Title: Credentialing and Recredentialing Policy

Policy No.: CR001_011

Previous Title (if applicable): Supersedes Previous Policy No. (if applicable): QM-CR-04-01, CR-07-01

Department Applicability: Credentialing and Contracting Policy Review Frequency: Annual

Lines of Business: Medi-Cal, Healthy Families, Healthy Kids, Agnews Date Originated: 06/2001

Originating Dept.: Credentialing Date Approved by P&P Committee:

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Dept. Approval: Revision Date(s): 7/7/04; 11/18/05, 6/25/07, 7/2/08, 9/3/08, 12/2/08, 5/6/09, 1/6/10, 3/3/10, 7/7/10, 2/2011

Chief Medical Officer/Medical Director Approval: CEO Approval:

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1. **Policy Statement**

Santa Clara Family Health Plan (SCFHP) ensures licensed health care practitioners meet credentialing standards prior to SCFHP participation.

2. **Purpose**

   The purpose of this policy is to establish the procedures for evaluating and determining a practitioner acceptance for initial and continued participation in SCFHP. Through this policy, SCFHP ensures that participating practitioners meet basic qualifications before delivering care to Members and re-verifies the qualifications of participating practitioners on an every three-year (36-month) basis. This policy establishes the standards for practitioner participation in SCFHP, as established by the National Committee for Quality Assurance (NCQA), the Department of Health Care Services (DHCS), and the Department of Managed Health Care (DMHC). It also describes the uniform process for collecting, validating, and evaluating the credentials of all contracted practitioners.
3. **Definitions**
   A. **PRCC** means Peer Review and Credentialing Committee.
   B. **QIC** means Quality Improvement Committee.
   C. **PQR** means Provider Quality Report.
   D. **Delegated Practitioner** means any practitioner in a group to whom SCFHP delegates credentialing and recredentialing activities.
   E. **PSV** means Primary Source Verification.
   F. **FSR MRR** means Facility Site Review and Medical Records Review.

4. **Procedures**

   A. **Applicability**
      1. This policy governs the credentialing/recredentialing and monitoring of: Physicians (MD), Dentists (DDS), Podiatrists (DPM), Doctors of Osteopathy (DO), Nurse Practitioners (NP), Physician Assistants (PA), Certified Nurse Mid-Wife (CNM), Clinical Nurse Specialists (CNS), Chiropractors (DC), Optometrists (OD), Clinical Psychologists (Ph.D.), Behavioral Health Practitioners such as Marriage Family Therapists (MFT), Licensed Clinical Social Workers (LCSW), Acupuncture (LAC), and other ancillary or mid-level practitioners who desire to participate with SCFHP.
      2. Any practitioner group to whom SCFHP delegates credentialing and recredentialing activities must meet the requirements of this policy. (refer to policy CR006-07 Delegated Credentialing and Recredentialing).

   B. **Responsibilities**
      1. **Governing Board** SCFHP’s Governing Board is ultimately responsible for the quality of patient care for all SCFHP members. The Governing Board has the authority to:
         a. Ratify credentialing and recredentialing decisions,
         b. Delegate the roles and responsibilities for the Peer Review and Credentialing Committees (PRCC)
      2. **Quality Improvement Committee (QIC)** The QIC oversees the quality of care and quality improvement of care provided to the members, and service to contracting practitioners.
         a. The QIC delegates credentialing activities to the PRCC.
         b. The QIC reviews and reports to the Governing Board all activities, reports, conclusions, and actions taken by the PRCC.
3. **Peer Review and Credentialing Committee (PRCC)** The PRCC consists of a multidisciplinary team of SCFHP contracted physicians, and other licensed practitioners as necessary, who are, preferably, board certified.

a. The PRCC Chair is recommended by SCFHP’s Chief Medical Officer/Medical Director and is appointed by SCFHP’s Governing Board.

b. PRCC members include a minimum of at least four (4) contracted physicians with a broad representation from primary care and specialty services as needed.

c. Only physician members have voting rights.

d. The PRCC is attended by the following SCFHP staff:
   i. Chief Medical Officer/Medical Director
   ii. Quality Improvement Representative
   iii. Credentialing Manager

e. Annually, the Credentialing Department ensures that all PRCC participants sign a Confidentiality and Conflict of Interest Agreement, and maintains these agreements within the department (refer to policy CR005-03 Credentialing Committee Confidentiality and Conflict of Interest Agreement).

f. Credentialing and recredentialing decisions are based upon a practitioner’s qualifications without unlawfully discriminating on the basis of race, sex, religion, color, ethnic/national identity, national origin, gender, age, physical disability, mental disability, U.S. military veteran status, sexual orientation, or marital status.

g. Credentialing and recredentialing decisions are not based solely on the kind of patients the practitioner serves or the kind of procedures in which the practitioner specializes.

h. SCFHP monitors and prevents discriminatory credentialing decisions by:
   - Periodic audits of credentialing files and practitioner complaints alleging discrimination; and
   - Maintaining a heterogeneous PRCC membership and requiring Committee members to annually sign an affirmative statement to make decisions in a non-discriminatory manner.
C. **Quorum and Meeting Frequency**
   1. A quorum consists of 51% of the voting members of the PRCC.
   2. The PRCC meets a minimum of eight (8) times per year and more frequently, if required.
   3. PRCC meetings are in person or via teleconference.
   4. The Credentialing Department takes and maintains the minutes and accompanying documents of each meeting.

D. **Functions** The PRCC is responsible for:
   1. Reviewing, investigating, and evaluating the qualifications of individual practitioner applicants.
      a. Committee members cannot be involved in personal or professional credentialing conflicts.
      b. Should such a conflict be identified, the involved Committee member is be excused from the Committee for the duration of that conflict.
   2. Monitoring trends and patterns of care by individual practitioners that may adversely affect SCFHP members and recommends appropriate action to the QIC.
   3. Making determinations and hearing practitioner appeals regarding initial and subsequent credentialing decisions.
   4. Reporting of credentialing actions to QIC.

E. **Chief Medical Officer/Medical Director** The Chief Medical Officer/Medical Director serves as QIC and PRCC advisor, and is responsible for professional medical oversight of the activities of the PRCC, QIC and the Credentialing Department.

F. **Application Process - Pre-Contractual Qualifying**
   1. Physician Practitioners (MD, DO, DPM) requesting participation are required to submit to the Credentialing Department a:
      a. Letter of Intent
      b. Copy of current Curriculum Vitae, CV, which includes the following information:
         i. All work history after completion of medical training.
         ii. Written documentation of any unexplained lapses in employment of a time period that exceeds six months.
2. SCFHP’s Chief Medical Officer/Medical Director conducts a preliminary review of the received documents.
   a. If the practitioner does not meet SCFHP requirements, Chief Medical Officer/Medical Director sends a denial letter. If the Chief Medical Officer/Medical Director determines the practitioner’s documents require additional review, they are forwarded to the Credentials Committee.
   b. If denied, the Credentials Committee sends the denial letter.
   c. If approved, the Credentialing Department sends a copy of the CV to the Contracting Department for network strategy assessment (confidential credentialing documentation remains in a fully secured area of the Credentialing Department).
      i. If approved, Credentialing Department sends application.
      ii. If not approved, Contracting Department sends denial letter.
3. The Credentialing Department forwards Mid-Level application requests directly to the Contracts Committee for network strategy assessment.
   i. If approved, Credentialing Department sends individual ancillary application.
   ii. If not approved, Contracting Department sends denial letter.

G. Application
   1. Interested practitioners submit a signed and completed California Participating Practitioner Application including at least ten (10) years work history, consent, release, attestation, all requested attachments, and current Curriculum Vitae. The attestation questionnaire includes the following:
      a. Reasons for inability to perform the essential functions of the position, with or without accommodation.
      b. Lack of present illegal drug use
      c. History of loss of license and felony convictions
      d. History of loss or limitation of privileges or disciplinary actions
      e. The correctness and completeness of the application
      f. Current malpractice insurance coverage
2. Current, valid, unrestricted, professional license to practice in the State of California from the appropriate licensing board.
3. Clinical privileges in good standing at one of SCFHP’s contracted hospitals, or documentation of other arrangements for admission of members that ensure continuity of care and are acceptable to SCFHP’s Governing Board.

4. Graduation from an accredited medical school or completion of the appropriate education, training and experience for the designated specialty.

5. Board Certification Status:
   a. Board certification is not required, but strongly encouraged.
   b. Board certified physicians are designated as such in the Provider directory.
   c. Board certification is not applicable to Primary Care Physicians with a specialty designation of general practitioner.

6. Proof of current professional liability insurance coverage (malpractice) in amounts equal to a minimum of one million ($1,000,000) per occurrence and three million ($3,000,000) aggregate.

7. Five (5) year professional liability claims history, which includes all malpractice suits that resulted in settlements or judgments paid by or on behalf of the practitioner.

8. Verified current Controlled Substance Registration certificate (DEA), and Clinical Laboratory Improvements Amendment (CLIA) certificates, when applicable.

9. Demonstration of 24 hours a day/7 days a week coverage for access to medical care and advice for SCFHP members, when applicable.

H. Incomplete Application
   If a submitted application is incomplete, the Credentialing Department takes the following steps:
   1. The Credentialing Department faxes a letter to the practitioner requesting submission of the missing information/documentation within ten (10) working days. The practitioner is informed that the application processing cannot begin until the application is completed.
2. If there is no response from the initial fax request, the Credentialing Department telephonically contacts the practitioner to acquire any missing information or documents.

3. If an application remains incomplete beyond 30 working days, the Credentialing Department mails a certified final closure letter to the practitioner advising that the application process:
   a. is closed without further action due to incomplete information, and
   b. may be reinitiated by submission of the missing information within 120 calendar days of the date of signature on the original application.

4. If the application information is received beyond 120 calendar days from the date of the original application, an updated application is required to reinitiate the credentialing process.

5. A report of practitioners whose applications have been closed due to incomplete information is submitted to the next PRCC meeting for review.

I. Completed Application
   1. When the completed and signed application is received, the Credentialing Department performs a complete review, evaluation and verification of the application.
   2. If the information obtained during the credentialing process varies from the information submitted by the practitioner, the Credentialing Department sends the practitioner written notification within ten (10) days of finding the discrepancy to request that the corrected information be submitted to the Credentialing Department within fourteen (14) calendar days. A letter of acknowledgement is sent to applicant within three (3) business days upon receipt of corrections.

J. Verification Process:
   1. Primary Source Verification Elements—The Credentialing Department verifies the following are valid and current:
      a. Medical Board of California or California license agency appropriate for profession or area of service.
      b. DEA certification.
c. Highest level of education defined as graduation from medical school or appropriate professional school, residency, board certification.

d. Board certification or candidacy, when applicable.

e. Malpractice and Medicare/Medi-Cal sanction history.

f. Clinical privileges in good standing from applicant’s primary admitting facility, when applicable.

2. Primary Source Verification--SCFHP relies on numerous sources to verify required elements. These sources include, but are not limited to:

   a. Med Advantage On-Line
   b. American Medical Association (AMA) 
   c. American Board of Medical Specialties (ABMS) 
   d. National Practitioner Data Bank (NPDB) 
   e. Healthcare Integrity and Protection Data Bank (HIPDB) 
   f. National Technical Information Service (NTIS) 
   g. Office of Inspector General (OIG) 
   h. General Service Administrator (GSA) lists 
   i. California State Boards of Licensing.

3. Unverified Elements--If verification can not be made through any of the above sources, then the Credentialing Department sends a query letter directly to the primary source for confirmation.

4. Visual Verification--The Credentialing Department requests current copies of the following:

   a. Curriculum Vitae
   b. Medical/Professional License(s) 
   c. DEA certificate, if applicable 
   d. Regulatory Agency Certification/Inspection, CLIA, if applicable 
   e. Malpractice Liability Insurance Certificate 
   f. City Business License, if applicable 
   g. Educational Commission for Foreign Medical Graduate (ECFMG) Certificate, if applicable 
   h. Mid-Level license, if applicable

5. Verification Time Limit--All verifications are completed within 180 days.

K. Facility Site /Medical Record Review (FSR/MRR)
The on-site FSR/MRR is conducted by the Quality Improvement Department (QI) as referenced in Quality Management Policy QM-FSR-
03-01. Documentation of the results are sent to the Credentialing Department.

L. **Recredentialing**
The Credentialing Department recredentialing practitioners every 36 months. The initial steps are identical to those outlined in 4.J. with the following exceptions:

1. **Recredentialing Process:**
   a. The curriculum vitae or SCFHP practitioner profile reflects changes that have occurred since the last credentialing date.
   b. Initial professional training is not re-verified.
   c. Submission of documentation of professional liability claims history is required for the past 36 months only.

2. **Verification Process--**In addition to verification of all qualifications outlined in 4.J and L.1, the Credentialing Department also reviews reports on:
   a. Member grievances.
   b. Results of any quality review studies, Provider Quality Reports (PQR), and peer review, related to the practitioner.
   c. Utilization Management evaluation reports related to the practitioner.

M. **Review and Approval Process**
1. The Credentialing Department ensures all credentialing and recredentialing documents are:
   a. Reviewed with the Chief Medical Officer/Medical Director, and
   b. Presented to the PRCC for determination within 180 days of the date of application. The PRCC may approve, delay, or deny any applicant upon review of the documentation presented.

2. **Recommendation for further review--**Application/reapplications are forwarded to the PRCC with a recommendation for further review in the following circumstances:
   a. Inability to score above the required 80% medical record and facility review rating
   b. Inability to meet or maintain minimum qualification criteria
   c. Negative responses to verification of:
      i. Education
      ii. License
iii. Sanctions
iv. Malpractice coverage
v. Other qualifications
d. Practitioners who have had his/her medical professional or business license revoked and not stayed, or suspended by any state licensing board.
e. Practitioners who have been convicted of a:
   i. Felony
   ii. Any criminal misdemeanor relating to the practice of a medical profession or other health care related matter
iii. Third-party reimbursement fraud
iv. Controlled substances violations
v. Child/elder abuse charges
vi. Any other matter that, in the opinion of SCFHP, would adversely affect the ability of the practitioner to participate with SCFHP.
f. Practitioners who have a:
   i. History of previous exclusion or preclusion from participation in the Medi-Cal, Medicare or Medicaid programs
   ii. Conviction of:
      1. Medi-Cal, Medicare fraud
      2. Medicaid fraud
      3. Other governmental fraud
      4. Private third party payer fraud
      5. Program abuse
   iii. Requirement to pay civil penalties.
g. Practitioners who have had medical staff appointment or clinical privileges:
   i. Denied
   ii. Revoked
   iii. Terminated by any health care facility
h. Practitioners with any malpractice liability history/legal actions involving claims of medical malpractice or one or more legal pending actions during the five (5) year period preceding the date of initial credentialing or the three (3) year period preceding the date of reappointment.
i. A response to any of the application questions which indicates a possible inability to perform the essential
functions of the position.

j. Lack Board certification.
k. Practitioners with no clinical privileges who have submitted
documentation of acceptable arrangements for hospital
admissions through another participating physician.
l. Practitioners who have had his/her medical professional or
business license revoked but stayed by any state licensing
board.
m. Inability to provide professional services of acceptable
quality as determined by SCFHP.
n. Failure to comply with SCFHP’s Utilization Review policies.
o. Failure to comply with SCFHP’s Quality Improvement
Program policies.
p. Failure to comply with the standards and provisions of the
service agreement.
q. Inconsistent or Incorrect Attestation answers.

N. Practitioner Notification and Appeal Process
1. PRCC approved practitioner—The Credentialing Department mails
   a letter of appointment to the practitioner within 60 calendar days
   of the PRCC decision.
2. PRCC denied practitioner--The Credentialing Department sends a
certified/return receipt letter of denial to the practitioner within 60
calendar days of the PRCC decision.
   a. The letter notifies the practitioner of the right to:
      i. Appeal decisions related to clinical competency or
         professional conduct. Refer to policy CR004-04, Fair
         Hearing.
      ii. Review information upon which the decision of
denial was based.
   b. A dated copy of the letter is included in the practitioner’s
      credentialing file.

O. Performance Monitoring
1. The Credentialing Department performs ongoing monitoring of
   sanctions and complaints, including discriminatory actions, against
   all SCFHP contracted practitioners.
2. SCFHP’s Chief Medical Officer/Medical Director, in consultation
   with SCFHP’s Compliance Department, files a report as required
   by applicable law, including California Business and Professions
Code Section 805 and the Health Care Quality Improvement Act if, as a result of the approval or re-approval of action taken by the Peer Review Committee for a medical practice disciplinary cause or reason, a practitioner’s status has been:
   a. Denied
   b. Suspended
   c. Restricted
   d. Terminated
3. The Credentialing Department performs sanctions, licensure actions or limitations, and exclusions monitoring according to Ongoing Monitoring of Practitioners policy CR008-01.

P. Credential File Maintenance
   All credentialing documents are kept confidential and in a locked area. The files are protected from discovery by Section 1157 of the California Evidence Code.

Q. Practitioner Rights
   1. A practitioner has the right to receive the status of his/her credentialing or recredentialing application, upon request.
   2. A practitioner has the right to review his/her credentialing file and has the right to correct any erroneous information.
   3. The practitioner is not allowed to review references, recommendations or other information that is peer review protected. (Refer to QM-CR-05-03 Peer Review Process).
   4. Notification of practitioner rights is included in application packet.

5. Confidentiality of Information
   In accordance with SCFHP’s Confidentiality Policy, and all applicable state and federal laws, any and all information that is required to be kept confidential, shall be kept confidential.

6. Recordkeeping
   Each department is responsible for retaining and maintaining documents/drafts/records/paperwork for a minimum of ten (10) years for their own department (refer to policy CP005 Record Retention).