5. CREDENTIALING AND REcredentialing

A. IEHP Practitioner Guidelines

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid) Providers.

POLICY:

A. IEHP promulgates credentialing and recredentialing decision guidelines for contracted IPAs delegated to perform these activities.
B. Delegated IPAs are expected to use these guidelines for recommended education and/or training for PCPs and specialists, patient age ranges for Practitioners, hospital arrangements, and recommendations for review of malpractice or other adverse history when making credentialing and recredentialing decisions.
C. IEHP follows these same guidelines for Practitioners directly credentialed by IEHP.
D. IEHP and IPAs adhere to all procedural and reporting requirements under state and federal laws and regulations regarding the credentialing and recredentialing process, including the confidentiality of Practitioner information obtained during the credentialing process.

PROCEDURES:

A. Effective January 1, 2017, IEHP Credentialing guidelines require Providers to meet the internship and residency requirements to be a Pediatric, Internal Medicine or Family Practice, or Public Health and General Preventive Medicine Provider in order to be credentialed as a Primary Care Provider in IEHP’s network. Practitioners are no longer able to be credentialed in the General Practice specialty as this is not a specialty recognized by the ABMS or the AOA. Existing General Practice Provider who do not meet this requirement will be grandfathered into the network, however if the Provider chooses to terminate, the Provider may not reapply or be reinstated as a Primary Care Provider. General Practice Practitioners whose credentialing profile was submitted prior to January 1, 2017 will be credentialed in accordance with prior IEHP policy, by submitting the following documentation:

1. General Practice (All ages or 14 and above only) submitted prior to January 1, 2017, must meet the following criteria as indicated:
   a. Facility Site Review (FSR)/Medical Record Review (MRR) Guidelines. PCP’s must pass all requirements for the FSR/MRR MED_QM 6A. Providers at a site without an active participating PCP must still have an FSR/MRR completed and passed to be considered a Non-Par Provider in the network. No PCPs or Non-Par Providers will be able to provide services at sites without completing an FSR/MRR.
5. CREDENTIALING AND RECREREDENTIALING

A. IEHP Practitioner Guidelines

b. Education and Training Guidelines
   1) Completion of one (1) year rotating internship or PGY-1 Family Practice; and
   2) Provide documentation of primary care practice in the United States for the past five (5) years which includes a mix of pediatric and adult patients. (See Attachment, “IEHP Addendum E” in Section 5);
      • Provide evidence of twenty-five (25) CME units in Pediatric Primary Care completed within the last three (3) years;
      • Provide evidence of twenty-five (25) CME units in Adult Primary Care completed within the last three (3) years;
      • Applicants must provide two (2) letters of recommendation from a physician coworker (i.e., Primary Care Providers with work experience associated with the applicant in the preceding twenty-four (24) months). The physician coworkers must hold an active board certification in Pediatrics or Family Practice; and
      • Applicants must provide two (2) letters of recommendation from a physician coworker (i.e., Primary Care Providers with work experience associated with the applicant in the preceding twenty-four (24) months). The physician coworkers must hold an active board certification in Internal Medicine or Family Practice.

c. Malpractice Insurance Coverage. Must have current and adequate malpractice insurance coverage that meets the following criteria:
   1) Minimum $1 million per claim/$3 million per aggregate.
   2) Coverage for the specialty the Provider is being credentialed and contracted for.
   3) Coverage for all locations the Provider will be treating IEHP patients.

B. IEHP and its Delegated IPAs must use the following guidelines when credentialing or recredentialing Practitioners for participation in IEHP’s network.

1. PCPs – physicians being reviewed for credentialing as a PCP must meet the following criteria as indicated.
   a. Facility Site Review (FSR)/Medical Record Review (MRR) Guidelines. PCP’s must pass all requirements for the FSR/MRR MED_QM 6A.
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Providers at a site without an active participating PCP must still have an FSR/MRR completed and passed to be considered a Non-Par Provider in the network. No PCPs or Non-Par Providers will be able to provide services at sites without completing an FSR/MRR.

b. Education and Training Guidelines

1) Pediatrics (Ages 0-18 or 0-21) Must meet the education requirements set forth by the ABMS or AOA:
   - Board certified in Pediatrics;
   - Three (3) years training in Pediatrics; or
   - One (1) year rotating internship plus two (2) years residency [Post Graduate Years (PGY-2, 3)] in Pediatrics.

2) Family Practice (all Ages or 14 and above only) Must meet the education requirements set forth by the ABMS or AOA:
   - Board certified Family Practice;
   - Three (3) years training in Family Practice; or
   - One (1) year rotating internship plus two (2) years residency (PGY-2, 3) in Family Practice.

3) Internal Medicine (14 and above, 18 and above, or 21 and above) Must meet the education requirements set forth by the ABMS or AOA:
   - Board certified in Internal Medicine; or
   - Three (3) years training in Internal Medicine.

4) Public Health and General Preventive Medicine (18 and above or 21 and above) Must meet the education requirements set forth by the ABMS or AOA:
   - Board certified in Public Health and General Preventive Medicine; or
   - Completion of training requirements set by the ABMS or AOA for Public Health and General Preventive Medicine, to include, evidence of nine (9) months direct patient care experience (completed during or after residency). The nine (9) months direct patient care is in addition to a twelve (12) month internship.
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5) OB/GYN PCP only (14 and above and restricted to females for outpatient care only), must meet the following criterion and be reviewed and approved by the IEHP Medical Director.

- Board certification in Obstetrics/Gynecology or four (4) years training in Obstetrics/Gynecology;
- Documentation of primary care practice in the United States;
- Twenty-five (25) Continuing Medical Education (CME) units for most recent three (3) year period, of which must be in primary care related areas;
- Applicants must provide two (2) letters of recommendation from a physician coworker (i.e. Primary Care Providers with work experience associated with the applicant in the preceding twenty-four (24) months); and
  - The physician coworkers must hold an active board certification in Primary Care Specialty (i.e. board certified in Internal Medicine, Family Practice or Pediatrics).
- In lieu of having full hospital delivery privileges, provide a written agreement with an OB Provider, that includes a protocol for identifying and transferring high risk Members, stated types of deliveries performed (i.e. low-risk, cesarean section etc), must be available for consultations, as needed and that the OB will provide prenatal care after twenty-eight (28) weeks gestation including delivery.
  - The Agreement must include back-up physician’s full delivery privileges at IEHP network hospital, in the same network as the non-admitting OB Provider.
  - The OB Provider must be credentialed and contracted within the same network.

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

6) Family Practice 1 (Family Practice including outpatient OB services) Must provide a copy of a signed agreement that states Member transfers will take place within the first twenty-eight (28) weeks of gestation and a protocol for identifying and transferring
5. CREDENTIALING AND RECREDENTIALING

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high risk Members with a contracted and credentialed OB. The OB must be contracted and credentialed by the same network as the Family Practice Provider and must hold admitting privileges to the IEHP hospital linked with that IPA. In addition, the Provider must meet one (1) of the following criterion:

- Board certified in Family Practice;
- Three (3) years training in Family Practice; or
- One (1) year rotating internship plus two (2) years residency (PGY-2,3) in Family Practice.

7) Family Practice 2 (Family Practice including full Ob services and delivery). Must have full delivery privileges at an IEHP network hospital and meet the following criteria:

- Board certified in Family Practice or three (3) years in training in Family Practice;
- Provide a written agreement for an available OB back up Provider is required. The OB Provider must be credentialed, contracted and hold admitting privileges to the IEHP hospital linked with the Family Practice Provider; and
- Provide a protocol for identifying and transferring high risk members and stated types of deliveries performed (i.e. low-risk, cesarean section, etc.).

Providers that fulfill these requirements may be referred to and see OB/GYN Members within the same IPA, as the referring physician.

8) Bariatric Surgery requirements effective January 1, 2019.

- Board Certified or eligible in General Surgery; or
- Completion of an accredited General Surgery residency and one of the following criteria:
  - Completion of an accredited bariatric surgery fellowship;
  - Documentation of didactic training in bariatric surgery (IEHP recommends the American Society for Metabolic and Bariatric Surgery Course). This information will be verified through:
    - Bariatric training certificate and/or supporting letter from supervising bariatric surgeon, which will be verified by
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Credentialing. Supporting letter will include the minimum criteria:

(i) Supervising bariatric surgeon qualifications;
(ii) Supervising bariatric surgeon relationship with applicant;
(iii) Duration of relationship of supervising bariatric surgeon with applicant; and
(iv) Assessment of applicants competency to perform bariatric surgery by supervising bariatric surgeon.

ii. Attestation of bariatric surgery case volume signed by applicant (See Attachment, “IEHP Bariatric Surgery Attestation” in Section 5) to include the following:

(i) Indicate volume of:
   1) proctored cases; and
   2) cases where applicant was the primary surgeon.

(ii) IEHP requires a minimum of fifteen (15) cases where applicant was the primary surgeon.

o Current or past “Regular or Senior Member” of American Society for Metabolic and Bariatric Surgery (ASMBS). Verification of membership will be obtained by the Credentialing Department.

IEHP recommends applicant actively participates with the MBSAQIP (Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program) or an equivalent regional or national quality improvement program.

- Supportive documentation of participation with program is to be submitted with Credentialing application.

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

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

2. Practitioners outside of scope - occasionally Practitioners may practice outside of scope with approval from the by the IEHP Medical Director or Chief Medical Officer. Further review may be completed by the Peer Review Subcommittee who will either approve or deny. The Provider must submit the documents referenced in this policy under Provider Privilege Adjustment, in addition to the following requirements:
   a. PCPs that have Members assigned ages 0-14 must enroll in the Vaccines for Children (VFC) Program.
   b. Education and Training Requirements
      1) Internal Medicine Providers with expanded age range to all ages, will be processed with a secondary specialty of General Practice, if they provide the following information:
         - Provide documentation of primary care practice in the United States for the past five (5) years which includes a mix of pediatric and adult patients. (See Attachment, “IEHP Addendum E” in Section 5);
         - Provide evidence of twenty-five (25) CME units in Pediatric Primary Care completed within the last three (3) years; and
         - Applicants must provide two (2) letters of recommendation from a physician coworker (i.e., Primary Care Providers with work experience associated with the applicant in the preceding twenty-four (24) months). The physician coworkers must hold an active board certification in Pediatrics or Family Practice.
      2) Pediatric Providers with expanded age range to all ages, will be processed with a secondary specialty of General Practice, if they provide the following information:
         - Provide documentation of primary care practice in the United States for the past five (5) years which includes a mix of pediatric and adult patients. (See Attachment, “IEHP Addendum E” in Section 5);
         - Provide evidence of twenty-five (25) CME units in Adult Primary Care completed within the last three (3) years; and
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A. IEHP Practitioner Guidelines

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

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

1) Minimum $1 million per claim/$3 million per aggregate.

2) Coverage for the specialty the Provider is being credentialed and contracted for.

3) Coverage for all locations the Provider will be treating IEHP patients.

3. Specialists – physicians being reviewed for credentialing as a Specialist must meet the following criteria:

a. Education and Training

1) Board Certified in the specialty and subspecialty, if applicable.

2) If the Practitioner is not board certified in the subspecialty in which he/she is applying, there must be evidence of verification of residency and training in the subspecialty (e.g. Fellowship in Cardiology, Rheumatology, Pediatric Endocrinology, etc.), as relevant to the credentialed specialty. Practitioners who do not meet graduate medical training requirements as set forth by ABMS or AOA for the Provider’s requested subspecialty, will be subject to review by the Medical Director and/or Chief Medical Officer. Further review may be completed by the Credentialing Subcommittee or Peer Review Subcommittee.

3) Specialties not recognized by either board are subject to Medical Director, Chief Medical Officer Review. Further review may be completed by the Peer Review Subcommittee who will either approve or deny.

b. Hospital Admitting Privileges

1) OB/GYN Specialists must provide OB, as well as GYN care to Members. All OB/GYN must have full delivery privileges at an IEHP network hospital.

c. Malpractice Insurance Coverage. Must have current and adequate malpractice insurance coverage that meets the following criteria:
5. CREDENTIALING AND REcredentialing

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

4. Urgent Care Providers – physicians being reviewed for credentialing for Urgent Care locations, must meet the following criteria:
a. Education and Training

1) Board Certified or eligible in a specialty and/or subspecialty recognized by the following boards:
   • American Board of Pediatrics
   • American Board of Family Practice
   • American Board of Internal Medicine
   • American Board of Obstetrics and Gynecology
   • American Board of Emergency Medicine
   • Osteopathic Board of Pediatrics
   • Osteopathic Board of Family Physicians
   • Osteopathic Board of Internal Medicine
   • Osteopathic Board of Obstetrics and Gynecology
   • Osteopathic Board of Emergency Medicine

2) If the Practitioner is board certified or eligible in a specialty and/or subspecialty recognized by the American Board of Medical Specialties or American Osteopathic Association not referenced above, then those Providers are subject to Medical Director, Chief Medical Officer Review. Further review may be completed by the Peer Review Subcommittee, who will either approve or deny. For their review and consideration, the following documents must be submitted:
   • Provide evidence of twenty-five (25) CME units in Pediatric Primary Care completed within the last three (3) years if the Provider is requesting to treat Pediatric patients;
   • Provide evidence of twenty-five (25) CME units in Adult Primary Care completed within the last three (3) years if the Provider is requesting to treat Adult patients; and
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- Applicants must provide two (2) letters of recommendation from a physician coworker (i.e., Primary Care Providers with work experience associated with the applicant in the preceding twenty-four (24) months). The physician coworkers must hold an active board certification in Pediatrics, Family Practice or Internal Medicine.

3) Specialties not recognized by either board are subject to Medical Director, Chief Medical Officer Review. Further review may be completed by the Peer Review Subcommittee who will either approve or deny.

b. Hospital Admitting Privileges

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

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

1) Minimum $1 million per claim/$3 million per aggregate.

2) Coverage for the specialty the Provider is being credentialed and contracted for.

3) Coverage for all locations the Provider will be treating IEHP patients.

5. Certified Nurse Midwives (CNMs) may provide care of mothers and newborns through the maternity cycle of pregnancy, labor, birth and delivery services only after they are fully credentialed and approved by the IPA or IEHP directly. CNM Providers must meet the following criteria:

a. Hospital Arrangements

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

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

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

b. Malpractice Insurance Coverage. Must have current and adequate malpractice insurance coverage that meets the following criteria:
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1) Minimum $1 million per claim/$3 million per aggregate.

2) Coverage for the specialty the Provider is being credentialed and contracted for.

3) Coverage for all locations the Provider will be treating IEHP patients.

C. Patient Age Ranges

1. Patient age ranges for PCPs and non-physician Practitioners must be specifically delineated as part of the IPA credentialing process.

2. Guidelines for age ranges for PCPs are:

<table>
<thead>
<tr>
<th>SPECIALTY</th>
<th>AGE RANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatrics</td>
<td>• 0 – 18&lt;br&gt;• 0 – 21</td>
</tr>
<tr>
<td>Family Practice</td>
<td>• All Ages&lt;br&gt;• 14 and above</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>• 14 and above&lt;br&gt;• 18 and above&lt;br&gt;• 21 and above</td>
</tr>
<tr>
<td>Public Health and General Preventive Medicine</td>
<td>• 18 and above&lt;br&gt;• 21 and above</td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td>• 14 and above; restricted to females</td>
</tr>
<tr>
<td>General Practice</td>
<td>• All Ages, if evidence of pediatric training, experience and/or CME is present&lt;br&gt;• 14 and above</td>
</tr>
</tbody>
</table>

3. PCPs that have Members assigned ages 0-14 must enroll in the Vaccines for Children (VFC) Program.

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

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

6. Patient age ranges for specialty physicians are specific to the specialty involved, training, and education of the physician.

D. Provider Privilege Adjustment

1. Providers are required to submit a detailed explanation when requesting a change in practice parameters such as an expansion or education in Member age range or specialty care privileges.

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

3. At a minimum, Provider submissions must include:
   a. A written explanation specifically outlining the material basis for the requested change;
   b. Documentation of any relevant training (e.g., Continuing Medical Education, post graduate/residency training, etc.);
   c. Practical experience relating to the request (e.g., years in clinical practice, direct care experience with the relevant membership, etc.); and
   d. All limitations or expansions of age ranges will be reviewed and approved by IEHP Medical Director or Chief Medical Officer. Further review may be completed by the Peer Review Subcommittee who will either approve or deny.

E. Adverse History Guidelines. IEHP and its Delegated IPAs and IEHP Direct must carefully review all Practitioners with evidence of adverse history, including malpractice history, adverse licensing, privileges, sanctions or other negative actions. These discussions must be documented in the Credentialing Subcommittee, Peer Review Subcommittee or Quality Management meeting minutes while making a credentialing decision. The discussions include, but are not limited to the following:

1. Licensure Actions. Practitioners who have any adverse history and/or events with the Medical Board of California, Osteopathic Medical Board of California, Board of Podiatric Medicine, Board of Behavioral Sciences, Board of Psychology, California Board of Chiropractic Examiners, Dental Board of California, California Board of Occupational Therapy, California Board of Optometry, Physical Therapy Board of California, Physician Assistant Committee, California Board of Registered Nursing, Speech-Language Pathology and Audiology Board, or any appropriate licensing board, must be fully discusses and reviewed by the Credentialing Subcommittee or Peer Review Subcommittee. The reason for the adverse history and/or events must be considered during the credentialing decision making process.
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2. Medical History. For Practitioners with a history of malpractice suits or decisions, the following criteria warrants full IEHP Medical Director review of the history and should be applied in making credentialing and recredentialing decisions:
   a. Number of claims - any claims within the prior seven (7) years.
   b. Results of cases - any settlements within the prior seven (7) years.
   c. Trends in cases - Practitioners with multiple malpractice claims in a similar area (e.g., missed diagnosis, negative surgical outcomes, etc.).
   d. Higher than average grievance rate or trend in grievances.

3. Medi-Cal Suspended and Ineligible List Providers are deemed suspended and ineligible from Medi-Cal will be terminated or not be credentialed and contracted with for Medi-Cal line of business.

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

5. Medicare Opt-Out Providers who are identified on the Medicare Opt-Out will not be contracted for Medicare line of business.

6. Loss of Clinical Privileges. Negative privilege actions or other negative actions against Providers (felony convictions, etc.) must be fully discussed and reviewed by the Credentialing Subcommittee.

IEHP verifies that the delegated IPA has performed the above functions as discussed in Policies 5C, “IEHP Quality Oversight of Participating Practitioners” and 13G, “Delegation Oversight Audit”.

F. If retrospective review by an IEHP Medical Director or Chief Medical Officer reveals that a Practitioner approved by an IPA does not meet the above requirements, IEHP can submit the Practitioner to the Peer Review Subcommittee for review as stated in Policy 5C, “IEHP Quality Oversight of Participating Practitioners.” IEHP reserves the right to approve, deny, terminate or otherwise limit Practitioner participation in the IEHP network for quality issues. If a Provider is denied participation due to quality of care and an 805 was filed with the appropriate licensing agency and the National Practitioner Data Bank (NPDB) then the Provider is not eligible to reapply. For administrative terminations or denials, he/she may reapply after one (1) year.

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

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B. Practitioner Credentialing Requirements

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Providers.

POLICY:

A. IEHP delegates all credentialing and recredentialing functions to IPAs that meet IEHP requirements for delegation. IEHP provides all credentialing and recredentialing functions for directly contracted participating Practitioners as delineated below.

B. Delegated IPAs are required to contract with and credential all of their Practitioners defined as PCPs, Specialists, non-physician Practitioners, and Physician Admitters, including employed physicians participating on the Provider panel and published in external directories, who provide care to Members. At a minimum, this includes all Physicians (MDs), Osteopaths (DOs), Podiatrists (DPMs), Nurse Practitioners (NPs), Physician Assistants (PAs), Certified Nurse Midwives (CNMs), Physical Therapists (PT), Occupational Therapists (OT), Speech/Language Therapists (S/LT), Audiologists (AUD), Dieticians and Nutritionists (R.D.), Chiropractors (D.C.) who are contracted to treat Members and who fall within the IPA’s scope of authority and action. IEHP is required to credential all Psychiatrists, Psychologists, Addiction Medicine Specialists, Master Level Clinical Nurses, Licensed Clinical Social Workers (LCSW), and Marriage, Family & Child Counselors (MFCC), and other behavioral health professionals licensed to provide behavioral health services in the state of California. IEHP requires IPAs to contract and credential Oral Surgeons (DDS or DMD) who provide medical services only (if applicable). IEHP does not require delegated IPAs to contract with Licensed Acupuncturists (L.Ac.), Opticians, or Optometrists (OD) where services rendered by these Practitioners are not covered by IEHP; however, must utilize the network provided by IEHP; therefore, credentialing and recredentialing of these Providers will be completed by IEHP. IEHP does not require covering Practitioners and locum tenens that do not have an independent relationship with IEHP or an IPA to be credentialled. IEHP does not require IPAs to credential Practitioners that are hospital based and do not see Members on a referral basis.

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

D. Verification of information submitted through one of the following means:

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

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

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

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

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

E. Delegated IPAs are required to verify the accreditation status, license, certification and standing with regulatory bodies of all subcontracted organizational Providers (as applicable), in compliance with the most current NCQA standards and IEHP requirements. Subcontracted organizational Providers include but are not limited to hospitals, home health agencies, laboratories, skilled nursing facilities, and freestanding surgical centers, including family planning facilities and alternative birth centers. Subcontracted mental health and substance abuse Providers include inpatient, residential, and ambulatory settings are carved out.

F. Delegated IPAs must obtain approval of Practitioners seeking participation with IEHP from the IPA Credentialing Committee and IPA Medical Director before submitting credentialed Primary Care Practitioners (PCPs) and Specialists to IEHP for review and assignment of Members. IPA credentialed and approved Practitioners must meet IEHP Practitioner guidelines for education, age limits and other criteria as specified in Policy 5A, “IEHP Practitioner Guidelines”.

G. Delegated IPAs must maintain a full credentialing file and perform all necessary credentialing activities per the most current IEHP, NCQA, State and Federal regulatory guidelines. Process to document IPA’s receipt and review of all documentation via date stamp and initials on the following:

1. Application;
2. Attestation;
3. Queries;
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4. Copies of Licensures and Certificates; and
5. Any document containing Practitioner signature.

H. IPAs may designate to their Medical Director the authority to determine and sign off on a credentialing and recredentialing file that meets the IPAs standards as complete, clean, and approved. The IPA may assign an associate medical director or other qualified medical staff member as the designated medical director if the individual has equal qualifications as the medical director and is responsible for credentialing, as applicable. The IPAs Credentialing Committee must review the credentials of all Practitioners being credentialed or recredentialed who do not meet the IPAs established criteria, and to provide advice and expertise for credentialing decisions.

I. IPAs must submit specific credentialing information to IEHP for all PCPs and for all other Practitioner as listed above. If the IPA wishes to add a Practitioner to its IEHP Network, the delegate must submit the Providers information via profile, contract (1st & signature pages and any applicable addendums) and W-9 via Secure File Transfer Protocol (SFTP) server.

J. All PCPs must undergo a facility review by the IPA as part of the credentialing process as specified in Policy 6A, “Site Review and Medical Record Review Survey Requirements and Monitoring”.

K. All PCPs must pass a required initial facility review performed by IEHP prior to receiving IEHP enrollment and treating Members. IEHP has ninety (90) days from the submission of all required credentialing information to complete the facility site review.

L. Delegated IPAs are responsible for recredentialing their contracted PCPs, non-physician Practitioners, specialists, and admitting physicians as defined above every thirty-six (36) months from their last credentialing decision date and submit specific updates to IEHP.

M. IEHP and IPAs are required to adhere to all procedural and reporting requirements under state and federal laws and regulations regarding the credentialing process, including the confidentiality of Practitioner information obtained during the credentialing process.

N. IEHP oversees delegated IPAs by monitoring, reviewing, and auditing the IPA’s credentialing and recredentialing processes prior to contracting and on an ongoing basis. IEHP reviews the IPA continued ability to perform delegated credentialing activities through annual credentialing audits. Audits include on-site reviews, evaluation and examination of the IPA existing credentialing and recredentialing processes, written policies and procedures, source data verification and file review using the Delegation Oversight Audit (DOA) tool that conforms to NCQA, ICE, DHMC, DHCS and IEHP standards.

O. IEHP reserves the right to rescind delegation of credentialing activities based on the outcome of monitoring activities or as determined by IEHP.
5. CREDENTIALING AND REcredentialing

B. Practitioner Credentialing Requirements

P. IEHP follows these same guidelines for Practitioners directly credentialed by IEHP.

PROCEDURES:

Credentialing Policies

A. IEHP requires that IPAs have a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent Practitioners to provide care to IEHP Members and that they meet the following criteria prior to being delegated to perform credentialing activities, and in order to remain delegated on an on-going basis. The Credentialing Guidelines and Program specifies:

1. The types of Practitioners it credentials and recredentials. At minimum, the IPA’s are required to credential and recredential Providers that fall under the following scope, Providers who are contracted, and treat IEHP Members and fall within the IPA’s scope of authority and action, which include but are not limited to:
   a. Doctors of Medicine (M.D.)
   b. Doctors of Osteopathic Medicine (D.O.)
   c. Doctors of Podiatric Medicine (D.P.M.)
   d. Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.), who provide medical services only
   e. Occupational Therapists (O.T.’s)
   f. Physical Therapy (P.T.)
   g. Physician Assistants (P.A.) or Physician Assistants Certified (P.A.-C)
   h. Certified Nurse Midwives (C.N.M.)
   i. Nurse Practitioners (N.P.)
   j. Speech Pathologists (S.P.)
   k. Audiologists (Au.)
   l. Registered Dieticians (R.D.) and Nutritionists
   m. Chiropractors (D.C.)

2. IEHP is required to credential all Behavioral Health Providers which include:
   a. Psychiatrists (M.D.’s)
   b. Licensed Marriage and Family Therapists (L.M.F.T.)
   c. Licensed Clinical Social Workers (L.C.S.W.)
   d. Psychologists (Ph.D., Psy.D.)
5. CREDENTIALING AND RECREREDENTIALING

B. Practitioner Credentialing Requirements

3. IEHP does not require delegated IPA to contract with the following Provider types, where services rendered by these Practitioners are not covered by IEHP, however, must utilize the network provided by IEHP; therefore, credentialing and recredentialing of these Providers will be completed by IEHP.
   a. Doctor of Chiropractic (D.C.)
   b. Licensed Acupuncturists (L.Ac.)
   c. Optometrists (O.D.)

4. IEHP does not require covering Practitioners and locum tenens that do not have an independent relationship with IEHP or an IPA to be credentialed. IEHP does not require IPAs to credential Practitioners that are hospital based and do not see Members on a referral basis. The policy and procedures must describe the verification sources and timeframes used to verify credentialing information of each of the following criterion:
   a. State License to Practice
      (Verification Time Limit (VTL): one hundred-eighty (180) calendar days prior to Credentialing decision date). Must be valid, current, and unencumbered at the time of committee and remain valid and current throughout the Practitioner’s participation with IEHP. Failure to maintain a valid and current license at all times, will result in an administrative termination of the Practitioner.
      All Practitioners must be licensed by the State of California by the appropriate state licensing agency. The following license verifications must be obtained by the licensing board or their designated licensing and enforcement systems. The following licensures may be verified through BreEZe Online services online or directly with the licensing board via phone or mail:
      1) Medical Board of California (M.D.)
      2) Osteopathic Medical Board of California (D.O.)
      3) Board of Podiatric Medicine (D.P.M.)
      4) Board of Behavioral Sciences (L.M.F.T., L.C.S.W., M.F.C.C)
      5) Board of Psychology (Ph.D., Psy.D.)
      6) Dental Board of California (D.D.S., D.M.D.)
      7) California Board of Occupational Therapy (O.T.)
      8) California State Board of Optometry (O.D.)
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9) Physical Therapy Board of California (P.T.)
10) Physician Assistant Committee (P.A., P.A.-C)
11) California Board of Registered Nursing (C.N.M., N.P.)

The following license verifications must be verified by the licensing board via online, mail or phone:
1) California Board of Chiropractic Examiners (D.C.)
2) Speech-Language Pathology & Audiology Board (S.P., Au)
3) Acupuncture Board (L.Ac.)

b. DEA Certificate or Controlled Dangerous Substance (CDS) certificate, as applicable. (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date). Must be valid and current at the time of committee and remain valid and current throughout the Practitioner’s participation with IEHP). Failure to maintain an active DEA, may result in an administrative termination of the Practitioner.

All Practitioners who are qualified to write prescriptions, except non-prescribing Practitioners, must have a valid and current DEA certificate. Verification may be in the form of a photocopy of the current DEA certificate or a query of the National Technical Information Service (NTIS) database. The copy of the Practitioner’s certificate or query must be initialed and date stamped to show receipt prior to the credentialing decision.

The delegate may credential a Practitioner whose DEA certificate is pending or pending a DEA with a California address, if the delegate has a documented process for allowing a Practitioner with a valid DEA certificate to write all prescriptions requiring a DEA number for the prescribing Practitioner until the Practitioner has a valid DEA certificate.

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

c. Education and Training
(VTL: Prior to the Credentialing Decision)
5. CREDENTIALING AND RECREDENTIALING

B. Practitioner Credentialing Requirements

All Practitioners must have completed appropriate education and training for practice in the U.S. or a residency program recognized by NCQA, in the designated specialty or subspecialty they request to be credentialed and contracted. The delegate verifies the highest of the following three levels of education and training obtained by the Practitioner, as appropriate.

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

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

1) The primary source from the Medical School or through a clearinghouse.

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

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

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

1) AMA Physician Masterfile.


3) Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986.

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

1) Primary source from the institution or clearinghouse where the postgraduate medical training was completed.
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2) AMA Physician Masterfile.
3) AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
4) FCVS for closed residency programs.
   - NCQA only recognizes residency programs accredited by the Accredited Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) (in the United States) or by the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada.

d. Board Certification

(VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date)

The delegate verifies current certification status of Practitioners who state that they are board certified. The delegate must document the expiration date of the board certification within the credential file. If a Practitioner has a “lifetime” certification status and there is no expiration date for certification, the organization verifies that the board certification is current and documents the date of verification. If board certification has expired it may be used as verification of education and training.

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

Below are the acceptable sources to verify board certification:

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

2) For Physicians (M.D., D.O.)
   - ABMS or its Member boards, or an official ABMS Display Agency, where a dated certificate of primary-source authenticity has been provided.
   - AMA Physician Master File.
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- AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
- Boards in the United States that are not Members of the ABMS or AOA if the organization documents within its policies and procedures which specialties it accepts and obtains annual written confirmation from the boards that the boards performs primary source verification of completion of education and training.

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

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

5) For Nurse Practitioners (N.P.)
- American Association of Nurse Practitioners (AANP)
- American Nurses Credentialing Center (ANCC)
- National Certification Corporation for the Obstetrics, Gynecology and Neonatal Nursing Specialties (NCC)
- Pediatric Nursing Certification Board (PNCB)
- American Association of Critical-Care Nurses (AACN)

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

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

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

e. Work History
5. CREDENTIALING AND RECREREDENTIALING

B. Practitioner Credentialing Requirements

(VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date)

The delegate must obtain a minimum of the most recent five (5) years of work history as a health professional through the application, Curriculum Vitae (CV) or work history summary/attachment, providing it has adequate information.

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

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

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

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

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

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

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

f. Malpractice Claim History

(VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date)

The delegate must obtain confirmation of the past five (5) years of malpractice settlements through one of the following sources:

1) Malpractice Insurance Carrier.
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2) National Practitioner Data Bank Query.

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

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

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

g. Current Malpractice Insurance Coverage

(VTL: Must be evidence that the Practitioner has current and adequate malpractice coverage prior to the Credentialing Committee date and remain valid and current throughout the Practitioner’s participation with IEHP). Failure to maintain current malpractice coverage for the specialty the Provider is being credentialled for and for all locations the Practitioner will be treating IEHP patients, will result in an administrative termination of the Practitioner.

All Practitioners must have current and adequate malpractice insurance coverage that is current and meets IEHP’s standard of $1 million/$3 million as well as the IPAs standards. The malpractice coverage must include coverage for the specialty the Provider is being credentialled for and for all locations the Practitioner will be treating IEHP patients. Professional Liability Insurance coverage and amounts of coverage must be verified with the insurance carrier or through the Practitioner via a copy of the policy and the signed attestation completed by the Practitioner. The copy of the Practitioner’s certificate must be initialed and date stamped to show receipt prior to the credentialing decision and to show it was effective at the time of the credentialing decision. If the specialty coverage and/or the locations are not identified on the malpractice insurance certificate, the coverage must be verified with the insurance carrier and documented in the Practitioner’s file.

h. Hospital Admitting Privileges

(VTL: one hundred-eighty (180) calendar days prior to Credentialing decision)
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B. Practitioner Credentialing Requirements

All Practitioners must have admitting privileges or appropriate admitter arrangements at a contracted IEHP Hospital, as necessary. Practitioners (in the appropriate specialties) must have a formal inpatient coverage arrangement. If the Practitioner does not have clinical privileges, the delegate must obtain a written statement delineating the inpatient coverage arrangement. Specialties such as Dermatology, Podiatry, or Ophthalmology may not have hospital privileges, documentation must be note in the file as to the reason for not having privileges (e.g. A note stating that they do not admit as they only see patients in an outpatient setting is sufficient).

Verification that all clinical privileges are in good standing to perform functions for which the Practitioner is contracted, to include verification of admitting privileges, must be confirmed with the Hospital, in writing, via approved website or verbally, and must include the date of appointment, scope of privileges, restrictions (if any) and recommendations. If a published Hospital directory is used, the list must include the necessary information and be accompanied by a dated letter from the Hospital attesting that the Practitioner is in “good standing.” If an admitter or hospitalist arrangement is used, a written agreement that meets IEHP admitter requirements (See Policy 5D, “Hospital Privileges”) confirming coverage for all inpatient work covering the entire age range of the Practitioner must be included in the Practitioner’s credentialing file.

i. State Sanctions and Restrictions on Licensure and Limitation on Scope of Practice

(VTL: one hundred-eighty (180) calendar days prior to Credentialing decision)

Verification sources for sanctions or limitations on licensure include:

1) Chiropractors: State Board of Chiropractic Examiners CIN-BAD, NPDB.
2) Oral Surgeons: State Board of Dental Examiners, or State Medical Board, NPDB.
3) Physicians: Appropriate state board agencies, FSMB, NPDB.
4) Podiatrists: State Board of Podiatric Examiners, Federation of Podiatric Medical Boards, NPDB.
5) Non-physician Healthcare Professionals: State licensure or certification board, appropriate state agency, NPDB.

For delegate’s using the Continuous Query (formerly Proactive Disclosure Service [PDS]):

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B. Practitioner Credentialing Requirements

1) Evidence of current enrollment must be provided.
2) Report must be reviewed within one hundred eighty (180) calendar days of the initial credentialing decision.
3) Evidence of review must be documented in the file or on checklist.

j. Medicare/Medicaid Sanctions

(VTL: one hundred-eighty (180) calendar days prior to Credentialing decision)

Verification Sources for Medicare/Medicaid Sanctions:

1) NPDB
2) FSMB
3) FEHB Program Department Record, published by the Office of Personnel Management, OIG
4) List of Excluded Individuals and Entities (maintained by OIG)
5) Medicare Exclusions Database
6) State Medicaid Agency or intermediary and the Medicare intermediary

For delegate’s using the Continuous Query (formerly Proactive Disclosure Service [PDS]):

1) Evidence of current enrollment must be provided.
2) Report must be reviewed within one hundred-eighty (180) calendar days of the initial credentialing decision.
3) Evidence of review must be documented in the file or on checklist.

For CMS only:

1) OIG must be the verification source for Medicare sanctions.
2) Date of query and staff initials must be evident on a checklist or the OIG page must be in the file.

For Medi-Cal only:

1) The Medi-Cal Suspended and Ineligible list must be the verification source for Medicaid sanctions.
2) Date of query and staff initials must be evidence on a checklist or the report page must be in the file.

k. National Provider Identifier (NPI) Practitioners are required to maintain an individual NPI number, which must be verified through CMS. The NPI
5. CREDENTIALING AND REcredentialing

B. Practitioner Credentialing Requirements

Number must be active while in the IEHP network and the Provider details must be kept current at all times, (i.e. Primary Practice Address must be registered to an address within California).

Providers that have a group NPI number may submit that information to IEHP, in addition to the mandatory individual NPI number.

1. Facility Site Reviews

Prior to credentialing, or when a Provider relocates, IEHP must perform an on-site facility site review for all contracted PCP’s. Delegate’s policy and procedure must meet IEHP’s facility site review requirements for the Medi-Cal Programs, as stated in Policy 6A, “Site Review and Medical Record Review Survey Requirements and Monitoring.” Documentation of site review must include:

1) Standards and thresholds for acceptable performance;
2) Evaluation of initial site, new site or relocation against standards;
3) Evidence of corrective actions for improvement of sites that do not meet established thresholds; and
4) Follow-up for sites with significant deficiencies to ensure compliance.

All PCPs must also pass an IEHP facility review at the time of initial credentialing and every three (3) years thereafter for Medi-Cal programs as stated in Policy 6A, “Site Review and Medical Record Review Survey Requirements and Monitoring”.

5. The policy and procedures must define the criteria required to reach a credentialing decision and must be designed to assess the Practitioner’s ability to deliver care, which may include but are not limited to:

a. A current and valid, unencumbered license to practice medicine in his/her state of practice.
b. Appropriate malpractice claim history.
c. Must not have engaged in any unprofessional conduct of unacceptable business practices.
d. Absence of sanctions or restrictions on licensure.
e. Current and valid DEA to practice in CA.
f. Absence of use of illegal drugs.
g. Absence of criminal history.
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6. The policy and procedures must include the process for making credentialing and recredentialing decisions. They must define the process used and the criteria required to reach credentialing decisions that are designed to assess the Practitioner’s ability to deliver care. At minimum, the Credentialing Committee must receive and review the credentials of Practitioners who do not meet the delegate’s established criteria. Policy must identify what is considered acceptable to be determined as a clean file, if the delegate utilizes a clean file process.

7. The delegate’s policies and procedures must describe the process used to determine and approve clean files. They must identify the Medical Director or equally qualified Practitioner as the individual with the authority to determine that a file is “clean” and to sign off on it as complete, clean and approved. If the delegate identifies equally qualified Practitioner to review the clean files, the Practitioner must be responsible for oversight of the credentialing process. If the Medical Director or equally qualified Practitioner signs off on clean files, the sign off date is the Committee date and there must be evidence of the designated Medical Director’s or designated physician’s review and approval in the Practitioner’s file or on a list of all Practitioners who meet the established criteria.

   a. The designed Medical Director may use a handwritten signature, handwritten initials, or unique identifier as documentation of sign off. Stamped signatures are not acceptable. If the delegate decides not to use the Medical Director or equally qualified Practitioner, the delegate can continue to send “clean files” to the Credentials Committee.

8. The delegate’s policy and procedures must specify the process used to delegate credentialing and recredentialing to include what may be delegate and how the delegate decides to delegate. An outside vendor such as an NCQA accredited CVO may perform portions of the verification process, however, the delegate, must provide oversight and document the process in approved policies and procedures that include:

   a. A mutually agreed upon document that describes the responsibility of the delegated agency;
   b. Document the process of IPA’s reporting at least semi-annually;
   c. Process by which the IPA evaluates the delegated agency’s performance;
   d. Remedies, including the revocation of the delegation by the IPA if the delegated agency does not fulfill its obligation;
   e. IPA retains the right and responsibility to review and approve Practitioner’s participation; and
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f. For delegation arrangements in effect for twelve (12) months or longer, the IPA must have reports on audited files for each that the delegation is in effect.

If the delegate does not delegate the credentialing policies and procedures must state that the delegate does not delegate credentialing activities to be compliant. If the delegate has policies and procedures for delegated credentialing, but are not currently delegating any credentialing functions then they do not have to include a statement that they are not currently delegating.

A mutually agreed upon document with the delegate or an outside vendor such as an NCQA accredited Credentialing Verification Organization (CVO) who have access to the Protected Health Information (PHI) on Members or Practitioners in the course of their work, must ensure that the information remains protected under the following provisions:

a. A list of the allowed uses of PHI;

b. A description of the delegates safeguards to protect PHI from inappropriate use or further disclosure;

c. A stipulation that the delegate will ensure that delegated agencies have similar safeguards;

d. A stipulation that the delegate will provide individuals with access to their PHI;

e. A stipulation that the delegate will inform IEHP if inappropriate use of information occurs; and

f. A stipulation that the IPA will ensure PHI is returned, destroyed, protected if the delegation agreement ends.

9. The delegate’s policies and procedures must explicitly state that credentialing and recredentialing decisions are not based solely on the applicant’s race, ethnic/national identity, gender, age, sexual orientation or patient in which the Practitioner specializes and describes the steps for monitoring and preventing discriminatory practices during the credentialing/crecredentialing process.

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

a. Periodic audits of Practitioner complaints to determine if there are complaints alleging discrimination.

b. Maintaining a heterogeneous Credentialing Committee membership and requiring those responsible for credentialing decisions to sign an affirmative statement to make decisions in a non-discriminatory manner.
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Monitoring involves tracking and identifying discrimination in credentialing and recredentialing processes, which may include but are not limited to:

1) Having a process for performing periodic audits of credentialing files (in-process, denied and approved files).

2) Having a process for performing periodic audits of Practitioner complaints about possible discrimination. (Can be reviewed and discussed during quarterly or semi-annual review of complaints).

Policy must indicate that monitoring will be conducted at least annually.

Preventing involves taking proactive steps to protect against discrimination occurring in the credentialing and recredentialing processes, which may include but are not limited to:

1) Maintaining a heterogeneous credentialing committee and requiring those responsible for credentialing decisions to sign a statement affirming that they do not discriminate.

10. The delegate’s policies and procedures must describe the process for notifying Practitioners if information obtained during the organization’s credentialing process varies substantially from the information they provided to the delegate. A statement that Practitioners are notified of discrepancies does not meet the requirement.

11. The delegate’s policies and procedures must ensure that Practitioners are notified of the credentialing and recredentialing decision within sixty (60) calendar days of the Committee decision. The delegate is not required to notify Practitioners regarding recredentialing approvals, but must have a process for notifying Practitioners of initial credentialing decisions (approvals/denials) and recredentialing denials.

12. The delegate’s policies and procedures must include the Medical Director or other designated physician’s direct responsibility and participation in the credentialing program, to include but not limited to:

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

13. The delegate’s policies and procedures must describe the process for ensuring the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law, and clearly state that the information obtained in the credentialing process is confidential.

The delegate’s policies must also describe the mechanisms in effect to ensure confidentiality of information collected, to include but not limited to:

a. The delegates policies must describe in detail the process used in making confidential credentialing and recredentialing decision and the mechanisms in place to maintain confidentiality. Procedures must include, but are not limited to:

1) Confidentiality statements are signed by Committees and Credentialing staff;
2) Practitioner files are maintained in locked file cabinets and are only accessible by authorized personnel; and
3) Security for database systems is maintained through passwords or other means to limit access to Practitioner information to authorized staff only.

14. The delegate’s policies must describe the organization’s process for ensuring that all information provided in Member materials and Practitioner directories is consistent with the information obtained during the credentialing process.

B. The delegate’s policies and procedures must state how the following three (3) factors are met and how the Practitioners are notified:

1. Review information submitted to support their credentialing application.
2. Correct erroneous information (submitted by another source).
   a. Policy must clearly state:
      1) The time frame for changes.
      2) The format for submitting corrections.
      3) Where the corrections must be submitted.
      4) How Practitioners are notified of their right to correct erroneous information.

3. Receive the status of the credentialing or recredentialing decisions, upon request.
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a. Must describe the process for responding to such request including information that the delegate may share with the Practitioners.

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

D. The delegate’s policies and procedures that it ensures that it only contracts with physicians who have not opted out. This will apply to all Providers that accept both Medi-cal and Medicare patients.

E. The delegate’s policies and procedures must have policies and procedures that prohibit employment or contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation (Practitioners or entities found on the OIG Report).

CREDENTIALING COMMITTEE

A. Delegate’s policies and procedures must document the structure of the Credentialing Committee that makes recommendations regarding credentialing decisions. At minimum, the policy and procedures must include:

1. Committee membership that includes participating Practitioners;
   a. Composition of Committee is comprised of a range of participating Practitioners that includes multi-disciplinary representation with the ability to seek the advice of participating Practitioners outside of the Committee, at the Committee’s discretion, when applicable. If the Credentialing Committee is comprised of PCP’s only, the policy must state that specialists are consulted, when necessary and appropriate.

      Evidence may include, but is not limited to:

      1) Representation includes a range of participating Practitioners in the delegates network;
      2) There is evidence through their Committee minutes that a specialist was consulted, when applicable; and
      3) There is a listing that indicates what specialists were used (if applicable).

2. Quorum requirements of Committee (minimum of three [3]);
   a. Meetings should include a quorum of Practitioners for each meeting.

3. Identity of voting members;
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4. Identity of who has authority to make final credentialing decisions and the relationship to the Governing Board (if applicable);

5. Frequency of Committee meeting (at minimum, quarterly);

6. Process to document, review and approve delegate credentialing policies and procedures by the Committee on an annual basis;

7. Committee’s opportunity to review documentation, criteria and credentials of all Practitioners being credentialed or recredentialed prior to rendering a recommendation; and

8. All primary source information obtained and reviewed in the credentialing or recredentialing process must be no more than one hundred eighty (180) days old at the time of the Committee decision.

B. The delegate must have policies and procedures, as well as evidence that the Credentialing Committee reviews credentials for Practitioners who do not meet established thresholds. The credentialing committee must give thoughtful consideration of the credentialing information and the committee’s discussion must be documented within the meeting minutes. Evidence may include, but is not limited to:

1. Meetings minutes document that the Credentialing Committee reviewed credentials for Practitioners who did not meet established thresholds.

C. The delegate must have policies and procedures that ensure files that meet established criteria are reviewed and approved by a Medical Director or designated physician. Evidence may include, but is not limited to:

1. The delegate may choose to continue to submit all Practitioner files to the Credentialing Committee for review, or it may implement a process for the Medical Director to review clean files, as described in the credentialing policies and procedures;

2. If the Medical Director or designated physician reviews the clean files, there must be evidence of the designated Medical Director’s or designated physician’s review and approval in the Practitioner’s file or on a list of all Practitioners who meet the established criteria; and

3. Reports may include Credentialing Committee meeting minutes or a list of approved Practitioners signed or initialed by the medical director, for evidence that the requirement is met.

INITIAL CREDENTIALING

A. The delegate verifies that the following are within the prescribed time limits, for all credentialing applications:
5. CREDENTIALING AND RECREREDENTIALING

B. Practitioner Credentialing Requirements

1. A valid license to practice;
2. A valid DEA or CDS certificate, if applicable;
3. Education and Training;
4. Board Certification Status, if applicable;
5. Work History;
6. A history of professional liability claims that resulted in the settlement or judgment paid on behalf of the Practitioner;
7. State sanctions, restrictions on licensure or limitations on scope of practice;
8. Medicare and Medicaid Sanctions;
9. Applications for credentialing include the following:
   a. Reasons for inability to perform the essential functions of the position;
   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. Current Malpractice Insurance coverage; and
   f. Current and signed attestation confirming the correctness and completeness of the application.
10. Hospital Admitting Privileges, if applicable; and
   a. Initial Credentialing is only for those Practitioners who are initiating a contract with the organization; and
   b. Practitioner Termination: If an organization terminates a Practitioner and later wishes to reinstate, the organization must initially credential if there is a break in service for more than thirty (30) days.

RECREREDENTIALING VERIFICATION

A. The delegate verifies that the following are within the prescribed time limits, for all credentialing and recredentialing applications:

1. A valid license to practice;
2. A valid DEA or CDS certificate, if applicable;
3. Board Certification Status, if applicable;
5. CREDENTIALING AND RECREREDENTIALING

B. Practitioner Credentialing Requirements

4. A history of professional liability claims that resulted in the settlement or judgment paid on behalf of the Practitioner;
5. State sanctions, restrictions on licensure or limitations on scope of practice;
6. Medicare and Medicaid Sanctions;
7. Applications for credentialing include the following;
   a. Reasons for inability to perform the essential functions of the position;
   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. Current Malpractice Insurance coverage; and
   f. Current and signed attestation confirming the correctness an completeness of the application.
8. Hospital Admitting Privileges, if applicable;
9. Monitoring Physicians Who Have Opted Out; and
10. Review of Performance Information.

B. The delegate includes information from quality improvement activities and Member complaints in the recredentialing decision-making process, to include but not limited to:

1. Quality activities (e.g. adverse events and data from quality improvement activities. Performance information may also include additional information such as: utilization management data, enrollee satisfaction surveys, other activities of the organizations).

2. Grievance/complaints:
   a. Late Recredentialing: Per NCQA, a Practitioner cannot be initially credentialed if their recredentialing is past due. The exception is: If a Practitioner is on active military assignment, maternity/medical leave or sabbatical. If the Practitioner is on active military assignment, maternity/medical leave or sabbatical, recredentialing must be completed within sixty (60) calendar days of when practice is resumed.
   b. Recredentialing: The delegate must formally recredential its Practitioners within thirty-six (36) months through information verified from primary source verifications. Failure to meet the thirty-six (36) month time frame will result in the administrative termination of the Practitioner.

ONGOING MONITORING
5. CREDENTIALING AND REcredentialING

B. Practitioner Credentialing Requirements

A. IEHP requires IPAs to submit specific information on Practitioner status to facilitate continuous monitoring of the IPA’s credentialing processes, as stated in Policy 5C, “IEHP Quality Oversight of Participating Practitioners”.

The delegate must implement ongoing monitoring and takes appropriate interventions by:

   a. The delegate is responsible for reviewing the information within thirty (30) calendar days of its release.
   b. Following a consistent process for ongoing monitoring.
   c. If the organization subscribes to a sanction alert service, they must have evidence of its subscription to the sanctions alert service.
   d. A spreadsheet/tracking log may be used as documentation for compliance. Name of Board/Entity, date of query, date of report, and signature/initiais of staff must be included.
   e. The IPA is responsible for notifying IEHP of any findings and the actions decided by the Credentialing Committee, to include (When the decision was made, IPA’s plan of action, frequency of monitoring (if applicable), and if any follows ups are scheduled).

2. Collecting and reviewing sanctions or limitations on licensure.
   a. The delegate is responsible for reviewing the information within thirty (30) calendar days for those boards that release on a set schedule. Any board that releases on a routine schedule (monthly/quarterly); this is considered a set schedule.
   b. If the organization subscribes to a sanction alert service, they must have evidence of its subscription to the sanctions alert service.
   c. In areas where reporting entities do not publish sanction information on a set schedule, the delegate must query this information at least every six (6) months.
   d. If the reporting entity does not release sanction information reports, the delegate is required to conduct individual queries for any affected Practitioner twelve to eighteen (12-18) months after the last credentialing cycle.
   e. A spreadsheet/tracking log may be used as documentation for compliance. Name of Board/Entity, date of query, date of report, and signature/initiais of staff must be included.
5. CREDENTIALING AND RECREREDENTIALING

B. Practitioner Credentialing Requirements

f. The IPA is responsible for notifying IEHP of any findings and the actions decided by the Credentialing Committee, to include (When the decision was made, IPA’s plan of action, frequency of monitoring (if applicable), and if any follow ups are scheduled).

3. Collecting and reviewing complaints.
   a. The delegate must investigate Practitioner specific complaints from Members upon their receipt.
   b. The delegate must evaluate the Practitioner’s history of issues, if applicable, at least every six (6) months.
   c. The IPA is responsible for notifying IEHP of any findings and the actions decided by the Credentialing Committee, to include (When the decision was made, IPA’s plan of action, frequency of monitoring (if applicable), and if any follow ups are scheduled).

4. Collecting and reviewing information from identified adverse events.
   a. The delegate must monitor Practitioner adverse events at least every six (6) months.
   b. The delegate may limit monitoring of adverse events to Primary Care Physicians and high-volume behavioral healthcare Providers.
   c. Quality / collecting and reviewing adverse events are not delegated and events must be forwarded to IEHP.

5. Implementing appropriate interventions when it identifies instances of poor quality related to 1-4.
   a. The delegate must have a process to determine if there is evidence of poor quality that could affect the health and safety of its Members and implement the appropriate policy based on action/intervention.
   b. Interventions can be identified in one of the following, but not limited to:
      1) Committee minutes; and
      2) Practitioner files.

6. The delegate must inform IEHP if they identify any Providers on following sanction reports:
   a. HHS-OIG Exclusions Report;
   b. Medicare Opt-Out Report; and
5. CREDENTIALING AND RECREREDENTIALING

B. Practitioner Credentialing Requirements

7. The delegate must have a process to verify and maintain Practitioner licensing status, DEA or CDS certificate, etc., and remedies if the license or certification expires or status changes during the Practitioner’s participation with IEHP regardless of whether or not the Practitioner is due for recredentialing.

NOTIFICATION TO AUTHORITIES AND PRACTITIONER APPEAL RIGHTS

A. The delegate has policies and procedures that specify the following:

1. The range of actions available to the organization that may be taken to improve the Practitioner performance before termination (i.e. Profiling, Corrective Actions, Monitoring, Medical Record Audit etc).

2. Reporting to Authorities. Policies must have clear procedures that describe what specific incidents are reportable to include, suspensions, terminations, restrictions, and revocations; how and when reporting to authorities occurs and to whom the incidents are reported, which should include, but not limited to:
   a. Appropriate Licensing Board;
   b. National Practitioner Data Banks; and
   c. Health Plans.

   They must specify the timeframes for reporting to:
   a. Medical Board of California 805 and 805.01 reports or the appropriate licensing board (fifteen (15) days after a recommendation or final determination); and
   b. National Practitioner Data Bank (thirty (30) days after the final determination).

   They must include the reporting responsibility of organization staff, to include what is expected of staff and outline accountabilities and at minimum, should identify the department or person responsible for filing or reporting to the appropriate authorities.

3. The delegate must give Practitioners the right to appeal and must include the following steps within the appeal process:
   a. Provide written notification when a professional review action has been brought against the Practitioner, reasons for the action and a summary of the appeal rights and process.
   b. Allow Practitioners to request a hearing and the specific time period for submitting the request.
   c. Allow at least thirty (30) calendar days after the notification for Practitioners to request a hearing.
5. CREDENTIALING AND REcredentialing

B. Practitioner Credentialing Requirements

d. Allowing Practitioner to be represented by an attorney or another person of their choice.

1) A Practitioner has the right to an attorney.
2) Policy cannot state that it is at the discretion of the chairperson for attorney representation.
3) Policy must state that the IPA cannot have an attorney, if the Practitioner does not have attorney representation. [Business & Professions Code 809.3 (c)].

e. Appoint a hearing officer or a panel of individuals to review the appeal.

f. Provide written notification of the appeal decision that contains the specific reasons for the decision.

4. The delegate must specify of address how the appeal process is made known to the Practitioner. The delegate may use an attachment, addendum, policy, contract or manual.

REPORTING TO APPROPRIATE AUTHORITIES

A. The organization must report Practitioner suspension or termination to the appropriate authorities, when applicable. If the delegate takes actions altering the participation of a Practitioner suspension, termination, restriction or revocation based on quality of care or service, the delegate must report it to the appropriate agency.

1. Within fifteen (15) days of a recommendation or final decision, when they are imposed or voluntarily accepted for a medical disciplinary cause or reason, the IPA must report to the Medical Board 805.

2. Within fifteen (15) days of a recommendation or final decision based on any of the following, an 805.01 will be filed:

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

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

B. Practitioner Credentialing Requirements

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

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

3. Within thirty (30) days of the final decision, the IPA must report to the NPDB.

4. Within thirty (30) days of the final decision, the IPA must report to IEHP.

5. Reporting to Appropriate authorities is not applicable in the following circumstances:

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

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

6. The delegate’s policy and procedures regarding suspension or termination of a participating physician require the organization to ensure that the majority of the hearing panel is peers of the affected physician. A peer is an appropriately trained and licensed physician in a practice similar to that of the affected physician. Panel members do not have to possess identical specialty training. Policies and procedures do not always have to state the word “majority” but at least 51% of the members must be peers.

**ASSESSMENT OF ORGANIZATIONAL PROVIDERS**

A. The delegate must have policy and procedures for assessing health care delivery Providers that specifies that before it contracts with a Provider, and at least for every three (3) years thereafter, it credentials and recredentials its organizational Providers, as delineated in Policy 5E, “Subcontracted Organizational Providers”.

**DELEGATION OF CREDENTIALING**

A. Any time you give another entity the responsibility to gather information for you, you are delegating. If you use a company and you log into their web-based system to then pull your queries for OIG or some other type of query, it is considered delegation. If you ask another entity to perform your ongoing monitoring, it is delegation.

B. IEHP confirms the IPA’s ability to meet delegation requirements as stated above at the time of contracting and at least annually thereafter in accordance with Policy 13G, “Delegation Oversight Audit”.
5. CREDENTIALING AND RECredentialing

B. Practitioner Credentialing Requirements

C. IPAs not meeting delegation requirements as determined through oversight activities are subject to rescission of delegated credentialing activities.

D. IEHP and any regulatory oversight agency, has the right, within two (2) working days advance notice to the IPA, to examine the IPA’s credentialing/recredentialing files or sites as needed to perform oversight of all Practitioners or to respond to a complaint or grievance.

E. All information obtained by the IPA and IEHP during the credentialing/recredentialing process is confidential to the extent required by law.

IPA REPORTING TO IEHP

A. Delegated IPAs must submit the following Practitioner credentialing information within thirty (30) days of the IPA’s Credentialing Committee approval of the Practitioner’s participation with the IPA to IEHP. Practitioner Profile or spreadsheet must contain the following information:

<table>
<thead>
<tr>
<th>PCP</th>
<th>SCP</th>
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<tbody>
<tr>
<td>1.</td>
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<tr>
<td>15.</td>
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</tbody>
</table>
## 5. CREDENTIALING AND REcredentialing

### B. Practitioner Credentialing Requirements

<table>
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<tr>
<th></th>
<th>PCP</th>
<th>SCP</th>
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<th>ELEMENT</th>
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</thead>
<tbody>
<tr>
<td>16.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Practitioner Tax Identification Number(s)</td>
</tr>
<tr>
<td>17.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Practitioner License Number and expiration date</td>
</tr>
<tr>
<td>18.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Initial Committee Approval Date</td>
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<td>19.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Recredentialing Committee Approval Date (if applicable)</td>
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<td>20.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>DEA Number and expiration date (if applicable)</td>
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<td>21.</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>Hospital Affiliations (Hospital Name, Status, and Type of Service provided - Specialty)</td>
</tr>
<tr>
<td>22.</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>Hospital Admitter arrangements (Name of Hospital, Name of Admitter)</td>
</tr>
<tr>
<td>23.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Malpractice Insurance Coverage (Name of carrier, policy number, coverage per claim, coverage per aggregate and expiration date)</td>
</tr>
<tr>
<td>24.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Board Certification (Name of Board, Expiration date/re-verification date, Certification status)</td>
</tr>
<tr>
<td>25.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Medical School (Name of Institution and Graduation Date MM/YY)</td>
</tr>
<tr>
<td>26.</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>Internship (Institution Name, Specialty, Training Type, Start Date MM/DD/YY, and End date MM/DD/YY)</td>
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<tr>
<td>27.</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>Residency (Institution Name, Specialty, Training Type, Start Date MM/DD/YY, and End date MM/DD/YY, if applicable)</td>
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<td>Fellowship (Institution Name, Specialty, Training Type, Start Date MM/DD/YY, and End date MM/DD/YY, if applicable)</td>
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<td>Individual NPI Number</td>
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<td>30.</td>
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<td>✓</td>
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<td>Name of Supervising Physician</td>
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<td>31.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Staff Languages spoken</td>
</tr>
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<td>32.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Medi-Cal Number</td>
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</table>

### B. Delegated IPAs must submit the following information for all initial credentialing submissions to be added to the IEHP Network:

<table>
<thead>
<tr>
<th></th>
<th>PCP</th>
<th>SCP</th>
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<tbody>
<tr>
<td>1.</td>
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<td>Provider Profile or spreadsheet</td>
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</table>
## 5. CREDENTIALING AND RECREDENTIALING

### B. Practitioner Credentialing Requirements

<table>
<thead>
<tr>
<th>PCP</th>
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</table>

### C. Delegated IPAs must recredential all contracted and/or employed Practitioners within thirty-six (36) months of the last IPA Committee approval date.

### D. Delegated IPAs must submit the following Practitioner recredentialing information by the 15th of the month, following the credentialing approval. The spreadsheet must contain the following information:

<table>
<thead>
<tr>
<th>PCP</th>
<th>SCP</th>
<th>ML</th>
<th>ELEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>✓</td>
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<td>2.</td>
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<td>3.</td>
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<td>4.</td>
<td>✓</td>
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<td>✓</td>
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</tbody>
</table>
### 5. CREDENTIALING AND REcredentialing

#### B. Practitioner Credentialing Requirements

<table>
<thead>
<tr>
<th>PCP</th>
<th>SCP</th>
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<th>ELEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Practitioner Name as it’s listed on License to Practice</td>
</tr>
<tr>
<td>6.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Practitioner Specialty</td>
</tr>
<tr>
<td>7.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Practice Name(s)</td>
</tr>
<tr>
<td>8.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Practitioner Address(es)</td>
</tr>
<tr>
<td>9.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Practitioner Phone and Fax numbers</td>
</tr>
<tr>
<td>10.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Practitioner Office Hours</td>
</tr>
<tr>
<td>11.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Practitioner D.O.B.</td>
</tr>
<tr>
<td>12.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Practitioner S.S.N.</td>
</tr>
<tr>
<td>13.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Practitioner Gender</td>
</tr>
<tr>
<td>14.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Practitioner Cultural Background (optional);</td>
</tr>
<tr>
<td>15.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Practitioner Languages spoken</td>
</tr>
<tr>
<td>16.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Practitioner Tax Identification Number(s)</td>
</tr>
<tr>
<td>17.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Practitioner License Number and expiration date</td>
</tr>
<tr>
<td>18.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Initial Committee Approval Date</td>
</tr>
<tr>
<td>19.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Recredentialing Committee Approval Date (if applicable)</td>
</tr>
<tr>
<td>20.</td>
<td>✓</td>
<td>✓</td>
<td>✓ DEA Number and expiration date (if applicable)</td>
</tr>
<tr>
<td>21.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Hospital Affiliations (Hospital Name, Status, and Tpe of Service provided - Specialty)</td>
</tr>
<tr>
<td>22.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Hospital Admitter arrangements (Name of Hospital, Name of Admitter)</td>
</tr>
<tr>
<td>23.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Malpractice Insurance Coverage (Name of carrier, policy number, coverage per claim, coverage per aggregate and expiration date)</td>
</tr>
<tr>
<td>24.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Board Certification (Name of Board, Expiration date/re-verification date, Certification status)</td>
</tr>
<tr>
<td>25.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Individual NPI Number</td>
</tr>
<tr>
<td>26.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Name of Supervising Physician</td>
</tr>
<tr>
<td>27.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Staff Languages spoken</td>
</tr>
</tbody>
</table>
5. CREDENTIALING AND RECREDENTIALING

B. Practitioner Credentialing Requirements

<table>
<thead>
<tr>
<th>PCP</th>
<th>SCP</th>
<th>ML</th>
<th>ELEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>✓</td>
<td>Name of Supervising Physician</td>
</tr>
<tr>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Medi-Cal Number</td>
</tr>
</tbody>
</table>

E. Delegated IPAs must submit the following recredentialing information to IEHP for PCPs, Specialists, and non-physician Practitioners Along with their recredentialing spreadsheet for continued participation in the IEHP Network:

<table>
<thead>
<tr>
<th>PCP</th>
<th>SCP</th>
<th>ML</th>
<th>ELEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Recredentialing spreadsheet</td>
</tr>
<tr>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>W-9 for all TIN’s utilized by the Provider, if there is a change since the last credentialing cycle</td>
</tr>
<tr>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Delegation of Services Agreement (applicable to P.A.’s only), if the Supervising Physician or practice location has changed</td>
</tr>
<tr>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Supervising Physician Form (applicable to P.A.’s only), if the Supervising Physician or practice location has changed</td>
</tr>
<tr>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Standardized Procedures (applicable to N.P.’s and C.N.M.’s only), if the Supervising Physician or practice location has changed</td>
</tr>
<tr>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>CME’s in Primary Care (Applicable to OB/GYN’s who practice as PCP’s) completed within the last three (3) years</td>
</tr>
<tr>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Hospitalist Group Agreement &amp; W-9, if applicable and there are changes since the last submission (include the Hospitalist Group Name, Specialty, Admitting Hospital including hospital privileges, Name of Hospital with arrangement, Group’s age range)</td>
</tr>
<tr>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Admitter Agreement &amp; W-9, if applicable and there are changes since the last submission (include the Practitioner Name, Specialty, Admitting Hospital including hospital privileges, Name of Hospital with arrangement, Practitioner’s age range)</td>
</tr>
</tbody>
</table>

F. All credentialing file information must be submitted to IEHP via the SFTP, into the IPAs assigned ‘Credentialing’ folder. Once the upload is complete, it is recommended that the IPA take a screenshot showing the files uploaded into the ‘Credentialing’ Folder. The IPA will need to email Provider Relations at CredentialingProfileSubmission@iehp.org
5. CREDENTIALING AND REcredentialing

B. Practitioner Credentialing Requirements

notifying IEHP when the credentialing files are posted. IEHP will then respond to your email with a confirmation that you are credentialing files were located. Submitted files will be forwarded to IEHP Credentialing for processing. Credentialing Files submitted through any other methods will be rejected and Delegated IPA will be directed to submit the files via the SFTP.

G. Upon receipt of credentialing files into the IPA’s SFTP ‘Credentialing’ folder, IEHP will begin the credentialing process.

H. Once all credentialing information is received, IEHP schedules a facility site review, as per Policy 6A, “Site Review and Medical Record Review Survey Requirements and Monitoring” for all PCP Practitioners. IEHP completes a Practitioner quality review in accordance with Policy 5C, “IEHP Quality Oversight of Participating Practitioners”.

I. If a Practitioner is changing from one IPA to another, the new IPA must submit a complete credentialing profile within sixty (60) days of the effective date of the change. Failure to meet this timeframe will result in “freezing” the Provider to auto-assignment of Members.

J. If a Practitioner’s profile for initial or recredentialing is incomplete and/or missing supporting documentation, the profile is returned to the IPA via email explaining that the process is terminated for the Practitioner until a new completed packet is received from the IPA.

K. Once the information is received for PCPs or OB/GYNs, IEHP schedules a facility site review for Medi-Cal Programs, as per Policy 6A, “Site Review and Medical Record Review Survey Requirements and Monitoring”.

L. IEHP completes a Practitioner quality review in accordance with Policy 5C, “IEHP Quality Oversight of Participating Practitioners”.

<table>
<thead>
<tr>
<th>NLAND EMPIRE HEALTH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chief Approval:</strong> Signature on file</td>
</tr>
<tr>
<td><strong>Chief Title:</strong> Chief Medical Officer</td>
</tr>
</tbody>
</table>
5. CREDENTIALING AND REcredentialing

C. IEHP Quality Oversight of Participating Practitioners

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Providers.

POLICY:

A. All IPAs are required to monitor the credentialing and recredentialing status and performance of their contracted Practitioners on a continuous basis in compliance with IEHP requirements and current NCQA, state and federal regulatory guidelines.

B. All IPAs are required to notify IEHP of any adverse actions against any of their contracted Practitioners. IPAs must provide IEHP sixty (60) calendar days advance notice of any significant change in their network, including the termination of a Practitioner.

C. IPAs must provide IEHP with a status report of their specialty network on a semi-annual basis during Provider Directory review. Delegates that do not require their Providers to be listed in the Provider Directory submit specialty networks quarterly.

D. IEHP notifies the IPA of any adverse actions it becomes aware of through sources other than the IPA. In addition, IEHP shares with all IPAs the results of performance monitoring through quality improvement studies, Member complaints and Member satisfaction surveys, as applicable. IEHP reviews the history of each delegated IPA’s credentialed and approved Practitioners, including PCP’s, specialists, non-physician Practitioners and other as defined in Policies 5A, “IEHP Practitioner Guidelines,” and 5B, “Provider Credentialing Requirements”.

E. Delegated IPA credentialed and approved PCPs must successfully pass an initial IEHP and State mandated facility site review prior to Members being assigned to the Practitioner and every three (3) years thereafter in order to retain assigned Members.

PROCEDURES:

Delegated IPAs

A. IEHP performs oversight of delegated IPAs’ ability to perform delegated credentialing activities as follows:

1. All delegated IPA credentialed and approved PCPs must successfully pass an IEHP State mandated facility site review during credentialing and every three (3) years thereafter per Policy 6A, “Site Review and Medical Record Review Survey Requirements and Monitoring”.

2. Within six (6) months of adding an IPA credentialed and approved Practitioner to the IEHP network, IEHP performs a quality review of each delegated IPA’s credentialed and approved Practitioner, consisting of the following:
5. CREDENTIALING AND REcredentialing

C. IEHP Quality Oversight of Participating Practitioners

a. Review of credentialed Practitioner specialty type against IEHP guidelines for education, training, practice experience as stated in Policy 5A, “IEHP Practitioner Guidelines”.

b. Review of requested age range for credentialed Practitioners against IEHP guidelines as stated in Policy 5A, “IEHP Practitioner Guidelines”.

c. Review of IPA submitted credentialing and/ or recredentialing packet and supporting documentation as stated in Policy 5B, “Provider Credentialing Requirements” for:

1) Malpractice history;
2) History of negative license action;
3) History of negative privileges action;
4) History of Medicare or Medicaid sanctions; and
5) Other adverse history (including felony convictions, etc.).

3. In cases where the delegated IPA submitted credentialing information is consistent with IEHP guidelines, no adverse history is present, and the Practitioner has successfully passed IEHP’s site review (if applicable), the PCPs, Specialists, and Mid-Levels are reviewed and signed off by Credentialing Department.

4. In cases where either the delegated IPA submitted credentialing information is inconsistent with IEHP guidelines, or there is evidence of significant adverse history, the Practitioner is forwarded to the IEHP Medical Director for further review.

a. The IEHP Medical Director reviews the Practitioner’s credentialing file and any other necessary supporting documentation from the IPA, Practitioner, or IEHP to determine if potential quality of care issues for Members exists.

1) If the IEHP Medical Director determines that no potential quality of care concern exists, no further action or review is undertaken.

2) If the IEHP Medical Director determines that a potential quality of care concern or adverse event does exist, the file is referred to the IEHP Peer Review Subcommittee for review at the next available meeting. The Peer Review Subcommittee may make recommendations to improve the performance of a Practitioner.

• The IEHP Peer Review Subcommittee reviews all pertinent information necessary, and takes any of the following actions:

  o No action, quality review complete, Practitioner continues to be a part of the IEHP network;
5. **CREDENTIALING AND RECREDENTIALING**

C. **IEHP Quality Oversight of Participating Practitioners**

- Request for additional information from IPA with review at next meeting;
- Individual counseling by the IPA or IEHP Medical Director;
- Focused audits of Practitioner’s practice by IEHP Quality Management staff;
- Continuing medical education or training;
- Restriction of privileges, including age range restrictions or other limitations;
- Termination of the Practitioner from the IEHP network; and
- Any other action appropriate for the circumstances.

5. Actions by the IEHP Peer Review Subcommittee that differ from the IPA Credentialing Committee decisions, including changes in privileges and termination are tracked by IEHP.
   a. The IEHP Medical Director reviews the tracking report, the credentialing files and any other supporting information as necessary.
   b. After review, IEHP takes any of the following action(s) against the delegated IPA:
      1) No action;
      2) Verbal or written request for additional information from the IPA Medical Director;
      3) Request an interim focused credentialing audit of the IPA by IEHP staff; or
      4) Any other action as appropriate, including revocation of delegated credentialing responsibilities.

6. IEHP also monitors delegated IPAs’ ability to perform delegated credentialing activities through annual or focused Delegation Oversight Audits as delineated in Policy 13G, “Delegation Oversight Audit”.

B. In addition to IEHP’s quality oversight, delegated IPAs are expected to monitor the performance of their credentialed Practitioners on a continuous basis and to review any performance issues as may be applicable during the recredentialing process obtained by the IPA, from other sources or IEHP.

**All IPAs**

A. On a semi-annual basis, IEHP provides IPAs with the Specialty Roster information via
5. CREDENTIALING AND RECredentialing

C. IEHP Quality Oversight of Participating Practitioners

Online verification reports on the Secure Provider Portal including admitters and ancillary Providers previously submitted by the IPA to IEHP that identifies the IPA’s current Provider Network that includes: Practitioner name, address, phone number, license number, specialty type, Hospital affiliations, IPA credentialing committee dates and, for obstetricians only the hospitals where they deliver.

B. IPAs are required to verify and update the following information:

1. IPA Credentialing Committee Date must be completed for all Practitioners with the most recent Committee Date.

2. Indicate for each specialist listed, as applicable, for the following:
   a. “New Hospital Privileges” – provided to indicate the Practitioner is adding new privileges with an IEHP network hospital. Indicate privileges (active, courtesy, etc.).
   b. “New Hospital Link” – provided to indicate which network hospital will be added to Practitioner.
   c. “Information is correct” – provided to specify information is correct and no changes are required.
   d. “Provider Term Date” – provided to indicate the Practitioner is no longer part of the IPA’s specialty network. Provide effective date of termination.
   e. “Term This Site Only” – provided to indicate the Practitioner is no longer at this location only. Provide effective date of location closure.
   f. “Updated information” – provided to specify new addresses, a typo, or any other changes to the information provided on the secure Provider Portal.

3. IEHP makes the indicated changes that will be reflected on the IPA’s roster.
   a. IPAs are required to update all information online and advise of completion to their Provider Services Representative (PSR) within thirty (30) days of receipt. The online verification reports being made available in IEHP’s secure portal.

C. IEHP expects all IPAs to continuously monitor Practitioner status and performance and to share the following information with IEHP:

1. IPAs are required to notify IEHP in writing immediately, upon its knowledge, if any of the following occurs with one of their contracted Practitioners:
   a. The surrendering, revocation or suspension of a license;
   b. The surrendering, revocation or suspension of DEA registration;
   c. A change in hospital staff status or hospital clinical privileges, including any restrictions or limitations;
5. CREDENTIALING AND REcredentialing

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d. A change in hospital admitting arrangements for Practitioners without IEHP affiliated hospital privileges;
e. If a Provider has opted-out of the Medicare program;
f. Loss of malpractice insurance; and
g. The notification must include the IPA’s proposed action and/or resolution.

2. IPAs are required to notify IEHP in writing within fifteen (15) days of its knowledge, if any of the following occurs with one of their contracted Practitioners:
   a. Any filing pursuant to Business and Professions Code Sections § 805, 805.01 or 809;
   b. Any filing with the NPDB; and
   c. The notification must include the IPA’s proposed action and/or resolution.

3. IPAs are required to provide sixty (60) days advance written notice to IEHP of any significant changes in the IPA’s network, including relocation, change in affiliation or termination of Practitioners. Refer to Section 18, “Provider Network” for more information.

4. IPAs have sixty (60) days from the effective date of a PCPs IPA affiliation change to submit the initial credentialing packet to IEHP. Failure to do so will result in freezing the PCP to new membership assignment or possible termination.

D. IEHP also monitors Practitioner credentialing status and performance directly, as follows:

1. Review of the following sources of information:
   a. Medicare and Medicaid OIG List of Excluded Individuals/Entities (LEIE); Collecting and reviewing sanctions or limitations on licensure;
      1) Medical Board of California (M.D.)
      2) Osteopathic Medical Board of California (D.O.)
      3) Board of Podiatric Medicine (D.P.M.)
      4) Board of Behavioral Sciences (L.M.F.T., L.C.S.W.)
      5) Board of Psychology (Psy.D., Ph.D.)
      6) California Board of Chiropractic Examiners (D.C.)
      7) Dental Board of California (D.D.S., D.M.D.)
      8) California Board of Occupational Therapy (O.T.)
      9) California Board of Optometry (O.D.)
5. CREDENTIALING AND RECREDENTIALING

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10) Physical Therapy Board of California (P.T.)
11) Physician Assistant Committee (P.A., P.A.-C)
12) California Board of Registered Nursing (C.N.M., N.P.)
13) Speech-Language Pathology & Audiology Board (S.P., Au)

b. Medi-Cal Suspended and Ineligible Provider List, published monthly by the Department of Health Care Services (DHCS);
c. Medicare Opt-Out List (Northern and Southern California Reports); published by Data.CMS.gov;
d. System for Award Management (SAM);
e. Any other source of information, e.g., phone calls from Members, other Practitioners, local news, etc.;
f. Quality improvement studies; and

g. Member complaints.

2. Providers identified on the Medi-Cal Suspended and Ineligible List will be automatically suspended from participation in all Medi-Cal lines of business, without appeal rights. All Members assigned to suspended Provider will be reassigned to new Providers. The suspended Provider will be presented to the Peer Review Subcommittee for further review and discussion. During Peer Review, the QM and Grievance Departments will also present any additional prior quality of care issues and Member complaints for the suspended Provider.

3. Providers identified on the HHS-Office Inspector General (OIG) Exclusions Report will be administratively terminated for all lines of business, without appeal rights due to IEHP prohibiting employment of contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation. Members will then be reassigned to new Providers. The Provider will be presented to the Peer Review Subcommittee for termination, further review and discussion. Prior to Peer Review, QM and Grievance Departments will be notified of Providers sanctioned identified on the HHS-Office of Inspector General (OIG) Exclusions Report, and will add any quality of care issues and Member complaints for the Provider to be reviewed completely to be included in the Peer Review Subcommittee Review.

4. If any information of adverse action regarding an IEHP Practitioner is obtained from any source, IEHP attempts to confirm the information through the following mechanisms:

a. Direct contact with pertinent licensing entity, in the event of a license action; and
5. CREDENTIALING AND RECREDENTIALING

C. IEHP Quality Oversight of Participating Practitioners

b. Direct contact with the IPA and Practitioner, if necessary.

5. Confirmed information is forwarded to the IPA for review and decision. IPAs are requested to inform IEHP in writing of their decision within thirty (30) days of the decision.

6. If IEHP believes that a Member’s health or safety may be at risk due to adverse events or quality concerns, IEHP may take one of the following actions:

   a. Refer the Practitioner to the next IEHP Peer Review Subcommittee meeting for direction;
   b. Immediately suspend the Practitioner from participation with IEHP with referral to the next IEHP Peer Review Subcommittee meeting; or
   c. Any other action as appropriate, given the circumstances and severity of the situation.

7. If IEHP has taken action against the Practitioner, IEHP informs the Practitioner of the proposed action in writing, and includes the following information:

   a. Advisement that a professional review action has been brought against the Practitioner, and reasons for the action;
   b. A brief summary of the Practitioner’s rights at the Level I Review meeting, conducted by the IEHP Peer Review Subcommittee;
   c. A statement that a Level I Review must be requested by the Practitioner in writing, addressed to the IEHP Chief Medical Officer, within thirty (30) days of the date of receipt of the notice by the Practitioner;
   d. A statement that the Practitioner may request that a Level I Review be conducted by the IEHP Peer Review Subcommittee in accordance with the “IEHP Peer Review Level I and Credentialing Appeal” (See Attachment, “IEHP Peer Review Level I and Credentialing Appeal” in Section 5);
   e. A notice that the proposed action, if implemented, must be reported to the National Practitioner Data Bank (NPDB) and the MBOC under California Business and Professions Code, Section 805, as applicable, and/or under any other applicable federal or state law; and
   f. If a recommendation or final decision based on any of the following, an 805.01 will be filed:

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

C. IEHP Quality Oversight of Participating Practitioners

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

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

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

8. IEHP also provides the IPA with copies of any Practitioner specific information such as Member complaints or studies received directly or conducted by IEHP.

E. Any Practitioner that has an adverse decision by IEHP that limits, restricts, suspends or terminates his/her status as a participating Practitioner with IEHP has the right to appeal the decision, as delineated in “IEHP Peer Review Level I and Credentialing Appeal” (See Attachments, “IEHP Peer Review Level I and Credentialing Appeal” and “IEHP Peer Review Process and Level II Appeal” in Section 5).

F. If a Practitioner does not appeal an adverse decision within specified timeframes, the decision by the Peer Review Subcommittee is final.
5. CREDENTIALING AND RECREREDENTIALING

D. Hospital Privileges

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Providers.

POLICY:

A. IEHP requires its IPAs to ensure that all of their contracted and subcontracted Practitioners have privileges at a designated IEHP contracted Hospital. The contracted Hospital must be within a fifteen (15) mile radius or thirty (30) minute drive via private or public transportation, of the Member’s residence, when applicable. In rural areas, or in specific situations, IEHP may approve PCP links to Hospitals outside of these standards (See Policy 18H, “Hospital Affiliations”).

B. IPAs are required to contract with dedicated Hospitalist group at the Hospitals they are linked to and where such Hospitalist group exists. IEHP requires that the IPA contract with the Hospitalist group contracted with IEHP Direct. The IPA may request to contract with another dedicated Hospitalist group present at the Hospital, subject to IEHP approval.

C. IPA’s are required to provide Admitter arrangements for all providers who do not have admitting privileges. If a Provider will be treating patients of all ages and do not have privileges they are linked with, they need to provide admitting coverage to cover all age ranges and specialties within their scope.

D. In a situation where a dedicated Hospitalist group does not exist at a particular Hospital, the IPA can contract with Admitters to admit their assigned Members. The Admitter must be an active Provider within the same network, specialty and cover the same age range, as the non-admitting Provider. An Admitter can only provide coverage for other PCP Providers.

E. If PCP does not or cannot obtain Hospital privileges directly, the IPA must arrange for an Admitter or Hospitalist (when required) to be responsible for admissions and providing inpatient care on behalf of the contracted Practitioner. The IPA must include these arrangements on their Provider profile to IEHP for review, by providing the name of the Hospitalist or Admitter they will be using and the Hospital where they will be providing services.

F. Admitting Practitioners must be contracted and credentialed (unless Practitioners are Hospital based only, see Policy 5B, “Practitioner Credentialing Requirements” for Admitter and Hospitalist requirement and responsibility) within the same network in accordance with regulatory standards and IEHP requirements.

G. If the IPA utilizes a Hospitalist group for Hospital admissions, the IPA must forward copies of the IPA/Hospitalist contract’s front and signature pages, NPI and W-9, as contract is executed and/or amended. The contract should be signed by both parties and
5. CREDENTIALING AND RECREREDENTIALING

D. Hospital Privileges

must include the age range, phone number, fax number, and Hospitals when the Hospitalist group will be treating patients.

H. Specialist Practitioners (in the appropriate specialties) must have a formal inpatient coverage arrangement. If the Practitioner does not have clinical admitting privileges, the delegate must obtain a written statement delineating the inpatient coverage arrangement, which must be documented in the Provider’s file.

I. If the Specialist Provider has another Provider admitting patients on his/her behalf, that Provider must be an active Provider within the same network, practice and specialty as non-admitting Provider. Specialties such as Dermatology, Podiatry, or Ophthalmology are not required to have Hospital privileges; however, documentation must be noted in the file as to the reason for not having privileges (e.g. A note stating that they do not admit as they only see patients in an outpatient setting is sufficient). All specialties with written arrangements are subject for review and approval by the Chief Medical Officer or Medical Officer, or Peer Review Committee.

J. IPAs must have established processes for outpatient and inpatient Utilization Management.

K. Utilizing on-call Hospital Practitioners without a contract is not an acceptable arrangement.

L. All Practitioners (in the appropriate specialties) must have a formal inpatient arrangement at an IEHP contracted Hospital, with a Specialist within the same specialty.

PROCEDURES:

A. During the credentialing process, IPAs that identify PCPs who do not have privileges at the designated IEHP contracted Hospital must arrange for an Admitter or Hospitalist (when required) to be responsible for admissions and providing inpatient care on behalf of the non-admitting Practitioner. The Admitter must be an active Provider within the same network, practice, specialty and cover the same age range, as the non-admitting Provider.

B. A written verification in the form of a signed agreement or letter from the admitting Practitioner that such arrangements are in place is required. This agreement must include the following information:

1. Type of Agreement (i.e. Hospitalist Agreement);
2. IPA Name;
3. Hospitalist or Admitter Name;
4. Age Range;
5. Hospitals affiliated with the Agreement;
5. CREDENTIALING AND RECRECREDENTIALING

D. Hospital Privileges

6. Hospitalist or Admitter Phone Number; and
7. Hospitalist or Admitter Fax Number.

In addition, the IPA must provide the following:

1. NPI; and

C. The agreement must stipulate a minimum of thirty (30) days advance notice of intent to terminate by either party. Notice of termination must be submitted to IEHP within five (5) days of the IPA’s knowledge of pending termination.

D. This agreement must be signed and dated by the non-admitting Practitioner and the admitting Practitioner.

E. The agreement must also specify that bills for services rendered are submitted to and paid by the IPA.

F. Upon receipt of the written admitting arrangements, IEHP verifies:

1. The non-admitting Practitioner’s specialty is completely covered by the admitting Practitioner’s specialty. (For example, a Family Practice Provider may admit patients for another Family Practice Provider or have an Internal Medicine and Pediatric Provider collectively cover admissions for a Family Practice Provider).

2. The admitting Practitioner(s) have admitting privileges to Hospitals they are admitting to, in place and in good standing, and confirms that the Provider has admitting privileges in their respective specialties, and are within the same IPA network.

G. No enrollment is given to any PCP until appropriate and complete arrangements for Hospital admissions are in place and verified by IEHP.

H. In the event it is discovered that a PCP with assigned enrollment does not have privileges at the designated IEHP contracted Hospital, and the IPA has not made arrangements with other Practitioners to provide admitting and inpatient care services for that Practitioner, IEHP may freeze the membership of the PCP and/or transfer these Members immediately. The IPA may request to unfreeze or open the Provider’s panel once they provide appropriate arrangements with other Practitioners to provide admitting inpatient care services for that Practitioner.

I. The Provider Services Coordinator (PSC) emails all IPAs on the 15th of each month for verification of all Admitters to ensure accurate information is obtained. Any changes from the IPAs must be submitted by the 25th of every month, via the Secure File Transfer
5. CREDENTIALING AND RECredentialing

D. Hospital Privileges

Protocol (SFTP) sever. On the last day of the month all network Hospitals are emailed the final Admitter list for that month. It includes Admitter’s name, phone number and fax number for each Provider who utilizes a Hospital Admitter. If Hospitals find discrepancies, they are emailed back to the Credentialing Coordinator who verifies with the individual IPA’s credentialing contact.

J. Failure of the IPA to respond by the 25th day of each respective month will result in noncompliance and may result in a corrective action plan on monthly delegation reporting.

REFERENCE:

A. Title 28, California Code of Regulations § 1300.51 (d)(H).
5. CREDENTIALING AND RECREDENTIALING

E. Health Care Delivery Organizational Providers

APPLIES TO:

A. This policy applies to all Subcontracted Providers.

POLICY:

A. IEHP directly contracts with Health Care Delivery Organizational Providers to provide medical services to Members as designated in the IEHP Financial Responsibility Matrix.

B. IEHP directly contracts with IPAs and Hospitals (Providers). In turn, Providers subcontract with Health Care Delivery Organizational Providers (subcontracted Providers) to provide services to Members as designated in the Financial Responsibility Matrix outlined in IEHP’s Capitated Agreements with the Hospitals and IPAs. Subcontracted Providers include, but are not limited to, Hospitals, Home Health Agencies, Skilled Nursing Facilities, Free-Standing Surgical Centers, Behavioral Health Providers (Intensive Outpatient Programs and Residential Treatment Programs), Hospice, Clinical Laboratories, Comprehensive Outpatient Rehabilitation Facilities, Outpatient Physical Therapy Providers, Outpatient Speech Pathology Providers, Providers of End-stage Renal Disease Services (Dialysis), Outpatient Diabetics Self-Management Training providers, Portable X-Ray Supplier, Rural Health Clinics, Federally Qualified Health Centers.

C. All delegated Provider Networks that subcontract with Health Care Delivery Organizational Providers and Providers contracted directly with IEHP must meet the following requirements:

1. Confirms that the Provider is in good standing with state and federal regulatory bodies; to include review of Sanctions that would prevent the Provider from participation in the IEHP network;

2. A current and unencumbered license;

3. Confirms that the Provider has been reviewed and approved by an accrediting body (e.g., The Joint Commission, AAAHC) or approved directly by IEHP;

4. Conducts an onsite quality assessment, if the Provider is not accredited. A site visit is not required if the state or CMS has not conducted a site review of the provider and the provider is in a rural area, as defined by the U.S. Census Bureau, as cited by NCQA. The onsite quality assessment will be conducted by IEHP’s Quality Management Department. IEHP’s assessment process and assessment criteria for each non-accredited Provider with which it contracts will include a process for ensuring that the Provider credentials its providers, in accordance to NCQA guidelines. A CMS or state review may be used in lieu of a site visit and may not be greater than three (3) years old at the time of verification/approval;

5. CMS signed participating agreement letter, if applicable; and
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6. IEHP expects the Health Care Delivery Organizational Providers to maintain its accreditation and license status in good standing and/or current at all times during their participation in the IEHP network. The Health Care Delivery Organization Provider is responsible for providing IEHP with copies of its renewed license and accreditation within sixty (60) days following the expiration of the license and accreditation.

D. IEHP delegates to IPAs that meet IEHP delegation requirements for credentialing, the responsibility for the initial and on-going assessment of subcontracted Providers that render services to Members and the delegate is responsible for claims payment for those Health Care Delivery Organization Providers. IEHP retains oversight responsibilities for all subcontracted Providers.

E. All delegated Providers and IEHP must review the accreditation status, license, and standing with regulatory agencies (i.e., sanctions/negative license activities) for each contracted or subcontracted Provider during initial contracting and at least once every three (3) years, thereafter. All delegated IPAs and IEHP Direct must have a tracking mechanism for ensuring that expirables and tri-annual reviews are compliant. IEHP audits delegated compliance annually.

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

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

PROCEDURES:

A. All contracted and subcontracted Providers that see Members must meet and maintain IEHP standards. Contracted and subcontracted Providers include, but are not limited to: Hospitals, Home Health Agencies, Skilled Nursing Facilities, Free-Standing Surgical Centers, Behavioral Health Providers (Intensive Outpatient Programs and Residential Treatment Programs), Hospice, Clinical Laboratories, Comprehensive Outpatient Rehabilitation Facilities, Outpatient Physical Therapy Providers, Outpatient Speech
5. CREDENTIALING AND REcredentialing

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Pathology Providers, Providers of End-stage Renal Disease Services (Dialysis), Outpatient Diabetics Self-Management Training Providers, Portable X-Ray Supplier, Rural Health Clinics, Federally Qualified Health Centers.

B. All contracted and subcontracted Providers must be accredited by an IEHP recognized body or meet the IEHP standards of participation, which includes submission and evaluation of the contracted or subcontracted Provider’s CMS or State review may be used in lieu of a site visit and may not be greater than three (3) years old at the time of verification/approval or an IEHP on-site quality assessment may be conducted. A Medicare certification number is acceptable for use in lieu of a site visit if a facility is not accredited. The process and assessment criteria for each type of non-accredited Provider with which it contracts which includes a process for ensuring that the Provider credentials its Providers.

C. Subcontracted Providers must also be appropriately licensed and have no sanctions or other negative license actions that may impact participation. Accreditation and licensure must be maintained throughout the duration of the subcontractors’ participation in the IEHP network.

D. IEHP recognized accrediting bodies are as follows:

1. Hospitals
   a. The Joint Commission (TJC)
   b. Healthcare Facilities Accreditation Program (HFAP) As of October 2015, the Healthcare Facilities Accreditation Program (HFAP) is no longer owned by the AOA, it is now managed by the Accredited Association for Ambulatory Health Care, Inc. (AAAHC)
   c. Det Norske Veritas National Integrated Accreditation of Healthcare Organization (DNVNIAHO)
   d. Center for Improvement in Healthcare Quality (CIHQ)

2. Home Health Agencies
   a. The Joint Commission (TJC)
   b. Community Health Accreditation Program (CHAP)
   c. Accreditation Commission for Health Care Inc (ACHC)

3. Skilled Nursing Facilities
   a. The Joint Commission (TJC)
   b. Commission on Accreditation or Rehabilitation Facilities (CARF)
   c. Continuing Care Accreditation Commission (CCAC)

4. Free-Standing Surgical Centers
   a. The Joint Commission (TJC)
5. CREDENTIALING AND REcredentialing

E. Health Care Delivery Organizational Providers

b. American Association for Accreditation for Ambulatory Surgical Facilities (AAAASF)

c. Accreditation Association for Ambulatory Health Care (AAAHC)

d. Healthcare Facilities Accreditation Program (HFAP) As of October 2015, the Healthcare Facilities Accreditation Program (HFAP) is no longer owned by the AOA, it is now managed by the Accredited Association for Ambulatory Health Care, Inc. (AAAHC)

e. The Institute for Medical Quality’s (IMQ’s) (CMS approved accrediting body verified by IEHP)

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

a. The Joint Commission (TJC)
b. Commission on Accreditation or Rehabilitation Facilities (CARF)
c. Healthcare Facilities Accreditation Program (HFAP)
d. Council on Accreditation (COA)

6. Hospice

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

7. Clinical Laboratories

a. The Joint Commission (TJC)
b. Clinical Laboratory Association Improvement (CLIA) Certificate or CLIA Waiver
c. Commission on Office Laboratory Accreditation (COLA)
d. College of American Pathology (CAP)

8. Comprehensive Outpatient Rehabilitation Facilities

a. The Joint Commission (TJC)
b. Commission on Accreditation or Rehabilitation Facilities (CARF)

9. Outpatient Physical Therapy Providers

a. American Association for Accreditation of Ambulatory Surgical Services (AAAASF)
5. CREDENTIALING AND RECREIDENTIALING

E. Health Care Delivery Organizational Providers

b. If no Accreditation, must be certified by Medicare (Must have Medicare Part A)

10. Outpatient Speech Pathology Providers

a. American Association for Accreditation of Ambulatory Surgical Services (AAAASF)

b. If no Accreditation, must be certified by Medicare (Must have Medicare Part A)

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

a. The Joint Commission (TJC)

b. If no Accreditation, must be certified by Medicare

12. Birth Centers

a. Commission for the Accreditation of Birth Centers (CABC)

13. Congregate Living Health Facility

a. The Joint Commission (TJC)

14. Outpatient diabetes self-management training Providers

a. American Association of Diabetes educators (AADE)

b. Indian Health Service (IHS)

15. Portable X-Ray Supplier

a. Federal Drug Administration (FDA) Certification

16. Rural Health Clinics

a. The Joint Commission (TJC)

b. American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF)

c. If no Accreditation, must be certified by Medicare

17. Federally Qualified Health Centers

a. The Joint Commission (TJC)

b. If no Accreditation, must be certified by Medicare

E. Delegated Providers that subcontract with Ancillary and organizational Providers are responsible for ensuring that their subcontracted Providers meet IEHP’s requirements as stated herein and in Policy 5B, “Practitioner Credentialing Requirements.” IEHP audits Delegate’s compliance with IEHP requirements on an annual basis, using the IEHP Delegation Oversight Audit Tool beginning with a pre-contractual assessment, in accordance with Policy 13G, “Delegation Oversight Audit.” Delegated IPAs are subject
5. CREDENTIALING AND REcredentialing

E. Health Care Delivery Organizational Providers

to corrective action as defined in Policy 13B, “Corrective Action Plan (CAP) Requirements”.

F. Directly contracted Health Care Delivery Organizational Providers that are not accredited are assessed by QM and reviewed and approved by the Credentialing Subcommittee.

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

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

I. If during the contract period, the IPA becomes aware of a change in the accreditation and/or CMS Site Survey, license, certification status, sanctions, fraudulent activity or other legal or remedial actions have been taken against any Provider, the IPA must notify IEHP’s Compliance Department by emailing compliance@iehp.org or fax (909) 477-8536 or via Compliance Hotline (866) 355-9038 within five (5) days of discovering any of our Providers have been added to disciplinary or exclusionary lists. The Director of Provider Contracting informs the Provider in writing that it is in violation of its contract with IEHP and begins the cure process. Depending on the seriousness of the offense, IEHP reserves the right to temporarily suspend or terminate the contract for cause, with appropriate notice as defined in the IEHP Provider Agreement. Additionally, IEHP may report the termination of the contract to regulatory agencies as per contractual requirements. Any services provided after the date of exclusion shall not be reimbursable or may be subject to recoupment.

REFERENCES:

A. NCQA HP Standards and Guidelines.

B. Medicare Managed Care Manual (Chapter 6 – Relationships with Providers).

C. Medi-Cal Law, Welfare and Institutions Code (W&I Code), § 14043.6 and 14123.

D. Department of Health Care Services (DHCS) All Plan Letter (APL) 16-017 supersedes APL 15-017, “Provision of Certified Midwife and Alternative Birth Center Facility Services.”
5. CREDENTIALING AND RECREDENTIALING

F. Credentialing Appeals Process

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Providers.

POLICY:

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

B. Practitioners have the right to appeal any adverse credentialing decision that impacts their participation status with IEHP, in accordance with the appeals procedures provided herein.

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

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

PROCEDURES:

A. The IEHP Peer Review Subcommittee performs oversight of credentialing activities of IPAs who have been delegated credentialing responsibilities, including retrospective Practitioner quality reviews referred by an IEHP Medical Director.

B. The IEHP Peer Review Subcommittee and/or IEHP Credentialing Subcommittee reviews Practitioner or Provider appeals for adverse credentialing decisions.

C. All credentialing decisions for Practitioners credentialed by IEHP are made by the IEHP Credentialing Subcommittee, based on information obtained during the credentialing process.

D. If the IEHP Credentialing Subcommittee denies a Practitioner’s participation in the IEHP network for reasons related to credentialing requirements or due to the Provider’s ability to deliver care, the Provider may be referred to IEHP’s Peer Review Subcommittee or IEHP
5. CREDENTIALING AND RECRECREDENTIALING

F. Credentialing Appeals Process

Credentialing Subcommittee for review and decision. If IEHP decides to terminate or suspend a Practitioner, the Practitioner is entitled to an appeal.

E. IEHP does not discriminate in terms of participation, reimbursement or indemnification, against any health care professional who is acting within the scope of their license, who serves high-risk populations, or who specializes in the treatment of costly conditions.

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

1. Notification that a professional review has been brought against the Practitioner, reasons for the actions and a summary of the appeal rights.

2. A brief description of the factual basis for the proposed action that includes but is not limited to:
   a. A lapse in basic qualifications such as licensure, insurance, or required medical staff privileges;
   b. A determination that the Practitioner cannot be relied upon to deliver the quality or efficiency of patient care desired by IEHP;
   c. A determination that the Practitioner cannot be relied upon to follow IEHP’s clinical or business guidelines or directives;
   d. Falsification of information provided to IEHP;
   e. Medicare/Medicaid sanctions;
   f. Adverse malpractice history;
   g. Adverse events that have potential for or have caused injury or negative impact to Members; and/or
   h. Felony convictions.

3. A statement that the Practitioner may request an appeal conducted by the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee in accordance with this policy.

4. Provider is notified that a request for an appeal must be requested by the Practitioner in writing, addressed to the IEHP Senior Medical Director or Medical Director designee, and received within thirty (30) days of the date of receipt of the notice by the Practitioner. The Practitioner’s written request must include:
   a. A clearly written explanation of the reason for the request; and
   b. A request to exercise the right to present the appeal orally, if so desired per below.
5. CREDENTIALING AND REcredentialing

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5. A summary of the Practitioner’s rights at the appeal and that the meeting takes place before the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee. The summary states:
   a. The Practitioner has the right to present additional written material for review by the IEHP Peer Review Subcommittee;
   b. The Practitioner has the right to present any information orally to the IEHP Peer Review Subcommittee, in person, at the time of the meeting; and
   c. That the appeal meeting is not a hearing, and procedural rights associated with formal peer review hearings do not apply for adverse credentialing decisions. At the appeal meeting, Practitioners may not be represented by a licensed attorney; however, they have a right to be represented by a non-attorney representative of their choice.

6. A notice that the action, if implemented, a report must be reported to the following boards:
   a. M.D. Medical Doctors
   b. D.D.S. Dentists and Oral Surgeons
   c. D.O. Osteopathic Physicians
   d. D.P.M. Podiatrists
   e. L.M.F.T. Licensed Marriage Family Therapists
   f. L.C.S.W. Licensed Clinical Social Workers
   g. Psy.D., Ph.D. Psychologists
   h. P.A. Physician Assistants

7. Other licensing agencies, and National Practitioners Data Bank (NPDB) as required by law, as applicable under California Business and Professions Code, Section 805 and/or 805.01 (if applicable), as applicable, and/or under any other applicable federal or state law.

G. If an appeal is submitted in a timely manner, IEHP arranges for a review of the appeal to be conducted at the next scheduled meeting of the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee. Prior to the meeting, IEHP sends a written notice to the Practitioner via FedEx informing the Practitioner of the date, time and place of the meeting.

H. When the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee completes its evaluation and renders a decision to uphold or overturn the denial made by the IEHP Credentialing Subcommittee, the Practitioner is notified, in writing, within thirty (30) business days of the decision.
5. CREDENTIALING AND REREDENTIALING

F. Credentialing Appeals Process

I. If the appeal decision by the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee upholds the original denial of the Practitioner’s participation in the IEHP network by the IEHP Credentialing Subcommittee, the written notice includes the following:

1. The decision, including a brief description of the decision and the reasons for it;
2. The decision will be adopted as the final action; and
3. The action, if implemented, a report must be reported to the following boards:
   a. M.D. Medical Doctors
   b. D.D.S. Dentists and Oral Surgeons
   c. D.O. Osteopathic Physicians
   d. D.P.M. Podiatrists
   e. L.M.F.T. Licensed Marriage Family Therapists
   f. L.C.S.W. Licensed Clinical Social Workers
   g. Psy.D., Ph.D. Psychologists
   h. P.A. Physician Assistants

4. Other licensing agencies, and National Practitioners Data Bank (NPDB) as required by law, as applicable under California Business and Professions Code, Section 805 and/or 805.01 (if applicable), or under any other applicable Federal or State law.

J. Practitioners that have been denied (initial or recredential) by Credentialing Subcommittee and upheld at the appeal meeting may request Level II Appeal.

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

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

1. Actions that are reported to the Medical Board of California, the Dental Board of California, the Osteopathic Medical Board of California, the Board of Podiatric Medicine, the California Board of Behavioral Sciences, the Board of Psychology, and the Physician Assistant Board, and other licensing agencies, and National
5. CREDENTIALING AND RECRECIENTALING

F. Credentialing Appeals Process

Practitioners Data Bank (NPDB) as required by law, as applicable, include a decision to deny or reject a Practitioner’s application for staff privileges or membership for a medical disciplinary cause or reason; a decision to terminate or revoke a Practitioner’s membership, staff privileges or employment for a medical disciplinary cause or reason; restrictions imposed or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of thirty (30) days or more for any twelve (12) month period, for a medical disciplinary cause or reason; and or a Practitioner’s resignation or leave of absence from membership, staff, or employment following notice of impending investigation based on information indicating medical disciplinary cause or reason.

2. An 805.01 will be filed, if a recommendation or final decision based on any of the following:
   a. Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury or to one or more patients in such a manner as to be dangerous or injurious to any person or the public.
   b. The use of, or prescribing for or administering to him/herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, or any other persons, or the public, or to the extent that such impairs the ability of the licentiate to practice safely.
   c. Repeated acts of clearly excessive prescribing, furnishing or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without good faith effort prior examination of the patient and medical reason therefore.
   d. Sexual misconduct with one or more patients during a course of treatment or an examination.

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

REFERENCES:
A. California Evidence Code §1157.
B. California Business and Professions Code § 805, 805.01.

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<th>INLAND EMPIRE HEALTH PLAN</th>
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<td><strong>Chief Approval:</strong> Signature on file</td>
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<td><strong>Chief Title:</strong> Chief Medical Officer</td>
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5. CREDENTIALING AND REcredentialing

Attachments

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<tr>
<th>DESCRIPTION</th>
<th>POLICY CROSS REFERENCE</th>
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<tr>
<td>Bariatric Surgeon Case Volume Attestation</td>
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<td>Delegation of Services Agreement and Supervising Physician Form</td>
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<tr>
<td>IEHP Peer Review Level I and Credentialing Appeal</td>
<td>5A, 5B, 5C, 5D</td>
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<td>IEHP Peer Review Process and Level II Appeal</td>
<td>5A, 5B, 5C, 5D</td>
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<td>IEHP Addendum E</td>
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BARIATRIC SURGEON
CASE VOLUME ATTESTATION

I, _____________________________________________ (Print: Provider Name), attest that the
information reported below accurately reflects the volume of bariatric surgery cases in which I
was both proctored and served as a primary surgeon. I do hereby attest that this information is true,
accurate, and complete to the best of my knowledge.

I understand Inland Empire Health Plan (IEHP) reserves the right to require me to provide clinical
documentation verifying the attested bariatric surgery cases below, which I agree to provide upon
IEHP’s request.

1. _________ Volume of applicant’s proctored cases

2. _________ Volume of cases where applicant was primary surgeon
   * IEHP requires a minimum of fifteen (15) cases where the applicant was the primary surgeon

______________________________   __________________________
PROVIDER’S SIGNATURE          DATE
Delegation of Services Agreements – Change in Regulations

Recently, Title 16, Division 13.8, Article 4, section 1399.540 has been amended to include several requirements for the delegation of medical services to a physician assistant. There are four specific changes with this amendment:

Background:

The Delegation of Services Agreement (DSA) is a document used by supervising physicians and physician assistants to meet requirements of Section 1399.540. The DSA is the foundation of the relationship between a supervising physician and the physician assistant, and specifies the names of the supervising physicians and what types of medical services the physician assistant is allowed to perform, how they are performed, how the patient charts will be reviewed and countersigned, and what type of medications the physician assistant will transmit on behalf of the supervising physician.

Regulatory Requirements:

1) A physician assistant may provide medical services, which are delegated in writing by a supervising physician who is responsible for patients, cared for by the physician assistant. The physician assistant may only provide services which he or she is competent to perform, which are consistent with their education, training and experience, and which are delegated by the supervising physician.

2) The delegation of services agreement is the name of the document, which delegates the medical services. More than one supervising physician may sign the delegation of services agreement only if each supervising physician has delegated the same medical services. A physician assistant may provide medical services pursuant to more than one delegation of services agreement.

3) The Physician Assistant Board or their representative may require proof or demonstration of competence from any physician assistant for any medical services performed.

4) If a physician assistant determines a task, procedure or diagnostic problem exceeds his or her level of competence, and then the physician assistant shall either consult with a physician or refer such cases to a physician.

Q: What if a physician assistant works for more than one supervising physician at a hospital or clinic? Do we need to have separate DSAs for each supervising physician?

A: The Board has had questions regarding how the DSA would be written if a physician assistant works for more than one supervising physician at a hospital or clinic. If the duties and medical services performed are consistent with each supervising physician, then one DSA can be written to include several supervising physicians. Each supervising physician must sign and date the DSA, along with the signature of the physician assistant.
Q: What if a physician assistant works for one supervising physician who is an ob-gyn, and also works for an ortho supervising physician, and both are at the same clinic or hospital?
A: If the duties and medical services provided by the physician assistant differ from one supervising physician to another, then it is recommended that a separate DSA be written for each supervising physician. However, one DSA could be used, but it would need to be separated with which duties are allowed under each supervising physician. Again, signatures and dates from all parties must be included on the DSA.

Q: What if the physician assistant works at several different clinics – can one DSA be written?
A: A separate DSA should be made for each hospital or clinic, regardless of how many supervising physicians the physician assistant works with. Alternatively, a physician assistant may have a DSA that specifies what services can be provided at a specific site.

Q: How long should I retain my DSA?
A: You should retain the DSA as long as it is valid. Additionally, it is recommended that you keep a copy of your DSA for at least one to three years after it is no longer the current DSA in case you need to reference the document. However, there is no legal requirement to retain the DSA once it is no longer valid and current.
DELEGATION OF SERVICES AGREEMENT BETWEEN
A SUPERVISING PHYSICIAN AND A PHYSICIAN ASSISTANT
&
SUPERVISING PHYSICIAN’S RESPONSIBILITY FOR SUPERVISION
OF A PHYSICIAN ASSISTANT

Title 16, Section 1399.540 of the Physician Assistant Regulations states, in part, “A physician assistant may only provide those medical services which he or she is competent to perform and which are consistent with the physician assistant’s education, training, and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant. b) The writing which delegates the medical services shall be known as a delegation of services agreement. A delegation of services agreement shall be signed and dated by the physician assistant and each supervising physician. A delegation of services agreement may be signed by more than one supervising physician only if the same medical services have been delegated by each supervising physician. A physician assistant may provide medical services pursuant to more than one delegation of services agreement.”

The following two sample documents are attached to assist you with meeting this legal requirement:

1) Delegation of Services Agreement (DSA) Between Supervising Physician and Physician Assistant; and

2) Supervising Physician’s Responsibility for Supervision of Physician Assistant Agreement.

These are sample documents. They are for your convenience, information, and use. Please feel free to duplicate or modify them as appropriate and consistent with law.

If you choose not to use the sample documents, please be aware that you are still required by law to execute a DSA with your supervising physician. The DSA must be signed and dated by you and your supervising physician. The original or a copy of this document should be maintained at all practice sites where the physician assistant practices, and should be readily accessible. It is recommended that you retain prior DSAs for one to three years after the DSA is no longer current or valid.

While every practicing physician assistant is required to have a DSA, you are not required to submit it to the Physician Assistant Board. If requested, you must make a copy of your DSA available to any authorized agent of the Medical Board of California, the Osteopathic Medical Board of California, or the Physician Assistant Board who may request it.

Failure to have a current DSA constitutes a violation of the Physician Assistant Regulations and is grounds for disciplinary action against a physician assistant’s license. In addition, failure by the physician assistant and supervising physician to comply with the supervision requirements specified in the Physician Assistant Regulations and in the Delegation of Services Agreement is ground for disciplinary action.

THE ATTACHED DOCUMENTS DO NOT NEED TO BE RETURNED TO THE PHYSICIAN ASSISTANT BOARD
PHYSICIAN ASSISTANT______________________________________________________________

Physician assistant, graduated from the _______________________________________________________
physician assistant training program on _________________________________.

He/she took (or is to take) the licensing examination for physician assistants recognized by the State of California
(e.g., Physician Assistant National Certifying Examination or a specialty examination given by the State of California)
on ___________________________.

He/she was first granted licensure by the Physician Assistant Board on ________________________, which expires
on ________________________, unless renewed.

SUPERVISION REQUIRED. The physician assistant named above (hereinafter referred to as PA) will be supervised
in accordance with the written supervisor guidelines required by Section 3502 of the Business and Professions Code
and Section 1399.545 of the Physician Assistant Regulations. The written supervisor guidelines are incorporated
with the attached document entitled, "Supervising Physician's Responsibility for Supervision of Physician Assistants."

AUTHORIZED SERVICES. The PA is authorized by the physician whose name and signature appear below to
perform all the tasks set forth in subsections (a), (d), (e), (f), and (g) of Section 1399.541 of the Physician Assistant
Regulations, when acting under the supervision of the herein named physician. (In lieu of listing specific lab
procedures, etc. the PA and supervising physician may state as follows: "Those procedures specified in the practice
protocols or which the supervising physician specifically authorizes.")

The PA is authorized to perform the following laboratory and screening procedures:

__________________________________________________________________________________________
__________________________________________________________________________________________

The PA is authorized to assist in the performance of the following laboratory and screening procedures:

__________________________________________________________________________________________
__________________________________________________________________________________________

The PA is authorized to perform the following therapeutic procedures:

__________________________________________________________________________________________
__________________________________________________________________________________________

The PA is authorized to assist in the performance of the following therapeutic procedures:

__________________________________________________________________________________________
__________________________________________________________________________________________

The PA is authorized to function as my agent per bylaws and/or rules and regulations of (name of hospital):

__________________________________________________________________________________________
__________________________________________________________________________________________

a) The PA is authorized to write and sign drug orders for Schedule: II, III, IV, V without advance approval (circle
authorized Schedule(s)). The PA has taken and passed the drug course approved by the Board on __________
(attach certificate). DEA #:_______________________________. Date

or

b) The PA is authorized to write and sign drug orders for Schedule: II, III, IV, V with advance patient specific approval
(circle authorized Schedule(s)). DEA #:_______________________________.
CONSULTATION REQUIREMENTS. The PA is required to always and immediately seek consultation on the following types of patients and situations (e.g., patient's failure to respond to therapy; physician assistant's uncertainty of diagnosis; patient's desire to see physician; any conditions which the physician assistant feels exceeds his/her ability to manage, etc.)

____________________________________________________________________________________________________________________________
(List Types of Patients and Situations)
__________________________________________________________________________________________

MEDICAL DEVICES AND PHYSICIAN’S PRESCRIPTIONS. The PA may transmit by telephone to a pharmacist, and orally or in writing on a patient's medical record or a written prescription drug order, the supervising physician’s prescription in accordance with Section 3502.1 of the Business and Professions Code.

The supervising physician authorizes the delegation and use of the drug order form under the established practice protocols and drug formulary. _______ YES ________ NO

The PA may also enter a drug order on the medical record of a patient at ______________________________
(Name of Institution) in accordance with the Physician Assistant Regulations and other applicable laws and regulations.

Any medication handed to a patient by the PA shall be authorized by the supervising physician's prescription and be prepackaged and labeled in accordance with Sections 4076 of the Business and Professions Code.

PRACTICE SITE. All approved tasks may be performed for care of patients in this office or clinic located at _______________________________ and, in ______________________________ hospital(s) and_________________________________________ skilled nursing facility (facilities) for care of patients admitted to those institutions by physician(s) ________________________________ .

EMERGENCY TRANSPORT AND BACKUP. In a medical emergency, telephone the 911 operator to summon an ambulance.

The __________________________________________ emergency room at ____________________________
(Name of Hospital) (Phone Number) is to be notified that a patient with an emergency problem is being transported to them for immediate admission. Give the name of the admitting physician. Tell the ambulance crew where to take the patient and brief them on known and suspected health condition of the patient.

Notify _____________________________________ at ___________________________________ immediately
(Name of Physician) (Phone Number/s)) (or within ________________ minutes).

PHYSICIAN ASSISTANT DECLARATION
My signature below signifies that I fully understand the foregoing Delegation of Services Agreement, having received a copy of it for my possession and guidance, and agree to comply with its terms without reservations.

_______________________________  ________________________________________________
Date        Physician's Signature (Required)

_______________________________
Physician's Printed Name

_______________________________
Date

_______________________________
Physician Assistant's Signature (Required)

_______________________________
Physician Assistant's Printed Name

SAMPLE ONLY
2 of 2
SUPERVISOR ________________________________________________________________________, M.D./D.O. is licensed to practice in California as a physician and surgeon with medical license number _______________. Hereinafter, the above named physician shall be referred to as the supervising physician.

SUPERVISION REQUIRED. The physician assistant (PA) named in the attached Delegation of Services Agreement will be supervised by the supervising physician in accordance with these guidelines, set forth as required by Section 3502 of the Business and Professions Code and Section 1399.545 of the Physician Assistant Regulations, which have been read by the physician whose signature appears below.

The physician shall review, countersign, and date within seven (7) days the medical record of any patient cared for by the physician assistant for whom the physician's prescription for Schedule II medications was transmitted or carried out.

REPORTING OF PHYSICIAN ASSISTANT SUPERVISION. Each time the physician assistant provides care for a patient and enters his or her name, signature, initials, or computer code on a patient's record, chart or written order, the physician assistant shall also enter the name of his or her supervising physician who is responsible for the patient. When the physician assistant transmits an oral order, he or she shall also state the name of the supervising physician responsible for the patient.

MEDICAL RECORD REVIEW. One or more of the following mechanisms, as indicated below, by a check mark (x), shall be utilized by the supervising physician to partially fulfill his/her obligation to adequately supervise the actions of the physician assistant named _______________________________________________________.

_____ Examination of the patient by a supervising physician the same day as care is given by the PA.

_____ The supervising physician shall review, audit, and countersign every medical record written by the PA within ___________________________________ of the encounter.

(Number of Days May- Not Exceed 30 Days)

_____ The physician shall audit the medical records of at least 5% of patients seen by the PA under any protocols which shall be adopted by the supervising physician and the physician assistant. The physician shall select for review those cases which by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

_____ Other mechanisms approved in advance by the Physician Assistant Board may be used. Written documentation of those mechanisms is located at ________________________________________________.

(Give Location)

_____ INTERIM APPROVAL. For physician assistants operating under interim approval, the supervising physician shall review, sign, and date the medical records of all patients cared for by the physician assistant within seven (7) days if the physician was on the premises when the physician assistant diagnosed or treated the patient. If the physician was not on the premises at that time, he or she shall review, sign, and date such medical records within 48 hours of the time the medical services were provided.

BACK UP PROCEDURES: In the event this supervising physician is not available when needed, the following physician(s) has (have) agreed to be a consultant(s) and/or to receive referrals:

________________________________________ Phone: _________________________
(Printed Name and Specialty)

________________________________________ Phone: _________________________
(Printed Name and Specialty)

PROTOCOLS NOTE: This document does not meet the regulation requirement to serve as a protocol. Protocols, if adopted by the supervising physician, must fully comply with the requirements authorized in Section 3502 (c) (1) of the Business and Professions Code.

_________________ __________________________________________________________________
Date                                                                   Physician's Signature

THIS DOCUMENT IS NOT TO BE RETURNED TO THE BOARD
SAMPLE ONLY
Addendum E
General Practice Providers & Obstetrics/Gynecology PCP’s only
Primary Care Experience – Attestation

Please indicate below the age of the patients for whom you have provided primary care services to in the last five (5) years. In order for a category to apply, it must represent at least 20% of your average practice and you must be familiar with and routinely follow standard preventative services, such as CHDP and the American Academy of Pediatrics (AAP), both for Pediatrics only, and the United States Preventative Task Force (USPTF). Please check all those that apply:

- [ ] Pediatrics (0 to 18 years of age)
- [ ] Pediatrics (0 to 21 years of age)
- [ ] Adults (14 years of age and above)
- [ ] Adults (18 years of age and above)
- [ ] Adults (21 years of age and above)
- [ ] Ob/Gyn PCP (14 years and above, restricted to females)
- [ ] If you desire age limits different from above, please specify:

__________________________________________________________________________

__________________________________________________________________________

NOTE: If your desire age limits different from above, you will not receive member auto-assignment.

I attest to the fact that all of the information submitted by me in this document is true and correct to the best of my knowledge and belief. I fully understand that any significant misstatement or omission from this attestation may constitute cause for denial of participation or dismissal from participation with Inland Empire Health Plan (IEHP).

Physician’s Name: ____________________________________________________________

Physician’s Signature: ____________________________________ Date: ______________

(Stamped signature is not acceptable)
INLAND EMPIRE HEALTH PLAN

PEER REVIEW (LEVEL I) AND CREDENTIALING APPEAL

Denial, Reduction, Suspension or Termination of Practitioner Status

(Adopted April 14, 1997)

(Amended January 2019)
INLAND EMPIRE HEALTH PLAN

PEER REVIEW (LEVEL I) AND CREDENTIALING APPEAL
Denial, Reduction, Suspension or Termination of Practitioner Status

Purpose:

A. To provide 1) a mechanism for peer review of IEHP Providers of Service (Practitioners), 2) a process for Practitioner to request review of negative peer review recommendations, decisions, and actions, for any reason related to quality of care issues, non-quality of care issues, and/or credentialing requirements, including, but not limited to, denial, reduction, suspension or termination of Practitioner status, as requested by the Inland Empire Health Plan (IEHP) Peer Review Subcommittee, the IEHP Quality Management (QM) Committee, the IEHP Credentialing Subcommittee, of the IEHP Medical Director, and 3) a mechanism for appropriate action.

Scope:

A. The following policies and procedures apply to all Practitioners participating or requesting participation as a Provider for IEHP, including, but not limited to, the following licentiates: Physicians (MD), Osteopathic Physician (DO), Podiatrists (DPM), Pharmacists (Pharm D or RPh), Oral Surgeons (DDS or DMD), Optometrists (OD), Chiropractors (DC), Audiologists, Clinical Psychologists, (PhD), Nurse Practitioners (NP), Physician Assistants (PA), Certified Nurse Midwives (CNM), Physical Therapists (PT), Occupational Therapists (OT), and Speech/Language Therapists (S/LT), psychiatrists, psychologists, master level clinical nurses, Licensed Clinical Social Workers (LCSW), Marriage, Family and Child Counselors (MFCC/LMFT) and other behavioral health professionals licensed to provide behavioral health services in the state of California.

Policy:

A. A Provider’s status or participation may be denied, reduced, suspended or terminated for any lawful reason, including, but not limited to, a lapse in basic qualifications such as licensure, insurance, or required medical staff privileges or admission coverage at an IEHP contracted hospital; a determination by IEHP that the Practitioner cannot be relied upon to deliver the quality or efficiency of patient care required by IEHP; a determination by IEHP that the Practitioner cannot be relied upon to follow IEHP’s clinical or business guidelines or directives; or a change in IEHP’s business needs.

B. A Practitioner may request review of any initial adverse recommendation, decision or action by IEHP that is based on quality of care issues, non-quality of care issues, and/or credentialing requirements, and impacts his or her participation status with IEHP, including denial, reduction, suspension, or termination of his or her participation status with IEHP, in accordance with the Level I Review procedures, as provided herein.

Procedure:
A. Issues raised about either an applicant or a participating Practitioner’s credentialing packet or performance as a Practitioner shall be considered initially by the IEHP Medical Director, who shall have the discretion to investigate and to determine the necessary and appropriate response and intervention as delegated to the IEHP Medical Director as a member of the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee. His/her options shall include, but not be limited to, maintaining a record of the matter without further investigation or action; investigating the matter personally and making a report and recommendation to the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee, as warranted; or referring the matter to the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee for investigation and the preparation of a report and recommendation to the IEHP Medical Director.

B. In instances where there may be an imminent danger to the health of any individual, the IEHP Medical Director and/or the IEHP Peer Review Subcommittee may summarily restrict or suspend the participating Practitioner’s privilege to provide patient care services, effective immediately upon written notice to the Practitioner. The notice shall be in the same format as described in Section 3 herein, pending consideration and action by the IEHP Peer Review Subcommittee. The IEHP Peer Review Subcommittee may continue to enforce the reduction or suspension pending further action.

C. If an unfavorable recommendation, decision or action is made or taken by the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee for a reason relating to quality of care issues, non-quality of care issues, and/or credentialing requirements, the Practitioner shall be entitled to a Level I Review. The Practitioner shall be sent a written notice, by Fedex, with a return receipt, of the recommendation or decision and shall be afforded thirty (30) days in which to respond in writing to request a Level I Review. A copy of the “IEHP Peer Review Level I and Credentialing Appeal” document shall be provided with the notice. The notice will state:

1. The action which has been proposed against the Practitioner;

2. A brief description of the factual basis for the proposed action;

3. That the Practitioner has the right to request that a Level I Review be conducted by the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee;

4. That a Level I Review must be requested by the Practitioner in writing, addressed to the IEHP Medical Director within thirty (30) days of the date of receipt of the notice by the Practitioner. The Practitioner’s written request for a Level I Review must state the reasons for the request clearly, and if the Practitioner wishes to exercise the right to present information orally at the Level I Review meeting as provided in Section 4b below, the Practitioner shall so indicate in the written request for Level I Review;

5. A brief summary of the Practitioner’s rights at the Level I Review, as set forth in Section 4 below;
6. That the Level I Review shall take place before the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee; and

7. That the action, if implemented, must be reported to the Medical Board of California under California Business and Professions Code Section 805 or 809 as applicable, National Practitioner Data Bank (NPDB), and/or under any other applicable federal or state law.

D. A Practitioner’s rights at the Level I Review include:

1. Right to present any additional written material for review by the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee.

2. Right to present any information orally to the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee in person at the time of the meeting for the Level I Review.

If the Level I Review is not requested by the Practitioner within the time and in the manner specified, all administrative Level I Review rights of the Practitioner shall be deemed waived, and the decision made by the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee shall be final.

E. If Level I Review is requested within the time and in the manner specified, the IEHP Medical Director shall arrange for the review to be conducted at the next scheduled meeting of the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee, and the Practitioner shall be sent a written notice via FedEx stating the date, time, and place of the Level I Review meeting. The Practitioner’s written response to the notice of action or proposed action shall be summarized in or attached to a report to the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee which shall be written by the IEHP Medical Director, as a member of the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee.

F. As provided in this “IEHP Peer Review Level I and Credentialing Appeal”, the Level I Review shall include an opportunity for the Practitioner to present information and arguments in writing and/or orally. However, the Level I Review meeting is not a hearing, and the procedural rights associated with formal peer review hearings do not apply in Level I Review. At a Level I Review meeting, Practitioners may not be represented by a licensed attorney; however, they have a right to be represented by a non-attorney representative of their choice. The IEHP Peer Review Subcommittee and IEHP Credentialing Subcommittee shall have the discretion to prescribe such additional procedural elements as it deems appropriate to the circumstances. When the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee is satisfied that sufficient information and arguments have been presented in this review process, it shall recommend or take such action as it deems appropriate and send written notice via FedEx to the Practitioner.

G. In cases where the decision by the IEHP Peer Review Subcommittee or Credentialing Subcommittee for the Level I Review will result in the denial, suspension, reduction or
termination of the Practitioner’s participation status with IEHP, the written notice will include the following:

1. The Level I Review decision, including a brief description of the proposed recommendation, decision or action and the reasons for it;

2. That the action, if implemented, must be reported to the Medical Board of California under Business and Professions Code Section 805 or 809 as applicable, National Practitioner Data Bank (NPDB), or under any other applicable federal or state law;

3. That the Practitioner may request a Level II Appeal hearing for adverse peer review decisions

4. That a Level II Appeal hearing must be requested in writing, within thirty (30) days of receipt of the notice by the Practitioner and the request must include a statement of the grounds for requesting a Level II Appeal;

5. A brief summary of the Practitioner’s rights with respect to the Level II Appeal hearing;

6. A statement that the Practitioner is required to exhaust the administrative remedies of the Level II Appeal hearing prior to seeking judicial review of the recommendations, decisions or actions of the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee; and

7. The Level II Appeal proceeding shall take place before a Hearing Officer, selected by the IEHP Medical Director in accordance with the procedures set forth in the Level II Appeal document, and the final action shall be taken by the Peer Review Subcommittee.

Request for a Level II Appeal

A. The Practitioner shall have thirty (30) days following the date of receipt of a notice of an adverse recommendation, decision or action resulting from a Level I Review to request a formal Level II Appeal. The request must be submitted in writing, directed to the IEHP Medical Director, and must be received at IEHP within the prescribed period. If the Practitioner does not request a formal Level II Appeal within the time and in the manner prescribed, they shall be deemed to have accepted the recommendation, decision, or action involved, and shall be deemed to have waived all administrative appellate review rights, and the recommendation, decision, or action may be adopted by the Peer Review Subcommittee or IEHP Credentialing Subcommittee as IEHP’s final action.

Reporting

A. IEHP shall comply with the reporting requirements of the Medical Board of California (MBOC) as required by law. IEHP shall comply with the reporting requirements of the California Business and Professions Code, the Federal Health Care Quality Improvement Act,
and the National Practitioner Data Bank (NPDB) regarding adverse credentialing and peer review actions. The Practitioner will be notified of the reports and its contents.

**B.** MBOC requires reports whenever a licentiate’s application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason; a licentiate’s membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason; restrictions are imposed or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of thirty (30) days or more for any 12-month period, for a medical disciplinary cause or reason; and/or a licentiate’s resignation or leave of absence from membership, staff, or employment following notice of impending investigation based on information indicating medical disciplinary cause or reason.

**C.** MBOC requires an 805 report whenever a peer review body makes a final decision or recommendation regarding the disciplinary action, resulting in a final proposed action to be taken against a licentiate based on the peer review body’s determination, following formal investigation of the licentiate that any of the facts listed below have occurred, regardless of whether a hearing is held pursuant to Section 809:

**D.** IEHP complies with all reporting requirements of the Medical Board of California, the Dental Board of California, the Osteopathic Medical Board of California, the Board of Podiatric Medicine, the California Board of Behavioral Sciences, the Board of Psychology, and the Physician Assistant Board, and other licensing agencies, and National Practitioners Data Bank (NPDB) as required by law. IEHP also complies with the reporting requirements of the California Business and Professions Code and the Federal Health Care Quality Improvement Act regarding adverse credentialing decisions. IEHP notifies the Practitioner of such reporting and its contents in writing.

1. Actions that are reported to the Medical Board of California, the Dental Board of California, the Osteopathic Medical Board of California, the Board of Podiatric Medicine, the California Board of Behavioral Sciences, the Board of Psychology, and the Physician Assistant Board, and other licensing agencies, and National Practitioners Data Bank (NPDB) as required by law, as applicable, include a decision to deny or reject a Practitioner’s application for staff privileges or membership for a medical disciplinary cause or reason; a decision to terminate or revoke a Practitioner’s membership, staff privileges or employment for a medical disciplinary cause or reason; restrictions imposed or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of thirty (30) days or more for any twelve (12) month period, for a medical disciplinary cause or reasons; and/or a Practitioner’s resignation or leave of absence from membership, staff, or employment following notice of impending investigation based on information indicating medical disciplinary cause or reason.

2. An 805.01 will be filed, if a recommendation or final decision based on any of the following:
   
a. Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury or to one or more patients in such a manner as to be dangerous or injurious to any person or the public
b. The use of, or prescribing for or administering to him/herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, or any other persons, or the public, or to the extent that such impairs the ability of the licentiate to practice safely.

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

d. Sexual misconduct with one or more patients during a course of treatment or an examination.

Confidentiality

A. All credentialing and peer review records and proceedings shall be confidential and protected to the fullest extent allowed by Section 1157 of the California Evidence Code, and any other applicable law.
INLAND EMPIRE HEALTH PLAN

PEER REVIEW PROCESS AND LEVEL II APPEAL

Reduction, Suspension or Termination of Practitioner Status

(Adopted April 14, 1997)

(Amended January 2019)
INLAND EMPIRE HEALTH PLAN

PEER REVIEW PROCESS AND LEVEL II APPEAL
Reduction, Suspension or Termination of Practitioner Status

Purpose:

A. To provide 1) a mechanism for peer review of IEHP Providers of Service (Practitioners); 2) a process for Practitioners (as defined below under section B, “Scope”) to appeal negative peer review recommendations, decisions and actions for any reason related to quality of care, non-quality of care, and/or other professional conduct issues including, but not limited to, denial, reduction, suspension or termination of practitioner status, as requested by the Inland Empire Health Plan (IEHP) Peer Review Subcommittee, the IEHP Quality Management (QM) Committee, or the IEHP Chief Medical Officer; and 3) a mechanism for appropriate final action.

Scope:

A. The following policies and procedures apply to all health care professionals participating or requesting participation as a Practitioner for IEHP (Practitioners), including, but not limited to, the following licentiates: Physicians (MD), Osteopathic Physician (DO), Podiatrists (DPM), Pharmacists (Pharm D or RPh), Oral Surgeons (DDS or DMD), Optometrists (OD), Chiropractors (DC), Audiologists, Clinical Psychologists, (PhD), Nurse Practitioners (NP), Physician Assistants (PA), Certified Nurse Midwives (CNM), Physical Therapists (PT), Occupational Therapists (OT), and Speech/Language Therapists (S/LT), psychiatrists, psychologists, master level clinical nurses, Licensed Clinical Social Workers (LCSW), Marriage, Family and Child Counselors (MFCC/MFT) and other behavioral health professionals licensed to provide behavioral health services in the state of California.

Policy:

A. A Practitioner’s status or participation may be denied, reduced, suspended or terminated for any lawful reason, including, but not limited to, a lapse in basic qualifications such as licensure, insurance, or required medical staff privileges or admission coverage at an IEHP contracted hospital; a determination by IEHP that the Practitioner cannot be relied upon to deliver the quality or efficiency of patient care required by IEHP; a determination by IEHP that the Practitioner cannot be relied upon to follow IEHP’s clinical or business guidelines or directives; or a change in IEHP’s business needs.

B. A Practitioner may appeal any adverse peer review Level I Review recommendation, decision or action by IEHP that is based on quality of care, non-quality of care, and/or other professional conduct issues and impacts his or her participation status with IEHP, including denial, reduction, suspension, or termination of participation status with IEHP, in accordance with the Level II Appeal procedures, as provided herein. A Practitioner may not appeal a recommendation, decision or action based on reasons unrelated to quality of care.
care, non-quality of care, and/or other professional conduct issues. For example, there is no right to appeal if any application is denied or not processed because the applicant fails to provide requested information, additionally Level II Appeal procedures are not available for initial adverse credentialing decisions upheld by the IEHP Peer Review Subcommittee or IEHP Credentialing Subcommittee.

Procedure:

A. Final Authority

IEHP, as a health care service plan, is defined as a peer review body under applicable law. Certain peer review functions have been delegated to the IEHP Peer Review Subcommittee and the IEHP Credentialing Subcommittee. The IEHP Peer Review Subcommittee serves as the final level of review and is the final authority in credentialing and peer review decisions. The IEHP Peer Review Subcommittee has delegated the hearing of any Level II Appeal to a Judicial Hearing Committee (JHC).

B. Judicial Hearing Committee

Whenever a Level II Appeal is required pursuant to this document “Peer Review Process and Level II Appeal” the Chief Medical Officer shall appoint a JHC consisting of at least three (3) physician Providers, and alternates as appropriate. The physician Providers selected to serve on the JHC shall be physicians from within the IEHP network who shall gain no direct financial benefit from the outcome and are neither in direct economic competition nor professionally associated (including in a referral relationship) with the subject of the hearing. None of the JHC members may have acted as an accuser, investigator, fact-finder or initial decision maker, or otherwise actively participated in consideration of the matter that forms the subject of the appeal prior to the recommendation or action. JHC members also should not have participated in the care of the patients (if any) whose care forms the subject of the appeal. Where feasible, the JHC shall include at least one member who practices in the same specialty as the Practitioner who requested the hearing. The Chief Medical Officer shall designate a Chairperson who shall handle pre-hearing matters and preside until a hearing officer, as described in the Hearing Officer Section 4, is appointed. The JHC shall make findings of fact, and issue a recommended decision for action by the Peer Review Subcommittee.

C. Request for a Level II Appeal

Notice of the right to a Level II Appeal shall be sent as provided in Level I Review, Section 9 (Request for a Level II Appeal). The Practitioner shall have thirty (30) days following the date of receipt of a notice of an adverse recommendation, decision or action resulting from a Level I Review to request a formal Level II Appeal. The request must be submitted in writing, directed to the IEHP Chief Medical Officer, and must be received at IEHP within the prescribed period. If the Practitioner does not request a formal hearing within the time and in the manner prescribed, the Practitioner shall be deemed to have accepted the recommendation, decision, or action involved, and shall be deemed to have waived all
administrative appellate review rights, and the recommendation, decision, or action may be forwarded to the Peer Review Subcommittee,

D. Hearing Officer

1. Selection

The Peer Review Subcommittee or its designee shall appoint a hearing officer to preside at the JHC hearing. The hearing officer shall be an attorney at law who has been admitted to practice before the courts of this State for at least five (5) years prior to appointment, and who is qualified by knowledge and experience to preside over a quasi-judicial peer review hearing. The hearing officer shall gain no direct financial benefit from the outcome of the hearing. The hearing officer must not act as a prosecuting officer, or as an advocate for IEHP, Peer Review Subcommittee, the body whose action prompted the hearing, or the Practitioner. If requested by the JHC, the hearing officer may participate in the deliberations of the JHC and be legal advisor to it, but he/she shall not be entitled to vote. The hearing officer may be a hearing officer for either Riverside or San Bernardino counties, provided he or she meets the other criteria established by this subsection. The hearing officer will be sent a letter of appointment by the Peer Review Subcommittee.

The Practitioner shall have the right to a reasonable opportunity to voir dire any JHC member and the hearing officer, and the right to challenge the impartiality of any JHC member and the hearing officer. Such challenges to the impartiality of any JHC member or the hearing officer shall be ruled on by the hearing officer.

2. Duties

The duties of the hearing officer shall be to preside over the hearing, including any pre-hearing and/or post-hearing procedural matters; to rule on the challenges to the impartiality of JHC members and/or the hearing officer; to rule on requests for access to information and/or relevancy; rule on requests for continuances; to rule on evidentiary and burden of proof issues; to prepare the written report and recommendation of the JHC; and to perform such other functions as may be necessary or appropriate to facilitate completion of a fair hearing process as expeditiously as possible.

E. Scheduling of Appeal/Notice of Hearing

Upon the selection of the JHC, the Level II Appeal shall be scheduled at a time and place mutually agreeable to the Practitioner and to IEHP. The Practitioner shall be given notice of the time, place and date of the hearing. IEHP shall make its best efforts to ensure that the date of the commencement of the hearing shall be not less than thirty (30) days nor more than sixty (60) days from the date that IEHP receives the request for a Level II Appeal. The time frames set forth herein may be shortened or extended for a reasonable time by mutual written agreement of the parties (or by the Chairperson of the JHC if the
hearing officer has not been appointed yet) upon a showing of good cause in accordance with Section 11 below. The peer review process shall be completed within a reasonable time after the Practitioner receives notice of a final proposed action or an immediate suspension or restriction of clinical privileges, unless the JHC issues a written decision that the Practitioner failed to comply with the discovery provision herein, or consented to the delay in the proceedings.

F. Notice of Charges

A Notice of Charges shall be sent to the Practitioner along with the Notice of Hearing, further specifying, as appropriate, the acts or omissions with which the Practitioner is charged. This Notice of Hearing also shall provide a list of the patient records, if any, which are to be discussed at the hearing, if that information has not been provided previously.

Witness lists (see Section D.8) shall be amended as soon as possible when additional witnesses are reasonably known or anticipated. A failure by either party to comply with this requirement, shall be good cause to postpone the hearing.

G. Discovery

1. Rights of Discovery and Copying

The Practitioner may inspect and copy (at his/her own expense) any documentary information relevant to the charges that the IEHP Peer Review Subcommittee has in its possession or under its control, as soon as practicable after the receipt of the Practitioner’s request for a Level II Appeal. The IEHP Peer Review Subcommittee shall have the right to inspect and copy (at its own expense) any documentary information relevant to the charges that the Practitioner has in his/her possession or control, as soon as practicable after the Practitioner’s receipt of the IEHP Peer Review Subcommittee’s request for such documents.

This right of discovery and copying does not create or imply an obligation to modify or create documents in order to satisfy a request for information. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable Practitioners, other than the Practitioner under review. Failure to comply with reasonable discovery requests at least ten (10) days prior to the Level II Appeal hearing shall be good cause for a continuance of the Level II Appeal hearing.

2. Limits on Discovery

The Hearing Officer, upon the request of either side, may impose safeguards including, but not necessarily limited to, the denial of a discovery request. The Hearing Officer when ruling upon requests for access to information and determining the relevancy thereof shall, among other factors, consider the
following:

a. Whether the information sought may be introduced to support or defend the charges;

b. Whether the information is “exculpatory” in that it would dispute or cast doubt upon the charges or “inculpatory” in that it would prove or help support the charges and/or recommendation;

c. The burden on the party of producing the requested information; and

d. Other discovery requests the party has previously made or has previously resisted.

H. Pre-Hearing Witness List and Document Exchange

At least (10) working days prior to Level II appeal hearing, the parties shall exchange lists of the names of witnesses expected to be called at the hearing and copies of all documentation expected to be introduced in the evidence at the hearing. A failure to comply with this rule shall be good cause for the hearing officer to grant a continuance. Repeated failures to comply shall be good cause for the hearing officer to limit introduction of any documents or witnesses not provided or disclosed to the other side in a timely manner.

I. Representation

Level II Appeals are provided for the purpose of addressing issues of professional conduct or competence in health care. Practitioner is required to notify IEHP if they intend to be represented by legal counsel. Accordingly, neither the Practitioner nor the peer review body whose decision prompted the hearing may be represented by an attorney at the hearing unless a majority of the JHC members, in their discretion, permit both sides to be so represented. In no case may the IEHP Peer Review Subcommittee be represented by an attorney if the Practitioner is not so represented. The foregoing shall not be deemed to deprive any party of its right to the assistance of an attorney for the purpose of preparing for the hearing. When attorneys are not allowed in the hearing, the Practitioner and the IEHP Peer Review Subcommittee each may be represented at the hearing by a licensed Practitioner who is not an attorney.

J. Failure to Appear

Failure, without good cause, of the Practitioner to appear and proceed at the Level II Appeal shall be deemed to constitute voluntary acceptance of the recommendation or action involved and it shall thereupon become the final action of the IEHP Peer Review Subcommittee.

K. Postponements and Extensions
After a timely request for a hearing has been received as described above, postponements and extensions of time beyond the times expressly permitted in this Level II Appeal Process may be effected upon written agreement of the parties or granted by the hearing officer (or the Chairperson of the JHC if the hearing officer has not been appointed yet) on a showing of good cause and subject to the hearing officer’s discretion to assure that the hearing proceeds and is completed in a reasonably expeditious manner under the circumstances.

L. **Record of the Hearing**

A record of the Level II Appeal shall be produced by using a certified court reporter to record the hearing (an audio tape recording of the proceedings may be made in addition). The Practitioner shall be entitled to receive a copy of the transcript upon paying his or her share of the court reporter’s fees, and the reasonable cost for preparing the transcript. Oral evidence shall be taken under oath administered by the court reporter.

M. **Rights of the Parties**

Both parties shall have the following rights, which shall be exercised in an efficient and expeditious manner and within reasonable limitations imposed by the hearing officer:

1. To be provided with all of the information made available to the JHC;
2. To have a record made of the proceedings as provided herein;
3. To call, examine and cross-examine witnesses;
4. To present and rebut evidence determined by the hearing officer to be relevant; and
5. To submit a written statement at the close of the hearing.

The Practitioner may be called by the IEHP Peer Review Subcommittee’s representative and examined as if under cross-examination. The JHC may interrogate the witnesses, or call additional witnesses, as the JHC deems appropriate. Each party has the right to submit a written statement at the close of the Level II Appeal. The JHC may request such a statement to be filed following the conclusion of the presentation of oral testimony.

N. **Rules of Evidence**

Rules relating to the examination of witnesses and the presentation of evidence in courts of law shall not apply in any hearing conducted herein. Any relevant evidence, including hearsay, shall be admitted by the hearing officer if it is evidence upon which responsible persons are accustomed to rely in the conduct of serious affairs. A Practitioner shall not be permitted to introduce information not produced upon request of the peer review body during the underlying peer review, application, or other credentialing process, unless the Practitioner establishes that the information could not have been produced previously in the exercise of reasonable diligence.
O. **Basis of Recommended Decision**

The recommended decision of the JHC shall be based on, but may not be limited to, the evidence produced at the hearing and any written statements submitted to the JHC.

P. **Burden of Going Forward and Burden of Proof**

In all Level II Appeals, the IEHP Peer Review Subcommittee shall have the burden of initially presenting evidence to support its recommendation, decision or action.

1. If the IEHP Peer Review Subcommittee’s recommendation is to deny initial IEHP affiliation, the Practitioner shall bear the burden of persuading the JHC, by a preponderance of the evidence, that he/she is sufficiently qualified to be awarded such affiliation in accordance with the professional standards of IEHP. This burden requires the production of information that allows for an adequate evaluation and resolution of reasonable doubts concerning the Practitioner’s qualifications, subject to the IEHP Peer Review Subcommittee’s right to object to the production of certain evidence as provided herein. A Practitioner shall not be permitted to introduce information not produced upon request of the peer review body during the application process, unless the initial applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

2. If the IEHP Peer Review Subcommittee’s action involves the termination of existing IEHP participation; or the suspension, reduction or limitation of privileges to perform patient care services, the IEHP Peer Review Subcommittee shall have the burden of persuading the JHC, by a preponderance of the evidence that its action is reasonable and warranted. The term “reasonable and warranted” means within the range of reasonable and warranted alternatives available, and not necessarily that the action is the only measure or the best measure that could be taken in the opinion of the JHC.

Q. **Preparation of Recommended Findings of Fact, Recommended Conclusions of Law and Recommended Decision**

Within a reasonable time after the final adjournment of the Level II Appeal hearing, the JHC shall issue a decision that shall include finding of fact and conclusions of law articulating the connection between the evidence produced at the hearing and the result. A copy shall be sent to the IEHP Chief Medical Officer, the Practitioner involved, and the IEHP Chief Executive Officer. Final action shall be taken by the Peer Review Subcommittee, as provided below.

There shall be no right of further appeal to the Peer Review Subcommittee following a formal Level II Appeal. The Practitioner shall receive a written decision of the Peer Review Subcommittee, including a statement of the basis for the decision, which shall be sent via FedEx. The notice shall contain a statement that there is no right of appeal the final decision of the Peer Review Subcommittee.
R. **Reports**

IEHP shall comply with the reporting requirements of the California Business and Professions Code, the Federal Health Care Quality Improvement Act, the National Practitioner Data Bank (NPDB), and any other applicable law regarding adverse peer review actions.

IEHP shall comply with the reports required by MBOC whenever a peer review body makes a final decision or recommendation regarding the disciplinary action, resulting in a final proposed action to be taken against a licentiate based on the peer review body’s determination, following formal investigation of the licentiate that any of the facts listed below have occurred, regardless of whether a hearing is held pursuant to Section 809.

MBOC requires reports whenever: a licentiate’s application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason; a licentiate’s membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason; restrictions are imposed or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of thirty (30) days or more for any 12-month period, for a medical disciplinary cause or reason; and/or a licentiate’s resignation or leave of absence from membership, staff, or employment following notice of impending investigation based on information indicating medical disciplinary cause or reason.

MBOC requires an 805 report whenever a peer review body makes a final decision or recommendation regarding the disciplinary action, resulting in a final proposed action to be taken against a licentiate based on the peer review body’s determination, following formal investigation of the licentiate that any of the facts listed below have occurred, regardless of whether a hearing is held pursuant to Section 809:

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

1. Actions that are reported to the Medical Board of California, the Dental Board of California, the Osteopathic Medical Board of California, the Board of Podiatric Medicine, the California Board of Behavioral Sciences, the Board of Psychology, and the Physician Assistant Board, and other licensing agencies, and National Practitioners Data Bank (NPDB) as required by law,, as applicable, include a decision to deny or reject a Practitioner’s application for staff privileges or membership for a medical disciplinary cause or reason; a decision to terminate or revoke a Practitioner’s membership, staff privileges or employment for a medical
disciplinary cause or reason; restrictions imposed or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of thirty (30) days or more for any twelve (12) month period, for a medical disciplinary cause or reasons; and/or a Practitioner’s resignation or leave of absence from membership, staff, or employment following notice of impending investigation based on information indicating medical disciplinary cause or reason.

2. An 805.01 will be filed, if a recommendation or final decision based on any of the following:
   a. Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury or to one or more patients in such a manner as to be dangerous or injurious to any person or the public.
   b. The use of, or prescribing for or administering to him/herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, or any other persons, or the public, or to the extent that such impairs the ability of the licentiate to practice safely.
   c. Repeated acts of clearly excessive prescribing, furnishing or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without good faith effort prior examination of the patient and medical reason therefore.
   d. Sexual misconduct with one or more patients during a course of treatment or an examination.

S. Confidentiality

All peer review records and proceedings held pursuant to this procedure shall be confidential and protected to the fullest extent allowed by Section 1157 of the California Evidence Code, and any other applicable State and/or Federal law.

T. Privileges and Immunities

All activities conducted pursuant to this Level II Appeal Process are in reliance on the privileges and immunities afforded by the Federal Health Care Quality Improvement Act (42 USC Section 11101, et seq.) California Business and Professions Code Section 805, et seq. and the California Civil Code Sections 43.7, 43.8 and 47(b)(4) and (c).

U. Severability

This document and the various parts, sections and clauses thereof are hereby declared to be severable. If any part, sentence, paragraph, section or clause is adjudged unconstitutional or invalid, such unconstitutionality or invalidity shall affect only that part, sentence, paragraph, section or clause of this document, or person or entity; and shall not affect or impair any of the remaining provisions, parts, sentences, paragraphs, sections or clauses of this document, or its application to other persons or entities.
V. **Applicability**

This document shall be applicable to all peer review Level II Appeals, and shall be controlling.

W. **Costs of Hearing**

1. The costs associated only with the conduct of the Level II Appeal hearing, excluding the costs listed in subsection 23.b below, shall be divided equally between the Practitioner and IEHP. Such costs shall include, but not be limited to, the costs of the certified shorthand reporter and rental of a hearing room, if applicable.

2. The costs to be divided between the practitioner and the IEHP shall not include the costs, fees, and any other charges associated with legal representation of either party; the cost of the JHC, if any; the costs of discovery; the costs of preparation for the hearing; mileage costs for either party or witnesses; witness fees; or the costs of obtaining copies of the hearing transcripts or tapes. Except for the costs of the hearing officer and JHC, which shall be borne by IEHP, each party shall bear its own costs for these items individually.

X. **Exhaustion of Administrative Remedies**

1. A Practitioner shall be required to exhaust the administrative remedies herein prior to seeking judicial review of the actions of the IEHP Peer Review Subcommittee.