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Section 1: Program Purpose

PHC California ensures the provision of superior health care to the community and for people living with HIV/AIDS. This is accomplished with a well-defined credentialing and recredentialing program for evaluating and selecting practitioners and health care delivery organizations to provide medical care and treatment. The Credentialing scope includes the following covered programs and services (as applicable)

- PHC California (Medi-Cal)

Specifically, the Program provides for the following:

- Direct credentialing and recredentialing activities to ensure quality care for people living with HIV/AIDS. Review all new applicant practitioner credentials prior to full participation using established criteria.
- Obtain meaningful advice and expertise from participating practitioners for credentialing decisions. Review of credentials for practitioners who do not meet established thresholds.
- Use a peer-review process to make recommendations regarding credentialing decisions. Approve or deny participation of all practitioners and institutional and ancillary providers.
- Review delegated credentialing documentation of provider groups, institutional or ancillary, including pre-delegation audit results.
- Conduct peer review clinical cases of potential quality of care to determine the need for disciplinary action.
- At least annual review of Credentialing and Peer Review policies and procedures.
- Monitor compliance with regulatory, accreditation and contractual requirements.

Through the Credentialing and Recredentialing Program, PHC California ensures that the network consists of quality practitioners who meet clearly defined criteria and standards. The Credentialing and Recredentialing Program was developed in accordance with the health plan standards of the National Committee for Quality Assurance (NCQA) and Accreditation Association for Ambulatory Health Care (AAAHC) and relevant federal and state requirements. The Credentialing Program is reviewed annually and revised and updated as needed.

In accordance with DHCS APL 19-004, in the event the Health Plan receives a rating of “excellent”, “commendable”, or “accredited” from the NCQA, it will be deemed to have met DHCS’ requirements for credentialing and therefore will be exempt from DHCS’ medical review audit of credentialing practices. The Health Plan retains overall responsibility for ensuring that credentialing requirements are met. Credentialing accreditation from entities other than the NCQA will be considered by DHCS upon request.

Section 2: Scope of Practitioners Credentialed and Recredentialed

The decision to accept or deny a credentialing applicant is based on the following criteria:

- Primary source verification
- Recommendation of peer practitioners
- Additional information as required.

The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under state and federal law.

Adequate numbers and types of independent practitioners are credentialed to meet plan member/patient/client health care needs. The scope of practitioners credentialed includes, but not limited to:

- Acupuncturists (LAC)
- Advanced Practice Registered Nurse (APRN)
- Clinical Nurse Specialists (CNS)
- Audiologists
- Behavioral Health Care Practitioners (Master's Level)
- Chemical Dependency Counselors
- Chiropractors (DC)
- Endodontist (DDS, DMD)
- Licensed Midwives (LM)
- Massage Therapists (LMT)
- Naturopaths (ND)
- Occupational Therapists (OT)
- Optometrists (OD)
- Oral Surgeons (DDS, DMD)
- Practicing Dentist (DDS, DMD)
- Dental Hygienists (RDH)
- Pharmacist (Pharm D)
- Physical Therapists (PT)
- Physicians (MD, DO)
- Physician Assistants (PA-C)
- Podiatrists (DPM)
- Psychologists (PhD, PsyD)
- Speech Language Pathologists

Primary Care Practitioner (PCP) is defined as a practitioner who has the responsibility for supervising, coordinating, and providing primary health care to Members, initiating referrals for specialist care, and maintaining the continuity of Member care. PCPs include, but are not limited to, Infectious Disease specialists, Pediatricians, Family Practitioners, General Practitioners, Internists, or Advanced Practice Registered Nurse (APRN), as designated by PHC California.

PHC California does not require credentialing for some types of practitioners who are credentialed by the organization(s) that employ or contract with them. If a practitioner meets any one of the following criteria, credentialing is not required:

- Practitioners who practice exclusively within the inpatient setting and who provide care for members only as a result of members being directed to the hospital or other inpatient setting.
- Practitioners who practice exclusively within freestanding facilities and who provide care for members only as a result of members being directed to the facility.
- Covering practitioners (e.g., locum tenens).
- Practitioners who do not provide care for members in a treatment setting (e.g. board-certified consultants.)

Section 3: Criteria for Participation and Primary Source Verification

There are established criteria for the evaluation and selection of practitioners for participation in the network and health care centers. This policy defines the criteria that are applied to applicants for initial participation

and recredentialing. This criterion is listed in the attached Practitioner Criteria and Primary Source Verification Table.

In addition to the criteria listed in the Practitioner Criteria and Primary Source Verification Table, the Health Plan must also receive the following information from every network provider, but does not need to verify this information through a primary source:

- Work history
- Hospital and clinic privileges in good standing
- History of any suspension or curtailment of hospital and clinic privileges
- Current Drug Enforcement Administration identification number
- National Provider Identifier number
- Current malpractice insurance in an adequate amount, as required for the particular provider type.
- History of liability claims against the provider

The Credentialing and Peer Review Committee reviews all practitioners not meeting the criteria stated in the attached Practitioner Criteria and Primary Source Verification Table. When justifiable circumstances exist, practitioners who do not meet certain credentialing criteria may be approved. The Credentialing and Peer Review Committee must explicitly approve any exceptions.

Practitioners previously denied participation in the network are not eligible to reapply for one year after denial. Practitioners previously terminated from the network are not eligible to reapply until the practitioner has completed five years of exemplary practice and if, in the judgment of the Credentialing and Peer Review Committee, the practitioner's standard of care does not pose a risk to member's health. The five years of exemplary practice begins after any suspensions, restrictions, reductions, limitations, sanctions, probations or monitoring have ended.

For Provisional, Initial Credentialing, and Recredentialing – Initial query from applicant's Malpractice carrier and National Provider Data Bank (NPDB) regarding malpractice claims and/ or settlements from the previous ten (10) years. If multiple claims/ settlements are found on initial screening (i.e., for multiple opiate related cases or multiple surgical complications), then an additional five (5) year query will be performed.

Initial Credentialing

At the time of initial credentialing, the applicant must complete a Practitioner Application and any applicable attachments to the application. The application must be completed in its entirety, including a current and signed attestation signed by the applicant within three-hundred and sixty-five (365) calendar days of the credentialing decision. A signature stamp or date stamp is not acceptable on the attestation. The attestation must include:

- Reason for any inability to perform the essential functions of the position, with or without accommodation
- Lack of present illegal drug use
- History of loss of license and felony convictions
- History of loss or limitation of privileges or disciplinary action
- Current malpractice insurance coverage and
- The correctness and completeness of the application

The completed application will be processed upon submission. If the application has not been signed or if information provided on the application is incomplete, the practitioner will be notified in writing and the missing information will be requested. If the practitioner does not provide the information in the time period requested, he/she will be deemed to have withdrawn his/her application for participation.

If the signature attestation will be older than three-hundred and sixty-five (365) calendar days at the time of the credentialing decision, the practitioner is required to update the attestation. A copy of the completed application with a new attestation form will be sent when requesting the practitioner update the attestation.

Practitioners are not eligible to apply for participation if:

- There are potential actions pending against their License by any state agency in the United States that disciplines practitioners (e.g. Statement of Chargers).
- Licensure is currently suspended, restricted, reduced, limited, sanctioned and/or on probation by any state agency in the United States that disciplines practitioners.
- Practitioner is currently censured or excluded (e.g. suspended or disqualified) by Medicare/Medicaid or have an invalid National Provider Identifier (NPI) number.

An additional attestation regarding HIV/AIDS CME and qualifications is required. AIDS Healthcare Foundation has qualifications for HIV/AIDS Specialist, which are verified at the time of credentialing and recredentialing. For California providers, AHF requires the completion of the *PHC Designation of HIV specialist Attestation* on an annual basis. Providers who specialize in HIV/AIDS may be listed as an HIV/AIDS Specialist in California if s/he meets specific criteria in Section 1374.16 of Standard Referral to HIV/AIDS Specialist Act. This Act provides the qualifications for Specialist designation. AHF Credentialing Department submits the approved qualified practitioners list to the Provider Relations Department and the Quality Management Committee. Provider Relations shares the list with Utilization Management and the Medical Executive Committee.

Behavioral Health Care Practitioners (Master's Level) Credentialing:

He AIDS Healthcare Foundation will verify the qualifications of a behavioral health care practitioner within sixty (60) days after receiving a completed provider credentialing application. Reference: California Assembly Bill 2581.

Appointment Process

PHC California uses the following criteria for appointment of providers:

- Need for PCP or Specialty in network or in a specific geographic area.
- Provider meets all initial credentialing requirements set forth in this policy.
- Provider accepts the terms of the contract set forth by the Plan.

The Credentialing and Peer Review Committee reviews the provider application along with all the supporting documentation and makes the decision to recommend the provider for appointment. The list of providers is included in the credentialing report that is submitted to the Executive Oversight Committee. This list is presented to the Board of Directors for final approval of appointment and signature.

Provisional Credentialing

Occasionally it can be in the interest of members to make practitioners available prior to completion of the entire initial credentialing process. In this case, the organization or its delegate has the option of provisional credentialing for practitioners applying to the organization for the first time. A practitioner may only be provisionally credentialed once.

Practitioners who had been in the organization's network via a delegation arrangement are not eligible for provisional credentialing by the organization if the delegation arrangement is terminated or if the practitioner is no longer affiliated with the delegate.

Only the following elements and factors are scored for practitioners who have been provisionally credentialed prior to initial credentialing.

- Primary-source verification of a current, valid license to practice.

The organization may not hold practitioners in provisional status for more than sixty (60) calendar days.

Credentialing for Intermediate Care Facilities/Developmentally Disabled (ICF/DD) Homes

In accordance with DHCS APL 23-023, the Health Plan may deem ICF/DD homes credentialled via attestation if the ICF/DD homes' state regulatory processes are current. To meet the Health Plan's credentialing requirements, ICF/DD homes must submit an ICF/DD attestation under penalty of perjury that the following credentialing requirements are satisfied:

- Completion of the Health Plan's specific provider training within the last two years
- Facility site audit from state agency
- No change in 5 percent ownership disclosure since the last submission to the Health Plan
- Possess an active CDPH license and CMS certification
- In good standing as a Regional Center vendor

For initial credentialing, ICF/DD Homes must submit the below items in addition to the ICF/DD attestation:

- W-9 Request for Taxpayer Identification Number and Certification
- Health Plan's ancillary facility network provider application
- Certificates of insurance (professional and general liability)
- City or county business license (excludes ICF/DD-H and -N homes with six or less residents)
- 5% Ownership Disclosure

This streamlined policy will be in effect until DHCS reassesses the risk level for ICF/DD homes. At such time, DHCS may require the Health Plan to complete full credentialing with ICF/DD homes.

If an ICF/DD home has a change to any requirement attested to between initial credentialing and re-credentialing, the home must report that change to the Health Plan along with any required documentation within 90 days of when the change occurred.

Provider Demographic Survey

The plan will include a provider demographic survey, including questions about race, ethnicity, sexual orientation, language spoken, and language providers can read and write.

Recredentialing

Practitioners are recredentialed at least every thirty-six (36) months. Recredentialing for ICF/DD homes is to occur every two years through re-submission of an ICF/DD attestation. Six (6) months before the recredentialing due date, a recredentialing packet is sent to the practitioner. This packet contains the following:

- Practitioner Attestations & Questions that include attestation by the applicant regarding:
- Reason for any inability to perform the essential functions of the position, with or without accommodation
- Lack of present illegal drug use
- History of loss of license and felony convictions
- History of loss or limitation of privileges or disciplinary action
- Current malpractice insurance coverage and
- The correctness and completeness of the application
- Current HIV/AIDS CME and practice status
- The Practitioner Authorization and Release of Information Form

Practitioners are instructed to update the information and make corrections as necessary, answer all professional questions and sign and date the attestation and release of information statements. A signature stamp or date stamp is not acceptable on the attestation.

If applicable, recredentialing must include documentation that the Health Plan has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, member grievances, and medical record reviews.

Privileging

The objective of privileging is to determine the specific procedures and treatments that a health care professional may perform in an AHF Healthcare Center. The privileging process:

- Determines the clinical procedures and treatments that are offered to patients.
- Determines the qualifications related to training and experience that are required to authorize an applicant to obtain each privilege.
- Establishes a process for evaluating the applicant's qualifications using appropriate criteria and approving, modifying, or denying any or all of the requested privileges in a non-arbitrary manner

Privileges to carry out certain procedures are granted by the Credentialing and Peer Review Committee during the course of initial credentialing and recredentialing. The health care professional must be legally and professionally qualified for privileges granted. The *Practitioner-Performed Procedures Request* is completed by the person requesting privileges and recommendations made by qualified medical personnel from the Credentialing and Peer Review Committee. A *Request* is submitted at time of initial credentialing, recredentialing or any time during active status if practitioner would like to add a new privilege (e.g. practitioner takes a certification class and seeks approval to perform said procedure in the clinic).

Administrative Termination/Closure

If a practitioner fails to return the completed recredentialing packet within eight weeks, it will result in an administrative termination from the network. The completed application will be processed upon submission. If the application has not been signed or if information provided on the application is incomplete, the practitioner will be notified in writing and the missing information will be requested. The Credentialing Department will make three attempts to retrieve the information from the practitioner by phone, fax or email. If attempts for the information are unsuccessful the Credentialing Department will notify Provider Relations Department and PR will then have one week to retrieve the missing document or information. In the event the practitioner does not provide all information requested on the recredentialing application, or all information requested by the Credentialing and Peer Review Committee within specified time parameters, the application will be deemed incomplete and the practitioner will be so notified. An incomplete application will result in administrative termination from the network.

Reappointment Process

The Credentialing and Peer Review Committee reviews the provider application along with all the supporting documentation and makes the decision to recommend the provider for reappointment. The list of providers recommended for reappointment is included in the reappointment report that is submitted to the Executive Oversight Committee. This list is presented to the Board of Directors for final approval of reappointment and signature.

Break in Contract

If a practitioner has a break in contract greater than thirty (30) calendar days, that practitioner is initially credentialed before the practitioner resumes seeing patients. The Credentialing and Peer Review Committee reviews all credentials and makes a final determination before the practitioner's re-entry into the network. If is unable to recredential a practitioner within 36-months because the practitioner is on active military assignment, maternity leave or sabbatical; but the contract between PHC California and the practitioner remains in place, the practitioner is recredentialed upon his or her return. The reason for the delay is documented in the practitioner's file. At a minimum, it will be verified that a practitioner who returns has a valid license to practice before he or she can resume seeing patients. Within sixty (60) days of notice when the practitioner resumes practice, the recredentialing cycle is completed. If either party terminates the contract or there is a break in service of more than thirty (30) days, the practitioner is initially credentialed before the practitioner rejoins the network.

Primary Source Verification

Oral, written and data available through databases and the internet are used to verify information. All documentation of primary source verification requires either a signature or the initials of the person verifying the information and the date it was verified. When the Internet is used for verification, only Web sites of the appropriate CMS, NCQA and AAAHC approved source for that element are used. The Director of National Credentialing/Coordinator performs monthly primary source monitoring on all specialty providers to verify continued Specialty Board certification. Where applicable, only the latest cumulative report is used as well as

the periodic updates released by the primary source. The date on which the report was queried and the volume used are noted in the file.

The direct credentialing verification sources:

Licensure

- **State Medical Boards** – Verify directly with the board in the provider's practicing state.
  - Website: FSMB.org

DEA/CDS Registration

- **Drug Enforcement Administration (DEA)**
  - Website: DEA Diversion Control Division
- **State CDS Registries** (if applicable)

Education & Training

- **Medical/Professional Schools** – Direct verification.
- **Board Certification** (can substitute for education/training verification):
  - **American Board of Medical Specialties (ABMS)** – www.abms.org
  - **American Osteopathic Association (AOA)** – osteopathic.org
  - **Educational Commission for Foreign Medical Graduates (ECFMG)** – www.ecfmg.org
  - **American Medical Association (AMA)** – ama-assn.org
  - **American Academy of Physician Assistants (AAPA)** – aapa.org
  - **American Academy of Nurse Practitioners (AANPCB)**-Verification of Certification - AANPCB
  - **National Student Clearinghouse-**National Student Clearinghouse |

Sanctions & Exclusions

- **SAM.gov** – For Medicare/Medicaid sanctions
  - Website: www.sam.gov
- **Office of Inspector General (OIG)** – Exclusion checks
  - Website: exclusions.oig.hhs.gov
- **State Licensing Boards** – For disciplinary actions

Malpractice History

- **National Practitioner Data Bank (NPDB)**
  - Website: www.npdb.hrsa.gov

Work History

- Verified via resume/CV with documented employment dates (month/year). Gaps >6 months must be explained

Burden of Proof

The practitioner applying for participation has the burden of producing adequate information for a proper evaluation of his/her experience, background, training, demonstrated ability and ability to perform as a practitioner without limitation, including physical and mental health status as allowed by law, and the burden of resolving any doubts about these or any other qualifications to participate.

Credentialing Checklists

Practitioner credential files contain a checklist that summarizes and tracks credentialing and/or recredentialing activities. The Director of Credentialing/Coordinator records the date and pertinent information for each activity as it is conducted and/or verified from primary sources and attests to completion by initialing the appropriate space following each activity. Checklists are reviewed and revised as needed.

Section 4: Credentialing and Peer Review Committee

The Credentialing and Peer Review Committee is designated to make recommendations regarding credentialing and recredentialing decisions using a peer review process. This peer-review process includes representation from a range of participating practitioners in the network. The Credentialing and Peer Review Committee assures that participating practitioners are competent and qualified to provide quality care to members and votes to make final decisions regarding credentialing determinations and disciplinary actions. In addition, the Committee recommends:

- Policies and procedures for well-defined credentialing and recredentialing process for evaluating and selecting practitioners and institutional and ancillary providers.
- Rigorous process to select and evaluate practitioners and institutional and ancillary providers.
- Approval of delegated credentialing based on established criteria.
- “For cause” denials for continued participation of participating providers and offer appeal rights per the Practitioner Fair Hearing Policy
- Follow-up disciplinary action, as necessary, with the practitioners.
- Strategies and corrective action to meet regulatory, accreditation and customer requirements.

The Credentialing and Peer Review Committee is responsible for reviewing and evaluating the qualifications of applicant practitioners and for approving or denying applicants for participation. A practitioner may not provide care to members until the final decision from the Credentialing and Peer Review Committee or in situations of “clean files” the final decision from the Chief of Medicine. Composed of participating practitioners, the Committee is responsible for performing peer review of medical information when requested by the Medical Director, and recommending actions based on peer review findings, if needed. The Committee reports to the Quality Improvement and Health Equity Committee (QIHEC) and the Executive Oversight Committee (EOC) of the Board of Directors.

Each Credentialing and Peer Review Committee member is immune, to the fullest extent provided by law, from liability to an applicant or practitioner for damages or other relief for any action taken or statements or recommendations made within the scope of the Committee duties exercised.

Committee Composition

The Chief of Medicine appoints Credentialing and Peer Review Committee members and each practitioner member is required to meet all of credentialing criteria. AHF maintains a heterogeneous credentialing committee and require The Credentialing Committee sign a nondiscrimination statement they will not discriminate. Credentialing and Peer Review Committee members must be current or retired representatives of practitioners. Other ad hoc practitioners may be invited to participate when additional specialty representation is needed. Ad

hoc committees representing a specific profession (e.g., Behavioral Health Practitioner, APRN, and Chiropractor) may be appointed by the Chair to screen applicants from their respective profession and make credentialing recommendations to the Credentialing and Peer Review Committee.

Roles and Responsibilities

Chief of Medicine

- The Board of Directors delegate's responsibility and accountability for ensuring the qualifications and competencies of the practitioner network though the Quality and Performance Improvement Program to the Health Plan Medical Director and/or Chief of Medicine.
- The Chief of Medicine or other representatives deemed appropriate presents the Credentialing and Peer Review Committee decisions to the QIHEC for informational purposes.
- The Chief of Medicine or other representative deemed appropriate presents the Credentialing decisions to the Board of Directors for informational purposes.
- The Chief of Medicine chairs the Credentialing and Peer Review Committee and has the responsibilities of the Committee Members listed below.

Committee Members

- Committee members participate in and support the functions of the Credentialing and Peer Review Committee by attending meetings, providing input and feedback and overall guidance of the Credentialing Program.
- Review/approve credentialing program and related policies on an annual basis, or more often as deemed necessary.
- Review and consider each applicant's information based on criteria and compliance requirements.
- Accesses clinical peer input when discussing standards of care for a particular type of practitioner when there is no committee member of that specialty.
- Ensures credentialing activities are conducted in accordance with the Credentialing Program.
- Reviews quality improvement findings as part of the recredentialing and the ongoing monitoring process.

Voting

Provider members (physicians, specialists, midlevel and allied health professionals) of the Credentialing and Peer Review Committee have voting privileges. Administrative support staff may attend but are not entitled to vote. The presence of three voting physicians at any regular or special meeting will constitute a quorum for the purpose of conducting business.

Notification of Decisions

The provider's welcome letter is sent to each practitioner, notifying them when the AHF Credentialing and Peer Review Committee has approved the provider to participate in the AHF network. This notification will be sent within sixty (60) calendar days from the date of the decision.

The provider's effective date is determined by the date indicated on our Human Resources (HR) Intake Form. Following our internal process, the AHF Learning and Development team has 10 business days from the provider's effective date to complete all required onboarding training.

Frequency of Meetings

At a minimum, the Credentialing and Peer Review Committee meets quarterly.

Minutes and Reporting

Minutes of each meeting are recorded and include at a minimum, recommendations for credentialing/recredentialing and disciplinary actions. The Credentialing and Peer Review Committee and Peer Review activities are reported quarterly to the QIHEC and the Executive Oversight Committee (EOC). Significant Credentialing and Peer Review actions are reported quarterly to the Board of Directors.

Confidentiality, Conflict of Interest and Discoverability

All Credentialing and Peer Review Committee members adhere to the confidentiality policies and procedures. These policies define and outline the protection of all confidential information received in the course of any individual's association with PHC California. All Committee members, support staff and guests sign a Confidentiality Agreement at least annually.

The Committee members adhere to the Conflict of Interest policy. A member of the Committee must refrain from voting when s/he has a professional involvement or conflict of interest that might have the appearance of partial judgment. The minutes will reflect all situations where a Committee member refrains from voting due to a conflict of interest. A member of the Committee will exercise his or her best efforts to maintain the confidentiality of all information and records of the Committee deliberations, except as otherwise required by law.

Section 5: Non-Discrimination

Credentialing and recredentialing decisions are not made based on an applicant's race, ethnic/national identity, gender, age or, sexual orientation, or on type of procedure or patient (e.g., Medicaid) in which the practitioner specializes. Preventing non-discrimination involves taking proactive steps to protect against discrimination occurring in the credentialing and recredentialing processes. This does not preclude including network practitioners who meet certain demographic or specialty needs; for example, to meet cultural needs of members. AHF monitors and prevents discriminatory credentialing through the following processes:

a. Tracking and trending of reasons for denial and/or terminations.

b. Semi-annual or at least Annual audits of files in process for greater than six (6) months to determine compliance with practitioner contact criteria.

c. The presence of nondiscrimination statement on the "Statement of Confidentiality" to be signed by members, staff and guests of the Credentialing Committee on an annual basis.

d. Maintain a heterogeneous credentialing committee and require The Credentialing Committee sign a nondiscrimination statement they will not discriminate.

e. The presence on a nondiscrimination statement on the Credentials Committee Attendance sign-in form.

f. Documents, and/or information, submitted to the Credentials Committee for in-process, denial, or termination, and approved files do not designate a practitioner's race, ethnic/national identity, gender, age, sexual orientation, and types of procedures performed or payor sources.

SAMPLE

It is the policy of AIDS Healthcare Foundation to hold as privileged and confidential all Credentials information, including materials presented to AHF Credentials/ Peer Review Committee. This includes all minutes and activities of the Committee.

AIDS HEALTHCARE FOUNDATION CONFIDENTIALITY STATEMENT

QUALITY IMPROVEMENT AND HEALTH EQUITY COMMITTEE AND SUBCOMMITTEES

At any time attending meetings of the PHC California Quality Management Committee and its subcommittees as a member or guest, I recognize that confidentiality is vital to the free and candid discussions necessary to carry out quality improvement activities. Subcommittees may include but not be limited to: Pharmacy & Therapeutics, Utilization Management, Member & Provider, Credentialing & Peer Review, HIPAA Subcommittee, Ryan White Quality, Risk Management and Infection Prevention and Control.

I agree to respect and maintain the confidentiality of all discussions, deliberations, records, and other information generated in connection with these activities. Any/all patient information is kept confidential. I will not make any voluntary disclosures of such information except to persons authorized to receive it. I also understand that while proceedings of the meetings may be recorded for the purposes of transcribing the meeting minutes, the official minutes are the written, signed and approved version.

Signature:

_____

Name:

_____

Date: _____

Section 6: Practitioner's Right to Review Credentials File

Practitioners have the right to review their credentials file at any time. Practitioners are notified of their right in a letter sent to them at the time the initial or recredentialing application is received. The practitioner must notify the Credentialing Department and request an appointed time to review their file and allow up to seven calendar days to coordinate schedules. A Medical Director and/or the Director of National Credentialing will be present. The practitioner has the right to review all information in the credentials file except peer references or recommendations protected by law from disclosure.

The only items in the file that may be copied are the application, the license and the DEA certificate. Practitioners may not copy documents that include pieces of information that are confidential in nature, such as the practitioner credentialing checklist, the responses from monitoring organizations (i.e., National Practitioner Data Bank, State Department of Health, Health Professional Quality Assurance), and verification of hospital privileges letters.

Section 7: Practitioner's Right to Notification and Correction of Erroneous Information

Practitioners have the right to correct erroneous information in their credentials file. Practitioners are notified of their right in a letter sent to them at the time the initial or recredentialing application is received. The practitioner is notified immediately in writing in the event that PHC California receives information that conflicts with information given by the practitioner. Examples include but are not limited to actions on a license, malpractice claims history or board certification decisions. The notification will detail the information in question.

The practitioner must submit a written response within thirty (30) calendar days of receiving notification to the Director of National Credentialing. The notification will detail the information in question. The practitioner must explain the discrepancy, may correct any erroneous information and may provide any proof that may be available. If the practitioner does not respond within thirty (30) calendar days, his/her application processing will be discontinued and participation will be denied.

Upon receipt of notification from the practitioner, the primary source information in dispute is reverified. If the primary source information has changed, correction will be made immediately to the practitioner's credentials file. The practitioner will be notified in writing that the correction has been made to his/her credentials file. If the primary source information remains inconsistent with practitioners' notification, the Credentialing Department will notify the practitioner. The practitioner may then provide proof of correction by the primary source body. The Credentialing Department will reverify primary source information if such documentation is provided.

Section 8: Practitioner's Right to be Informed of Application Status

Practitioners have a right, upon request, to be informed of the status of their application. Practitioners applying for initial participation are sent a letter when their application is received and are notified of their right to be informed of the status of their application in this letter.

The practitioner can request to be informed of the status of their application by telephone. A response to the request is made within two working days. PHC California may share with the practitioner where the application is in the credentialing process to include any missing information or information not yet verified. PHC California does not share with or allow a practitioner to review references or recommendations, or other information that is peer-review protected.

Section 9: Confidentiality

All practitioner information obtained during the credentialing process is private and confidential except where otherwise specified by law or at the discretion of the Credentialing and Peer Review Committee or Board of Directors. This policy includes both voting and non-voting members of the Committee, invited guests of the Committee and Credentialing staff who is involved in the data collection and file preparation for the credentialing and recredentialing process.

Information, documents and/or evidence created, collected, maintained or otherwise arising out of matters that are under review, or have been reviewed pursuant to these policies, will be kept confidential by all participants except as required by law or at the discretion of the Committee or the Board of Directors, in order to encourage candor and careful assessment necessary to effect peer review and quality assurance.

All members (voting and non-voting) and guests of the Credentialing and Peer Review Committee, or any other committee performing any peer review functions or other individuals who participate in peer review functions

will sign the Statement of Confidentiality at least annually. Members and guests of the Committee will not discuss, share or use any information for any purpose other than peer review.

Credentials information is kept in a credentials file, filed by the practitioners' last name. Practitioner files are stored in locked file cabinets or locked rooms and are retained for forty (40) years following the end of the practitioner's association with PHC California.

The Manager, Credentialing grants access to credentials files only as necessary to complete credentialing work or as required by law. Access to these documents will be restricted to authorized staff, Credentialing and Peer Review Committee members as authorized by the Credentialing and Peer Review Committee or the Board of Directors. Minutes, reports and files of Credentialing and Peer Review Committee meetings will be stored in locked cabinets in the Credentialing Department and will be protected from discovery under all applicable laws.

Copies of minutes and any other related meeting materials will not be removed from meetings and Credentialing staff will shred extra sets of information from such meetings. Electronic data and/or information are password protected and staff are advised not to divulge passwords to their coworkers.

Section 10: Practitioner Listings in Directories and Other Member Materials

PHC California ensures that listings in practitioner directories and other materials for members are consistent with credentialing data. Status of practitioner education, training or certification is not published in materials distributed to members. Practitioner specialty is published in the Provider Directory. After each practitioner is credentialed, the Provider Services Department generates the provider profile is generated and loaded into Health Suite, the claim payment system. These data are used to generate the Provider Directories. Members have the ability to call the Member Service Department to request additional information regarding practitioner qualifications to include practitioner's education, training, certification and designated specialty. This information given to members comes directly from the Credentialing database.

Section 11: Site and Medical Recordkeeping Practice Reviews

A process is employed to ensure that the offices of all Primary Care Practitioners (PCP) and high-volume specialty health care practitioners meet the office-site standards. There is an assessment of the quality, safety and accessibility of office sites where care is delivered. Standards and thresholds for office site criteria and medical treatment and record-keeping practices have been adopted by and approved by the Credentialing and Peer Review Committee. These guidelines are distributed to all practitioners before a site review is conducted and are also listed in the Provider Manual. The site and medical record keeping review is conducted prior to the initial credentialing decision. The Credentialing and Peer Review Committee considers site and medical record keeping review reports with other criteria and information about the practitioners when making initial credentialing determinations. A site review is conducted at each location in which a Primary Care Practitioner and/or high-volume specialty health care practitioner sees members. See Attachment A: Full Scope Site Review Tool. For multiple-site practices, medical treatment record-keeping practices are reviewed at each site. If multiple practitioners are at one site, records reviewed will be based on number of physicians based on DHCS MMCD requirements.

New practitioners who are joining a contracted medical group that has been reviewed and found to be 90% or more in compliance with the site review guidelines will not require another site review. Sites with an 80-89% score will have to show proof of a corrective action plan. A copy of the medical group's site and medical record keeping practices review report will be filed in the practitioner's credentials file and reviewed by the Credentialing and Peer Review Committee as part of the initial credentialing process.

A standard site-visit survey form is completed at the time of each visit. This form includes the Site and Medical Record Keeping Practice Guidelines outlined below and the thresholds for acceptable performance against the criteria. This includes an assessment of:

- Physical accessibility
- Physical appearance
- Adequacy of waiting- and examining-room space
- Availability of appointments
- Adequacy of medical/treatment record keeping

Adequacy of Medical Recordkeeping Practices

During the site-visit, PHC California discusses office documentation practices with the practitioner or practitioner's staff. This discussion includes a review of the forms and a method used to keep the information in a consistent manner and includes how the practice ensures confidentiality of records. One medical/treatment record is assessed for orderliness of record and documentation practices. To ensure member confidentiality, a "blinded" medical/treatment record or a "model" record is reviewed instead of an actual record.

Site Reviews for Medi-Cal Managed Care Primary Care Providers (California)

The Health Plan must conduct onsite reviews of network provider sites as part of the initial credentialing process and every three years (DHCS APL 19-004). In accordance with DHCS/MMCD requirements, these sites are reviewed by PHC California State Certified Master Trainer and/or designated Site Reviewer certified in accordance with DHCS MMCD Policy Letter No. 03 02. These sites are reviewed and scored. Corrective action plans are implemented in accordance with DHCS MMCD Policy Letter No. 03006. Site reviews are required as part of the initial credentialing when both the provider and site have been added to the California Medi-Cal Managed Care Network; thereby, both the site review and credentialing requirements can be completed at the same time. A new site review is not required when new providers join an approved site within three years of the site's previous passing review. Results of the review are factored into the formal credentialing process and housed within the credentialing file.

High Volume Specialty Health Care

Prior utilization data is used to identify high volume specialty health care practitioners. In January of each year a report of utilization data is analyzed. The top five (5) practitioners utilized will be identified. Site and medical record keeping practice reviews will be conducted for those five practitioners. Site and medical record keeping practices review reports are included in specialty health care practitioners joining a high-volume practice. The report is included in the credentials file and reviewed by the Credentialing and Peer Review Committee as part of the initial credentialing process. If a high-volume practitioner moves to a new location, s/he will be required to have a site review conducted of the new location prior to recredentialing. If one of the five practitioners identified in January has already had a review at their current location with passing scores, another review is not required.

Site Reviews for Accredited Facilities

If a practitioner has an office in facility accredited by The Joint Commission (TJC), the survey report is accepted in lieu of performing a site review. A copy of TJC survey report will be obtained. The report must show that the survey includes the practitioner's office and meets the quality assessment criteria.

Relocations and Additional Sites

The Provider Relations Department sends a monthly notification to the Credentialing Department that contains relocation information for PCPs and high-volume specialty health care practitioners. This information includes, but is not limited to, the following instances:

- Practitioner leaves a group practice to open his/her own office
- Practitioner moves an office site from one location to another
- Practitioner opens an additional office

When notification is received that a PCP or high-volume specialty health care practitioner relocates or opens an additional office, a site review of the new office will be conducted before the practitioners recredentialing date. Practitioners who are joining a contracted medical group that has been reviewed and found to be 80% or more in compliance with the site review guidelines will not require another site review. A copy of the medical group's site review report will be filed in the practitioner's credentials file and reviewed by the Credentialing and Peer Review Committee as part of the recredentialing process.

Reporting

Statistical reports summarizing site review scores are submitted quarterly to the Credentialing and Peer Review Committee. All site review reports and corrective action plans (as applicable) are included in the practitioner's permanent credentials file.

Compliance Standards

Practitioner sites must demonstrate an overall 90% compliance with the Medical Record Keeping Practice Guidelines**.** For medical managed care PCP sites, scores 80-89% will require a corrective action plan. If a serious deficiency is noted or the score achieved is less than 80%, a corrective action plan will be requested within forty-five (45) days and a follow-up visit within ninety (90) days.

Improvement Plans/Corrective Action Plans

Within thirty (30) calendar days of the review, a copy of the site review report and a letter will be sent to the medical group or practitioner notifying them of their results. If the medical group does not achieve the required compliance with the site review standards, the Manager, Provider Relations will do all of the following:

1. Send a letter to the practitioner that identifies the compliance issues.

2. Send sample forms and other information to assist the practitioner to achieve a passing score on the next review.

3. Request the practitioner to submit a written corrective action plan within thirty (30) calendar days.

4. Send notification that another review will be conducted of the office in ninety (90) days.

When compliance is not achieved, the practitioner will be required to submit a written corrective action plan (CAP) within thirty (30) calendar days of notification. The request for a CAP will be sent certified mail, return receipt requested. This improvement plan should be submitted by the office manager or practitioner and must include the expected time frame for completion of activities. The Manager, Provider Relations or designee

conducts additional site reviews of the office at ninety (90) day intervals until compliance is achieved. The information and any response made by the practitioner is included in the practitioner's permanent credentials file and reported to the Credentialing and Peer Review Committee. If compliance is not attained at follow-up visits, an updated CAP will be required.

Detecting Deficiencies Subsequent to Initial Visits

Once a site review has been conducted and the medical group has met the required 80% compliance, the medical group will not require another site review unless deficiencies are detected. Several processes are employed for detecting deficiencies after the initial site review. This process includes monitoring of the following:

1) Member complaints/grievances: Reports are sent to the Credentialing Department of all member complaints/grievances attributed to a practitioner. The complaints/grievances are filed in the practitioner's credentials file. The complaint/grievance(s) are reviewed by the Credentialing and Peer Review Committee and may require a site review be conducted.

2) Reports from Provider Relations visits: When a Provider Relations Representative discovers anything unusual or concerning in a visit to a practitioner office, they immediately report their findings to the Director of National Credentialing. This information is filed into the practitioner's credentials file and reviewed by the Credentialing and Peer Review Committee.

3) Access and Availability of care and services data: All access and availability of care reports collected through phone surveys, site reviews and member complaints/grievances are kept in the practitioner's credentials file. If a pattern of inaccessibility and/or unavailability develops, a site review may be requested and reviewed by the Credentialing and Peer Review Committee.

4) Case review of adverse events: The Quality Management Department forwards reports of quality of care cases to the Chief of Medicine, Medical Director and Credentialing Department upon closure of the case. Any time during or after an investigation a site review may be requested, performed and reviewed by the Credentialing and Peer Review Committee.

Section 12: Ongoing Monitoring of Sanctions, Complaints, Adverse Events and Quality Issues

Practitioner sanctions, complaints, grievances, adverse events and other potential quality of care issues are monitored between recredentialing cycles and appropriate action is taken against practitioners when occurrences of poor quality are identified. Information obtained during the ongoing monitoring process is always included in the practitioner's credentials file and is also evaluated at the time of recredentialing. The list of entities below is queried for sanctions, complaints, grievances, adverse events and other potential issues:

- Medi-Cal Provider Suspended and Ineligible List
- Office of Inspector General-List of Excluded Individuals Entities
- SAM- System For Award Management
- Noridian/CMS –California

Medicare and Medicaid Sanctions

The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program releases a monthly report identifying individuals and entities excluded from Medicare and Medicaid programs. This report is reviewed within thirty (30) calendar days of its

release. If it is determined that a participating practitioner or health care delivery organization (HDO) is on the exclusion report, the practitioner or HDO contract with PHC will be immediately terminated.

Medi-Cal Provider Suspended and Ineligible List

Medi-Cal law, *Welfare and Institutions Code* (W&I Code), sections 14043.6 and 14123, mandate that the Department of Health Care Services (DHCS) suspend a Medi-Cal provider of health care services (provider) from participation in the Medi-Cal program when the individual or entity has:

- Been convicted of a felony;
- Been convicted of a misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service;
- Been suspended from the federal Medicare or Medicaid programs for any reason;
- Lost or surrendered a license, certificate, or approval to provide health care; or
- Breached a contractual agreement with the Department that explicitly specifies inclusion on this list as a consequence of the breach.

The Medi-Cal Provider Suspended and Ineligible List are reviewed within thirty (30) calendar days of its release. If it is determined that a participating practitioner or health care delivery organization (HDO) is on the Suspended and Ineligible, Credentialing department will notify Provider Relations department immediately and Provider Relations will terminate the contract of the practitioner or HDO immediately. Credentialing will forward this information to the next credentialing committee meeting for informational purpose. AHF will notify the Medi-Cal Managed Care Program/Program Integrity Unit within ten (10) State working days of removing a suspended, excluded, or terminated provider from its provider network and confirm that the provider is no longer receiving payments in AHF network.

Sanctions or Limitations on Licensure

All sanctions or limitations against licensure are released immediately by the State Department of Health. This information is released on the State Department of Health website. These News Releases are reviewed weekly. All news releases regarding disciplinary action taken against health care practitioners are maintained in the Credentialing Department. Practitioners identified on the report that are part of the network will be reviewed at the next scheduled Credentialing and Peer Review Committee meeting for a decision on appropriate action to be taken.

Member Complaints/Grievances

Member complaints/grievances about their care are forwarded to the Quality Management Department. The Quality Improvement Manager reviews each complaint/grievance to determine if there is a potential quality of care issue. If it is determined that there is a potential concern, the case is sent to the Medical Director or Chief of Medicine and an investigation is initiated. Network service complaints are forwarded to the Provider Relations Department for follow-up.

Additionally, complaints and grievances regarding providers, service, access or billing and financial issues are investigated and sent to the Credentialing Department. Hard copy reports are filed in the permanent credentials file. Practitioners who have three or more complaints/grievances in a twelve-month period are sent a letter notifying them of the complaints/grievances and are asked to provide a response within 30 calendar

days for review by the Credentialing and Peer Review Committee. This information is taken along with the practitioner's entire credentials file to the next scheduled meeting for review.

The Credentialing and Peer Review Committee reviews the entire credentials file and the complaint/grievance information and makes a determination. If the Committee identifies instances of poor quality that could affect the health and safety of members, an appropriate intervention will be initiated according to the PHC California Fair Hearing Plan.

Adverse Events and Quality of Care

The Quality Management Department investigates complaints, grievances, adverse events and other potential quality of care issues. Cases assigned a level 3 or level 4 are taken to the next scheduled Credentialing and Peer Review meeting for review. If a level 3 or 4 case involves a practitioner credentialed by a group delegated for credentialing, the Credentialing and Peer Review Committee will notify the delegated Peer Review Committee of the adverse event. A response will be required from the delegate's Peer Review Committee concerning the event.

The Credentialing and Peer Review Committee reviews the entire credentials file and makes a determination. If the Committee identifies instances of poor quality that could affect the health and safety of members and clients, an appropriate intervention will be initiated according to the Fair Hearing Plan.

These data are also reviewed at the time of recredentialing. The QM Department may request the Credentialing and Peer Review Committee to review a practitioner or a group of practitioners' performance related to opportunities identified for improvement at any time.

Section 13: Corrective Action, Notification to Authorities and Practitioner Appeal Rights

Established criteria are used in the review of practitioners' performance. All adverse actions taken by the Credentialing and Peer Review Committee are conducted in compliance with applicable state peer-review laws, the federal Fair Hearing Plan, the Healthcare Quality Improvement Act of 1986, and PHC Fair Hearing policies and procedures.

Practitioners who fail to meet the minimum credentialing standards or who fail to meet performance expectations pertaining to quality of patient care will be subject to corrective action, suspension or termination from network participation. This applies to all practitioners who are contracted by PHC. This policy does not apply to applicants who do not meet basic conditions of participation and are ineligible for participation. The purpose of this policy is to provide a mechanism for implementation of corrective action, suspension or termination of practitioners.

If at any point a practitioner fails to meet the minimum standards and criteria for credentialing, or fails to meet performance expectations with regard to quality of patient care, the Credentialing and Peer Review Committee may act to implement corrective action, suspend or terminate the practitioner's participation status. Suspension or Termination may be taken after reasonable effort has been made to obtain all the facts of the matter and the opportunity to appeal has been afforded to the practitioner. Failure to meet expectations can be identified through activities, which include, but are not limited to:

- Denial of initial application for Provide status
- Recredentialing process
- Revocation, termination of, or expulsion from Provider status

- Reduction of authority to provide care to AHF patients
- Suspend Provider from AHF network for a cumulative period of more than thirty (30) days in any twelve (12) month period
- Summary suspension of authority to provide care to AHF patients for more than fourteen (14) consecutive days
- Ongoing monitoring of sanctions, complaints and adverse events
- Quality/Utilization review activities
- Medical record chart reviews
- Claims data review
- On site reviews, review of medical record keeping practices, patient safety procedures or other patient care and practice management functions.

Corrective Action

In cases where altering the conditions of participation is based on issues related to quality of care and/or service, PHC California may work with the practitioner to establish a corrective action plan to improve performance, prior to, or in lieu of suspending or terminating his or her participation status.

A corrective action plan is a written improvement plan, which may include, but is not limited to the following:

- Identifying the performance issues that do not meet expectations
- What actions/processes will be implemented for correction
- Who is responsible for the corrective action
- What improvement/resolution is expected
- How improvements will be assessed
- Scheduled follow-up, monitoring (compliance review, normally not to exceed six (6) months).

Practitioners subject to corrective action will be notified within ten (10) working days, via a certified letter from the Medical Director or Chief of Medicine. Such notification will outline:

- Reason for the corrective action
- Corrective action plan

If the corrective actions are resolved, the practitioner's performance may or may not be monitored, as deemed appropriate. If the corrective action(s) are not adequately resolved within the designated time, depending on the circumstances of the case, the Credentialing and Peer Review Committee may recommend that the practitioner continue on an improvement plan, or recommend suspension or termination. All recommendations for termination that result from a lack of appropriate practitioner response to corrective action will be brought to the Credentialing and Peer Review Committee for review and decision.

Summary Suspension

In cases where the Chief of Medicine or the Credentialing and Peer Review Committee determines the circumstances pose an immediate risk to patients, a practitioner may be summarily suspended from

participation in the network, without prior notice, pending review and investigation of information relevant to the case.

Such summary suspension will become effective immediately upon imposition, and the Chief of Medicine will promptly notify the practitioner of the suspension, via a certified letter. Notification will include the following:

- Action being taken
- Reason(s) for the action and/or information being investigated
- Information (if any) required from the practitioner
- Estimated timeline for determining whether or not to reinstate or terminate the practitioner
- Opportunity to a fair hearing (see Fair Hearing Plan policy)

Upon initiation of the suspension, the Chief of Medicine and credentialing staff will commence investigation of the issues. Findings of the investigation will be presented to the Credentialing and Peer Review Committee. The Credentialing and Peer Review Committee has the authority to implement corrective action, place conditions on the practitioner's continued participation, discontinue the suspension or terminate the practitioner.

Termination

After review of appropriate information, the Credentialing and Peer Review Committee may determine that the practitioner does not meet performance expectations pertaining to quality of care, services or established performance/professional standards. The Credentialing and Peer Review Committee may then vote to terminate the practitioner. Within ten (10) business days of the Committee's decision, the practitioner is sent written notice of termination, via a certified letter from the Chief of Medicine, which includes the following:

- Effective date of termination
- Reason for termination
- Obligations of the practitioner regarding further care of patients/members
- The opportunity to a fair hearing (see Fair Hearing Plan policy)

Termination criteria include but are not limited to the following:

- Hospital privileges are refused, revoked, suspended, or reduced at any hospital.
- License or DEA certificate revoked, suspended, placed on probation or otherwise limited.
- Placed on probation, reprimanded, fined or has his/her practice restricted by any state agency in the United States that disciplines practitioners.
- Is or was censured or excluded (e.g. suspended or disqualified) by Medicare or Medicaid.
- Indicted for or convicted of a felony.
- Fails to comply with credentialing/recredentialing processes.
- Fails to comply with the provisions of his/her provider contract.
- Renders or has rendered services outside the scope of his/her license.
- Fails to comply with procedures implemented in connection with the administration of utilization review or fails to cooperate with quality management.

- Has or has had a chemical dependency/substance abuse problem without verified evidence of successful treatment.
- A practitioner has a physical or mental health condition that may impair his/her ability to practice with the full scope of licensure and qualifications or might pose a risk of harm to patients.
- Other acts, behavior or omissions that the Credentialing and Peer Review committee reasonable judgment constitutes reason for termination.

Notification to Authorities

In cases where the Credentialing and Peer Review Committee suspends a practitioner's authority for more than thirty (30) days; denies or terminates a practitioner's contract based on unprofessional conduct based on quality of patient care; or accepts the resignation of the practitioner from the network while the practitioner is under investigation related to possible incompetence or improper professional conduct or in return for not conducting such an investigation/proceeding (collectively "adverse action") there is a procedure for notifying the appropriate authorities of the action.

When adverse action has been taken against a practitioner as described in the Fair Hearing Plan, the action is reported to the Board of Medical Examiners (that is, the body with the responsibility for the licensing of physicians in the applicable state). The report will contain the name of the practitioner involved; a description of the acts/omissions or other reasons for the action or, if known, for the resignation; such other information respecting the circumstances of the action or surrender as the Secretary of Health and Human Services deems appropriate. The form of the report will be as set forth in 42 USC Section 11134 and will be made within a month of the final adverse action.

When adverse action has been taken, a certified letter is sent to the practitioner describing the adverse action taken and notifying the practitioner of his/her right to a Fair Hearing. A copy of the Fair Hearing Plan is included with the letter. The practitioner is given thirty (30) days to request a Fair Hearing.

Any other final action by the Credentialing and Peer Review Committee and/or the Board of Directors that by its nature is reportable to the Licensing Board or the NPDB.

Prior to submitting reports to any external agency or Board, they must be sent to the Legal Department for review and approval.

Section 14: Health Delivery Organizations

Initial quality assessments are conducted for any Health Delivery Organization (HDO) applying for Network participation. Reassessments are conducted of HDOs every thirty-six (36) months. The Credentialing and Peer Review Committee reviews information obtained in the quality assessments and makes the determination for participation.

Quality assessments are conducted on the following types of HDOs:

- Hospitals
- Behavioral Health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting-*as applicable*
- Free Standing ambulatory surgical centers-*as applicable*
- Home health care agencies-*as applicable*

- Skilled nursing facilities/nursing homes-*as applicable*
- Urgent Care Centers (UCC) -*as applicable*
- Clinical Laboratories-*as applicable*
- Comprehensive outpatient rehabilitation facilities (CORF) -*as applicable*
- Outpatient physical therapy providers-*as applicable*
- Speech pathology providers-*as applicable*
- Hospice-as applicable
- End-stage renal disease services providers-*as applicable*
- Outpatient diabetes self-management training providers-*as applicable*
- Portable x-ray suppliers-*as applicable*
- Rural health clinics (RHC) -*as applicable*
- Federally Qualified Health Centers-*as applicable*
- Durable Medical Equipment (DME)-*as applicable*

Before contracting, it is verified that the HDO has met the following criteria for network participation:

1) Meets all state and federal and licensing requirements

2) Is in good standing with state and federal regulatory agencies

3) Lack of sanctions prohibiting participation in Medicaid/Medicare

4) Professional liability coverage limit of at least $1,000,000/$3,000,000 which covers the facility and all providers practicing at the facility

5) Reviewed, approved and in good standing by one of the accrediting agencies approved by PHC California or a passing site survey by an accrediting agency, state or federal government agency, or by PHC California as described below.

6) Non-accredited Hospitals, Skilled Nursing Facilities, Free Standing Surgery Centers, and Behavioral Health Facilities must be either Medicare-certified or have passed a site survey by one of the accrediting agencies approved to participate. The HDO must provide a copy of the most recent survey results, including HDOs corrective action plans (CAPs) to any survey deficiencies; and, a copy of the letter verifying acceptance of the CAP by the survey agency. It is verified that the review was done and meets PHC California standards.

7) As part of its evaluation and ongoing monitoring activities, other types of quality information may be used for Contracted HDOs such as publicly available quality reporting information (e.g., Hospital Compare). Any information considered is placed in the initial and recredentialing files.

The following documentation is required from HDO:

1) Completed Health Delivery Organization Application

2) Copy of state license (if applicable)

3) Copy of the most recent accreditation survey or the most recent Medicare site survey including HDOs corrective action plan to any deficiencies and a copy of the letter verifying acceptance of the CAP by the survey agency.

4) Professional liability insurance declaration page showing dates and amount of coverage

5) Copy of current DEA certificate (if applicable)

Approved accrediting agencies accepted by PHC California are the following:

- Accreditation Association for Ambulatory Health Care (AAAHC)
- National Committee for Quality Assurance (NCQA)
- The Joint Commission (TJC)
- Commission for Accreditation of Rehabilitation Facilities (CARF)
- American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF)
- The Community Accreditation Program, Inc. (CHAP)
- Accreditation Commission for Health Care (ACHC)
- The Compliance Team Inc's "Exemplary Provider Award Program"
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Healthcare Quality Association on Accreditation (HQAA)
- National Association of Boards of Pharmacy (NABP)
- The National Board of Accreditation for Orthotic Suppliers (NBAOS)
- American Board of Certification in Orthotics and Prosthetics (ABC)
- Board of Certification/Accreditation International (BOC)

After the initial assessment, PHC California confirms at least every thirty-six (36) months that the HDO continues to be in good standing with state and federal regulatory bodies and if applicable, reviewed and approved by an accrediting body.

Section 15: Delegation

This section establishes the PHC California requirements for delegating credentialing and recredentialing functions to provider organizations. PHC California will delegate credentialing and recredentialing activities to Independent Practice Associations (IPA) and Provider Groups that meet requirements for delegation. The Credentialing and Peer Review Committee approve all delegation and sub-delegation arrangements and retain the right to limit or revoke any and all delegated credentialing activities when a delegate fails to meet PHC California requirements.

The Credentialing and Peer Review Committee retains the right to approve new practitioners and practitioner sites and terminate or suspend practitioners, providers and sites of care based on requirements in the Credentialing Policy.

To be delegated for credentialing, IPAs and Provider Groups must:

- Be National Committee for Quality Assurance (NCQA), Joint Commission or URAC accredited for credentialing or pass the PHC California credentialing delegation pre-assessment, which is based on NCQA credentialing standards, with a score of at least 80%.
- Comply with the Accreditation Association for Ambulatory Health Care (AAAHC), National Committee for Quality Assurance (NCQA) and Centers for Medicare & Medicaid Services (CMS) requirements for Medicare Advantage practitioners and providers.
- Correct deficiencies within mutually agreed upon time frames when issues of non-compliance are identified by at pre-assessment.
- Agree to PHC California contract terms and conditions for credentialing delegates.
- Submit timely and complete reports to Quality Management Department/Credentialing Department as described in the credentialing delegate reporting policy and procedure.
- Comply with all applicable federal and state laws.

In accordance with DHCS APL 22-013, IPAs and provider groups may obtain a Provider Organization Certification (POC) from the National Committee on Quality Assurance (NCQA) at their discretion. The POC focuses on the groups' role as the agent performing the credentialing functions on behalf of the Health Plan. The Health Plan may accept evidence of NCQA POC in lieu of a monitoring site visit at delegated physician organizations. If the Health Plan delegates credential verification activities, it will establish a formal and detailed written agreement with that entity. Such agreements need not be revised until the parties to the agreement change the agreement's terms and conditions.

If the IPA or Provider Group subdelegates primary source verification to a Credentials Verification Organization (CVO), the CVO must be NCQA certified in all ten areas of accreditation. If the IPA or provider Group sub-delegates to a hospital credentialing department, the hospital credentialing department must be NCQA accredited with full compliance in the medical staff services standards.

Section 17: Practitioner Criteria and Primary Source Verification Table

CRITERIA	Applicable Practitioner Type(s)	VERIFICATION SOURCE	Time Limit	When Required
		APPLICATION		
At initial credentialing, practitioner must submit a complete Practitioner Application to include any attachments. The attestation(s) and release must be signed and dated by the practitioner. At recredentialing, practitioner must submit a complete recredentialing profile or a complete Practitioner Application.	All practitioner types	Review application to assure every section is complete or designated N/A, every question is answered, attestation(s) are signed and dated and the release is signed and dated. Practitioner must submit detailed written responses to any yes answer on the professional questions.	180 calendar days	Initial & recredentialing
Attestation regarding HIV/AIDS CME and qualifications is required. AIDS Healthcare Foundation has qualifications for HIV/AIDS Specialist, which are verified at the time of credentialing and recredentialing.	All practitioner types	HIV specialist attestation form is completed on an annual basis in California.	360 calendar days	Initial & recredentialing
Practitioner must have no physical or mental health condition that might impair the practitioner's ability to practice within the full scope of licensure and qualifications, or that may impose a significant risk of harm to patients.	All practitioner types	Professional questions answered and the practitioner's signature and date on the attestation to the correctness and completeness of the application.	360 calendar days	Initial & recredentialing
Practitioner must not have a current untreated chemical dependency or substance abuse problem impacting his or her ability to practice.	All practitioner types	Professional questions answered and the practitioner's signature and date on the attestation to the correctness and completeness of the application.	360 calendar days	Initial & recredentialing
		In situations where there is a history of chemical dependency/substance abuse, primary source verification of successful treatment is obtained.	180 calendar days	Initial & recredentialing
Practitioner should not have history of criminal conviction(s).	All practitioner types	Professional questions answered and the practitioner's signature and date on the attestation to the correctness and completeness of the application.	360 calendar days	Initial & recredentialing
		In situations where there is a history of an indictment or conviction, primary source verification is obtained from the appropriate agency.	None	Initial & recredentialing
Practitioner should never have had their license in any state denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation or not renewed. Practitioner should never have voluntarily relinquished, withdrawn, or failed to proceed with an application in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct.	All practitioner types	• Professional questions answered and the practitioner's signature and date on the attestation to the correctness and completeness of the application • NPDB • Directly with each Licensing Board.	180 calendar days	Initial & recredentialing
Practitioner should never have had hospital privileges denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation or not renewed. Practitioner should never have voluntarily relinquished, withdrawn, or failed to proceed with an application in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct.	All practitioner types	Professional questions answered and the practitioner's signature and date on the attestation to the correctness and completeness of the application.	360 calendar days	Initial & recredentialing
	All practitioner types	NPDB	180 calendar days	Initial & recredentialing
	APRNs, CNMs, Oral Surgeons,	Current hospital privileges are primary source verified as noted in applicable section.	180 calendar days	Initial & recredentialing

CRITERIA	Applicable Practitioner Type(s)	VERIFICATION SOURCE	Time Limit	When Required
	Practicing Dentist, Physicians, Physician Assistants, Podiatrists			
MALPRACTICE INSURANCE				
Practitioner must have and maintain professional malpractice liability insurance with limits that criteria as outlined below. This coverage will extend to members and the practitioners' activities on behalf of PHC California. Florida permits practitioners to practice without professional liability insurance coverage; however, the practitioner must furnish a bond and place a notice in a prominent place in his or her office that states that s/he does not carry professional liability insurance.	All practitioner types	A copy of the current certificate. The certificate must be legible and show the provider is specifically covered under the policy and the dates and amounts of professional liability coverage.	Current	Initial & recredentialing
Minimum coverage of $1 million per occurrence and $3 million aggregate. CA: $1million per $3 million	APRNs practicing as primary care practitioners and women's health practitioners, CNMs, Licensed Midwives, Oral Surgeons, Practicing Dentist, Dental Hygienists, Physicians, Physician Assistants, Podiatrists			
Minimum coverage of $1 million per occurrence and $1 million aggregate.	APRNs practicing in Behavioral Health, Behavioral Health Practitioners, Chemical Dependency Counselors, Naturopaths, Optometrists, Psychologists			

CRITERIA	Applicable Practitioner Type(s)	VERIFICATION SOURCE	Time Limit	When Required
Minimum coverage of $200,000 per occurrence and $600,000 aggregate.	Acupuncturists, Chiropractors, Occupational Therapists, Physical Therapists, Speech Language Pathologists			
LICENSE				
Practitioners must hold an active, current, valid license to practice in the state as outlined below:	All practitioner types	Verified directly with the appropriate state regulatory agency. This verification is conducted by one of the following methods: • On-line verification program	current	Initial & recredentialing
Licensed as an Acupuncturist.	Acupuncturist	• Documented phone verification directly from the appropriate state agency. Verification must be signed and dated by the person verifying. • In writing directly from the appropriate state agency. Verification must be signed and dated by the person verifying.	current	Initial & recredentialing
Licensed as an Advanced Practice Registered Nurse in one of the following areas: • Family Nurse Practitioner (FNP) • Pediatric Nurse Practitioner (PNP) • Adult Nurse Practitioner (ANP) • Geriatric Gerontological Nurse Practitioner (GNP)	APRN practicing as primary care practitioners	• Must have a full-sized copy of the current AP license in the file for all APRNs.	current	Initial & recredentialing
Licensed as an Advanced Practice Registered Nurse in one of the following areas: • Family Nurse Practitioner (FNP) • Adult Nurse Practitioner (ANP)	APRN practicing as women's health practitioners	• Must have a full-sized copy of the current AP license in the file for all APRNs	current	Initial & recredentialing
Licensed as an Advanced Practice Registered Nurse to practice as a: • Psychiatric Nurse Practitioner or • Clinical Specialist in Psychiatric-Mental Health Nursing	APRN practicing in Behavioral Health	• Must have a full-sized copy of the current AP license in the file for all APRNs	current	Initial & recredentialing
Licensed Clinical Social Worker	LCSW	Any AHF-employed "social worker" who is a licensed clinical social worker at the time of employment or acquires licensure during time of his or her AHF	current	Initial & recredentialing

CRITERIA	Applicable Practitioner Type(s)	VERIFICATION SOURCE	Time Limit	When Required
		employment will be subject to credentialing and recredentialing.		
Licensed as one of the following: • Licensed Mental Health Counselor • Licensed Social Worker • Licensed Marriage and Family Therapist	Behavioral Health Practitioners		current	Initial & recredentialing
Licensed as a Licensed Chemical Dependency Counselor.	Chemical Dependency Counselors		current	Initial & recredentialing
Licensed as a Chiropractor.	Chiropractors		current	Initial & recredentialing
Licensed as an Occupational Therapist.	Occupational Therapists		current	Initial & recredentialing
Licensed as an Optometrist.	Optometrists		current	Initial & recredentialing
Licensed as a Pharmacist	Pharmacists		current	Initial & recredentialing
Licensed as a Dentist.	Oral Surgeons		current	Initial & recredentialing
Licensed Practicing Dentist	DDS, DMD		current	Initial & recredentialing
Licensed Dental Hygienist	Dental Hygienists		current	Initial & recredentialing
Licensed as a Physical Therapist.	Physical Therapists		current	Initial & recredentialing
Licensed as a Physician or Osteopathic Physician.	Physicians		current	Initial & recredentialing
Licensed as a Certified Physician Assistant (PA-C) or a Certified Osteopathic Physician Assistant	Physician Assistants		current	Initial & recredentialing
Licensed as a Podiatrist.	Podiatrists		current	Initial & recredentialing
Licensed as a Psychologist.	Psychologists			
Licensed as a Speech and Language Pathologist.	Speech Language Pathologists			
PA-C must meet all requirements for remote site, utilization, limitations, geographic. Supervising physician must be contracted and credentialed PHC. Physician Assistant's must have a completed Delegation of Services Agreement Between a Supervising Physician and a Physician Assistant.	Physician Assistant	Copy of the practice plan approved for remote site. Copy of Physician Assistant's Delegation of Services Agreement between a Supervising Physician and a Physician.	current	Initial & recredentialing
DEA				

CRITERIA	Applicable Practitioner Type(s)	VERIFICATION SOURCE	Time Limit	When Required
Practitioner must hold a current, valid, unrestricted DEA Certificate.	Oral Surgeons, Physicians, Physician Assistants, Podiatrists	Verification of a current DEA certificate will be conducted on-line directly with the National Technical Information Service (NTIS) database.	Current at PRC decision	Initial & recredentialing
If a practitioner has a pending DEA certificate, PHC California has a written prescription plan from the practitioner. This plan must describe the process for allowing another practitioner with a valid DEA certificate to write all prescriptions requiring a DEA number.	APRNs, CNMs, Oral Surgeons, Physicians, Physician Assistants, Podiatrists	A written prescription plan from the practitioner that describes the process for allowing another practitioner with a valid DEA certificate to write all prescriptions requiring a DEA number.	180 calendar days	Initial & recredentialing
If practitioner does not have a DEA, the practitioner must be licensed in the state with prescriptive authority.	APRNs, CNMs, Physician Assistants	A copy of the State license showing the prescriptive authority designation.	Current at decision	Initial & recredentialing
EDUCATION				
Practitioner must have graduated from an accredited school as noted below:	All practitioner types	• The highest level of education is primary source verified by one of the following methods: • Primary source verification of Board Certification. • In writing directly from the source by letter or fax. Verification must be signed and dated by the person verifying. • Querying the American Medical Association (AMA) Physician Master File • Querying the American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File • Confirmation from the state licensing agency when Documentation that the state agency conducts primary source verification of the highest level of education. This documentation from the state agency must be renewed at least annually. • Documented phone verification directly from the source. Verification must include the type (specialty) of education and the date started and date completed. The verification must be signed and dated by the person verifying.	None	Initial
Graduated from an accredited school of nursing.	APRN			
Graduated from an accredited school of nursing and completion of an accredited school of midwifery.	CNMs			

CRITERIA	Applicable Practitioner Type(s)	VERIFICATION SOURCE	Time Limit	When Required
Graduated with a master's degree in counseling or related field from an accredited school.	APRNs practicing in Behavioral Health			
Graduated with a master's degree in counseling or related field from an accredited school.	Behavioral Health Practitioners			
Graduated with a Doctor of Chiropractic degree from a chiropractic school accredited by the Commission on Accreditation of the Council on Chiropractic Education.	Chiropractors			
Graduated with a Baccalaureate degree in occupational therapy from an accredited college.	Occupational Therapists			
Graduated with a Doctor of Optometry degree from a school accredited by the Council of Optometric Education of the American Optometric Association.	Optometrists			
Graduated from an accredited school of dentistry.	Oral Surgeons			
Graduated from an accredited school of dentistry.	DMD, DDS			
Graduated from an accredited school of dental hygienists	DH			
Graduated with a Baccalaureate degree in physical therapy from an accredited college.	Physical Therapists			
Graduated from an accredited school of medicine or school of osteopathic medicine with an MD or DO degree.	Physicians			
Graduated from a physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA).	Physician Assistants			
Graduated with a Doctor of Podiatric Medicine degree from an accredited school of podiatry.	Podiatrists			
Graduated with a doctoral degree from an accredited PhD or PsyD program.	Psychologists			
Foreign medical graduates must be ECFMG certified	Foreign medical graduates	• Primary source verification of Board Certification (as noted in applicable section). • Copy of ECFMG. • On-line by purchasing an AMA Physician Master File profile. • On-line by purchasing an AOA Profile.	No	Initial
TRAINING				
Practitioner must have satisfactorily completed a residency program in the specialty in which they are practicing.	Oral Surgeons, Physicians, Podiatrists	• The highest level of training is primary source verified by one of the following methods: • Primary source verification of Board Certification (as noted in applicable section).	No	Initial

CRITERIA	Applicable Practitioner Type(s)	VERIFICATION SOURCE	Time Limit	When Required
		• In writing directly from the source by letter or fax. Verification must be signed and dated by the person verifying. • Querying the American Medical Association (AMA) Physician Master File • Querying the American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File • Documented phone verification directly from the source. Verification must include the type (specialty) of training and the date started and date completed. The verification must be signed and dated by the person verifying.		
BOARD CERTIFICATION				
Board certification in appropriate specialty is preferred. Initial applicants who are not Board Certified may be considered for participation to improve access to medical care in medically underserved areas if, in the judgment of the Credentialing and Peer Review Committee, the practitioner's standard of care does not pose a risk to members health. Board Certification is monitored on a monthly basis; any expired certifications are updated at the time of monitoring. Lifetime certifications are noted. Non-board-certified practitioners are evaluated based on having satisfactorily completed a residency program in the specialty in which they are practicing, and maintained a practice in their specialty in good standing for a minimum of five years. Practitioners that completed their education/training prior to the incorporation of the approved Specialty Board may also be considered for participation.	Oral Surgeons, Physicians, Podiatrists	Board Certification is primary source verified through one of the following: American Board of Medical Specialties, (ABMS) • On-line via the American Board of Medical Specialties Board Certified Docs on-line verification program • On-line by purchasing an AMA Physician Master File profile • In writing directly from the Board by letter or fax. Verification must be signed and dated by the person verifying at the Board. • Documented phone verification directly from the Board. Verification must include the specialty of the certification(s), the original certification date, and the expiration date. The verification must be signed and dated by the person verifying. American Osteopathic Association (AOA) • On-line by purchasing an Official Osteopathic Physician Profile Report or AOA Physician Master File • In writing directly from the Board by letter or fax. Verification must be signed and dated by the person verifying at the Board. • Documented phone verification directly from the Board. Verification must include the specialty of the certification(s), the original certification date, and the	Current at decision. Any NCQA-approved source is valid for up to one year, unless the source produces more than one edition. The most current edition must be used.	Initial & recredentialing

CRITERIA	Applicable Practitioner Type(s)	VERIFICATION SOURCE	Time Limit	When Required
		expiration date. The verification must be signed and dated by the person verifying. American Board of Podiatric Surgery • Copy from the most current American Board of Podiatric Surgery Directory • In writing directly from the Board by letter or fax. Verification must be signed and dated by the person verifying at the Board. • Documented phone verification directly from the Board. Verification must include the specialty of the certification(s), the original certification date, and the expiration date. The verification must be signed and dated by the person verifying. American Board of Podiatric Orthopedic and Primary Medicine (ABPOPM) • On-line from the ABPOPM verification website • In writing directly from the Board by letter or fax. Verification must be signed and dated by the person verifying at the Board. • Documented phone verification directly from the Board. Verification must include the specialty of the certification(s), the original certification date, and the expiration date. The verification must be signed and dated by the person verifying. • Copy from the most current American Board of Podiatric Orthopedic and Primary Medicine Directory Royal College of Physicians and Surgeons of Canada • On-line from the verification website www.royalcollege.ca • In writing directly from the Board by letter or fax. Verification must be signed and dated by the person verifying at the Board. • Documented phone verification directly from the Board. Verification must include the specialty of the certification(s), the original certification date, and the expiration date. The verification must be signed and dated by the person verifying.		

CRITERIA	Applicable Practitioner Type(s)	VERIFICATION SOURCE	Time Limit	When Required
Residency trained practitioners who are completing a course of training in preparation for final certification exam must remain in good standing with the specialty board and complete and pass the exam on time as scheduled.	Oral Surgeons, Physicians, Podiatrists	Practitioner must provide a signed written statement that includes the date s/he plans to take the Board exam.	180 calendar days	Initial & recredentialing
WORK HISTORY				
Practitioner must supply a minimum of 5 years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If the practitioner has practiced fewer than 5 years from the date of Credentialing, the work history starts at the time of initial licensure. Experience practicing as a non-physician health professional (e.g. registered nurse, nurse practitioner, clinical social worker) within the 5 years should be included.	All practitioner types	Work history must be included on the application or curriculum vitae and must include the beginning and ending month and year for each work experience. Any gaps exceeding six months will be reviewed and clarified in writing.	180 calendar days	Initial
PROFESSIONAL LIABILITY CLAIMS HISTORY				
Practitioner must supply a full history of malpractice and professional liability claims.	All practitioner types	Documentation of malpractice and professional liability claims history is requested from the practitioner. If there is an affirmative response to the related disclosure question on the application, a detailed response is required from the practitioner.	180 calendar days	Initial & recredentialing
	All practitioner types	NPDB	180 calendar days	Initial & recredentialing
STATE SANCTIONS, RESTRICTIONS ON LICENSURE AND/OR LIMIATATIONS ON SCOPE OF PRACTICE				
Practitioner should never have had their license in any state denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation or not renewed. Practitioner should never have voluntarily relinquished, withdrawn, or failed to proceed with an application in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct.	All practitioner types	NPDB	180 calendar days	Initial & recredentialing
	All practitioner types	Verified directly with the appropriate regulatory agency. In situations where there is a history of sanction or any disciplinary action, formal or informal, a copy is obtained from the appropriate regulatory agency.	180 calendar days	Initial & recredentialing
	All non-MD/DO practitioners	• HIPDB • Verified directly with every state licensing board in which the practitioner has held a license in the past five years. Verification of any sanctions or limitations is obtained from each licensing board. In situations where there is a history of sanction or any disciplinary action, formal or informal, a copy is obtained directly from the licensing board.	180 calendar days	Initial & recredentialing
Practitioner's participating in Medicare must not be listed on the Medicare Opt-Out Report.	All practitioner types participating in Medicare	PHC receives regular updates via email from Noridian of the Washington practitioners who have chosen to Opt-Out of Medicare. If a physician or other practitioner opts out of Medicare, that physician or other practitioner may not accept Federal reimbursement for a period of 2 years. In such cases, PHC does an Administrative Termination for the provider contract and notifies the provider.	180 calendar days	Initial & recredentialing
MEDICARE & MEDICAID SANTIONS				

CRITERIA	Applicable Practitioner Type(s)	VERIFICATION SOURCE	Time Limit	When Required
Practitioner must have no Medicare or Medicaid sanctions	All practitioner types	National Practitioner Data Bank (NPDB)	180 calendar days	Initial & recredentialing
	All practitioner types	Office of Inspector General Medi-Cal Provider Suspended and Ineligible List AHCA Sanctioned and Terminated Provider List	180 calendar days	Initial, recredentialing and monthly.
HOSPITAL ADMITTING PRIVILEGES				
Practitioners must have admitting privileges in good standing in their specialty and without restrictions. If a practitioner has temporary admitting privileges, s/he can be approved on "watch" status for follow-up in three months to ensure privileges advance to active status. Practitioners practicing exclusively on a consultative basis are not required to have admitting hospital privileges.	APRNs, CNMs, Oral Surgeons, Physicians, Physician Assistant, Podiatrists	All current hospital privileges are primary source verified by one of the following: • In writing directly from the hospital by letter or fax. Verification must be signed and dated by the person verifying at the hospital. • Documented phone verification directly from the hospital. Verification must include the category and type (specialty) of privileges and verification that the practitioner is in good standing. The verification must be signed and dated by the person verifying. • Copy of a current published hospital roster that includes the category and type (specialty) of privileges and verification that the practitioner is in good standing. Copy must be initialed and dated by person verifying. If a practitioner has temporary admitting privileges s/he can be approved on "watch" status for follow-up in 3 months to ensure privileges advance to active status.	180 calendar days	Initial & recredentialing
Practitioners that have privileges only allowing admissions under the supervision of another physician (e.g. Allied) must provide written evidence of this arrangement that includes the name(s) of the supervising physician(s). CNMs must have an OB/GYN supervising.	APRNs, CNMs	Practitioners that have privileges only allowing admissions under the supervision of another physician (e.g. Allied) must provide written evidence of this arrangement that includes the name(s) of the supervising physician(s). This evidence may be provided directly from the hospital. If the supervising physician(s) are not in partnership with the practitioner, this arrangement will be verified directly with the physician(s) providing the supervision.	180 calendar days	Initial & recredentialing
Supervising physician will be required to have full admitting hospital privileges for the scope of all the PA-Cs patients.	Physician Assistants	Supervising Physician must be credentialed that includes primary source verification of admitting hospital privileges.	No	Initial & recredentialing
Practitioners who are eligible for privileges (never denied, revoked or voluntarily relinquished to avoid an investigation) but choose not to have a hospital practice or are in the process of obtaining privileges may be considered for participation. These practitioners must include evidence of a written admitting agreement with credentialed Participating practitioners whose privileges meet criteria. The covering	APRNs, CNMs, Oral Surgeons, Physicians, Physician Assistant, Podiatrists	Verify the admitting agreement in writing with the admitting practitioners when the agreement includes practitioners other than medical group partners.	180 calendar days	Initial & recredentialing

CRITERIA	Applicable Practitioner Type(s)	VERIFICATION SOURCE	Time Limit	When Required
practitioner(s) must have full admitting privileges for the scope of all the practitioners' patients.				
REFERENCES				
Practitioner must have at one reference, in writing, which attests positively to the applicant's competencies. The reference must be from a practitioner in a similar specialty. At the discretion of the Credentialing and Peer Review Committee, additional references may be requested.	All practitioners	Letters are sent directly to the practitioner providing the reference.	180 calendar days	Initial
SITE REVIEW				
A site review is conducted at every location in which the practitioner sees members. A minimum of 80% overall compliance with site review standards is required. The definition of a high-volume behavioral health practitioner is detailed in the Site Review section of the policy.	PCPs, OB/ GYNs and high-volume behavioral health practitioners.	Copy of the site review report is included in the credentialing file.	None	Initial & recredentialing for any new location
FL: The Agency for Health Care Administration has state-specific requirements for (1) provider site visit and (2) definition of providers with "active patient load."	Participating providers to include but not be limited to MDs, DOs, DPMs, DCs and DDS.	Provider Site Visits are addressed in PHC Florida policy CR 103 and Active Patient Load is addressed in CR 106.	Site visit performed prior to credentialing	Initial
MEDICAL RECORD REVIEW				
At recredentialing a medical record review is conducted unless the location has fewer than 50 members assigned. Practitioner must demonstrate an overall 80% compliance with the medical record documentation guidelines.	PCPs	Copy of the medical record review report is included in the credentialing file.	None	Recredentialing
24-HOUR COVERAGE				
The practitioner must have a plan for shared call coverage that includes 24-hour, seven days per week and 365 days per year. The covering practitioner(s) must have full admitting privileges for the scope of all the practitioners' patients. Practitioners that have shared call agreements with non-participating practitioners will be responsible to notify the non-participating practitioners that they are responsible for members when they are providing coverage. Practitioners practicing in the following specialties are not required to have 24-hour coverage: • Anesthesiology, Genetics, Dermatology, Emergency Medicine, Hospice & Palliative Medicine, Occupational Medicine, Pain Management, Preventative Medicine, Sports Medicine (not performing surgery) and Urgent Care.	APRNs, Behavioral Health Practitioners, CNS, Chemical Dependency Counselors, CNMs Oral Surgeons, Physicians, Physician Assistants, Podiatrists, Psychologists	Statement from the practitioner included with the application.	180 calendar days	Initial & recredentialing

CRITERIA	Applicable Practitioner Type(s)	VERIFICATION SOURCE	Time Limit	When Required
• Practitioner's only providing outpatient consultative services do not need 24-hour coverage.				
PHC California staff may waive the requirement for provision of 24-hour coverage if the practitioner's setting demands no cross-coverage or need for after-hours access to the practitioner involved. A Medical Director can make this judgment after review of the file. The Medical Director may include a telephone consultation with the practitioner if any cross-coverage issues need clarification. The Medical Director can defer approval and send the coverage issue to full Committee review. Typical, acceptable situations with limited cross-coverage: 1. A specialist whose practice is limited in scope, typically within a focused-care, outpatient clinic; e.g. a neurologist who practices only consultations, only in a multiple sclerosis clinic. 2. An internist or pediatrician subspecialist may have cross-coverage from any other internist or pediatrician where appropriate.	APRNs, CNS, Behavioral Health Practitioners, Chemical Dependency Counselors, CNMs, Licensed Midwives, Oral Surgeons, Physicians, Physician Assistants, Podiatrists, Psychologists	Statement from the practitioner included with the application.	180 calendar days	Initial & recredentialing
Practitioners using the emergency room as their 24-hour coverage must provide written evidence of their arrangement with the emergency room to provide this service.	As stated in above section	Copy of written evidence of arrangement with Emergency Room to provide coverage.	180 calendar days	Initial & recredentialing
Practitioner must have an OB/GYN back up providing 24-hour coverage. Family Practitioners providing obstetric care may provide the back-up in rural areas that do not have an OB/GYN.	CNMs, Licensed Midwives	Statement from the practitioner included with the application.	180 calendar days	Initial & recredentialing
Leaving the phone number to a crisis line on the answering machine is considered appropriate coverage.	Behavioral Health Practitioners, Chemical Dependency Counselors, Psychologists	Documentation of crisis-line phone number.	180 calendar days	Initial & recredentialing

Attachment A

Credentialing and Recredentialing Recommendation Page
Name:

RECOMMENDATIONS OF THE CHAIR

Review of Applicant's Qualifications for Recredentialing

	Satisfactory	**Needs Improvement	Unsatisfactory	N/A
Quality of Patient Care (Including Ambulatory)	✔			
Technical Skill	✔			
Professional Judgment	✔			
Member Complaints/Grievances	✔			
Site Audit	✔			

(Explanation required on separate sheet of paper)**

I have reviewed the quality and appropriateness of care delivered by this applicant through:

☐ **Consultation with the following physician**

_____ _____
Physician Reviewer Date

☐ **Direct Observation**
✔ **Review of Credentialing File**

_____ _____
Physician Reviewer Date

Review of Applicant's Qualifications

I have reviewed this applicant's qualifications. I have also assessed to the best of my knowledge the applicant's physical and emotional health status (including possible physical, mental and behavioral impairments, injury, alcohol and/ or drug related problems) and make the following recommendation:

☐ Recommend Approval of Credentialing ✔ Recommend Approval of Recredentialing
☐ Recommend against Credentialing/Recredentialing (Please summarize decision on a separate sheet)
☐ Recommend Approval of Provisional Credentialing (60-Day Credential Period)

RECOMMENDATIONS OF THE CREDENTIALS COMMITTEE OR DESIGNATED PROVIDER*

✔ **Approved**
☐ **Denied**

_____ _____
Chair, Credentials Committee/Designated Physician Date

APPROVAL BY THE GOVERNING BODY

_____ _____
Board of Governors Date