcomes.

*Educational Commission for Foreign Medical Graduates (ECFMG)*- An organization that certifies providers who have graduated from a medical school in another country. ECFMG verifies each provider's diploma with the medical school prior to issuing certification.

*Facility-based Provider*- A provider who sees CenCal Health's members only as a result of the member being directed to a hospital, freestanding facility, or other inpatient setting. Examples of this type of provider are hospitalists, pathologists, radiologists, anesthesiologists, neonatologists, and emergency room physicians. The facility is responsible for credentialing these providers.

*Freestanding Facilities*- A health care facility that is physically, organizationally, and financially separate from a hospital and whose primary purpose is to provide immediate or short-term medical care on an outpatient basis. Examples of this type of facility include, but are not limited to, mammography centers, urgent care centers, surgical centers, and ambulatory behavioral health care facilities. CenCal Health assesses these facilities as Organizational Providers.

*Healthcare Integrity and Protection Data Bank (HIPDB)*- A nationwide flagging system established by the Health Insurance Portability and Accountability Act of 1996, Section 221(a), Public Law 104 191, to create a databank of healthcare related adverse actions, including civil judgments, criminal convictions, and actions taken by federal and state agencies responsible for licensing and certification of healthcare practitioners, providers, and suppliers.

*Independent Relationship*- An independent relationship exists between CenCal Health and a provider when CenCal Health directs its members to see a specific provider or group of providers. An independent relationship is not synonymous with an independent contract.

*Medical Disciplinary Cause or Reason* – Refers to an aspect of a provider’s competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

*Member* – A person enrolled in one of the health care programs administered by CenCal Health.

*National Practitioners Data Bank (NPDB)*- An information clearinghouse established by Title IV of Public Law 99-660 (the Health Care Quality Improvement Act of 1986), to collect and release certain information related to the professional competence and conduct of physicians, dentists, and other health care providers. The U.S. Government established the Data Bank to enhance professional review efforts by making certain information concerning medical malpractice payments and adverse actions available to eligible entities and individuals.

*Office of Inspector General (OIG)*- In response to legislation preventing certain individuals and businesses from participating in federally-funded health care programs (e.g. Medicare), the OIG developed a program to exclude these individuals and entities, and maintains a list of all currently excluded parties. Querying the OIG identifies parties excluded due to sanctions imposed by federally-funded health care programs.

*Provider*- In this context refers to an individual Medical Doctor (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic (DC), or Doctoral level Psychologist (PhD, PsyD).

*Primary Source Verification*- Refers to contacting the entity, agency, or institution that issues a provider’s credential for verification of the document’s authenticity. For some credentials, the primary source does not need to be contacted directly if they make verification available through another source. For the purposes of this policy, primary source verification means contacting either the actual issuer or another recognized monitoring source approved for verification by the National Committee for Quality Assurance (NCQA). For example, board certification may be verified by contacting the appropriate specialty board (the issuer) or the NCQA approved source of the American Board of Medical Specialties (ABMS) directory.

*Verification File*- A provider’s complete credentialing application with all verifications and documentation gathered during the credentialing verification process, including quality improvement data furnished by the Health Services Department.

*180-Day Timeframe-* To ensure that the Credentials Committee does not consider an applicant whose credentials may have changed since verification, CenCal Health and its staff will adhere to strict timeframes for the credentialing process. All verifications, attestations, and information releases will be less than 180 days old at the time of the credentialing decision as per NCQA standards, with the exception of those designated by NCQA as 365 (360) day time limited. For written verifications, the 180-day time limit begins with the date on the written verification from the entity that verified that particular credential. Unless otherwise stated, all verification timeframes in this policy are 180 days prior to the decision.

#### **IV. PROCEDURE**

##### **1. AUTHORITY AND RESPONSIBILITY**

CenCal Health's Board of Directors (the "Board"), as the governing body of CenCal Health, has a responsibility to maintain a system that encourages, promotes, and requires a high quality of care to be delivered to its members. The Board has the authority to delegate roles and responsibilities for the credentialing process to the appropriate CenCal Health staff and the Credentials Committee. The responsibilities of the respective delegated bodies are as follows:

- 1.1. The Director of Provider Services Department (or designee) has been delegated authority to make decisions and take actions regarding:
  - 1.1.1. compliance with CenCal Health's standards, protocols, policies, and provisions specified in the Physician Service Agreements;
  - 1.1.2. the oversight and review of the Provider Credentialing Policy to ensure it reflects current requirements of the appropriate regulatory bodies and CenCal Health's standards and policies;
  - 1.1.3. the preview of the verification files to ensure accuracy and completeness prior to the Credentials Committee meetings;
  - 1.1.4. the oversight of the credentialing verification process, staff; and
  - 1.1.5. the coordination of each Credentials Committee meeting in regards to the time, place, member attendance, agenda, and minutes of each meeting.
- 1.2. The Medical Director/Associate Medical Director have been delegated authority to:
  - 1.2.1. provide input regarding criteria for facility and medical record review;
  - 1.2.2. review member and provider clinical quality of care complaint summaries which are presented in the recredentialing decision making process;
  - 1.2.3. preview clinical quality of care cases to be reviewed by the Credentials Committee;
  - 1.2.4. review files with potential issues or problems.

- 1.3. The Medical Director/Associate Medical Director has also been delegated authority to make decisions and take actions regarding:
  - 1.3.1. the monitoring and reporting of each primary care physician's performance on facility and medical record reviews and ensuring the Quality Improvement summaries are present in the verification files when presented to the Credentials Committee;
  - 1.3.2. the review of the list of providers to be presented for review prior to the Credentials Committee meetings to determine if any of them have clinical quality of care issues that may require referral to Peer Review; and
  - 1.3.3. the coordination and follow-up on clinical quality of care recommendations made by the Credentials Committees.
- 1.4. The Credentials Committee reviews and evaluates the qualifications of each provider applying to become a contracted provider or seeking reappointment as a contracted provider. The Credentials Committee has been delegated authority to:
  - 1.4.1. review the quality of care findings resulting from CenCal Health's credentialing and quality monitoring and improvement activities;
  - 1.4.2. act as the final decision maker in regards to the initial and subsequent credentialing of providers based on clinical competency and/or professional conduct;
  - 1.4.3. monitor the credentialing policies and procedural activities and make recommendations to the Board for changes to these policies; and
  - 1.4.4. impose corrective actions, as described in CenCal Health's Corrective Action Policy.

## 2. CREDENTIALS COMMITTEE

### 2.1. Membership of the Credentials Committee

- 2.1.1. The credentials functions of the Credentials Committee are performed by six (6) providers credentialed by and contracted with CenCal Health and at least three of the following Ex-officio, non-voting members of the Committee: the Director of Provider Services, the Medical Director/Associate Medical Director, the Provider Services Quality Improvement Manager, and the Credentialing Specialist. The Director of Legal Affairs, the Chief Executive Director, and the Chief Operating Officer are also available as needed as ad-hoc non-voting members. The provider members of the committee shall be representative of the provider network.
- 2.1.2. The provider members are recruited from the contracted provider network, approved by the current members for a two-year period, and are the only voting members. A quorum is three provider members. The voting provider members shall be Officers of CenCal

Health when acting within the scope of their duties as members of the Committee.

- 2.1.3. The six providers shall represent various specialties of the contracted provider network. When credentialing providers with a specialty not represented on the Committee, the Committee may designate an Auxiliary Member (with that specialty) and request that the Auxiliary Member review the application. After the Auxiliary Member advises the Committee on the application, the appointed members of the Committee will make the final decision regarding the application. Auxiliary Members must be providers contracted with CenCal Health whose credentialing applications have been approved by the Credentials Committee.

## 2.2. Member Duties and Responsibilities

- 2.2.1. Each member of the Credentials Committee will be responsible for maintaining an objective view of credentials review activities.
- 2.2.2. Each member will be required to sign CenCal Health's Oath of Confidentiality, which includes a statement regarding conflict of interest, wherein the member agrees to maintain the confidentiality of credentialing activities and to refrain from participating in activities that may represent a conflict of interest.
- 2.2.3. The Credentials Committee will meet quarterly or more frequently if necessary.
- 2.2.4. At the first meeting each calendar year, the voting members shall elect a Chair and Vice-Chair to serve for one year.
- 2.2.5. Recommendations for filling vacant seats on the committee may be made by any committee member or CenCal Health staff serving on the committee. The Provider Services department may coordinate recruitment for new members.

## 2.3. Committee Goals and Objectives

The Credentials Committee will:

- 2.3.1. Review each provider's request for participation in CenCal Health's programs.
- 2.3.2. Provide final decisions regarding initial or subsequent credentialing based on clinical competency and professional conduct.
- 2.3.3. Provide a re-evaluation of each of the providers in the network at least every three years based on clinical competency and professional conduct.
- 2.3.4. Identify and address potentially serious quality concerns and recommend corrective actions when necessary.

2.3.5. Review the credentialing policy annually and report substantial changes, if any, to the Board of Directors.

#### 2.4. Credentials Committee Minutes

The Credentials Committee minutes, as maintained by the Provider Services staff, will record the following items:

- 2.4.1. The Committee members in attendance.
- 2.4.2. Providers approved for participation or denied for participation and those not acted upon (due to need for additional information, incomplete applications, or pending interviews).
- 2.4.3. For each provider discussed, the minutes will identify the specialty and office location for that provider, any discussion regarding that provider, the Committee's final decision, and the rationale for its decision.
- 2.4.4. These minutes may be in a standardized form, which identifies the members in attendance and the providers discussed.

### 3. PROVIDERS TO BE CREDENTIALLED

3.1. The scope of the providers to be credentialed and recertified by CenCal Health under this policy includes all licensed and contracted Medical Doctors (MDs), Doctors of Osteopathy (DOs), Doctors of Podiatric Medicine (DPMs), Doctors of Chiropractic (DCs), doctoral level behavioral health practitioners (PhDs, PsyDs), and any dentists who provide services under medical benefits (e.g., oral surgeons). CenCal Health will credential and recertify:

- 3.1.1. all providers who have a contracted, independent relationship with CenCal Health;
- 3.1.2. all providers who see members outside the inpatient hospital setting or outside ambulatory freestanding facilities;
- 3.1.3. all physician executives who serve in an administrative capacity for CenCal Health;
- 3.1.4. all providers who are hospital-based but see CenCal Health's members as a result of their independent relationship with CenCal Health. An example of this type of provider would be an anesthesiologist with a pain management practice.

3.2. CenCal Health will not credential and recertify:

- 5.4.1. providers who practice exclusively within the inpatient setting and who provide care for CenCal Health's members only as a result of the members obtaining care at the hospital or inpatient setting;
- 5.4.2. providers who practice exclusively within freestanding facilities and who provide care for CenCal Health's members only as a result of the members obtaining care at the facility;

- 5.4.3. non-physician medical professionals who do not have an independent relationship with CenCal Health.

#### 4. NON DISCRIMINATION POLICY FOR PROVIDERS

No provider shall be denied an agreement with CenCal Health, have any corrective actions imposed, or have his/her agreement suspended or terminated solely on the basis of race, color, age, gender, marital status, sexual orientation, religious creed, ancestry, national origin, physical or mental disability, or the types of procedures or the patients in which the provider specializes.

#### 5. CREDENTIALING APPLICATION AND LETTER

- 5.1. When the Provider Services Department receives a request from a provider to contract with CenCal Health, the Credentialing Specialist or Provider Services Representative will immediately mail out a credentialing application and contract agreement with a letter that outlines:
  - 5.1.1. the requirements for the contract;
  - 5.1.2. the provider's right to review the information submitted in support of his/her credentialing application;
  - 5.1.3. the provider's right to correct erroneous information; and
  - 5.1.4. the provider's right to be informed of the status of his/her application during the credentialing process, upon request.
- 5.2. When recruiting for physician executives, CenCal Health's CEO and Human Resources Director will determine at what point a candidate will complete a credentialing application.
- 5.3. A credentialing application, attestation, and contract agreement must be completed, signed, and returned to CenCal Health by each provider interested in participation. If the provider has signed a contract as a Primary Care Provider or OB/GYN, the Provider Services Department will notify the Health Services Department Quality Management Specialist of the need to schedule and perform a facility audit at the provider's office(s).
- 5.4. The application must be complete, legible, and accompanied by all requested documents. If the provider is notified that the application is incomplete or illegible, the provider must provide the missing information for the credentialing process to continue. The provider is responsible for providing the information to satisfy the process. It is the responsibility of the provider to resolve any difficulties in verifying or obtaining any of the documentation.
- 5.5. The application includes an attestation, which includes, but is not limited to, the following statements by the applicant regarding:
  - 5.5.1. reasons for any inability to perform the essential functions of the position with or without accommodation;
  - 5.5.2. lack of present illegal drug use;

- 5.5.3. history of loss of license and felony convictions;
  - 5.5.4. history of loss or limitation of privileges or disciplinary activity;
  - 5.5.5. current adequate malpractice insurance coverage as per the Physician Service Agreement; and
  - 5.5.6. a signed and dated attestation by the applicant of the correctness and completeness of the application.
- 5.6. The application requests a copy of the current professional state license, current DEA certificate (if applicable), malpractice insurance policy face sheet indicating term and liability limits, and written documentation of:
- 5.6.1. all work history activities since completion of postgraduate training, either on the application or a Curriculum Vitae, with a written or verbal explanation of any gaps of six months or more in the work history (gaps in work history exceeding one year must be explained in writing); and
  - 5.6.2. an explanation of all positive answers to attestation questions on the application.
- 5.7. Malpractice coverage for physician executives may be demonstrated through corporate coverage.
- 5.8. The application also requests information regarding board certification, professional training, ECFMG (if applicable), clinical privileges, peer references, felony convictions, malpractice history, Medicare and Medi-Cal certificate numbers, and pertinent information regarding office features.
- 5.9. Physician executives are not required to have clinical privileges, nor are they subject to facility site reviews or medical record reviews.

## 6. INITIAL CREDENTIALING

- 6.1. The Credentialing Specialist reviews the application utilizing the credentialing software. The provider's information is entered into the credentialing database system for tracking and reporting purposes. Documentation is filed in the provider verification folders. All credentials must be valid at the time the Credentials Committee reviews the provider's application. All verifications, attestations, and information releases will be less than 180 days old (or for some, 365 days) at the time of the credentialing decision as per NCQA standards.

### Initial Primary Source Verification

At time of credentialing, at least the following information is verified from the primary source or an NCQA approved verification source:

- 6.1.1. A current valid license to practice in the State of California, verified with the Medical Board of California or the California Board of Chiropractic Examiners. Alternate means of verification include entry in the AOA or AMA Physician Master Files.

- 6.1.2. The status of clinical privileges at any hospital listed by the provider on the application, if applicable, by contacting the hospital's medical staff office. If an applicant does not have adequate clinical privileges, as determined by the provider's agreement with CenCal Health, the provider must supply the name(s) of provider(s) who will provide inpatient coverage for the applicant. The Credentialing Specialist will then verify the privileges of the covering provider(s). A provider may also designate the hospitalist program at a participating hospital as his inpatient coverage. Clinical privileges are not required for physician executives.
- 6.1.3. A valid DEA certificate, as applicable, by obtaining a photocopy of the original certificate. Alternate means of verification include: documented visual inspection of the original certificate, or entry in the AMA or AOA Physician Master Files. If an M.D., D.O., or DPM does not have all schedules on his DEA Certificate, the Credentialing Specialist will write to the provider for an explanation of the missing schedules, and the provider's plan for continuity of care if those missing schedules are required for treatment of a patient under his care.
- 6.1.4. Two (2) peer references with current knowledge of the provider's practice.
- 6.1.5. Education and training of providers. If the provider is not board certified, the Credentialing Specialist verifies the provider's highest level of education and training, by contacting the school or residency program. Providers' specialties will be listed in CenCal Health's Contracted Provider List according to their highest level of education and training: i.e. board certification or completed residency in their indicated specialty. Any provider not meeting the above criteria will be listed as a General Practitioner in the Contacted Provider List. A General Practitioner must have completed a residency in a field that qualifies him to act as a Primary Care Provider. The Credentials Committee has determined that residency programs meeting these criteria include: Internal Medicine, Family Practice, and Pediatrics.
- 6.1.6. If the provider has been identified as an HIV/AIDS Specialist, the following additional criteria is verified prior to indicating this sub-specialty in provider listings:
- Provider is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; **OR**
  - Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualification, in the field of HIV medicine; **OR**

- Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications:
  - A) In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; **AND**
  - B) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; **OR**
- Meets the following qualifications:
  - A) In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; **AND**
  - B) Has completed any of the following:
    - 1) In the immediately preceding 12 months has obtained board certification or re-certification in the field of infectious diseases from a member board of the American Board of Medical Specialties; **OR**
    - 2) In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; **OR**
    - 3) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

6.1.7. Board certification. If the provider states that he/she is board certified on the application, certification is verified through the specific board, the ABMS, or entry in the AMA or AOA Physician Master Files. If the provider is board certified, the Credentialing Specialist does not verify the provider's education and training since that information is verified by the specialty boards prior to certification.

6.1.8. History of professional liability claims by querying the NPDB. Documentation of the complete claims history is maintained in the provider's file, but only those claims that meet or exceed the

following criteria will be brought to Credentials Committee for review:

- *Financial*: claims that resulted in financial settlements or judgments above \$50,000 paid by or on behalf of the provider;
- *Frequency of professional liability claims*: more than two cases per year;
- *Severity of professional liability claims*: one or more cases in which there was proven patient injury or death;
- *Pattern*: two or more cases associated with the same procedure or diagnosis in the past two years;
- *Performance*: suit associated with documented opportunity to improve after peer review;
- *Necessity*: suit associated with non-indicated procedure;
- *Research*: case associated with experimental procedure;
- *Failure to divulge*: case known to physician but not revealed.

6.1.9. Sanction information by querying the NPDB, HIPDB, CIN-BAD, the appropriate state medical boards, and/or the AMA/AOA Physician Master Files.

6.1.10. Medicare/ Medicaid sanctions by querying the NPDB, CIN-BAD, or OIG.

6.2. Additional verifications: for all providers new to CenCal Health, or when clarification is required to support the information in any provider's credentialing application, the Credentialing Specialist will also verify:

6.2.1. Past clinical privileges;

6.2.2. Work history;

6.2.3. Malpractice insurance coverage;

6.2.4. Any positive answers on the Attestation Questions Form;

6.2.5. Recommendations or complaints made by peers, hospitals, educational facilities, or insurance carriers.

6.3. Initial Credentialing Site Visits. For all PCPs, all OB/GYNs, and high-volume behavioral health providers (Psychiatrists or doctoral level Psychologists), a Facility Review of the provider's primary care office location(s), including an audit of patients' medical records, is included in the credentialing file. The facility review evaluates the office or clinic as compared to CenCal Health's and the Department of Health Services' standards. The medical record review evaluates the documentation of appropriate care to ensure conformity with CenCal Health's and the Department of Health Services' standards.

6.3.1. High-volume behavioral health providers will be identified through available prior utilization data. Behavioral health providers that

serve 25 or more members annually over a 2 year period will be considered high-volume behavioral health providers

## 7. RECREDENTIALING

7.1. The recredentialing process is repeated at least every three years but may be repeated more frequently when required by a change in relevant information or if the Credentials Committee makes such a recommendation. The three-year credentialing cycle begins with the date of the initial credentialing decision. Providers and physician executives are recredentialed within three years of their last credentialing date, which is the date the Credentials Committee rendered their decision regarding the provider's participation. Prior to the provider's recredentialing date, the Credentialing Specialist sends the provider a Recredentialing Provider Profile and requests an update of the information from the original application. Included with the Profile is a Professional Questions Attestation Form and Information Release / Acknowledgment form for the provider to complete and sign.

7.2. Recredentialing Primary Source Verification. During recredentialing, at least the following information is verified from the same primary sources as those used for initial credentialing:

7.2.1. a valid state license to practice;

7.2.2. a valid DEA certificate (if applicable). If an M.D., D.O., or DPM does not have all schedules on his DEA Certificate, the Credentialing Specialist will write to the provider for an explanation of the missing schedules, and the provider's plan for continuity of care if those missing schedules are required for treatment of a patient under his care.

7.2.3. malpractice insurance is current and adequate;

7.2.4. the status of clinical privileges at all hospitals that the provider lists on the application (as applicable);

7.2.5. board certification, if the provider states that he/she is board certified. If board certification has lapsed since the previous cycle, the provider must provide an explanation in writing;

7.2.6. If the provider has been identified as an HIV/AIDS Specialist, the following additional criteria is re-verified in order to continue indicating this sub-specialty in provider listings:

- Provider is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; **OR**
- Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualification, in the field of HIV medicine; **OR**

- Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications:
  - A) In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; **AND**
  - B) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; **OR**
- Meets the following qualifications:
  - A) In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; **AND**
  - B) Has completed any of the following:
    - 1) In the immediately preceding 12 months has obtained board certification or re-certification in the field of infectious diseases from a member board of the American Board of Medical Specialties; **OR**
    - 2) In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; **OR**
    - 3) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

7.2.7. history of professional liability claims. Documentation of the complete claims history is maintained in the provider's file, but only those claims that meet or exceed the following criteria are brought to the Credentials Committee for review:

- *Financial:* settlements or judgments above \$50,000 paid by or on behalf of the provider;
- *Frequency:* more than two cases per year;
- *Severity:* one or more cases in which there was proven patient injury or death;

- *Pattern*: two or more cases associated with the same procedure or diagnosis in the past two years;
- *Performance*: suit associated with documented opportunity to improve after peer review;
- *Necessity*: suit associated with non-indicated procedure;
- *Research*: case associated with experimental procedure;
- *Failure to divulge*: case known to physician but not revealed.

7.2.8. Sanctions Information. The Medical Board of California, the NPDB, and CIN-BAD (as applicable) are queried for any reported sanctions or actions against the provider's license since last review. Sanction information may also be identified through querying the HIPDB or entry in the AMA/AOA Physician Master Files. If the provider has been licensed in another state within the past five years, that state's medical board will be contacted for status and sanction history.

7.3. Performance Monitoring. For primary care providers and specialty care providers, the Credentials Committee incorporates the following minimum data in its recredentialing review:

7.3.1. Member complaint data as reported by Member Services Department. All member complaints in the previous credentialing cycle will be documented in the provider's file, but only those complaints that meet or exceed the following criteria are brought to the Credentials Committee for review;

- *Pattern*: 3 or more complaints of the same type in the previous credentialing cycle
- *Severity*: 3 or more "with merit" in the previous credentialing cycle

7.3.2. Provider complaint data as reported by Provider Services Department;

7.3.3. Information from quality improvement activities, which may include routine medical record audits as appropriate and any quality of care concerns known to CenCal Health that may be useful to the Committee in making an informed recommendation regarding clinical competency and/or professional conduct. Quality of care concerns include those reviewed by the Health Services Department and by other committees of CenCal Health.

7.4. Recredentialing Site Visits. An office visit and assessment of medical record keeping practices is conducted for all PCP practice sites within the three-year period before a recredentialing decision. Primary Care Providers must attain a passing score on facility and chart audit, or submit a corrective action plan if required within the specified time frame.

7.5. Continuous Monitoring of credentials. In order to verify that all providers' licenses, DEA certificates, and liability coverage have not lapsed during the three year recredentialing cycle, the Credentialing Specialist will routinely

request current documentation either via the internet or by contacting the provider.

- 7.6. Continuous Monitoring of quality and performance. The Health Services staff and Medical Director/Associate Medical Director also routinely monitor quality issues that may impact the credentialing process, including member/provider complaints and other quality of care concerns. These quality issues may be referred to the Peer Review Committee, which may in turn refer the matter to the Credentials Committee for discussion and possible action during the interval between formal credentialing.
- 7.7. Continuous Monitoring of sanctions. The Credentialing Specialist routinely monitors for sanctions and medical board actions by obtaining periodic reports via the internet from the following sources and maintaining binders of these reports:
  - Medical Board Action Reports (*quarterly*);
  - Medi-Cal Suspended & Ineligible Provider List (*monthly*);
  - Disciplinary Summary of the Medical Board “Hot Sheets” (*monthly*).

## 8. DELEGATION OF CREDENTIALING

Delegation is the formal process by which a managed care organization (MCO) such as CenCal Health, gives another entity (e.g. an Independent Practice Association (IPA), Credentials Verification Organization (CVO), hospital, medical group, or mental health provider) the authority to perform credentialing functions on its behalf. If any functions are delegated, the MCO, i.e. CenCal Health (i) would be responsible and accountable for assuring its members that the same standards of participation are maintained throughout its provider network; (ii) retains the right to approve, suspend, or terminate all providers and sites of care; (iii) and ensures that a consistent and equitable process is used throughout its network by requiring:

- 8.1. that the delegated entity adheres to at least the same criteria outlined in this policy and by reviewing the delegated entity’s written policies and procedures. CenCal Health will evaluate the delegated entity’s capacity to perform the delegated activities prior to delegation;
- 8.2. a mutually agreed upon document, which may be a contract, letter, memorandum of understanding, or other document, which clearly defines the performance expectations for CenCal Health and the delegated entity. This document will define CenCal Health’s and the delegate’s specific duties, responsibilities, activities, reporting requirements, and identifies how CenCal Health will monitor and evaluate the delegate’s performance. This mutually agreed upon document will also specify the remedies available to CenCal Health, including (but not limited to) revocation of the delegation if the delegate does not fulfill its obligations;
- 8.3. CenCal Health’s staff to audit the delegate’s files on an annual basis to evaluate whether the delegated entity’s activities are being conducted in accordance with CenCal Health’s expectations and NCQA standards. The

only exception to the oversight requirements is when CenCal Health delegates to an entity that is NCQA Certified for Credentialing or NCQA Accredited. CenCal Health does not need to conduct an annual audit or evaluation and may assume that the delegate is carrying out responsibilities in accordance with NCQA standards;

- 8.4. if monitoring reveals deficiencies in the delegate's credentialing and recredentialing processes, CenCal Health will work with the delegate to set priorities and correct the problems. If serious problems cannot be corrected, CenCal Health will revoke the delegation arrangement;
- 8.5. that CenCal Health retains the right, based on quality issues, to approve, to suspend or terminate providers.

## 9. PROVIDER APPLICATION REVIEW AND EVALUATION

- 9.1. The credentialing or recredentialing Verification File is forwarded to the Director of Provider Services and/or the Provider Services Quality Improvement Manager for review. The Director of Provider Services and/or the Provider Services Quality Improvement Manager, and the Credentialing Specialist determine if the file represents a "No Verification Issues for Discussion" (No Issues) status in order to assist the Credentials Committee with the review of each application. If the Director of Provider Services and/or the Provider Services Quality Improvement Manager and Credentialing Specialist determine that an application has verification issues (With Issues) for discussion, they will request that the Credentials Committee review the file, citing the reason the application needs further review. A "No Issues" application is defined as an applicant's file with:
  - 9.1.1. all documentation (e.g. license, liability policy) in the application is verified and current;
  - 9.1.2. full, current DEA schedule and prescribing capability (as applicable);
  - 9.1.3. no history of professional liability claims that resulted in financial settlements or judgments above \$50,000 paid by or on behalf of the provider;
  - 9.1.4. no frequency of professional liability claims more than two cases per year;
  - 9.1.5. no severity of professional liability claims with one or more cases in which there was proven patient injury or death;
  - 9.1.6. no pattern of two or more cases associated with the same procedure or diagnosis in the past two years;
  - 9.1.7. no performance suits- those associated with documented opportunity to improve after peer review;
  - 9.1.8. no necessity suits- those associated with non-indicated procedure;
  - 9.1.9. no research suits- cases associated with experimental procedures;
  - 9.1.10. no failure to divulge- cases known to physician but not revealed;

- 9.1.11. no history of loss of licensure and/or felony convictions;
- 9.1.12. no history of loss or limitation of clinical privileges or disciplinary actions;
- 9.1.13. no adverse peer references against the applicant; and
- 9.1.14. no quality of care issues identified by Health Services staff.

9.2 The Medical Director/Associate Medical Director and the Quality Management Specialist will review a list of providers whose applications will be considered at the Provider Credentials Committee meeting. If they determine that an applicant has clinical or quality of care issues for discussion (“With Issues”), they will request that the Credentials Committee review the file, citing the reason the application needs further review. A “No Issues” application is defined as an applicant’s file with:

- 9.2.1. no complaints or grievances with clinical or quality of care concerns filed with CenCal Health against the applicant;
- 9.2.2. a passing score on chart and facility audits or a closed corrective action plan on file, if required, and
- 9.2.3. no other quality of care issues identified by Health Services staff.

9.3. CenCal Health staff may also identify files that have associated informational items that they wish to bring to the Committee’s attention. These items may or may not directly relate to the credentialing process. Such items include, but are not limited to: (i) a change in board certification status; (ii) previous affiliations in the community; (iii) a pending facility/medical record review corrective action plan (CAP); (iv) or pending additional verifications.

## 10. PROVIDER APPLICATION RECOMMENDATIONS AND ACTIONS

- 10.1. The Credentials Committee may make its final decision based on the assessment that the provider has a “No Issues for Discussion” application. The Committee may approve a list of all “No Issues” files being presented for review in its entirety without reviewing each individual file. If it is established that the applicant has verification or clinical issues for discussion, the Credentials Committee must review the file and make its final decision based on thoughtful consideration of the documentation and reports received during the credentialing verification and quality assessment processes.
- 10.2. The Credentials Committee upon receipt and review of the completed file may take any of the following actions:
  - 10.2.1. Final approval of the application for participation, with or without limitations or restrictions;

- 10.2.2. Approval of the application for a period less than the routine three years, pending certain conditions;
  - 10.2.3. Final denial of the application for participation;
  - 10.2.4. Recommend corrective action;
  - 10.2.5. Return the application to Provider Services for clarification or further investigation of any aspect of the application that is unclear or of concern to the Committee. (If the Committee defers making a decision, the verification information for that provider will be re-verified if necessary to maintain compliance with the 180- and 365-day timeframes.)
- 10.3. The Credentials Committee decision is final. The Committee may still credential a provider despite documentation of unfavorable information (e.g., malpractice claims, deficient site audits, sanctions).
- 10.4. The decisions of the Credentials Committee are based on a risk of harm to CenCal Health's members. Such a risk may be based on (but is not limited to) one or all of the following:
- 10.4.1. clinical incompetence;
  - 10.4.2. improper professional conduct;
  - 10.4.3. malpractice claims history;
  - 10.4.4. disciplinary actions and sanctions;
  - 10.4.5. lack of work history or unexplained gaps in work history;
  - 10.4.6. a history of restrictions and/or revocations of licensure, DEA certification, clinical privileges, and/or participation in other medical organizations;
  - 10.4.7. felony convictions and/or illegal drug use;
  - 10.4.8. member complaints and/or unsatisfactory member surveys;
  - 10.4.9. fraudulent credentials or misrepresentation of credentials;
  - 10.4.10. noncompliance/nonresolution with CenCal Health's quality improvement plan and quality of care issues.
- 10.5. The Credentialing Specialist will notify the providers of the Credentials Committee decisions via mail.

## 11. EXPEDITED CREDENTIALING

In consideration of necessity to ensure quality care for CenCal Health's members, upon the recommendation of CenCal Health's Director of Provider Services and the Medical Director/Associate Medical Director, CenCal Health may expedite the initial credentialing process. In extenuating circumstances, due to an identified need in the network, a "no-issues" file may be signed off by the Director of Provider Services, the Medical Director/Associate Medical Director and the Committee Chair or acting Committee Chair. While NCQA recognizes this sign-off date as the committee approval date, these files will be

presented to the Credentials Committee at the next regularly scheduled meeting for ratification by the committee.

An expedited review of one or more files may also be accomplished through review by a quorum of the Credentials Committee. This is the method used when there are issues for discussion by the committee. The expedited review process shall consist of the following procedures:

- 11.1. A complete application has been signed and returned by the provider.
- 11.2. Initial Primary Source Verification, initial sanction information, and initial credentialing site visit (if applicable) has been completed and reviewed by the Director of Provider Services and the Medical Director/Associate Medical Director and there are no quality of care issues identified.
- 11.3. The Credentialing Specialist shall contact three Credentials Committee members to review the credentials of practitioners expeditiously. This review may be done via teleconference and the use of faxed documents confirming the members' actions.
- 11.4. Based on thoughtful consideration of the documentation and reports, a quorum of the Credentials Committee members shall make a decision.
- 11.5. The Credentialing Specialist will notify the provider and the other members of the Credentials Committee of the final decision.

## 12. CORRECTIVE ACTIONS

The Credentials Committee may impose corrective actions, as described in CenCal Health's Corrective Action Policy, after a governmental agency takes action against a provider that affects the provider's license or credentials to practice or authorization to prescribe controlled substances.

## 13. FAIR HEARING RIGHTS AND PROVIDER APPEAL OF CORRECTIVE ACTION DECISIONS

- 13.1. If the Credentials Committee denies participation of an applicant or terminates participation of a contracted provider, based on a medical disciplinary cause or reason, the provider has the right to request a hearing as stated in CenCal Health's Fair Hearing Policy. If the Credentialing Committee denies participation of an applicant or terminates participation of a contracted provider, not based on a medical disciplinary cause or reason, the provider has the right to appeal this decision as stated in CenCal Health's policy titled Provider Grievance System.
- 13.2. A provider must exhaust the remedies afforded by CenCal Health's policies on Fair Hearing and the Provider Grievance System before resorting to formal legal action which:
  - 13.2.1. challenges any decision made pursuant to this Credentialing Policy or the procedures used to arrive at such a decision, or

- 13.2.2. asserts any claim against CenCal Health or any participants in the decision process.
- 13.3. If the Credentialing Committee terminates a provider's participation in CenCal Health's network of providers and the provider does not request a hearing or appeal or the decision of the Credentials Committee is upheld, Provider Services shall immediately proceed, pursuant to the terms of the provider's agreement with CenCal Health, to terminate the agreement.
14. MEDICAL BOARD OF CALIFORNIA AND NATIONAL PRACTITIONER DATA BANK (NPDB) REPORTING
- 14.1. Pursuant to Business and Professions Code, Section 805, the Credentialing Specialist shall report any reportable actions related to a "medical disciplinary cause or reason" to the Medical Board of California and/or the National Practitioner Data Bank after the Credentials Committee has adopted a final decision. The Committee and staff will obtain input from CenCal Health's Director of Legal Affairs to determine if an action is reportable. The Credentialing Specialist shall report any revisions to the reportable action, including any expiration of the reportable action, consistent with the terms of the final action.
- 14.2. If no hearing was requested, pursuant to CenCal Health's Fair Hearing Policy, a provider who is the subject of a proposed adverse action reportable to the Medical Board of California or the NPDB may request an informal meeting with the Director of Provider Services to dispute the text of the report filed regarding verification issues, and/or with the Medical Director/Associate Medical Director regarding any Quality of Care dispute. The report dispute meeting shall not constitute a hearing and shall be limited to the issue of whether the report to be filed is consistent with the final action. If a hearing was held, pursuant to CenCal Health's Fair Hearing Policy, the report dispute process shall be deemed to have been completed.

**DISCLOSURE:**

1. PROVIDER CREDENTIALING POLICY AND PROCEDURE

Providers are informed of the credentialing policy and procedure through their Provider contract agreements and amendments, CenCal Health's Provider Manuals, CenCal Health's website, Provider Bulletin articles, and other materials issued by CenCal Health.

2. PROVIDER RIGHT TO REVIEW INFORMATION

Providers will be notified during the application process of their right to review the information obtained by CenCal Health to evaluate their credentialing application. This notification will be either in the application cover letter and/or the application instruction form. Providers requesting access to the information within their own records may do so at the discretion of CenCal Health and its legal counsel. Some information obtained and reviewed during

credentialing and recredentialing is privileged and confidential to the extent confidentiality is permitted by applicable federal and state laws and regulations. CenCal Health will not allow a provider to review references, recommendations, or other information that is protected by applicable peer review laws and regulations.

### 3. THE NOTIFICATION AND CORRECTION OF ERRONEOUS INFORMATION

- 3.1. Providers will be notified during the application process of their right to be notified and to correct information received from other sources that varies from the information supplied in their application. This notification will be either in the application cover letter and/or the application instruction form.
- 3.2. When the staff or Committee members, who are designated in this policy to review credentialing files, discover a discrepancy between the information submitted in the application and the information received from another source, the provider will be notified of the discrepancy in writing by the Credentialing Specialist within five (5) business days of said discovery. The provider will be asked in the notification to correct the erroneous information with an explanation of the reason for the discrepancy and to submit the appropriate documentation to the Credentialing Specialist within ten (10) business days.
- 3.3. The Credentialing Specialist will also notify providers of their options if the information cannot be corrected within the stated timeframe. If the provider cannot correct the erroneous information within the above timeframe, the provider must submit in writing that he is in the process of correction, and when the appropriate documentation will be available. CenCal Health may decide to suspend or terminate the credentialing process until the corrected information is available. The provider will be notified immediately if CenCal Health decides to suspend or terminate the credentialing process. The provider will also be notified at that time of the steps he must undertake to begin or restart the credentialing process once the erroneous information is corrected, and documentation of the correction is available to support his application.

### **CONFIDENTIALITY:**

#### 1. MAINTAINING CONFIDENTIALITY OF CREDENTIALING RECORDS

All information received through the application or the verification process will be kept in strict confidence in order to protect all parties involved. Only CenCal Health personnel and committees named in this policy shall have access to the credentialing files and credentialing software records. In order to secure this information, the following security measures shall be implemented:

- 1.1. All filing cabinets containing credentialing and recredentialing files will be kept locked at all times except when the Credentialing Specialist, the Director of Provider Services, the Medical Director/Associate Medical Director, or the Quality Management Specialist are accessing the files

during the course of their regular delegated duties. In addition to the Credentialing Specialist, the Director of Provider Services/Provider Services Quality Improvement Manager will hold a key to the filing cabinets.

- 1.2. The Credentialing Specialist and the Quality Management Specialist will maintain password protections on all credentialing software records. The Credentialing Specialist and Quality Management Specialist will share these passwords with only the Director of Provider Services, the Provider Services Quality Improvement Manager, and the Medical Director/Associate Medical Director.
- 1.3. All credentialing and recredentialing verification files, documentation, and records will be seen or reviewed only by the personnel and committees delegated authority and responsibility in this policy. Knowledge gained from the information and documentation contained within the files and records will be shared with other staff, administration, or committees on a need-to-know basis at the discretion of the Director of Provider Services, the Provider Services Quality Improvement Manager, the Medical Director/Associate Medical Director, and the Credentials Committee members.
- 1.4. Providers requesting access to the information within their own records may do so at the discretion of CenCal Health and its legal counsel. Some information obtained and reviewed during credentialing and recredentialing is privileged and confidential to the extent confidentiality is permitted by applicable federal and state laws and regulations. CenCal Health will not allow a provider to review references, recommendations, or other information that is protected by applicable peer review laws and regulations.
- 1.5. All CenCal Health employees and committee members must sign an Oath of Confidentiality prior to any access to the credentialing files and information.
- 1.6 Any Individual Identifiable Health Information (IIHA) obtained during the course of communications with providers, members and CenCal Health staff shall be protected from loss, tampering, destruction, alteration and unauthorized or inadvertent disclosure in accordance with federal HIPAA and state laws. Refer to CenCal Health's HIPAA Privacy Policy and Procedure.
- 1.7 In the event CenCal Health elects to tape record any Credentials Committee meetings in order to create meeting minutes, any such tapes shall be destroyed immediately after the minutes have been prepared.

#### **MONITORING:**

##### 1. REPORTS

The Credentialing Specialist will prepare a monthly summary of credentialing activities to be included in the Board Report.

## 2. ANNUAL REVIEW

This policy will be reviewed and revised annually, approved by the Network Management Committee, and forwarded to the Healthcare Operations Committee.

### **V. FORMS**

None

### **VI. REFERENCE**

**DHCS:** California Department of Health Care Services Contract 01-16328, Sections 2.2.1 & 8.7

**Knox-Keene:** Knox-Keene Health Care Service Plan Act Of 1975: Article 1367, Section (b)

**NCQA:** 2008 National Committee for Quality Assurance “Standards and Guidelines for the Accreditation of Managed Care Organizations”, Standards for Credentialing and Recredentialing, CR Standards

**POLICIES:** CenCal Health policies regarding: Facility Site and Medical Record Quality Improvement Program, Fair Hearing Policy, Corrective Action Policy

### **PROVIDER**

**CONTRACTS:** Physician Service Agreements

*Also replaces 500-2012-B “Doctor of Chiropractic/ Ancillary Provider Credentialing Policy”*